

Department of Health and Human Services



**Office of  
Inspector General**

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**WORK PLAN**  
**FISCAL YEAR 2002**



# Department of Health and Human Services Office of Inspector General

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## *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.

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## *Vision*

*We Are Guardians  
of the Public Trust*

- Working with management, we will ensure effective and efficient HHS programs and operations.
  - Working with decision-makers, we will minimize fraud, waste, and abuse in HHS programs.
  - Working with our talented and motivated staff, we will manifest the highest standards as a Federal OIG.
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## *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 2002*

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### INTRODUCTION

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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) 2002 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 major entities of the Department of Health and Human Services (HHS): the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration), the public health 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 2002. 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 2002.

## **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 use 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 and monitoring of corporate integrity agreements for certain providers that have settled their False Claims Act liability with the Federal Government. It also develops and promotes industry-specific voluntary compliance program guidance. The OCIG 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 anti-kickback statute. Finally, OCIG counsels and represents OIG components on personnel and operations issues, subpoenas, audit and investigative issues, and other legal authorities.

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### **Internet Address**

*The FY 2002 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>

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**Department of Health and Human Services**

**Office of  
Inspector General**



**WORK PLAN FOR FISCAL YEAR 2002**

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## MEDICARE HOSPITALS

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### **Medicare Payment Error Prevention Program**

We will assess the progress of the Medicare peer review organizations' Payment Error Prevention Program in reducing hospital payment errors. This \$148 million program began in August 1999 with a State-by-State surveillance system, including an aggregate sample of about 60,000 medical review cases. We will use these data, along with interviews with various beneficiary and provider organizations, to identify the nature of payment errors, the actions taken by peer review organizations, and the extent of recoupment by fiscal intermediaries.

*OEI; 00-00-00000*

### **Medical Education Payments**

This series of reviews will evaluate the efficiency of controls over Medicare payments for medical education. We will visit fiscal intermediaries and providers to determine the validity of claims for these payments. Our pilot review at one large hospital disclosed problems in computing full-time equivalents for interns and residents.

*OAS; W-00-01-30010; A-04-01-01002*

### **Hospital Privileging Activities**

We will review the nature and extent of hospital privileging activities within the context of Medicare conditions of participation. One of the most fundamental internal safeguards in hospitals is the routine practice of granting initial or renewed privileges to physicians. Hospital privileging is the process by which a hospital determines the scope of allowable practice for each physician within that hospital. It occurs at the onset of a physician's relationship with a hospital and on some recurring basis thereafter.

*OEI; 00-00-00000*

### **One-Day Hospital Stays**

We will evaluate controls designed to ensure 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 controls to detect and deny

inappropriate payments for 1-day stays and the Centers for Medicare and Medicaid Services (CMS) program integrity studies in this area.

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

### **Hospital Discharges and Subsequent Readmissions**

This series of reviews will examine Medicare claims for beneficiaries who were discharged and subsequently readmitted relatively soon to the same or another acute care prospective payment system hospital. We will review procedures at selected hospitals, fiscal intermediaries, and peer review organizations for these time-related admissions. With the assistance of CMS medical review resources, we plan to 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 diagnosis- and/or time-related admissions.

*OAS; W-00-00-30010; A-14-00-00430, -03-01-00011*

### **Consecutive Inpatient Stays**

We will examine the extent to which Medicare beneficiaries receive acute and postacute care through sequential stays in different providers. Medicare allows care in different facilities according to each beneficiary's needs; however, inpatient services may be denied, based on peer review organization review, for patients admitted unnecessarily for one stay or multiple stays. As part of our review, we will assess CMS instructions for identifying and evaluating consecutive beneficiary stays, including those in skilled nursing facilities, long-term-care hospitals, and prospective payment system-exempt units.

*OEI; 03-01-00430*

### **Payments to Acute Care Prospective Payment System Hospitals**

This update will examine diagnosis-related groups that have a history of abusive coding to determine whether some prospective payment system hospitals continue to exhibit aberrant coding patterns. Our study will incorporate the results of a recent review by the Payment Error Prevention Program on diagnosis-related groups with significant patterns of coding errors.

*OEI; 00-00-00000*

## **Implementation of Critical Access Hospital Program**

We will examine the implementation of the critical access hospital program. This program allows certain small, limited-service hospitals to receive Medicare reimbursement for acute care on a cost basis rather than a prospective payment basis. We will assess the approved State plans for compliance with statutory provisions and CMS regulations. We will also characterize utilization in these new Medicare providers, including the length of stays and geographic locations of beneficiaries who use them.

*OEI; 00-00-00000*

## **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 CMS 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 During Hospital Mergers**

We will determine the extent to which 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.

*OAS; W-00-98-30010; A-06-00-00044*

## **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 applies to certain diagnosis-related

groups. Our prior reviews indicated that a lack of controls had resulted in significant overpayments.

*OAS; W-00-00-30010; A-04-00-01220, -02162*

### **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, W-00-01-30010; Various CINs*

### **Periodic Interim Payments**

This review will evaluate the need for some hospitals to continue to receive periodic interim payments. These payments are based on historical data, rather than the number and diagnoses of current Medicare patients. At the close of a hospital’s cost reporting period, the payments are reconciled with the actual claim volume processed by the hospital. According to CMS records, approximately 1,000 hospitals receive periodic interim payments.

*OAS; W-00-01-30010; A-07-01-02616*

### **Uncollected Beneficiary Deductibles and Coinsurance**

We will continue a series of reviews addressing the reasonableness of Medicare payments to inpatient and outpatient 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, -06010, -14-00-00445*

### **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. 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 current 72-hour diagnosis-related group payment window are not allowed whether the claims are submitted by hospital providers or by Part B providers.

*OAS; W-00-01-30010; A-01-01-00502*

### **Expansion of Diagnosis-Related Group Payment Window**

We will determine the extent of preadmission services rendered outside the current 72-hour diagnosis-related group payment window and the amount of savings that can be achieved by expanding the payment window. In a 1994 report, we identified \$91.8 million of nonphysician outpatient services rendered 4 to 7 days before the day of admission. Our analysis indicated that \$77.2 million, or 84 percent, of these services either were scheduled before the admission or resulted in inpatient admissions. The CMS's longstanding policy is to treat nonphysician outpatient services related to an admission as inpatient services. Our previous review found that the industry practice is to provide preadmission services beyond the current 72-hour payment window.

*OAS; W-00-02-30010; A-01-02-00000*

### **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 CMS'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*

### **Reporting of Restraint and Seclusion Use in Psychiatric Hospitals**

This followup study will evaluate the extent of mandatory State reporting of restraint and seclusion use, document how States use the reported information, and identify how reporting affects restraint and seclusion usage. The extent to which restraints and seclusion are used in psychiatric hospitals is unknown nationally, since reporting and monitoring are inconsistent and are often hospital- or case-specific or limited to only State public psychiatric hospitals. Recently enacted Medicare conditions of participation for psychiatric hospitals require only reporting on restraints and seclusion that led to a death.

*OEI; 00-00-00000*

## **Outpatient Prospective Payment System**

We will continue to review the 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-00-00-30026; A-03-01-00013, -06-00-00045*

## **Outlier Payments Under Outpatient Prospective Payment System**

We will determine the appropriateness of outlier payments under the outpatient prospective payment system and identify any outlier payments paid in error. Significant overpayments can result if providers submit claims with clerical errors that result in overstated charges for services.

*OAS; W-00-02-30026; A-01-02-00000*

## **Outpatient Services on Same Day as Discharge and Readmission**

We plan to review outpatient services provided on the same day that a beneficiary was discharged and readmitted to the same prospective payment system hospital. Our previous review identified Medicare claims for beneficiaries who were discharged and subsequently readmitted on the same day to the same acute care prospective payment system hospital. This review will determine (1) whether beneficiaries were discharged from a prospective payment system hospital, transported to another prospective payment system hospital for outpatient services, and readmitted to the first hospital on the same day and (2) the appropriateness of Medicare reimbursement for the outpatient services.

*OAS; W-00-02-30026; A-01-02-00000*

## **Outpatient Pharmacy Services at Acute Care Hospitals**

Our review will determine the effectiveness of controls over pharmacy services rendered on an outpatient basis. With certain exceptions, Medicare Part B does not cover self-administered drugs. Our work indicates that some hospitals 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; Various CINs*

## **Outpatient Medical Supplies at Acute Care Hospitals**

This review will assess the effectiveness of controls intended to ensure that medical supply services rendered on an outpatient basis are billed and reimbursed in accordance with Medicare requirements. Our work indicates that some hospitals 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-01-01-00501, -00503, -00509*

## **Procedure Coding of Outpatient and Physician Services**

We plan to review the procedure coding of outpatient services billed by a hospital and a physician for the same service. In a previous review, we identified a 23-percent nationwide rate of inconsistency between hospital outpatient department procedure coding and physician procedure coding for the same outpatient service. This review will determine whether these coding differences continue and, if so, how they affect the Medicare program.

*OAS; W-00-02-30026; A-01-02-00000*

## **Peer Review Organization Sanction Authority**

This study will determine the types of providers and types of violations for which peer review organizations bear responsibility for sanction referral. We will also examine program performance and any reasons for changes over time, and we will look at other Medicare contractors that hold similar responsibilities.

*OEI; 00-00-00000*

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## **HOME HEALTH**

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### **Oversight of Home Health Care Quality**

This study will assess the overall capacity of systems designed to monitor the quality of Medicare home health care, particularly the State survey and certification program. All home health agencies participating in Medicare must be surveyed by the State in order to be certified as meeting Federal requirements. We will follow up on a recent OIG report which raised concerns about the infrequency of home health surveys and noted inconsistencies among State survey protocols.

*OEI; 00-00-00000*

## **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 to both 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*

## **Home Health 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, as well as controls over advance payments to providers. We will also determine whether payments are appropriately 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-00-01-30009; Various CINs*

## **Coding of Home Health Resource Groups**

This review will determine whether home health agencies classified their patients in the appropriate case-mix category. Under the prospective payment system, home health agency payments are based on a 60-day episode and are case-mix- and wage-adjusted. The case mix is based on data elements from the patient's medical assessment that incorporates the Outcomes and Assessment Information Set and the projected number of therapy hours. We will assess whether home health agencies received higher payments than warranted due to miscoding.

*OEI; 00-00-00000*

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## NURSING HOME CARE

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### **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 composed 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 CMS 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. This review is one of a series on the quality of care in nursing homes.

*OEI; 01-01-00090*

### **Nurse Aide Training**

We will determine whether the Omnibus Budget Reconciliation Act of 1987 nurse aide training requirements are followed. The act requires that each nurse aide 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; 05-01-00030*

### **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 CMS 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*

### **Three-Day Stay Requirement**

We will follow up on the CMS response to the findings and recommendations of our prior review of patient eligibility for care in skilled nursing facilities. We found that some Medicare patients were not eligible for such care because they had not received sufficient hospital/nursing home care before the skilled nursing care.

*OAS; W-00-02-30014; A-05-02-00000*

*Expected Issue Date: FY 2003*

### **Consolidated Billing Requirements**

We will monitor CMS's efforts to determine the extent of overpayments during Calendar Year 2000 for certain 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 Medicare contractors made millions of dollars of separate Part B overpayments 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. We will also monitor the success of CMS's collection of previously identified overpayments.

*OAS; W-00-00-30014; A-01-00-00538, -01-01-00528*

### **Survey and Certification Process**

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, CMS has taken a number of steps to strengthen survey and enforcement efforts. We will evaluate these nursing home initiatives.

*OEI; 00-00-00000*

### **Use of Penalties**

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, CMS

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*

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## **HOSPICE CARE**

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### **Plans of Care**

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 Homes**

We will examine the financial implications of Medicare hospice payments made on behalf of patients residing in nursing facilities. Our previous work found that 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; 05-01-00170*

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## **PHYSICIANS**

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### **Beneficiary Access to Preventive Services**

This study will evaluate beneficiaries' access to the expanded preventive services offered by Medicare since the passage of the Balanced Budget Act of 1997. The act created four classes of covered preventive services: annual screening mammography for all women aged 40 and

over; screening pap smear and pelvic exams every 3 years; colorectal screening; and bone mass measurements to identify bone mass, detect bone loss, or determine bone quality.

