

**Department of Health and Human Services**



**Office of  
Inspector General**

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**WORK PLAN  
FISCAL YEAR 2000**

**June Gibbs Brown  
Inspector General**



# 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 2000*

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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) 2000 by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The first three chapters present the full range of projects planned in each of the Department of Health and Human Services' (HHS) major entities: the Health Care Financing Administration, the Public Health Service agencies, and the Administrations for Children, Families, and Aging. The fourth chapter embraces those projects related to issues that cut across Department programs, including State and local government use of Federal funds, as well as the functional areas of the Office of the Secretary.

In preparing this edition of the OIG Work Plan, we have provided a brief description of the various project areas that we perceive as critical to the mission of the OIG and the Department. Unless otherwise noted, reports on all projects are expected to be issued in FY 2000. 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 2000.

## **Program Inspections**

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

## **Investigative Focus Areas**

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

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

## **Legal Counsel Focus Areas**

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

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### **Internet Address**

*The FY 2000 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**

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Inspector General**



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## HOSPITALS

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

We will evaluate the reasonableness of Medicare inpatient hospital payments for beneficiaries discharged after spending only 1 day in a hospital. Recent data indicate that approximately 10 percent of all Medicare patients admitted are released the following day.

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

### **Same-Day Discharge and Readmission to Same Hospital**

This series of reviews will continue to examine Medicare claims for beneficiaries who were discharged and subsequently readmitted on the same day to the same acute care prospective payment system hospital. We will review procedures in place for these readmissions at selected hospitals, fiscal intermediaries, and peer review organizations (PRO). With the assistance of Health Care Financing Administration (HCFA) and PRO staff, we will determine if these claims were appropriately paid. We will also review claim processing procedures to determine the effectiveness of existing system edits used to identify and review readmissions. We may expand our reviews to include readmissions within several days and readmissions to another prospective payment system and hospital.

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

### **Payments for Related Hospital and Skilled Nursing Stays**

We will determine the extent of Medicare payments for short- and long-stay hospital and skilled nursing facility care when provided sequentially to the same beneficiary. Hospitals are prohibited by law from admitting patients unnecessarily, admitting them multiple times, or engaging in other inappropriate medical practices. As part of our review, we will assess HCFA's instructions for identifying and evaluating consecutive beneficiary stays at different providers, including skilled nursing facilities and prospective payment system-exempt units.

*OEI; 00-00-00000*

### **Skilled Nursing Facility Coverage After Unnecessary Hospital Stays**

This review will determine whether Medicare pays for skilled nursing care when the qualifying hospital stay was determined to be not medically necessary. Medicare requires that all covered skilled nursing facility stays be preceded by a 3-day, medically necessary hospital stay. Current indications are that fiscal intermediaries do not have procedures to deny skilled nursing

claims when peer review organizations determine that the qualifying hospital stay was not medically necessary. We will estimate the cost to Medicare for such claims.

*OEI; 00-00-00000*

### **Prospective Payment System Transfers**

We will continue to support the Department of Justice's assistance to the Department in seeking recovery of Medicare overpayments to prospective payment system hospitals that incorrectly reported transfers. The transfer payment policy stipulates that when a Medicare patient is transferred between prospective payment system hospitals, the first (transferring) hospital receives a per diem payment limited to the length of stay, while the hospital receiving the transferred patient is paid a diagnosis-related group payment based on the final discharge code. Incorrect reporting of these transfers allows both hospitals to receive the full payment amount. We also plan to issue a report recommending recovery of overpayments from hospitals that are not covered by the Justice Department's project.

*OAS; W-00-98-30010; A-06-98-00010*

### **Prospective Payment System Transfers Between Chain Members**

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

*OAS; W-00-98-30010; A-06-98-00024*

### **Prospective Payment System Transfers: Administrative Recovery**

We will work with HCFA and the Medicare fiscal intermediaries to administratively recover overpayments resulting from incorrectly reported prospective payment system transfers. Our work will focus on the incorrectly reported transfers declined for investigation. We are currently working with HCFA to draft instructions to the fiscal intermediaries. The intermediaries' performance will determine whether it is necessary to issue individual regional

reports recommending resolution action on the part of the HCFA regions. We plan to issue an advisory report to the HCFA Administrator during the first half of Fiscal Year (FY) 2000.