*OEI; 00-00-00000*

### **Advance Beneficiary Notices**

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*

### **Physicians at Teaching Hospitals**

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-00-02-30021; A-03-02-00000*

*Expected Issue Date: No Report*

### **Billing for Residents' Services**

We will determine whether hospitals have properly used residents' physician identification numbers to bill Medicare. Medicare regulations allow residents, who are licensed physicians, to be issued physician identification numbers for purposes of billing Medicare for their services. However, residents may bill Medicare only when they are "moonlighting," which is defined as providing medical treatment, other than in their field of study, in an outpatient clinic or an emergency room.

*OAS; W-00-02-30021; A-00-02-00000*

*Expected Issue Date: FY 2003*



## **Physician Evaluation and Management Codes**

We will determine whether physicians correctly coded evaluation and management services in physician offices and effectively used documentation guidelines. We will also assess whether carriers identified any instances of incorrect coding and what corrective actions they took. Medicare payments for evaluation and management codes total approximately \$18 billion per year and account for almost half of Medicare spending for physician services. Since 1992, Medicare has used visit codes developed by the American Medical Association to reimburse physicians for evaluation and management services. Generally, the codes represent the type and complexity of services provided and the patient status, such as new or established. Revised guidelines were issued in the 1995 and again in 1997. Following the issuance of the 1997 guidelines, providers were told that they could use either the 1995 guidelines or the 1997 guidelines. Revised guidelines are again under development.

*OEI; 00-00-00000*

## **Consultations**

This study will determine the appropriateness of billings for physician consultation services and the financial impact on the Medicare program from any inaccurate billings. In addition, we will determine the primary reasons for any inappropriate billings. In 2000, total allowed charges to Medicare for consultations were \$2 billion.

*OEI; 00-00-00000*

## **Inpatient Dialysis Services**

This review will determine whether Medicare payments for inpatient dialysis services met the billing requirements of Medicare Part B. The Medicare Carrier Manual requires that the physician be physically present with the patient at some time during the dialysis and that the medical records document this in order for the physician to be paid on the basis of dialysis procedure codes. If the physician visits the dialysis inpatient on a dialysis day, but not during the dialysis treatment, physician services are billable under the appropriate hospital visit codes. Fee schedule amounts for inpatient dialysis codes are higher than those for hospital visit codes.

*OAS: W-00-01-30021; A-09-01-00068*

## **Bone Density Screening**

We will evaluate the impact of the recent standardization and expansion of Medicare coverage of bone density screening. Bone mineral density studies 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*

### **Services and Supplies Incident to Physicians' Services**

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*

### **Reassignment of Benefits**

We will examine the use of staffing companies and how this practice affects emergency room physicians. We will also identify any vulnerabilities in relation to Medicare reassignment rules. Hospitals commonly contract with billing and staffing companies to handle administrative functions. Over 50 percent of the hospitals in the United States use practice management or staffing companies to administer the daily operation and coverage of emergency room departments. Under these arrangements, emergency room physicians work for the staffing companies as either employees or independent contractors. These physicians may reassign their Medicare benefits only if they are employees of the staffing company.

*OEI; 04-01-00080*

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## **MEDICAL EQUIPMENT AND SUPPLIES**

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### **Medical Necessity of Durable Medical Equipment**

We will determine the appropriateness of Medicare payments for certain items of durable medical equipment, including wheelchairs, support surfaces, and therapeutic footwear. We will assess whether the suppliers' documentation supports the claim, whether the item was medically necessary, and whether the beneficiary actually received the item.

*OEI; 00-00-00000*

## **Medicare Pricing of Equipment and Supplies**

We will compare Medicare payment rates for certain medical equipment and supplies with the rates of other Federal and State health programs, as well as with wholesale and retail prices. Our review will cover manual wheelchairs, support surfaces, blood glucose test strips, diabetic supplies, and parenteral and enteral nutrition.

*OEI; 00-00-00000*

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## **LABORATORY SERVICES**

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### **Clinical Laboratory Improvement Amendments Certifications**

We will determine whether laboratories conduct tests and bill 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 Testing**

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 Testing**

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*

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## **END STAGE RENAL DISEASE**

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### **Utilization Service Patterns of Beneficiaries**

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®**

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. Subsequently, the rate was reduced by statute 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-00-02-30025; A-01-02-00000*

### **Method II Billing**

We will assess method II billing for end stage renal disease services for program vulnerabilities, the adequacy of CMS 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*

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## **DRUG REIMBURSEMENT**

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### **Medicare Coverage of Prescription Drugs**

We will assess whether prescription drugs paid for by Medicare met coverage requirements and determine the extent to which drug coverage decisions varied among Medicare carriers. Medicare does not pay for over-the-counter or most outpatient prescription drugs. However, under specific circumstances, Medicare Part B covers drugs used with durable medical equipment or infusion devices. Medicare also covers certain drugs used in association with organ transplantation, dialysis, chemotherapy, and pain management for cancer treatment. Additionally, the program covers certain vaccines, such as those for influenza and hepatitis B.

*OEI; 00-00-00000*

### **Drug Prices Paid by Medicare Versus Other Sources**

This study will compare Medicare reimbursement for prescription drugs with costs incurred by the Department of Veterans Affairs, the physician/supplier community, and Medicaid. Although Medicare does not pay for most outpatient prescription drugs, Medicare Part B covers certain prescription drugs under specific circumstances. Medicare and its beneficiaries paid \$3.9 billion for prescription drugs in 1999. Previous OIG reports showed that Medicare reimbursed for prescription drugs at significantly higher prices than those available to the Department of Veterans Affairs, Medicaid, and the physician/supplier community.

*OEI; 00-00-00000*

### **Medicare Billings for Nebulizer Drugs**

This study will determine whether Medicare payments for inhalation drugs are appropriate and whether the drugs are priced appropriately. Medicare covers prescription inhalation drugs used with nebulizers if the nebulizer provides effective therapy for a beneficiary's respiratory illness. Allowances for inhalation drugs have increased steadily, from more than \$332 million in 1995 to over \$540 million in 1999. We will determine whether suppliers' documentation supports their claims and whether the claims are medically necessary. In addition, we will compare Medicare fee schedules for inhalation drugs with other sources, such as third-party coverage available to beneficiaries and prices paid by other Federal insurers.

*OEI; 00-00-00000*

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## OTHER MEDICARE SERVICES

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### **Beneficiaries' Experiences With Medigap Insurance**

This study will examine 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, such as affordability and available pricing and premium information.

*OEI; 00-00-00000*

### **Rural Health Clinics**

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 CMS could take to improve the functioning and oversight of this program.

*OEI; 00-00-00000*

### **Medicare Payments for Clinical Trials**

This study will determine whether Medicare payments associated with clinical trials were made in accordance with program requirements. We will also assess program safeguards related to clinical trial claim processing requirements. Clinical trials are research studies designed to evaluate the safety and effectiveness of medical care. They are key to understanding the appropriate use of medical interventions of all types and informing payers about what services to cover. Beginning in September 2000, Medicare began paying for items and services related to clinical trials. Payment now includes costs associated with items and services that Medicare would otherwise cover if they were not provided in the context of a clinical trial. Also covered are items and services required "solely for the provision of the investigational item or service," as well as monitoring and evaluation, device implantation, and other costs, such as room and board during a hospital stay required as part of a clinical trial. Medicare does not pay for the investigational intervention being tested in a trial.

*OEI; 00-00-00000*

## **Medicare Mental Health National Error Rate**

We will develop a national payment error rate for Medicare fee-for-service mental health claims. Medicare paid approximately \$4.85 billion in 1999 for services related to mental health. Hospital inpatient services amount to almost three-quarters of the total, while physicians, skilled nursing facilities, home health agencies, and community mental health centers account for lesser amounts. We will conduct medical reviews of a sample of claims to determine medical necessity, coding accuracy, coverage, and (for inpatient services) setting of care.

*OEI; 00-00-00000*

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## **MEDICARE MANAGED CARE**

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### **Adjusted Community Rate Proposals**

We will examine the trend factors used by managed care organizations (MCOs) to price their medical package of benefits over a several-year period. Through adjusted community rate proposals, MCOs present to CMS their estimate of funds needed to cover the costs of providing a Medicare package of covered services to an enrolled Medicare beneficiary. The proposals serve as a payment safeguard, requiring plans to demonstrate that the money received from Medicare is used to provide services to Medicare beneficiaries, and are used to verify compliance with the Medicare statute regarding required benefits and cost-sharing provisions. A plan's ability to accurately project its costs in an upcoming contract year affects its participation in the Medicare managed care program. We will also review the impact of changes to adjusted community rate proposals brought about by the Benefits Improvement and Protection Act of 2000.

*OAS; W-00-02-30012; Various CINs*

### **General and Administrative Costs**

This review, expected to be completed early in FY 2002, 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. Initiated at the request of the prior CMS administration, the review will include several MCOs located throughout the United States.

We will also review MCOs' increased use of management fees and their impact on additional benefits and the pricing of a plan's medical package.

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

### **Cost-Based Managed Care Plans**

At CMS'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 CMS currently contracts with more than 30 of these plans, which provide services to more than 300,000 members. The plans file cost reports with CMS 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. Our review will also determine whether cost-based plans received any duplicate payments through the fee-for-service program. We will coordinate our review with CMS and its contractors.

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

### **Enhanced Managed Care Payments**

We will complete several reviews to determine whether CMS made proper enhanced capitation payments to MCOs. Medicare provides enhanced capitation payments for beneficiaries who are institutionalized, in end stage renal disease status, or dually eligible for Medicare and Medicaid. Our reviews are focused on the accuracy of controls at both CMS and the MCOs regarding special status categories warranting these enhanced payments.

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

### **Managed Care Organization Profits**

This review will compare the profitability of the Medicare line of business with operating results from MCOs' other lines of business. Under the terms of a Medicare risk-based contract, an MCO 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 evaluate whether Medicare funding is adequate, how profits affect the benefit package, and whether CMS needs to establish criteria on the profitability of Medicare risk-based MCOs.

*OAS; W-00-02-30012; A-14-02-00000*



## **Managed Care Additional Benefits**

This review will analyze the cost to Medicare MCOs for providing additional benefits to beneficiaries and determine the extent to which beneficiaries receive such benefits. Additional benefits, which are provided to beneficiaries as part of their basic Medicare benefit package, vary among MCOs. Our review will also determine whether the value of additional benefits, as presented in adjusted community rate proposals, is consistent with the benefits actually provided.

*OAS; W-00-02-30012; A-14-02-00000, -06-00-00073*

## **Educating Beneficiaries About Medicare+Choice**

We will evaluate the adequacy of CMS's most recent initiatives to educate beneficiaries about Medicare+Choice. As part of this review, we will assess the ease of obtaining program information, the various methods of education, and beneficiaries' understanding of the program.

*OEI; 00-00-00000*

## **Physician Perspectives on Managed Care Organizations**

This followup study will determine whether the experiences and perspectives of physicians who work with Medicare+Choice MCOs have changed since our May 1998 report. That study found that overall satisfaction with Medicare MCOs was low. Forty-three percent of physicians who contracted with Medicare MCOs said that they were very or somewhat dissatisfied, compared with 18 percent who said that they were somewhat or very satisfied. These physicians had numerous concerns relating to the MCO referral process, clinical independence, patient access to care, the complaint and appeal system, quality assurance efforts, and MCO marketing practices.

*OEI; 00-00-00000*

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## **MEDICAID HOSPITALS**

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### **Medicaid Graduate Medical Education Payments**

This review will examine Medicaid graduate medical education (GME) payment programs, the coordination of these payments with Medicare GME payments, and the existence and effectiveness of CMS safeguards and controls over the payment process. Although Medicaid GME payments are not specifically authorized by Medicaid statute, CMS has approved a wide

range of payment arrangements through the State plan amendment process and 1115 waivers. Annual payments by State Medicaid programs for GME are estimated to total over \$3 billion.

*OAS; W-00-02-30013; A-00-02-00000*

### **Hospital-Specific Disproportionate Share Payment Limits**

At CMS'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 FYs beginning in 1994 and 1995 for public and private hospitals, respectively. The CMS 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; Various CINs*

### **Medicaid Hospital Patient Transfers**

This review will examine the propriety of Medicaid claims for hospital patient transfers in States that use prospective payment principles in reimbursing hospitals for inpatient admissions. In these States, the payment policy stipulates that when a 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. This review is an extension of a previous Medicare review that identified significant overpayments as a result of incorrectly reported transfers.

*OAS; W-00-02-30013; Various CINs*

### **Outpatient Clinical Diagnostic Laboratory Services Under Ambulatory Procedure Group Systems**

A nationwide review will determine the appropriateness of Medicaid payments to hospitals for outpatient clinical diagnostic laboratory services in States that use an ambulatory procedure group payment methodology. Specifically, we will determine whether Medicaid payments for certain laboratory and pathology tests exceeded rates allowed by Medicare. An analysis of

claim data found that one State paid hospitals substantially more than Medicare's allowable fee schedule for laboratory services.

*OAS; W-00-02-30027; A-01-02-00000*

### **Credit Balances in Inpatient Accounts**

This national review will determine whether credit balances in Medicaid beneficiary inpatient accounts at hospitals are identified and returned to the appropriate State agencies. We will build upon recent work in one State and prior reviews performed in the early 1990s.

*OAS; W-00-02-30013; A-05-02-00000*

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## **MEDICAID MANAGED CARE**

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### **Marketing and Enrollment Practices**

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*

### **Public-Sponsored Managed Care Health Plans**

This review of the funding arrangements between States and public-sponsored health plans will determine to what extent intergovernmental transfers or other financing mechanisms are used to maximize Federal Medicaid reimbursement. States are developing managed care programs for special populations (e.g., mentally ill and developmentally disabled people) by contracting exclusively with public-sponsored health plans.

*OAS; W-00-02-30013; A-00-02-00000*

### **Managed Care Payments as Part of the Fee-for-Service Upper Payment Limit Calculation**

We will determine whether States have expanded their Medicaid upper payment limit financing arrangements by applying fee-for-service upper payment limits to managed care

payments. Traditional Medicaid fee-for-service payments and Medicaid managed care payments are subject to separate upper payment limits. If a State pays an MCO to assume the risk of caring for Medicaid patients, the payments and beneficiary days should not be included in calculating enhanced payments available under the fee-for-service upper payment limit regulations.

*OAS; W-00-02-30013; A-00-02-00000*

### **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 to which 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*

### **Pharmacy Benefit Managers**

We will determine the number and experiences of States that contract with pharmacy benefit managers and the extent and effectiveness of CMS and State oversight. Pharmacy benefit managers have emerged as significant players who can help payers and health plans control rising drug costs and improve drug-related services. Our 1995 report indicated that the use of pharmacy benefit managers by Medicare and Medicaid MCOs yielded significant cost savings; however, the MCOs provided minimal oversight of the managers' performance. In 1998, Medicaid paid almost \$14 billion for prescription drugs.

*OEI; 00-00-00000*

### **HIV/AIDS Antiretroviral Drug Therapy**

We will evaluate the relationship between Medicaid MCOs and HIV/AIDS antiretroviral drug therapy coverage and payment. The Balanced Budget Act of 1997 authorized States to require that Medicaid beneficiaries enroll in MCOs. States may opt to exclude HIV/AIDS drug coverage from the MCO contract, in which case Medicaid pays for the drugs on the traditional fee-for-service basis. This study will evaluate the variations among the States' practices and policies on payment for antiretroviral therapy and the impact of MCO payment systems on access to appropriate services for AIDS patients.

*OEI; 00-00-00000*

## **Cost Containment of Medicaid Mental Health Drugs**

We will compare the amounts that Medicaid reimburses for mental health drugs with the prices paid by other Government purchasers. The rising cost of mental health pharmaceuticals presents a budgetary challenge to State Medicaid programs. Although many States have mandatory managed care plans in place for the mentally ill, States typically exclude coverage of prescription mental health drugs from their managed care contracts because of the difficulties in accurately setting capitation rates for those benefits. Therefore, most beneficiaries receive their prescription drugs through Medicaid's traditional fee-for-service system. We will survey States to identify the most-prescribed mental health drugs and to determine whether Medicaid is paying appropriate prices for these drugs.

*OEI; 00-00-00000*

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## **MEDICAID/STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

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### **Adolescent Enrollment in Medicaid/State Children's Health Insurance Program**

We will examine how States manage Medicaid and State Children's Health Insurance Program (SCHIP) outreach and enrollment procedures to reach eligible adolescents. We will also highlight approaches that appear to enhance this population's access to these programs. Medicaid has extended eligibility to 19 years of age for children born after September 30, 1983, who are living at or below 100 percent of the poverty level. Under SCHIP, States also have the option to provide coverage to all children or a focused segment of children who are not eligible for Medicaid, under age 19, and at or below 200 percent of the Federal poverty level. Despite the opportunities offered by the Medicaid expansion and SCHIP, an American Academy of Pediatrics study issued in 1999 projected that in 2000 nearly 2.4 million, or one in six, adolescents aged 13 through 18 would be eligible for but not enrolled in Medicaid or SCHIP. This population has a higher rate of uninsurance than most age groups in the United States.

*OEI; 00-00-00000*

### **Educating Families of Children Newly Enrolled in Medicaid Managed Care**

We will determine whether materials provided by State MCOs adequately inform the families of newly enrolled children in Medicaid and Medicaid expansion programs of (1) the benefits available and (2) the system in place for accessing the services. In addition, we will determine how well States monitor beneficiaries' actual use of services. The CMS reported that as of December 1999, 54.5 percent of the Medicaid-eligible population was served through managed care systems, compared with 23.2 percent in 1994. Providing clear and

comprehensive information to new enrollees will facilitate their entry into the health system, while not offering such information may affect their access to services and possibly impinge on their patient rights.

*OEI; 00-00-00000*

### **Disenrollment From State Children's Health Insurance Program**

We will describe the current levels of SCHIP 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 CMS anticipated. Measuring the extent of disenrollment is problematic because States have different ways of capturing and reporting these data.

*OEI; 06-01-00370*

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## **OTHER MEDICAID SERVICES**

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### **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 CMS 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 CMS'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 MCOs. These organizations are required to provide all Medicare-covered services in exchange for the capitation payments they receive. Most MCOs 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 MCO.

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

### **Upper Payment Limit Calculations**

We will determine whether State Medicaid agencies correctly calculated Medicare upper payment limits. States have the flexibility to pay different rates to the same class of providers (such as hospitals or nursing facilities) as long as the payments, in aggregate, do not exceed the upper payment limits (what Medicare would have paid for the services). The aggregate limit applies separately to each type of facility in the State (private, State operated, and city/county operated). Federal funds are not available for expenditures that exceed the aggregate limits.

*OAS; W-00-02-30013; A-00-02-00000*

### **Intergovernmental Transfers**

We will analyze the extent to which States use intergovernmental transfers as a means of increasing Federal Medicaid matching funds. Our prior work involving upper payment limits and disproportionate share hospital payments showed, in some cases, that public providers returned Medicaid funds to State agencies through the use of intergovernmental transfers. Once returned, the funds could be used for purposes unrelated to the Medicaid program. We will determine whether Federal Medicaid payments other than those available under upper

payment limits and disproportionate share hospital payments were returned to States through intergovernmental transfers.

*OAS; W-00-02-30013; A-00-02-00000*

### **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-00-02-30013; A-06-02-00000*

### **Medicaid Services for the Severely Mentally Ill**

We will review how CMS uses Medicaid home- and community-based services waivers to implement provisions of the U.S. Supreme Court’s Olmstead decision. The decision requires States to provide community-based, integrated services and treatment for people with mental and other disabilities when treatment professionals determine that such treatment is appropriate. According to recent CMS guidance, States may meet these requirements by using Medicaid waiver funds to pay for creative case management, accessibility evaluations, home modifications, and rehabilitation services. This study will focus on the role that the Medicaid program can play in providing integrated, community-based treatment for people with serious mental illness.

*OEI; 00-00-00000*

### **Medicaid Benefits for the Homeless Mentally Ill**

We will review States’ activities to reduce barriers to accessing Medicaid for the homeless mentally ill and follow up on our recommendations that CMS expand access to Medicaid for the homeless. Recent research shows that barriers to access still appear to present a problem for the homeless, especially the homeless mentally ill. This study will determine whether State and local Medicaid enrollment policies and procedures are responsive to the needs of the homeless mentally ill and whether CMS has made any progress in increasing access to Medicaid for eligible homeless people.

*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*

## **Payments for Inmates of Public Institutions**

We will evaluate the extent to which States use Federal Medicaid funds to pay for health care services provided to inmates and the nature of those payments. Our work involving DSH payments has shown that several States include the cost of providing health services to inmates in the calculation of uncompensated care costs. We will examine current CMS policy regarding the appropriateness of both Federal financial participation and DSH payments for health care services provided to inmates.

*OAS; W-00-00-30013; A-14-00-04001*

## **Restraints and Seclusion in Residential Treatment Centers**

We will evaluate compliance with CMS standards for restraints and seclusion at residential treatment facilities (nonhospital settings) for children and youth. In January 2001, CMS issued a new condition of participation requiring psychiatric residential treatment facilities for individuals under age 21 to establish standards on using restraints or seclusion that protect the health and safety of residents. The new condition provides for the use of restraints or seclusion only in emergency situations to ensure the safety of the resident or others and only until the emergency situation ends. The new condition also prohibits the simultaneous use of restraints and seclusion and requires a facility to inform both the resident and, in the case of a minor, his or her parent(s) or guardian(s) of its policy regarding the use of restraints or seclusion. This study will look at States' policies and procedures for complying with the new condition of participation.

*OEI; 00-00-00000*

## **Discharge Planning: Intermediate Care Facilities/Institutions for the Mentally Retarded**

We will evaluate compliance by intermediate care facilities/institutions for the mentally retarded (ICF/MR) with CMS discharge planning requirements. Currently, about 110,000 developmentally disabled individuals reside in about 6,700 ICF/MRs. Individuals can be transferred or discharged from the facilities for a variety of reasons, such as when the facility can no longer meet the individual's needs, the individual no longer requires an active treatment program in an ICF/MR setting, the individual chooses to reside elsewhere, or another level of service or living situation would be more beneficial. The CMS regulatory guidance on discharge planning includes specific actions that a facility must take, including providing a postdischarge plan of care.

*OEI; 00-00-00000*

## **Durable Medical Equipment Reimbursement Rates**

This review will determine the extent to which Medicaid payments for durable medical equipment (DME) 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 that exceed 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*

## **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*

## **Average Wholesale Drug Prices Reported to Medicaid**

We will compare the average wholesale prices reported to Medicaid by First Databank with actual acquisition costs for providers and the Department of Veterans Affairs. All 50 States and the District of Columbia offer prescription drug coverage for Medicaid recipients. Medicaid payments for prescription drugs totaled almost \$14 billion in 1998, accounting for nearly 10 percent of all Medicaid expenditures. Most State Medicaid agencies reimburse pharmacies based on the average wholesale price of a drug less a discount ranging from 4 to 15 percent. Previous OIG reports showed that reported average wholesale prices were significantly higher than the actual prices available to the physician/supplier community and the Department of Veterans Affairs. This study will examine State Medicaid agencies' use of revised average wholesale prices.