*OAS; W-00-99-30010; A-04-99-00000*

### **Prospective Payment System Transfers During Hospital Mergers**

We will review cases in which patients were transferred from acquired prospective payment system hospitals to acquiring prospective payment system hospitals without leaving their hospital beds. We will determine whether Medicare paid the acquired hospital under the prospective payment system transfer policy (per diem based payments) and the acquiring hospital the full diagnosis-related group payment. The prospective payment system was designed to pay a hospital for all care a Medicare beneficiary needed for discharge. However, when a hospital is acquired, the new owner receives a new provider number, and the patient does not leave the hospital bed, only one Medicare payment should be made. We have noted a number of situations in which Medicare contractors paid both the acquired and the acquiring hospitals.

*OAS; W-00-98-30010; A-06-98-00012*

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

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

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

### **Updating Diagnosis-Related Group Codes**

This study will evaluate the process by which HCFA updates diagnosis-related group codes. Under the prospective payment system, the basis for payments to hospitals is the diagnosis-related group code for each discharge. Each code represents the average resources required to care for cases in that particular group relative to the average resources used to treat cases in all diagnosis-related groups. Resources required to care for hospitalized Medicare beneficiaries can increase over time due to changes in the distribution of cases among codes and increases in the average resource requirements of cases assigned to specific diagnosis-related groups.

We will assess the adequacy of the data used in recalibrations and reclassifications and examine how new technologies and treatments are incorporated into diagnosis-related groups.

*OEI; 00-00-00000*

### **Medicare Payment for Diagnosis-Related Group 14**

This study will analyze reasons for miscodings of diagnosis-related group 14, Specific Cerebrovascular Disorders Except Trans Ischemic Attack. We examined upcoding in this group in three previous studies. Our recent examination of 1996 data raises concerns that upcoding is again a problem. We will further analyze the results from our recent upcoding analysis and identify hospitals with typically high billing patterns for diagnosis-related group 14.

*OEI; 03-99-00240*

### **Diagnosis-Related Group Payment Limits**

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

*OAS; W-00-00-30010; A-04-00-00000*

### **Outlier Payments for Expanded Services**

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

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

### **Changes in the Inpatient Case Mix Index for Medicare**

We will examine trends in the case mix index of individual hospitals to determine whether historic increases and the recent decline in case mix occurred uniformly across the industry. We will also identify any diagnosis-related group that significantly influenced national trends

or individual hospital variations. The case mix index may be a tool to identify hospitals that systematically upcode patient diagnoses to inflate reimbursement.

*OEI; 00-00-00000*

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

This review will (1) determine whether hospitals have complied with settlement agreements with the Office of Inspector General (OIG) to preclude duplicate billing for nonphysician outpatient services under the prospective payment system and (2) determine the extent of duplicate claims submitted by Part B providers for services, e.g., ambulance, laboratory, or x-ray services, provided to hospital inpatients. Under the prospective payment system, hospitals are reimbursed a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis-related group. Separate payments for nonphysician services rendered within the diagnosis-related group payment window are not allowed.

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

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

### **Hospitals Exempt From the Prospective Payment System**

We will conduct a series of reviews of hospitals exempt from the prospective payment system. In 1996, almost 3,500 hospitals, which received almost \$10.3 billion in Medicare payments, were exempt. We will evaluate controls at Medicare fiscal intermediaries to review costs at these facilities, as well as the imposition of cost control measures mandated by the Balanced Budget Act of 1997.

*OAS; W-00-00-30010; A-04-00-00000*

### **Outpatient Hospital Psychiatric Claims**

We will review outpatient psychiatric services rendered by both acute care and psychiatric hospitals to Medicare beneficiaries. Our reviews will determine whether the claims were for



services actually provided and whether all Medicare billing and reimbursement requirements were met.