*OEI; 03-00-00010*

## **Medicaid Outpatient Prescription Drug Pricing**

At CMS'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., change the 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*

## **Medicaid Rebates for Physician-Administered Drugs**

We will determine whether State Medicaid agencies received rebates for physician-administered drugs. All 50 States and the District of Columbia offer prescription drug coverage for Medicaid recipients. For most drugs, Medicaid uses national drug codes to identify and reimburse for covered drugs. Each drug manufactured or distributed in the United States has a unique code. However, certain injectable and infusion drugs administered by medical professionals are often billed to the Medicaid program on a Medicare claim form and identified using the CMS Common Procedure Coding System rather than national drug codes. Because rebates are based on these product-specific codes, States may not receive rebates for drugs billed via the Common Procedure Coding System.

*OEI; 00-00-00000*

## **Collection of Medicaid Drug Rebates**

We will examine current rebates being collected for Medicaid drugs. To be eligible for Medicaid reimbursement, drug manufacturers are required by Federal law to enter into rebate agreements with Medicaid. Certain products, such as vaccines, are statutorily exempt from rebates. Previous OIG work identified a number of drugs for which there was no rebate amount listed in the CMS Medicaid Drug Rebate Initiative system, yet these drugs did not appear to meet the statutory exemptions. Without a rebate amount, States cannot collect rebates for these drugs. We will identify the dollars lost due to the missing information.

*OEI; 00-00-00000*

## **Medicaid Coverage for the Poor Working Disabled**

We will identify barriers to ensuring continuity of health coverage and increased employment levels among disabled Supplemental Security Income (SSI) recipients. People with disabilities indicate that fear of losing Medicaid coverage is a significant barrier to employment. Those receiving SSI benefits lose SSI eligibility if earned income exceeds \$700 a month (i.e., they are no longer considered disabled). Loss of SSI eligibility means loss of Medicaid eligibility. However, SSI recipients may work off their cash assistance while retaining Medicaid coverage. According to Social Security Administration data, rates of participation in this benefit vary considerably across and within States.

*OEI; 00-00-00000*

## **School-Based Health Services**

We will determine whether Medicaid payments for school-based health services were made in accordance with applicable laws and regulations. States are permitted to use their Medicaid programs to help pay for certain health care services delivered to children in schools, such as physical and speech therapy. Schools may also receive Medicaid reimbursement for the costs of administrative activities, such as Medicaid outreach, application assistance, and coordination and monitoring of health services.

*OAS; W-00-02-30013; A-00-02-00000*

## **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*

## **Escheated Warrants**

This review will determine whether Medicaid payments were properly reported and promptly credited to the Federal program for uncashed or canceled checks, known as escheated warrants. Federal regulations require States to refund the Federal share of uncashed or canceled checks received. Also, at the end of each calendar quarter, States must identify those checks that remain uncashed beyond 180 days after issuance. Previous reviews found that States did not always report warrants timely or properly to ensure that monies were returned to the Federal Government.

*OAS; W-00-02-30013; Various CINs*

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# **MEDICARE CONTRACTOR OPERATIONS**

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## **CMS Oversight of Contractor Evaluations**

This study will evaluate CMS oversight of the Contractor Performance Evaluation process, which is intended to monitor contractor performance. We will review contractor evaluation findings and recommendations, as well as carrier corrective actions. We will also determine

whether the evaluation process is an effective mechanism for monitoring contractor performance.

*OEI; 00-00-00000*

### **Program Safeguard Contractors**

This study will determine whether program safeguard contractors are meeting their intended objectives and are performing in accordance with their contracts. The Medicare Integrity Program was established, in part, to strengthen CMS's ability to deter fraud and abuse in the Medicare program. As part of this program, CMS has established program safeguard contractors dedicated to program integrity and enhanced data capabilities.

*OEI; 00-00-00000*

### **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 noted deficiencies in carriers' ability to properly identify potentially fraudulent activity and to consistently develop payment information, as well as deficiencies in case documentation and internal and external proactive safeguards. In our November 1998 report, 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*

### **Information System Controls**

As a secretarial initiative, we will conduct an ongoing assessment of information system controls at selected Medicare contractors. The reviews will focus on corrective action plans developed by contractors in response to previously identified audit findings, as well as any new areas of vulnerabilities identified during the reviews. We will cover all six major areas of general controls, as outlined in the General Accounting Office *Federal Information System Controls Audit Manual*.

*OAS; W-00-00-40002; A-17-00-02501*

## **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 CMS, include training providers and their staff on the complexities of submitting claims (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*

## **Medicare Comprehensive and Component Procedure Codes**

This nationwide review will determine the adequacy of fiscal intermediary and carrier procedures and controls to prevent inappropriate Medicare payments for comprehensive and component procedure codes. The CMS has identified coding combinations and has developed related computer edits to preclude improper payments. The coding combinations involve "comprehensive and component" procedures for services provided to the same beneficiary by the same provider during the same session. In such situations, Medicare Part B should pay for the "comprehensive" procedure code and deny payment for the "component" code, which is included in the comprehensive code.

*OAS; W-00-02-30003; A-01-02-00000*

## **Payments for Incarcerated Persons**

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

*OAS; W-00-00-30003; A-04-01-05005*

## **Payments for Deported Individuals**

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

*OAS; W-00-00-30003; A-04-01-05004*

## **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 bankruptcy later reentered the Medicare program under a different provider number.

*OEI; 00-00-00000*

## **Contractors' Administrative Costs**

This series of reviews requested by CMS 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 CMS staff.

*OAS; W-00-00-30004; Various CINs*

## **Medicare Data Center Claim Processing Costs**

We will determine whether the processing costs charged by a claim processing data center are reasonable, allowable, and allocable and meet contractual conditions. Several Medicare contractors act as Medicare claim processing data centers for other Medicare contractors (users) through subcontract arrangements known as interplan operating agreements. Under the agreements, processing fees charged by the data centers are to be based on costs and billed on a per-claim basis. User contractors include the amounts paid to the data centers as part of their administrative cost submissions to CMS. Thus, CMS pays 100 percent of the claim processing costs.

*OAS; W-00-02-30004; A-00-02-00000*

## **Unfunded Pensions**

This series of reviews requested by CMS 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-00-00-30005; Various CINs*

### **Pension Segmentation/Costs Claimed**

At CMS'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-00-00-30005; Various CINs*

### **Pension Termination**

At CMS'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-00-00-30005; Various CINs*

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## **GENERAL ADMINISTRATION**

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### **Government Information Security Reform Act**

We will satisfy the requirements of the Government Information Security Reform Act of 2000 by evaluating CMS's security program and critical systems. The results of this effort will be included in the Department's annual report to the Office of Management and Budget (OMB) and the Congress, as required by law. The purpose of the Government Information Security Reform Act is to provide a comprehensive framework for establishing and maintaining effective controls over the information resources that support Federal operations and assets. It also creates a mechanism for improved oversight of Federal agency information security programs to ensure compliance with applicable laws and regulations regarding computer security. The law has two requirements for the OIG: to conduct reviews of each operating

division's security program and to test an appropriate subset of the Department's critical systems.

*OAS; W-00-02-40016; A-17-02-00000*

### **Improper Medicare Fee-for-Service Payments**

We will determine whether FY 2001 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 2000, estimated improper payments totaled \$11.9 billion, or 6.8 percent of the \$173.6 billion total spent on Medicare fee-for-service claims.

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

### **Medicare Secondary Payer**

We will continue 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 General Accounting Office 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 current CMS procedures for identifying and resolving credit balance situations; i.e., situations in which payments from Medicare and other insurers exceed the providers' charges. In addition, we will evaluate the effectiveness of data sharing between Medicare and private insurers. Lastly, we will determine the extent to which Medicare pays for defective devices and other nontherapeutic items.

*OAS; W-00-01-30030; Various CINs*

### **Group Purchasing Organizations**

We will review payments (fees) received by selected group purchasing organizations from vendors. These reviews will evaluate whether the group purchasing organizations' reporting

arrangements satisfy the statutory and regulatory requirements that exempt such payments from being considered kickbacks.

*OAS; W-00-02-30030; Various CINS*

### **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-00-01-30019; Various CINS*

*Expected Issue Date: No Report*

### **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 CMS 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-00-01-30001; Various CINS*

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## **INVESTIGATIONS**

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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.

Investigative activities are designed to prevent fraud and abuse in departmental programs by identifying systemic weaknesses in vulnerable program areas. These weaknesses 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 intended beneficiaries.

Each year, literally thousands of complaints from various sources are brought to the OIG's attention for development, investigation, and appropriate conclusion. Although managers will continue to make their investigative decisions on a case-by-case basis, this Work Plan

identifies 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.

## **Health Care Fraud**

The costs of our Nation's health care dictate that OI spend a significant amount of resources investigating fraud committed against the Medicare and Medicaid programs. The OI also conducts investigations in conjunction with other law enforcement agencies, such as the Federal Bureau of Investigation, the United States Postal Inspection Service, the Internal Revenue Service, and the various State Medicaid fraud control units.

The OI will investigate individuals, facilities, or entities that bill the Medicare and/or Medicaid program for services not rendered, claims that manipulate payment codes in an effort to inflate reimbursement amounts, and other false claims submitted to obtain program funds. Special focus areas include pharmaceutical fraud and quality-of-care issues for beneficiaries residing in care facilities. The OI will also investigate business arrangements that violate anti-kickback statutes.

The OI will not allocate resources to conduct investigations of individuals, facilities, or entities that committed errors or mistakes on claims submitted to the Medicare or Medicaid program. The OI will work with CMS contractors, specifically the program safeguard contractors, to identify specific patterns of misconduct detected by reviewing a compilation of integrated Medicare Part A and Part B claims.

## **Provider Self-Disclosure**

To encourage health care providers to promptly self-disclose improper conduct that threatens Federal health care programs, including Medicare and Medicaid, the OIG has made a cognizant effort to educate providers on the protocol and advantages of the self-disclosure program. This program offers health care providers specific steps, including a detailed audit methodology, that may be undertaken if they wish to work openly and cooperatively with the OIG.

In October 1998, the OIG announced a new, more flexible provider self-disclosure protocol for use by all health care providers doing business with Federal health care programs. Numerous providers have been accepted into the program under the new protocol. These providers range from hospitals to laboratories to physicians. The OIG believes that both the Government and the providers benefit from this program.

The self-disclosure protocol is designed only for providers that believe a potential violation of the law has occurred. Matters exclusively involving overpayments or errors that do not

indicate violations of the law should be brought directly to the attention of the entity responsible for claim processing and payment.

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## LEGAL COUNSEL

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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 use 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 2002 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 2002 pertaining to ambulance companies, pharmaceutical companies, and mental health service providers. The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse, and waste in Federal health care programs 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' and Medicare contractors' compliance with the terms of over 500 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 systems reviews to determine whether a provider's or a contractor's compliance mechanisms are appropriate and to identify any problem areas and establish a basis for corrective action. Additionally, we will increase our coordination with CMS on appropriate measures regarding entities with ongoing problems. We will also modify the requirements of corporate integrity agreements, e.g., audit and training provisions, to

reduce the costs associated with implementing the agreements, while continuing to promote the integrity of Federal health care programs.

*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 2002, 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 2002. 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 OI, we anticipate increasing the number of program exclusions pursued by the OIG. We also expect to initiate program exclusions against individuals and entities that submitted false or fraudulent claims, failed to provide services that met professionally recognized standards of care, or otherwise engaged in conduct actionable under section 1128 of the Social Security Act.

*Expected Completion Date: Ongoing*

## **Civil Monetary Penalties**

We expect to continue to pursue civil monetary penalty cases based on the submission of false or fraudulent claims; the offer, payment, solicitation, or receipt of remuneration (kickbacks) in violation of section 1128B (b) of the Social Security Act; improper conduct by Medicare or Medicaid MCOs; and other offenses actionable under section 1128A of the act.

*Expected Completion Date: Ongoing*

**Department of Health and Human Services**

**Office of Inspector General  
Projects**



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## AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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### **Patient Safety Efforts**

We will evaluate the progress of the Agency for Healthcare Research and Quality in improving patient safety and reducing medical errors. In a 1999 report on medical errors and patient safety, "To Err Is Human, Building a Safer Health Care System," the Institute of Medicine noted that, based on studies in New York, Utah, and Colorado, 44,000 to 98,000 persons die each year in hospitals as a result of medical errors. The report recommended the establishment of a Center for Patient Safety in the Agency for Healthcare Research and Quality and outlined a detailed agenda for the proposed center.

*OEI; 00-00-00000*

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## CENTERS FOR DISEASE CONTROL AND PREVENTION

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### **Ethics and Conflict of Interest - Review Panels**

We will assess the Centers for Disease Control and Prevention (CDC) controls to preclude conflicts of interest on the part of employees involved in the research awards process. These employees, who are members of review panels, are responsible for evaluating the scientific or technical merit of proposals being considered for funding. The CDC funds extramural research through, for example, the Prevention Research Center Program, which supports a prevention research agenda at schools of public health throughout the country. In evaluating potential research and awarding funds, CDC employees are obliged to maintain objectivity and integrity.

*OAS; W-00-02-50003; A-04-02-00000*

### **Oversight of Grants**

We will review CDC's oversight of its external grants. In FY 2000, through its extramural program, CDC awarded approximately \$2.1 billion to State, local, and territorial health departments; colleges and universities; nonprofit organizations; and other entities. These awards supported CDC's initiatives in such critical areas as childhood immunization, disease prevention, and AIDS education. Our review will determine whether CDC has adequate

controls to ensure that grantees properly carry out their programmatic and fiscal management responsibilities.

*OAS; W-00-02-50003; A-04-02-00000*

### **Funding for AIDS Activities**

At the request of the Deputy Secretary, we will review concerns regarding CDC's fiscal and administrative practices for AIDS-related funds. In FY 2001, the agency was appropriated over \$1 billion in funding to prevent and control HIV/AIDS.

*OAS; W-00-02-50003; A-04-02-00000*

### **Prevention Research Center Program**

This review will evaluate the impact of the National Center for Chronic Disease Prevention and Health Promotion's Prevention Research Center Program on community public health programs and policies. Since 1986, this program has funded academic institutions across the country to develop, in collaboration with the communities they serve, health promotion and disease prevention strategies and apply them at the community level. The program has never been evaluated. This study will attempt to identify common indicators of successful community-based health promotion and disease prevention programs and best practices.

*OEI; 00-00-00000*

### **Breast and Cervical Cancer Medicaid Benefit for Uninsured Women**

We will assess the collaboration of CDC, the Centers for Medicare and Medicaid Services, and the States in implementing the Medicaid treatment benefit for low-income, uninsured women with breast or cervical cancer. Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, States receive enhanced matching funds to provide full Medicaid benefits to uninsured women under age 65, with incomes up to 250 percent of poverty, who are identified as needing treatment for breast or cervical cancer through CDC's National Breast and Cervical Cancer Early Detection Program. This program has been in operation since 1991. Successful implementation of the new Medicaid benefit requires a coordinated effort between State Medicaid and public health agencies and between the Centers for Medicare and Medicaid Services and CDC. This review will focus on the nature and extent of the collaboration and the impact of the new benefit on the existing CDC-funded breast and cervical cancer early detection programs.

*OEI; 00-00-00000*

## **Released INS Detainees With Tuberculosis**

We will assess the extent and effectiveness of the Public Health Commission Corps' efforts to control tuberculosis in paroled illegal immigrants with tuberculosis. The Immigration and Naturalization Service (INS) is responsible for the detention of illegal immigrants before their deportation. About 400 to 500 illegal immigrants in detention facilities who are awaiting dispositional hearings are paroled each month into the community. Commission Corps staff, who provide health care in INS detention facilities, give paroled individuals with tuberculosis a "starter" supply of medicine, and the individuals are expected to follow up with local medical authorities. However, neither INS nor Commission Corps personnel formally follow up on these individuals to ensure that they continue treatment once paroled. Lapses in treatment can lead to continued tuberculosis transmission and development of drug-resistant tuberculosis.

*OEI; 00-00-00000*

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## **FOOD AND DRUG ADMINISTRATION**

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### **Oversight of Imported Food**

We will assess the effectiveness of Food and Drug Administration (FDA) strategies for overseeing imported foods and ensuring their safety. Since 1992, the level of food imports has increased three-fold and is expected to continue to increase. Currently, about 38 percent of produce and about 50 percent of the seafood consumed in the United States is imported. The FDA relies on seven key strategies to oversee imports: border exams, foreign inspections, equivalency determinations, country assessments, technical assistance to foreign governments, sample surveys of imported foods, and responses to emergencies. We will quantify the recent growth of food imports into the United States, consider the strategies being used to oversee food imports and their effectiveness in ensuring the safety of imported food, and assess how effectively FDA is allocating its limited resources among the various strategies.

*OEI; 00-00-00000*

### **Prescription Drug User Fee Act**

At the request of the FDA Center for Drug Evaluation and Research, we will review the effects of the Prescription Drug User Fee Act on the regulatory review of new drug applications. We will examine the FDA process for reviewing these applications under the act

and identify process and program areas that can improve the effectiveness and stringency of these reviews.

*OEI; 01-01-00590*

### **Sponsors' Oversight of Clinical Trials**

We will examine how sponsors of clinical trials monitor the implementation of the trials by clinical investigators. Sponsors are drug, device, or biologic manufacturers that plan to submit an application for FDA approval. They are responsible for ensuring that their clinical trials are conducted in accordance with FDA's regulations by selecting qualified clinical investigators, providing the clinical investigators with the information needed to conduct the clinical investigation, and reviewing ongoing clinical investigations. Sponsors, along with institutional review boards and clinical investigators, provide the first line of defense in protecting human subjects from harm.

*OEI; 00-00-00000*

### **Biennial Inspection Requirement**

In a series of three reviews, we will assess FDA's strategy for meeting its statutory mandate to inspect registered human drug, animal drug, biologic, and device manufacturing establishments at least once every 2 years. According to FDA, the agency has not been able to meet this requirement because of limited resources. Our reviews will focus on the effectiveness of FDA's inspection planning and execution process and the accuracy of the computerized database of more than 100,000 establishments under the agency's jurisdiction that must be inspected. Only a fraction of these establishments are subject to the biennial inspection requirement.

*OAS; W-00-01-50004; A-15-01-20001*

### **Postmarketing Studies of Prescription Drugs**

We will follow up on FDA's practices regarding the monitoring of postmarketing studies of prescription drugs. A 1996 OIG report provided recommendations for improving FDA's system for monitoring and tracking studies requested after drugs were approved for marketing. We will review FDA's progress in implementing our recommendations and its tracking of postmarketing studies.

*OEI; 00-00-00000*

## **Effectiveness of MedWatch**

We will evaluate the effectiveness of MedWatch, the FDA Medical Products Reporting Program, and its web-based postings on product safety and labeling changes for industry and health care professionals. MedWatch provides and solicits reports of adverse events and product problems; educates providers, manufacturers, and patients; and serves as the “front door” for the drug and device adverse event reporting system database. The MedWatch program is intended to enhance the effectiveness of postmarketing surveillance of medical products as they are used in clinical practice and to rapidly identify significant health hazards associated with these products. However, it is estimated that only 1 to 10 percent of adverse events are actually reported.

*OEI; 00-00-00000*

## **Pharmaceutical Company Gifts and Payments to Providers**

We will evaluate the extent of gifts and payments to physicians from pharmaceutical companies. The pharmaceutical industry currently spends about \$12 billion a year on marketing to physicians, and some of these gifts may present an inherent conflict of interest between the legitimate business goals of manufacturers and the ethical obligation of providers to prescribe drugs in the most rational way. Depending on the facts and circumstances, gifts may also violate the Federal anti-kickback statute if they are intended to induce referrals.

*OEI; 00-00-00000*

## **Medical Device Reviews**

We will evaluate the effectiveness of FDA’s premarket review processes for both new and investigational medical devices, as well as those devices that have been “grandfathered” pending approval. One of the objectives of the 1997 Food and Drug Administration Modernization Act was to shorten the time needed to approve medical devices by using contractors as auxiliary review staff. Concerns have been raised about the potential for reviewer bias and about the recall of certain medical devices soon after they come to market.

*OEI; 00-00-00000*

## **Accreditation and Quality Oversight of Mammography Facilities**

We will assess the accreditation and regulatory oversight mechanisms for mammography facilities since the enactment of the Mammography Quality Standards Act of 1992. In

response to the growing concern over breast cancer and the quality of mammography services, the act established national quality standards for mammography. Responsibility for this legislation was delegated to the FDA Center for Devices and Radiological Health Mammography Program. This study, a followup to a 1994 OIG report, will evaluate the impact on the quality of mammography screenings and services.

*OEI; 00-00-00000*

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## **HEALTH RESOURCES AND SERVICES ADMINISTRATION**

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### **Reducing Perinatally Transmitted HIV**

This study will evaluate technical assistance that the Health Resources and Services Administration (HRSA) and the Department offer to assist States in reducing the incidence of perinatal HIV transmission. Approximately 6,000 to 7,000 HIV-infected women give birth every year. Because many HIV-positive pregnant women are unaware of their HIV status and therefore do not receive treatment, the number of children born with HIV is still unacceptably high. We will estimate the total number of HIV-positive infants born in the United States during FY 1999 for whom the mother's HIV status was unknown to the attending obstetrician. We will also identify barriers that may discourage or prevent an obstetrician from routinely testing all pregnant woman and/or all newborns whose mothers' HIV status is unknown.

*OEI; 05-01-00260*

### **HIV/AIDS Care and Prevention: Collaboration Among HHS Grantees**

This study will evaluate the nature and extent of collaboration among community-based organizations funded by departmental grant programs to improve prevention and care for people with HIV/AIDS. In recent years, increasing Federal grant money has been distributed directly to community-based organizations serving individuals with HIV/AIDS. However, some of these organizations may be duplicating efforts or crafting programs that are not responsive to the needs of their communities.

*OEI; 00-00-00000*

### **AIDS Education and Training Centers**

We will determine whether regional AIDS education and training centers and local performance sites have adapted to significant changes in the HIV/AIDS epidemic and identify best practices for adapting to such changes. Under the Ryan White Comprehensive AIDS



Resources Emergency (CARE) Act, HRSA awards grants to 14 regional education and training centers and over 70 local performance sites to provide state-of-the-art treatment education, training, consultation, and support to health care professionals treating HIV-positive patients. Since the mid-1990s, two trends in the epidemic have become particularly relevant to this program: the increasing impact of HIV/AIDS on the underserved, minority, and marginalized segments of society and the dramatic impact of new clinical treatment modalities on health outcomes of people living with HIV/AIDS.

*OEI; 00-00-00000*

### **Eligibility for Ryan White CARE Act Funding**

This followup review will determine whether a Northeastern city and its contracted service providers ensure that clients are qualified to receive services under Title I of the Ryan White CARE Act. The act authorizes emergency funding relief to metropolitan areas with the highest incidences of HIV disease. In FY 2000, the city received \$12.5 million in CARE Act funds to be used for a range of community-based services, such as outpatient health care, home health care, housing and transportation assistance, and inpatient case management services. In a previous review, OIG identified problems with the city's ability to properly document the eligibility of CARE Act clients.

*OAS; W-00-02-50005; A-01-02-00000*

### **Conformity of State AIDS Drug Assistance Programs With Public Health Treatment Guidelines**

We will evaluate whether eligibility criteria and the availability of therapeutics within State AIDS Drug Assistance Programs conform to public health agencies' guidelines for the treatment of HIV/AIDS. The HRSA requires States to use a portion of Title II Ryan White CARE Act funding to establish Drug Assistance Programs for low-income people diagnosed with HIV. States have wide latitude in establishing program eligibility criteria and formularies that may not be consistent with the most recent guidelines for the treatment of HIV disease and related infections.