*OAS; W-00-00-30026; Various CINs*

### **Outpatient Hospital Revenue Centers Without Common Procedure Codes**

We will examine outpatient hospital claims that contain revenue centers (e.g., the hospital emergency room) with no HCFA common procedure code to describe the service. Since July 1987, HCFA has required hospitals to use these codes when reporting outpatient services to Medicare beneficiaries. However, a review of a sample of 1997 claims indicated that nearly 35 percent of the revenue centers had no associated codes. The lack of a descriptive code creates the potential for duplicate payments for supplies and services, as well as inclusion of nonallowable costs. Because outpatient claims data are being used to establish prospective payment system rates, such errors could have impact beyond improper payment for the individual claim or cost report.

*OEI; 00-00-00000*

### **Billing Routine Services on a “Stat” Basis**

This review will analyze billing practices where there are two levels of billing for the same medical procedure depending on whether the services are ordered on a “routine” basis or on an immediate, or “stat,” basis. Billing on a stat basis generally results in a higher charge to Medicare and more income for the hospital.

*OAS; W-00-00-30010; A-09-00-00000*

### **Payments for Capital Items**

We will study the financial impact of the prospective payment system on Medicare reimbursement to hospitals for capital items, such as buildings and equipment. Since 1991, Medicare has been gradually shifting from a cost reimbursement system to a prospective payment system for capital items.

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

## **Graduate Medical Education Payments**

We will evaluate the financial impact of the prospective payment system on Medicare payments for graduate medical educational activities. Starting in 1990, Medicare shifted from a cost reimbursement system to a facility-specific prospective payment system.

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

## **Hospital Closures: 1998**

We will examine the extent, characteristics, reasons for, and impact of hospital closures in 1998, the 12<sup>th</sup> in a series of annual reports. In the mid to late 1980's, closure of general, acute-care hospitals generated considerable public and congressional interest. Our first report on closures in 1987 showed that the problem was not as severe as generally believed. Few hospitals had closed, most were small and had low occupancy, and few patients were affected. The closure of hospitals is continuing in a downward trend. Nevertheless, there is continuing interest in this issue, and our annual reports have become a standard reference.

*OEI; 04-99-00330*

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## **HOME HEALTH**

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### **Home Health Compliance Programs**

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

*OEI; 00-00-00000*

### **Physician Involvement in Approving Home Health Care**

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

frequently physicians examine home care patients and identify obstacles to physician involvement in monitoring their patients.

*OEI; 00-00-00000*

### **Screening of Home Health Beneficiaries**

This review will evaluate whether home health agencies are discouraging admission of very ill beneficiaries. The home health interim payment system created by the Balanced Budget Act of 1997 imposed a new per-beneficiary limit based on historical visit rates, and the prospective payment system, to be implemented in FY 2000, provides a simple payment per episode of care under either it or the interim payment system. As a result, home health agencies now have an incentive to keep visits and associated expenditures down. We will determine whether the agencies are “dumping” their sicker beneficiaries or are cutting off care before it is medically warranted.

*OEI; 00-00-00000*

### **Payments Based on Location of Service**

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

*OAS; W-00-99-30009; A-06-99-00063, A-04-00-00000*

### **Reasonableness of Current Payments**

At the request of the HCFA Administrator, we will review 1998 data and compute error rates for Medicare payments to home health agencies in several States. Prior OIG reviews computed error rates for earlier periods. This current review should assist in measuring the effectiveness of corrective actions on the part of providers.

*OAS; W-00-00-30009; A-04-00-00000*

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## **NURSING HOME CARE**

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### **Nursing Home Resident Assessments**

We will determine how implementation of nursing home resident assessments affects quality of care and nursing home reimbursement. Federal law requires nursing homes to conduct initial and periodic assessments of each resident's functional capacity that are comprehensive, accurate, and standardized and then to develop a comprehensive plan of care based on the assessment. The assessment information is also used to determine the level of Medicare and Medicaid payments to nursing homes. We plan to examine the process used to perform the resident assessments, the extent to which the assessments are used to develop plans of care, and payment accuracy. This review is one of a series on the quality of care in nursing homes.