*OEI; 00-00-00000*

### **Ryan White CARE Act Title III Evaluation Systems**

We will assess the evaluation systems used by Ryan White Title III grantees to monitor service inputs and outputs and to track the outcomes of the people they serve and the program impact within targeted communities. Title III grants go directly to community-based organizations to expand their ability to provide early intervention and primary care services for people with

HIV/AIDS. Grantees are responsible for designing and executing their own evaluation systems. While some grantees have implemented fully functional evaluation systems, others have not. This study will follow up on our earlier reviews of Titles I and II and the AIDS Drug Assistance Program of the Ryan White CARE Act.

*OEI; 00-00-00000*

### **Administration and Oversight of Ryan White CARE Act Funds**

At the request of the Senate Committee on Finance, we will review administration of funds awarded to grantees--eligible metropolitan areas and States--and subgrantees under the Ryan White CARE Act. In FY 2001, CARE Act appropriations totaled over \$1.8 billion. We will examine the grantees' expenditures, fiscal capabilities, and program performance as well as HRSA's monitoring of grantees' administrative actions.

*OAS; W-00-02-50005; Various CINs*  
*OEI; 00-00-00000*

### **State Administration of AIDS Funds**

We will review the administration of Ryan White CARE Act funds by a State and its contractor. The HRSA asked us to focus our review on the contractor's fiscal and administrative practices and its stewardship of CARE Act funds, the State's administrative and fiscal processes related to contractor oversight, and the propriety of the State's practice of providing all Care Act funds to the contractor to carry out grantee obligations.

*OAS; W-00-01-50005; A-05-01-00073*

### **Hemophilia Treatment Centers' Access to Blood Clotting Factor at 340B Prices**

At HRSA's request, we will examine hemophilia treatment centers' ability to purchase blood clotting factor in general and at 340B discounted prices. Section 340B of the Public Health Service Act authorizes grantees to purchase covered drugs at discounted prices by entering into contracts with the prime vendor. Since this law was passed, HRSA has received anecdotal information that blood clotting factor has not been available to some hemophilia treatment centers at the 340B price.

*OAS; W-00-01-50005; A-15-01-30001*

## **Section 340B Drug Ceiling Prices**

We will review the rebate percentage calculations used by drug manufacturers to determine the ceiling prices for outpatient drugs sold to covered 340B entities. Manufacturers' "best price" determinations for Medicaid-covered drugs are used as a basis for computing the 340B prices. As pointed out in a March 2001 OIG report, some drug manufacturers improperly excluded from their Medicaid best price determinations sales to repackagers that were also health maintenance organizations. As a result, the Medicaid program lost drug rebates totaling \$80.7 million. This review will determine whether covered 340B entities were also overcharged and, if so, quantify the impact.

*OAS; W-00-01-50005; A-06-01-00060*

## **Hemophilia Treatment Centers' Disposition of 340B Program Income and Patient Choice Policy**

At HRSA's request, we will assess hemophilia treatment centers' disposition of income obtained from participating in the 340B discount pricing program for the purchase of blood clotting factor and evaluate their policies on patient choice of providers of blood clotting factor. According to grant requirements, hemophilia treatment centers are to use program income to complement or expand the services provided by the program. The HRSA officials have expressed concern that some centers that purchase blood clotting factor at the 340B price have used the profits for activities unrelated to patient care. There is also concern that some centers have limited patients' rights to choose their blood clotting factor provider.

*OAS; W-00-01-50005; A-03-01-03500*

## **Multiple Registrations for Organ Transplantation**

We will examine the United Network for Organ Sharing (UNOS) policy that allows patient registrations at more than one transplant center and the impact of the policy on Medicare costs. According to UNOS data, approximately 5 percent of patients (about 8,200 individuals) on waiting lists were registered at more than one transplant center for the period 1995 through 1999. For Medicare-eligible patients, Medicare covers all costs relating to multiple registrations, including the \$400 UNOS fee that is required for registering at each center and the costs of initial and ongoing medical evaluations and lab work. Debate about the distribution of scarce organs to transplantation has included the issue of whether patients should have the right to place themselves on waiting lists at several transplant centers, thereby gaining an advantage over other potential donors.

*OEI; 00-00-00000*

## **Organ Donation at Transplant Hospitals**

We will assess the performance of hospital organ transplant programs in organ donation. About 260 medical institutions operate hospital organ transplant programs in the United States. To help alleviate the organ shortage, Medicare conditions of participation required that hospitals, as of August 21, 1998, notify organ procurement organizations about individuals whose deaths are imminent or who die in the hospital. Because of their recognition of the need for organ donation, it seems logical that hospitals that operate transplant programs would be leaders in organ donation. Despite this expectation, there are indications that donation rates at hospitals with transplant programs are considerably lower than those at other hospitals.

*OEI; 00-00-00000*

## **Healthcare Integrity and Protection Data Bank**

We will review the implementation of the Healthcare Integrity and Protection Data Bank (HIPDB). The Health Insurance Portability and Accountability Act of 1996 directed the Secretary of the Department of Health and Human Services, acting through OIG and the U.S. Attorney General, to create HIPDB to help combat fraud and abuse in health care delivery. The HIPDB is a national data bank containing “adverse actions” taken against health care practitioners and suppliers; such adverse actions include OIG exclusions, criminal convictions, and civil judgments related to health care. The HRSA operates HIPDB under a memorandum of agreement with OIG.

*OEI; 00-00-00000*

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## **INDIAN HEALTH SERVICE**

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### **Alcohol and Substance Abuse Programs**

We will follow up on Indian Health Service (IHS) progress in achieving the goals of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986. This act was designed to provide a coordinated and comprehensive plan to address the problem of Indian alcohol and substance abuse, particularly among young people. In several studies conducted in the early 1990s, we identified a number of problems in implementing the act, including a failure to meet quality assurance objectives, ineffective information management systems, inappropriate use of funds, and a failure to establish regional treatment centers and emergency shelters. This study will focus on IHS policies and procedures that promote coordination of Indian alcohol and substance abuse programs.

*OEI; 00-00-00000*

## **Prescription Drug Contracts With Tribes**

We will review IHS drug distribution systems for tribes that purchase prescription drugs under Federal discount pricing programs. The IHS is authorized to access various Federal discount drug programs. Based on information and inquiries from some contractors and from the IHS Regional Supply Service Center, there is reason to believe that questionable activity may be occurring in the IHS contractors' purchase or distribution of pharmaceuticals, such as unusually large-volume orders or resale to entities not entitled to the discounts. This study will identify the extent to which these concerns need to be addressed.

*OEI; 00-00-00000*

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## **NATIONAL INSTITUTES OF HEALTH**

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### **Superfund Financial Activities for Fiscal Year 2001**

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 2000, agency obligations and disbursements of Superfund resources amounted to \$62.9 million and \$59.4 million, respectively.

*OAS; W-00-02-50025; A-04-02-00000*

### **Cancer Information Service Outreach Program**

This study will evaluate 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." Similar to the Cancer Information Service's toll-free phone service, the outreach program disseminates information via 19 regional contractors. Unlike the phone service, outreach program staff do not interact directly with the public; instead, they partner with State and regional organizations that serve the target audiences. This study will examine issues relating to the outreach program's target audiences and the effectiveness of specific outreach program activities.

*OEI; 00-00-00000*

## **Oversight of Grants**

We will review the National Institutes of Health (NIH) oversight of its external grants. In FY 2001, NIH spent about \$15.7 billion to support biomedical research, primarily at colleges and universities. With continuing congressional support, this amount is expected to increase significantly in the coming years. We will assess NIH's effectiveness in ensuring that grantees properly carry out their research and fiscal management responsibilities.

*OAS; W-00-02-50025; A-15-02-00000*

## **Funding of General Clinical Research Centers**

We will assess the effectiveness of NIH procedures for awarding funds to general clinical research centers. For FY 2001, NIH estimated that it would award \$227 million to more than 75 centers nationwide. The mission of these centers is to provide a research infrastructure for clinical investigators who receive their primary support from NIH components and other Federal agencies. The NIH uses two approaches to fund the centers. Under the discrete method, the expected cost of research days, nursing, and other fixed expenses is calculated in the grant award, and the grant must be reimbursed when the center uses the facilities for nonresearch patients. Under the per diem basis, the center is reimbursed for the research days actually used. Previous OIG reviews revealed problems with the discrete funding method. This review will determine whether NIH has an adequate process for determining the most effective form of center funding.

*OAS; W-00-01-50025; Various CINs*

## **Recruiting Human Subjects for Clinical Trials**

This followup will assess investigator efforts to recruit human subjects for NIH clinical trials in a timely fashion. Difficulties in recruiting an adequate number of human subjects for clinical trials have been blamed for a quarter of the delays in developing new drugs. We will determine the extent and nature of these difficulties, and we will describe the range of recruitment strategies and oversight of recruitment practices.

*OEI; 00-00-00000*

## **Commercialization of NIH-Funded Inventions**

This evaluation will determine how NIH has applied the mandate of the Bayh-Dole Act of 1980 to commercialize publicly funded inventions on reasonable terms. Government-funded biomedical research, dominated by the NIH extramural grant program, is integral to improving public health by advancing medical technology to prevent, diagnose, and treat diseases. The

“practical application” clause of the Bayh-Dole Act applies broadly to most inventions funded in part or entirely by the Federal Government and licensed to the private sector on either an exclusive or a nonexclusive basis. The law mandates that these inventions be not merely made available to the public, but available at “reasonable terms.” This study will examine the practical application of the law and its impact on commercial research.

*OEI; 00-00-00000*

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## **SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION**

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### **Dissemination of Mental Health Technology Information**

This study will assess the Substance Abuse and Mental Health Services Administration (SAMHSA) role in disseminating research knowledge and best practices for treating mental illness to the treatment community. The SAMHSA supports a national network of technical assistance centers to disseminate information on promising, evidence-based prevention and treatment interventions, as well as best practices resulting from mental health research. In addition, the agency offers community action and other grants to induce communities to test new practices and adopt them if they work.

*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 for improvements.

*OEI; 05-01-00440*

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## **PUBLIC HEALTH AGENCIES-WIDE ACTIVITIES**

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### **Government Information Security Reform Act**

As required by the Government Information Security Reform Act of 2000, we will evaluate the eight public health agencies’ security programs and their critical systems. The results of

this effort will be included in the Department's annual report to the Office of Management and Budget (OMB) and the Congress, as required by law.

The purpose of the Government Information Security Reform Act is to provide a comprehensive framework for establishing and maintaining effective controls over the information resources that support Federal operations and assets. It also creates a mechanism for improved oversight of Federal agency information security programs to ensure compliance with applicable laws and regulations regarding computer security. The law has two requirements for the OIG: to conduct reviews of each operating division's security program and to test an appropriate subset of the Department's critical systems.

*OAS; W-00-02-40016; Various CINs*

### **Disclosure Statements Filed by Colleges and Universities**

Our continuing reviews will assist the Department's Division of Cost Allocation in determining the adequacy and compliance of college and university disclosure statements. The OMB Circular A-21, revised May 8, 1996, requires that colleges and universities disclose their cost accounting practices in 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. We will determine whether the cost accounting practices presented in the disclosure statements are complete, accurate, current, and consistent with cost accounting standards and OMB Circulars A-21 and A-110.

*OAS; W-00-02-50007; Various CINs*

### **Cash Management at Colleges and Universities**

We will evaluate the cash management procedures used by selected colleges and universities to account for Federal funds awarded by the Department and other agencies. In FY 2000, colleges and universities were awarded about \$10 billion from the Department alone. The OMB Circular A-110 requires that the institutions limit the amount and timing of cash withdrawals to immediate needs and remit any interest earned to the Federal Treasury. We will also evaluate the institutions' processes for determining funding requests and reconciling the Federal Cash Transactions Report with their accounting records. As a result of four similar prior audits, institutions remitted \$1.4 million in interest income.

*OAS; W-00-01-50025; Various CINs*



## **Research Management Service Costs**

We will review the allowability of research management service costs charged by a university to federally funded awards from July 1, 1994, through June 30, 2001. The OMB Circular A-21 states that costs incurred for the same purpose in like circumstances should be treated consistently as either direct costs or facilities and administrative costs.

*OAS; W-00-01-50012; A-09-01-04003*

## **Recipient Capability Audits**

At the public health 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-00-02-50013; Various CINs*

## **Reimbursable Audits**

We will conduct a series of audits in accordance with the Department's 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-00-02-50012; 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-00-02-50010; 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-00-02-50019; Various CINs*

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## **INVESTIGATIONS**

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### **Referrals by Office of Research Integrity**

As a result of a closer relationship 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 departmental policies, the Office of Research Integrity may not directly investigate such issues but refers them to OIG when appropriate.

**Department of Health and Human Services**

**Office of Inspector General  
Projects**



**ADMINISTRATIONS FOR CHILDREN,  
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## TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

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### **Recoupment of AFDC Assistance**

This nationwide review will examine State practices for recouping Aid to Families with Dependent Children (AFDC) assistance. Although the AFDC program has been repealed and replaced with Temporary Assistance for Needy Families (TANF), States must return the Federal share of AFDC recoupments to the Federal Government. A recoupment is the collection of AFDC benefits paid to eligible individuals. Certain State laws allow the recoupment of any welfare assistance provided when a recipient receives a financial windfall (such as lottery winnings or estate settlements). A review in one State disclosed that the Federal Government had not been reimbursed for its share of a substantial amount of recoupments.

*OAS; W-00-02-20016; A-01-02-00000*

### **Collecting AFDC Overpayments**

We will determine whether States have reimbursed the Federal Government for its share of AFDC overpayment recoveries. Although the AFDC program has been repealed and replaced with TANF, States must return the Federal share of AFDC overpayment recoveries. A nonfederal audit in one State, as well as OIG reviews in other States, disclosed that the Federal Government had not been reimbursed for its share of recoveries. We will determine whether this situation exists in additional States.

*OAS; W-00-01-20016; Various CINs*

### **Temporary Assistance for Needy Families Time Limits**

This study will evaluate States' plans for addressing the upcoming Federal TANF time limits and examine how States are working with families who have already reached State-imposed time limits. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ended welfare as an entitlement program and created the TANF program. Under the act, families have a 60-month lifetime limit on receiving Federal assistance (or less at States' discretion). Twenty States have chosen to shorten the lifetime limit for certain categories of recipients, and families have already lost their Federal benefits due to shorter State time limits in 18 States. We will describe States' difficulties and best practices in addressing the service

needs of this population. Our study will complement work conducted by the Assistant Secretary for Planning and Evaluation.

*OEI; 00-00-00000*

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## **CHILD CARE**

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### **Temporary Assistance for Needy Families Funds Used for Child Care Services**

We will evaluate the extent to which States use TANF funds to directly fund child care services for low-income families and compare the oversight of TANF-funded child care programs with that of Child Care and Development-funded programs. With the rapid decline in welfare caseloads and the increase in eligible low-income working families, approximately 15 million children are eligible for Federal child care support. In FY 1999, the Department estimated that only 12 percent of eligible children were receiving federally subsidized child care assistance. In addition, under the Child Care and Development Block Grant Act of 1990, all child care providers must meet basic health and safety requirements set by States. However, there are currently no departmental standards for child care providers funded by direct TANF funds. This review will provide descriptive and quantitative information on how these programs differ.

*OEI; 00-00-00000*

### **Timeliness and Validity of Child Care Development Fund Data**

We will ascertain the validity and timeliness of the data that States report to the Child Care Bureau regarding the Child Care Development Fund and identify technical assistance offered to States to improve timeliness. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 appropriated new entitlement child care funds to be administered jointly with the discretionary funds of the Child Care and Development Block Grant Act of 1990. Under the 1996 act, States must collect case-level and aggregate financial data to receive Federal funds. This study will address both the difficulties encountered by States and the best practices States have used to collect accurate data and meet reporting deadlines.

*OEI; 00-00-00000*

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## CHILD SUPPORT

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### **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. Customer access to child support enforcement agencies is a necessary ingredient to the success of these new initiatives. We have encountered anecdotal evidence that customer access is problematic.

*OEI; 06-00-00460*

### **Using New Hire Data to Locate Noncustodial Parents**

We will describe States' use of new hire information to locate noncustodial parents and alleged fathers, highlight promising approaches, and explore any challenges or vulnerabilities. Federal law requires that State child support agencies match information in their State Case Registry to information provided by employers in the State Directory of New Hires. New hire data can provide valuable information about the location of noncustodial parents or alleged fathers in cases requiring establishment of a child support order or needing paternity establishment. During recent reviews of closed cases, we noticed several new hire matches for which no employment verification or service of process appeared to occur before the cases were closed. This occurred even when the reason for closure was an inability to locate the noncustodial parent or establish paternity of the alleged father. This study will focus on States' use of intrastate new hire data.

*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 check any child support debt before making payment. We will determine which States have enacted and implemented insurance intercept legislation and identify best practices that can be shared with other States. 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-00-02-20005; A-01-02-00000*

### **Financial Institution Data Matches**

We will describe the progress of the Office of Child Support Enforcement (OCSE) and States in implementing the financial institution data match and highlight promising approaches to maximize child support collections. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 required that State child support agencies develop agreements with in-State financial institutions, and the Child Support Performance and Incentive Act of 1998 simplified data matches with multi-State financial institutions. The agreements among States, financial institutions, and OCSE allow for quarterly matches of customer information supplied by financial institutions against the names of delinquent obligors. When a match occurs, States may attach and levy the assets of a delinquent obligor, and the financial institution is required to freeze or surrender the assets. A number of difficulties have delayed full implementation of this data match, requiring OCSE and States to adapt their processes as they work with various institutions.

*OEI; 00-00-00000*

*Expected Issue Date: FY 2003*

### **Availability of Health Insurance for Title IV-D Children Through SCHIP**

This nationwide review will determine whether children under the Child Support Enforcement Program are receiving State Children's Health Insurance Program (SCHIP) benefits because private health insurance is unavailable or unaffordable to noncustodial parents. We will also determine whether States could establish alternative insurance arrangements that would allow noncustodial parents to meet their responsibility to provide health insurance while reducing SCHIP expenditures. A similar review involving Medicaid found that noncustodial parents in one State could afford to pay \$11.4 million (Federal and State share combined) of the Medicaid per capita premiums for their children.

*OAS; W-00-01-20005; A-01-01-02500*

### **State Child Support Case Closure Activities**

We will describe State case closure activities, highlight successful strategies, and explore 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, OCSE issued revised regulations intended to balance the concern that all children receive the child support help they need with the administrative



concern that State caseloads include only those cases in which there is adequate information or likelihood of successfully providing child support. Given the present incentive payment system, which rewards States for successfully providing certain service, such as creating a support order, some advocates fear that States may close some workable cases and deny needed services to families.

*OEI; 06-00-00470*

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## INVESTIGATIONS

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### **Child Support Enforcement Task Force Model**

The OIG's Office of Investigations and OCSE developed a task force model that is being implemented in Columbus, Ohio; Baltimore, Maryland; Dallas, Texas; New York, New York; Sacramento, California; and Atlanta, Georgia. It calls for the Office of Investigations, the Federal Bureau of Investigation, U.S. Marshals, U.S. Attorney Offices, local law enforcement, local prosecutors, State child support agencies, and other interested parties in 25 States and the District of Columbia to join forces in creating a coordinated effort to identify, investigate, and prosecute criminal nonsupport cases. Because the task forces investigate intrastate as well as interstate cases, the involvement of local law enforcement and prosecutors is critical. Depending on resources, additional task forces will be established in the future.

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## FOSTER CARE

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### **Foster Care Children's Access to Medicaid**

We will examine the extent to which foster care children have access to Medicaid services. Foster care children are entitled to Medicaid benefits, including early and periodic screening, diagnosis, and treatment services.

*OEI; 02-00-00360*

### **Child Abuse and Neglect in Foster Care**

This review will assess the process used by States to investigate reports of abuse and neglect of foster care children and the impact on child safety. We will gather information on States' efforts in (1) maintaining and sharing information from the child abuse and neglect central registry, (2) conducting central State registry background checks on all persons having contact

with children in foster care, and (3) encouraging child placement agencies to exchange information on foster and adoptive parents who move from one agency to another.

*OAS; W-00-02-20008; A-06-02-00000*

### **Protections for Foster Children in Juvenile Justice Cases**

We will assess the extent to which children in Title IV-E foster care-funded juvenile justice cases receive the protections required under law. Federal foster care funding primarily supports child welfare placements. However, Federal guidelines to States allow the use of foster care funds to support juveniles who are wards of the court and who are placed in family foster care arrangements. Juvenile justice cases account for approximately 4 percent of all children supported by foster care funds. According to the General Accounting Office, about \$300 million, or 10 percent of all foster care funding, was spent on juvenile justice placements in FY 1998. This study will complement other recent OIG work.

*OAS; W-00-02-20008; A-02-02-00000, -03-02-00000*  
*OEI; 00-00-00000*

### **Foster Home License Renewal Procedures**

This nationwide review will examine the timeliness of States' renewal of foster care home licenses. We will also determine whether any health and safety violations remain undisclosed and uncorrected when foster homes are not relicensed on a timely basis. Although Federal law provides the States with individual discretion when establishing standards on licensing and relicensing foster homes, States must enforce such standards to be in compliance with their State plans. In one State whose standards called for annual relicensing of foster homes, we found that some homes had not been relicensed for as long as 12 years, and over half of the homes that had not been relicensed in over 3 years had at least one safety violation (such as contaminated water, fire code violations, or substantiated child abuse). We also noted that required annual fire inspections had not been performed.

*OAS; W-00-02-20008; A-01-02-00000*

### **Training Costs**

We will determine whether training costs charged to Title IV-E were in accordance with applicable laws, regulations, and program policies. A survey in one State identified training costs that benefited State-funded foster care programs but were charged to Title IV-E. Also, the State failed to reclassify some staff members from trainees to protective service workers

when their training was completed. As a result, Federal reimbursement was claimed at a higher rate. Depending on the results of this review, we may expand our work to other States.

*OAS; W-00-02-20008; A-05-02-00000*

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## HEAD START

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### **Head Start Teacher Credentialing**

We will examine Head Start grantees' efforts to meet teacher degree requirements specified in the Head Start Act Amendments of 1998 and the effect of turnover on these efforts. We will also identify any problems and vulnerabilities in meeting the academic requirements for 50 percent of Head Start teachers by FY 2003.

*OEI; 07-01-00560*

### **Mental Health Services**

We will review how well Head Start grantees follow Administration for Children and Families (ACF) requirements in identifying children and families needing mental health services and how well they provide services to meet these needs. Head Start performance standards require grantees to perform appropriate screening within 45 calendar days of a child's entry into the program. However, studies show that grantees have had difficulty in meeting screening standards and providing appropriate mental health services. To some extent, these problems have been constant throughout Head Start's history, but starting in the mid-1990s, reports have shown an increase in the level of need and stress among many Head Start children, families, and staff. This study will focus on identifying ways to provide appropriate mental health services for Head Start enrollees.

*OEI; 00-00-00000*

### **Lead Screening**

We will assess how effectively Head Start grantees ensure that children receive adequate screening and treatment for lead poisoning and determine what efforts are made to ensure that facilities are inspected and lead-free. Recent research indicates that while the average blood lead levels in children aged 1 to 5 years have decreased significantly since the late 1970s, elevated levels remain more common among low-income children, urban children, and those

living in older housing. The research found that the primary sources of childhood lead exposure were deteriorated lead paint and contaminated soil and dust in old housing.

*OEI; 00-00-00000*

*Expected Issue Date: FY 2003*

### **Construction and Renovation of Head Start Facilities**

This followup review will evaluate ACF's procedures for reviewing, approving, and accounting for the construction and renovation of facilities by Head Start grantees. A prior OIG report made various recommendations to ACF for improving its oversight of facility acquisitions under the Head Start Improvement Act of 1992.