*OEI; 02-99-00040*

### **Role of the Nursing Home Medical Director**

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

*OEI; 00-00-00000*

### **Quality Assessment and Assurance Committees**

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

*OEI; 00-00-00000*

## **Nurse Aide Training**

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

*OEI; 00-00-00000*

## **Family Experience With Nursing Home Care**

We will assess the quality of care that Medicare and Medicaid beneficiaries receive in nursing homes, as perceived by their family members. 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*

## **Nursing Home Vaccination Rates: State Initiatives**

We will describe initiatives taken by State governments to increase influenza and pneumococcal vaccination rates in nursing homes. The Healthy People 2010 objective is to increase the immunization rates for influenza and pneumococcal disease to 90 percent for institutionalized chronically ill or older people. However, some evidence suggests that immunization rates may be much lower than the target rate. We will identify ways to accelerate fulfillment of the Healthy People 2010 objective. This review is one of a series on the quality of care in nursing homes.

*OEI; 01-99-00010*

## **Implementing the Skilled Nursing Facility Prospective Payment System**

We will review the implementation of the new payment system for care rendered by Medicare’s skilled nursing facilities. Effective July 1, 1998, a prospective payment system replaced the traditional cost reimbursement system for these facilities. On a pilot basis at selected payment contractors and providers, we will determine, among other things, whether current claims are properly calculated and documented. We will also review the use of claim edits and their adjudications.

*OAS; W-00-00-30014; A-01-00-00000, A-02-00-00000*

## **Beneficiary Access to Skilled Nursing Facility Care**

We will examine the impact of the skilled nursing facility prospective payment system on beneficiary access to Part A services. Concern exists that some beneficiaries may be unable to find a skilled nursing facility placement after a hospital stay because the anticipated cost of their care may be “too expensive.” We will examine whether beneficiaries are experiencing difficulties in finding placements and the reasons for those difficulties.

*OEI; 02-99-00400*

## **Financial Screening and Distinct Part Rules**

At HCFA’s request, we will examine the extent to which financial screening and distinct part rules in nursing homes create access problems for low-income and minority beneficiaries. Distinct part certification rules provide a mechanism by which nursing homes can limit the number of Medicaid-eligible residents they admit. Additionally, nursing homes can financially screen private-pay applicants and use such information to refuse admission to individuals they believe will soon be eligible for Medicaid.

*OEI; 02-99-00340*

## **Physician Routine Nursing Home Visits**

This review will assess whether HCFA needs to establish controls over Medicare payments for routine nursing home visits. Currently, physicians bill one of three possible procedure codes, depending on the level of care, when providing services to nursing home residents. The HCFA allows payments for physicians’ routine monthly examinations, in addition to other medically necessary services. Our analysis in five States revealed that physicians sometimes billed for more services than they could perform in a normal workday. In these States, Medicare paid over \$120 million for nursing home visits in FY 1998. Based on the level of care required for the codes billed, we have concerns about the quality of care provided to beneficiaries and the payments allowed for these services.

*OAS; W-00-00-30014; A-06-00-00000*

## **Therapy Services in Skilled Nursing Facilities**

We will determine the medical necessity of physical and occupational therapy services provided to patients of skilled nursing facilities. The Medicare skilled nursing facility benefit is intended to provide post-hospital care to persons requiring intensive skilled nursing and/or rehabilitative services, including physical and occupational therapy. A probe sample in one State revealed significant evidence of medically unnecessary therapy services and other issues

related to the provision of therapy services. Because of these findings, we plan to conduct a national review.

*OEI; 09-97-00121*

### **Ancillary Medical Supplies**

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

*OAS; W-00-00-30014; A-04-00-00000, A-09-00-00000*

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## **PHYSICIANS**

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### **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-00-99-30021; Various CINs*

### **Automated Encoding Systems for Billing**

We will determine whether errors found in Medicare billings for physician services are associated with providers' use of automated encoding software. We will also examine billing processes to identify vulnerabilities that occur when physician offices bill independently or through use of a third party system.

*OEI; 05-99-00100*

### **Reassignment of Physician Benefits**

We will evaluate the practice of allowing physicians to reassign their billing numbers to clinics. Clinics that employ more than one doctor may accept a reassignment of the physicians' billing numbers, thus allowing the clinic to handle all billing and keep all fees for services provided by the physicians, usually in exchange for paying a flat fee or salary to the

physicians. This practice, known as reassignment of benefits, provides considerable convenience to both physicians and the clinic business offices. Typically, in these instances, the physician never sees what is billed under his or her physician number. This practice shifts the accountability and liability for billing abuses away from the physician to the clinics. We will examine past reassignment abuses to determine specific vulnerabilities.

*OEI; 00-00-00000*

### **Podiatrists' Medicare Billings**

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

*OAS; W-00-00-30021; A-09-00-00000*

### **Podiatry Services**

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

*OEI; 00-00-00000*

### **Myocardial Perfusion Imaging**

We will assess the medical appropriateness of myocardial perfusion imaging and explain the high increase in utilization since 1997. Myocardial perfusion imaging is a cardiac imaging procedure that is used to detect coronary artery disease and determine prognoses. This type of imaging procedure accounted for a large portion of the 23 percent increase in billing for all nuclear imaging services between 1997 and 1998.

*OEI; 00-00-00000*



## **Private Physician Contracting**

This study will review the impact of private contracting between Medicare beneficiaries and physicians. Under the 1997 Balanced Budget Act, physicians and beneficiaries may enter into agreements specifying that the beneficiary will pay out-of-pocket for Medicare-covered services provided by that physician. Physicians who choose to provide covered services under these contracts must “opt out” of the Medicare program for 2 years. They may not receive payment from Medicare for any service regardless of whether it is provided on a fee-for-service or capitated basis. Though relatively few physicians have chosen this option, its impact on beneficiaries’ access to care, as well as other beneficiary protections, is unclear.

*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*

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# **MEDICAL EQUIPMENT AND SUPPLIES**

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## **Operations of Durable Medical Equipment Carriers**

We will assess whether the establishment of durable medical equipment regional carriers has met its intended objectives. Starting October 1, 1993, HCFA began consolidating claim processing activities for durable medical equipment, prosthetics, orthotics, and supplies into four regional carriers. The four carriers replaced more than 30 local carriers which previously received and processed claims for these services. We will assess the effectiveness of the regional carriers with respect to medical guidelines, oversight of claim processing, and detection and referral of fraudulent activity.

*OEI; 04-97-00330*

## **Duplicate Billings for Medical Equipment and Supplies**

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

*OEI; 04-97-00460*

## **Balance Billing for Medical Equipment and Supplies**

This review will determine the extent to which Medicare beneficiaries are subject to financial liability when receiving medical equipment and supplies. Currently there is no restriction on amounts that suppliers can “balance-bill” a beneficiary for services if the supplier does not accept Medicare assignment. This is not the case in other areas of the program. For example, Medicare does not allow beneficiaries to be charged more than 20 percent of the allowed amounts for inpatient hospital stays, and Medicare limits amounts beneficiaries can be billed for the balance of physician service charges. We will assess the extent to which those suppliers that do not accept assignment bill beneficiaries in excess of 20 percent of the Medicare-allowed amount.

*OEI; 00-00-00000*

## **Appropriateness of Home Medical Equipment and Supplies**

We will conduct a series of studies on the appropriateness of Medicare payments for certain medical equipment used in the home. Such studies may include reviews of osteogenesis stimulators, airway pressure devices, ventilators, lower limb prosthetics, and seat lift mechanisms. With the assistance of medical staff, we will review randomly selected claims to assess the appropriateness of Medicare payments.

*OEI; 00-00-00000*

## **Medicare Payments for Orthotics**

This study will determine the extent to which Medicare may be continuing to inappropriately pay for orthotics. An October 1997 OIG report noted that at least 19 percent of orthotics were medically unnecessary. The report also found that the most problematic claims were those submitted by durable medical equipment companies and those submitted for beneficiaries residing in nursing homes. The OIG made recommendations to improve the coding system for orthotics and to institute stricter standards for who is allowed to bill for orthotics. While HCFA concurred with our recommendations, corrective action has yet to be implemented.