*OAS; W-00-02-20009; A-09-02-00000*

### **Grantee Terminations**

We will review grantee terminations for the past 5 years to determine the effectiveness of program oversight through independent nonfederal audits and through grantees' governing bodies. In past years, most of the Head Start grantees that were terminated from the program were removed after long periods of noncompliance with fiscal and program requirements. In most cases, a lack of involvement by the grantees' boards of directors and advisory councils allowed managers to operate the program without the required oversight. We also noted some cases in which nonfederal audits and program monitoring efforts did not disclose these issues.

We will evaluate the actions taken by grantees and by program management and determine whether management should take additional actions to avoid these problems in the future.

*OAS; W-00-02-20009; A-12-02-00000*

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## **OTHER ISSUES**

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### **Government Information Security Reform Act**

As required by the Government Information Security Reform Act of 2000, we will evaluate ACF's security program and any critical systems. The results of this effort will be included in the Department's annual report to the Office of Management and Budget (OMB) and the Congress, as required by law.

The purpose of the Government Information Security Reform Act is to provide a comprehensive framework for establishing and maintaining effective controls over the information resources that support Federal operations and assets. It also creates a mechanism for improved oversight of Federal agency information security programs to ensure compliance

with applicable laws and regulations regarding computer security. The law has two requirements for the OIG: to conduct reviews of each operating division's security program and to test an appropriate subset of the Department's critical systems.

*OAS; W-00-02-40016; A-12-02-00000*

### **Protection and Advocacy Programs for Persons With Developmental Disabilities**

We will review the activities of protection and advocacy programs in ensuring that persons with developmental disabilities receive a standard of care in accordance with State and Federal policies. The Developmental Disabilities Protection and Advocacy Program provides \$30 million in grants for State programs to protect the legal and human rights of persons with developmental disabilities. Although protection and advocacy programs have traditionally focused on problems in intermediate care facilities for the mentally retarded, they have recently begun to address community-based issues.

*OEI; 00-00-00000*

### **Cash and Medical Assistance**

This review will determine if States have controls in place to prevent the payment of cash and medical assistance funds after refugees' eligibility periods expire. Federal regulations allow Refugee and Entrant Assistance Program funds to be used for cash and medical assistance for the 8-month period after a refugee's entry into the United States. A nonfederal audit disclosed that in about 17 percent of the cases tested, these benefits were provided for periods ranging from 1 to 5 months beyond the time allowed by Federal regulations.

*OAS; W-00-02-20019; A-04-02-00000*

### **Discretionary Grants**

This nationwide review of discretionary grants will assess grantees' (1) performance in achieving project objectives and complying with the terms and conditions of the grants and (2) accountability for Federal funds. Prior OIG reviews of one ACF program identified problems with Federal oversight and grantee performance. However, some grant programs have received little or no coverage. To gain a broader perspective of ACF discretionary grants, we plan to review a sample of grants by the Administration on Children, Youth, and Families; the Office of Community Services; and the Office of Refugee Resettlement. We will assess the need for better screening of potential grantees, technical assistance to current grantees, and Federal oversight.

*OAS; W-00-01-20019; A-12-01-00007*

## **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. 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 has taken adequate steps to validate State data.

*OAS; W-00-01-20002; A-12-01-00060*

## **State Agency Child Welfare Information System**

We will determine the appropriateness of costs charged to a State Agency Child Welfare Information System for activities conducted by the system development contractor. This HHS-financed computer system (75-percent matching for implementation) is designed to allow child welfare workers online 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 nationally.

*OAS; W-00-01-20002; A-02-01-02001*

## **Joint Work With State Auditors/Comptrollers**

We will provide the expanded Partnership Plan to all State Governors and State auditors and invite them to work with us in reviewing ACF State-administered programs. The OIG developed the Partnership Plan to provide broader coverage of the Medicaid program by conducting joint reviews with State auditors. Our planned expansion could cover such issues as child protective services, State contracting, program and financial systems, child placement agencies, subrecipient accountability of Federal funds, child care, Head Start, and the reliability of Government Performance and Results Act data. A recent Ohio Statewide audit identified administrative cost exceptions related to child placement agencies. By partnering with Ohio and other State auditors, we can expand coverage on this issue nationwide. We also hope to begin joint work with State auditors on the licensing of foster care homes and requiring noncustodial parents to contribute toward Children's Health Initiative Program premiums for their children.

*OAS; W-00-01-20002; A-12-01-00011*

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## ADMINISTRATION ON AGING

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### **Government Information Security Reform Act**

As required by the Government Information Security Reform Act of 2000, we will evaluate the Administration on Aging's (AoA) security program and any critical systems. The results of this effort will be included in the Department's annual report to OMB and the Congress, as required by law.

The purpose of the Government Information Security Reform Act is to provide a comprehensive framework for establishing and maintaining effective controls over the information resources that support Federal operations and assets. It also creates a mechanism for improved oversight of Federal agency information security programs to ensure compliance with applicable laws and regulations regarding computer security. The law has two requirements for the OIG: to conduct reviews of each operating division's security program and to test an appropriate subset of the Department's critical systems.

*OAS; W-00-02-40016; A-12-02-00000*

### **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 since the early 1990s. 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*

### **Elderly Caregivers With Developmentally Disabled Children**

We will assess how State developmental disability councils and other State agencies address the needs of elderly caregivers who take care of their adult developmentally disabled children. The shift in caring for developmentally disabled children at home rather than in institutions has now matured to the point that the parents are becoming elderly. For FY 2001, the Congress appropriated \$125 million for the National Family Caregiver Support Program. This program was a component of the reauthorized Older Americans Act, which became law in November 2000. The act mandates that States give priority to services for older individuals

with the greatest social and economic need and older individuals who provide care and support to persons with mental retardation and related developmental disabilities.

*OEI; 00-00-00000*



# Department of Health and Human Services

## Office of Inspector General Projects



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## FINANCIAL STATEMENT AUDITS

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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 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 2001 consolidated HHS financial statements are due to the Office of Management and Budget (OMB) by February 27, 2002.

### **Audits of FY 2001 Financial Statements**

The following audits of FY 2001 financial statements will be completed and reports issued during FY 2002:

**Centers for Medicare and Medicaid Services**

*OAS; W-00-01-40008; A-17-01-02001*

**Administration for Children and Families**

*OAS; W-00-01-40010; A-17-01-00003*

**Health Resources and Services Administration**

*OAS; W-00-01-40013; A-17-01-00005*

**Indian Health Service**

*OAS; W-00-01-40013; A-17-01-00006*

**National Institutes of Health**

*OAS; W-00-01-40013; A-17-01-00009*

**Centers for Disease Control and Prevention**

*OAS; W-00-01-40013; A-17-01-00010*

**Food and Drug Administration**

*OAS; W-00-01-40013; A-17-01-00008*

**Substance Abuse and Mental Health Services Administration**

*OAS; W-00-01-40013; A-17-01-00004*

**Program Support Center**

*OAS; W-00-01-40003; A-17-01-00007*

**Administration on Aging**

*OAS; W-00-01-40010; A-17-01-00019*

**Consolidated HHS Financial Statements**

*OAS; W-00-01-40009; A-17-01-00001*

**FY 2001 Statement on Accounting Standards (SAS) 70 Examinations**

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

**Center for Information Technology** (National Institutes of Health Computer Center)

*OAS; W-00-01-40012; A-17-01-00012*

**Program Support Center - Major Administrative Support Services:**

**Payment Management System**

*OAS; W-00-01-40012; A-17-01-00013*

**Accounting Operations - Division of Financial Operations**

*OAS; W-00-01-40012; A-17-01-00011*

**Payroll Operations**

*OAS; W-00-01-40012; A-17-01-00014*

**FY 2001 Financial-Related Reviews**

**Federal Agencies' Centralized Trial Balance System Verification**

*OAS; W-00-01-40012; A-17-01-00015*

**Office of Personnel Management Agreed-Upon Procedures**

*OAS; W-00-01-40012; A-17-01-00016*

**Payment Management System Agreed-Upon Procedures**

*OAS; W-00-01-40012; A-17-01-00017*

## **Audits of FY 2002 Financial Statements**

Work is expected to begin in FY 2002 on the following audits of FY 2002 financial statements:

### **Centers for Medicare and Medicaid Services**

*OAS; W-00-02-40008*

*Expected Issue Date: FY 2003*

### **Administration for Children and Families**

*OAS; W-00-02-40010*

*Expected Issue Date: FY 2003*

### **Health Resources and Services Administration**

*OAS; W-00-02-40013*

*Expected Issue Date: FY 2003*

### **Indian Health Service**

*OAS; W-00-02-40013*

*Expected Issue Date: FY 2003*

### **National Institutes of Health**

*OAS; W-00-02-40013*

*Expected Issue Date: FY 2003*

### **Centers for Disease Control and Prevention**

*OAS; W-00-02-40013*

*Expected Issue Date: FY 2003*

### **Food and Drug Administration**

*OAS; W-00-02-40013*

*Expected Issue Date: FY 2003*

### **Substance Abuse and Mental Health Services Administration**

*OAS; W-00-02-40013*

*Expected Issue Date: FY 2003*

### **Program Support Center**

*OAS; W-00-02-40003*

*Expected Issue Date: FY 2003*

**Administration on Aging**

*OAS; W-00-02-40010*

*Expected Issue Date: FY 2003*

**Consolidated HHS Financial Statements**

*OAS; W-00-02-40009*

*Expected Issue Date: FY 2003*

**FY 2002 SAS 70 Examinations**

The following SAS 70 examinations of HHS service organizations will support FY 2002 financial statement audits:

**Center for Information Technology (National Institutes of Health Computer Center)**

*OAS; W-00-02-40012*

*Expected Issue Date: FY 2003*

**Program Support Center - Major Administrative Support Services:**

**Payment Management System**

*OAS; W-00-02-40012*

*Expected Issue Date: FY 2003*

**Accounting Operations - Division of Financial Operations**

*OAS; W-00-02-40012*

*Expected Issue Date: FY 2003*

**Payroll Operations**

*OAS; W-00-02-40012*

*Expected Issue Date: FY 2003*

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**PROGRAM INTEGRITY AND EFFICIENCY**

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**Government Information Security Reform Act**

As required by the Government Information Security Reform Act of 2000, we will evaluate the security programs and any critical systems of the Office of the Secretary and the OIG. The results of this effort will be included in the Department's annual report to OMB and the Congress, as required by law.

The purpose of the Government Information Security Reform Act is to provide a

comprehensive framework for establishing and maintaining effective controls over the information resources that support Federal operations and assets. It also creates a mechanism for improved oversight of Federal agency information security programs to ensure compliance with applicable laws and regulations regarding computer security. The law has two requirements for the OIG: to conduct reviews of each operating division's security program and to test an appropriate subset of the Department's critical systems.

*OAS; W-00-02-40016; A-17-02-00000*

### **Electronic Data Processing Internal Controls**

As part of our responsibilities under the Chief Financial Officers Act, we will oversee tests of the internal controls over the Department's electronic data processing (EDP) systems. The act requires that the OIG, or an independent auditor chosen by the OIG, obtain an understanding of the components of internal controls and conduct sufficient tests to support a low assessed level of control risk. This work covers the relevant EDP general and application controls and controls relating to intra-agency and intragovernmental transactions and balances. Any internal controls that are found to be improperly designed, not placed in operation, or ineffective should be reported. The results of this effort will be included in our report on the consolidated HHS FY 2001 financial statements.

*OAS; W-00-01-40017; Various CINs*

### **Annual Accounting of Drug Control Funds**

We will determine whether HHS agencies are in compliance with the Office of National Drug Control Policy requirements for annual accounting of drug control funds. Each year, agencies that participate in the National Drug Control Program are required to submit to the Office of National Drug Control Policy 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 2001 drug control funds, estimated at \$3.3 billion.

*OAS; W-00-02-50019; A-15-02-00000*

### **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-00-99-20011; A-02-99-02004*

### **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.