*OEI; 02-99-00120*

## **Blood Glucose Test Strips**

We will review the appropriateness of Medicare claims and payments for blood glucose test strips. These disposable accessories for blood glucose monitors are used by insulin-dependent diabetics to manage their illness. Billings and payments for the strips have increased sharply in recent years. We will contact suppliers and beneficiaries to identify factors contributing to these increases. We will also examine the appropriateness of utilization rates.

*OEI; 03-98-00230*

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## **END STAGE RENAL DISEASE**

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### **External Oversight of Dialysis Facilities**

We will assess the extent and nature of HCFA's monitoring and oversight of quality of care for Medicare beneficiaries on dialysis. We will examine end stage renal disease network activity, State surveys and certification, complaint processes, and data collection and analysis regarding dialysis quality.

*OEI; 01-99-00050*

### **Separately Billable Services**

This review will determine the type and extent of separately billable maintenance dialysis services, the Medicare reimbursement for these services, and whether these services were included in the composite reimbursement rate. Under the prospective method of paying for maintenance dialysis, HCFA uses a composite rate per treatment to reimburse renal dialysis facilities for maintenance dialysis. This is a comprehensive payment for all services related to

the dialysis treatment. Only those services whose costs were specifically excluded from the composite rate calculation are separately billable.

*OAS; W-00-99-30025; A-01-99-00506*

### **Method II Billing for End Stage Renal Disease**

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

*OEI; 00-00-00000*

### **Medical Appropriateness of Tests and Other Services**

We will assess the medical appropriateness of laboratory tests and other services ordered for end stage renal disease patients. A recent General Accounting Office (GAO) report found that clinically similar patients received laboratory tests at widely disparate rates. It concluded that the wide variation was probably the result of financial incentives, as well as a lack of knowledge and differences in medical practices. We will select a random sample of end stage renal disease beneficiaries and, with the assistance of medical staff where appropriate, conduct medical reviews to determine if laboratory and other services provided to these individuals were medically necessary and provided in accordance with Medicare requirements.

*OEI; 04-98-00470*

### **Questionable Dialysis Claims**

We will examine claims for dialysis services to assess the variability in provider billing patterns and to identify any aberrant providers. Dialysis treatments may be provided and billed either as single visits (common procedure codes 90935 and 90945) or, for patients with more complications, as multiple visits (codes 90937 and 90947) which are reimbursed by Medicare at a higher rate. On average, the ratio of services for the high to low codes is approximately 1 to 7. A fraud alert was issued to carriers to periodically make comparisons in their areas to

determine if any nephrologist is extremely deviant from the norm. Aberrant providers would be easy to identify by examining data showing the physicians' billing patterns.

*OEI; 00-00-00000*

### **Duplicate Payments for Office Visits to Nephrologists**

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

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

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## **DRUG REIMBURSEMENT**

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### **Effect of Average Wholesale Price Discount on Medicare Prescription Drugs**

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

*OEI; 03-97-00291*

### **Medicare Outpatient Prescription Drugs**

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

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

## **Medicare Payments for “Not Otherwise Classified”**

This study will determine whether carriers have been properly paying for common procedure code J9999, defined as “not otherwise classified antineoplastic drug.” Medicare does not pay for most over-the-counter outpatient prescription drugs. However, under specific circumstances, Medicare Part B covers drugs for certain purposes, including chemotherapy. The HCFA and its carriers use codes in HCFA’s Common Procedure Coding System to define the type of drug and, in most cases, a dosage amount. However, HCFA has not classified every drug into a code; therefore, code J9999 is used to bill for chemotherapy (anti-neoplastic) drugs that meet coverage guidelines but do not have their own code. Total allowances for J9999 were over 12 times higher in 1997 than in 1995, increasing from \$11 million to \$147 million. Ten carriers accounted for 56 percent of the 1997 allowance for J9999.

*OEI; 03-98-00500*

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## **OTHER MEDICARE SERVICES**

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### **Outpatient Rehabilitation Facilities**

We will conduct a six-State review of outpatient rehabilitation facility (ORF) providers to determine whether their services met Medicare eligibility and reimbursement requirements. In addition, we will review selected ORF providers’ cost reports to determine the types of expenditures included and the allowability of those items. Under Medicare Part B, ORF providers may be reimbursed only for outpatient therapy services, specifically, physical therapy, occupational therapy, and speech pathology services. These services are often provided at offsite locations, such as nursing homes and assisted living facilities.

*OAS; W-00-00-30026; A-04-00-00000*

### **Comprehensive Outpatient Rehabilitation Facilities**

We will conduct a nationwide review of comprehensive outpatient rehabilitation facility (CORF) providers to determine whether the services provided met Medicare eligibility and reimbursement requirements. The review will determine whether the beneficiaries were eligible for the services and whether the services provided were medically necessary and rendered in accordance with Medicare requirements. In addition, we will review selected providers’ cost reports to determine the types and allowability of expenditures. To participate as a CORF, a provider must furnish at least physicians’ services, physical therapy, and social or psychological services. Unlike an outpatient rehabilitation facility, services are often furnished on the premises of the CORF, and the Medicare provider number applies to the

certified location only. A CORF must provide the services of a physician who specializes in rehabilitation medicine, and these services must be part of a CORF treatment plan.

*OAS; W-00-00-30026; A-04-00-00000*

### **Vulnerable Medicare Beneficiaries**

We will examine the postaudit utilization patterns of beneficiaries who received unnecessary or noncovered services in community mental health centers. Prior reviews identified an extremely high rate of unnecessary services in several centers. Little is known about how beneficiaries became entangled with illegitimate providers or, more importantly, what happened to them after their mental health centers withdrew from the Medicare program or were terminated. This review will test the theory that following claims activity for beneficiaries who were victims of dishonest providers might lead to the discovery of other, undiscovered questionable providers or services.

*OEI; 00-00-00000*

### **Clinical Laboratory Proficiency Testing**

We will determine whether clinical laboratories that serve the Medicare population participate in proficiency testing programs and take appropriate action in response to failures. The Clinical Laboratory Improvement Amendments of 1988 established quality standards for all laboratory testing. A key condition of participation is proficiency testing in which a lab is sent samples for analysis and is graded on its performance in each testing specialty. This review will assess how well laboratories perform on these tests and what actions are taken in the case of unsatisfactory test results.

*OEI; 00-00-00000*

### **Excess Payments for Ambulance Services**

This review will determine whether excess Medicare payments are being made for certain types of ambulance services. We recently completed a review of medical claims for one company's ambulance services and found that the carrier's system did not prevent excess payments for some ambulance transports. We plan to determine if similar situations are occurring at other ambulance providers throughout the United States.

*OAS; W-00-00-30021; A-03-00-00000*

## **Hyperbaric Oxygen Treatment**

We will examine the extent and appropriateness of hyperbaric oxygen treatment provided to Medicare beneficiaries. Medicare covers this treatment for 14 different conditions, though its effectiveness for many of these and other conditions is controversial. There are concerns that some physicians may be using the treatment for noncovered conditions or conditions for which the appropriate traditional treatments have not been tried. For example, though not covered, hyperbaric oxygen treatments for decubitus ulcers and diabetic foot wounds have been revealed through medical review. We will analyze payment and utilization trends, assess medical appropriateness, and examine the qualifications of hyperbaric oxygen treatment chambers and providers.

*OEI; 06-99-00090*

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## **MEDICARE MANAGED CARE**

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### **New Adjusted Community Rate Proposal Process**

At HCFA's request, we will audit the adjusted community rate proposals of managed care organizations as required by the Balanced Budget Act. The new adjusted community rate proposal process is designed for managed care organizations to present to HCFA their estimate of funds needed to cover the costs of providing a Medicare package of covered services to an enrolled Medicare beneficiary. The HCFA will initiate the new process effective January 2000. Our audits will focus on the propriety and accuracy of the proposals submitted.

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

### **General and Administrative Costs**

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

*OAS; W-00-98-30012; A-03-98-00046, A-04-99-00000, A-07-00-00000*



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

At HCFA's request, we will evaluate the integrity of the cost reporting process used by cost-based managed care plans (Section 1876 Cost Plans and Health Care Prepayment Plans). The HCFA currently contracts with over 60 of these plans which provide services to more than 475,000 members. The plans, which receive about \$1 billion a year in Medicare payments, file cost reports with HCFA outlining the costs they incur in providing health care. Although the reports are audited to ensure that costs are properly allocated, they do not undergo medical reviews to ensure that only Medicare-covered services are included.

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

## **Enhanced Managed Care Payments**

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

*OAS; W-00-99-30012; A-03-99-00003; A-05-99-00027*

## **HMO Profits**

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

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

## **Investment Income Earned by Risk-Based HMOs**

This review will determine the potential financial impact on the Medicare program if risk-based HMOs were held accountable for investment income earned on Medicare funds. Since HCFA pays HMOs on a prospective basis for each Medicare beneficiary enrolled in their health plan, the HMOs have an opportunity to earn investment income on Medicare funds until they are used to pay for services rendered during the month. Any investment income earned on Medicare funds is not factored into the HMO's payment rates, nor is it required to

be used for the benefit of the Medicare beneficiary. We will estimate the amount of investment income earned on Medicare funds.

*OAS; W-00-98-30012; A-02-98-01005*

### **Physician Incentive Plans**

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

*OEI; 00-00-00000*

### **National Marketing Guidelines**

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

*OEI; 03-98-00270*

### **Usefulness of Medicare+Choice Performance Measures**

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

beneficiaries interpret and use the various performance measures and determine the adequacy of these measures for beneficiary decision-making.

*OEI; 00-00-00000*

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

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

*OEI; 00-00-00000*

### **Managed Care Health Plan Data**

We will assess how HCFA uses and ensures the quality of Health Plan Employers Data and Information Set data submitted by Medicare managed care organizations. The HCFA required managed care organizations to submit these data, which provide encounter-level health care quality information, for the first time in 1997 and annually thereafter. In addition to reviewing the accuracy of the data, we will analyze how HCFA uses the data to assess the performance of managed care organizations and how plans are held accountable for poor performance.

*OEI; 00-00-00000*

### **Managed Care Additional Benefits**

We will determine the extent to which (1) beneficiaries understand the additional benefits offered by Medicare managed care plans and (2) these benefits affect beneficiaries' decisions to join managed care plans. Medicare managed care plans that generate profits exceeding Medicare allowances have the option of refunding excess profits to HCFA or offering additional services to beneficiaries. These additional benefit packages differ from plan to plan and are approved by HCFA regional offices. We will also review the marketing materials associated with the additional benefits.

*OEI; 02-99-00030*

## **Enrollment Incentives/Disincentives**

This review will assess the extent to which Medicare managed care organizations encourage the enrollment of healthy beneficiaries and discourage the enrollment of sick beneficiaries. Managed care organizations are currently paid a set amount to provide all Medicare-covered services to beneficiaries enrolled in their programs and, under the current payment method, have a financial incentive to enroll healthier beneficiaries. Although Medicare HMOs are required to enroll all eligible Medicare beneficiaries regardless of their age, health status, or the cost of the health services needed, there is some evidence that this does not always occur. Prior OIG work found that 18 percent of beneficiaries said that they were asked about health problems at the time of their application.

*OEI; 00-00-00000*

## **Enrollee Access to Emergency Services**

We will determine whether existing Federal protections for access to emergency treatment are adequate as the health care delivery system increasingly relies on managed care and gatekeeping mechanisms. The anti-dumping law, which applies to all Medicare-reimbursed hospitals, restricts the way in which a hospital may transfer or deny treatment to a person who comes to the emergency room. Violation of either of these protections may result in sanctions, including penalties and program exclusion. We will examine whether Federal enforcement authorities adequately protect patients who need and seek emergency care but are prevented from receiving such care by managed care rules or hospital policies.

*OEI; 09-98-00220*

## **Chiropractic Services**

At HCFA's request, this review will provide baseline data on chiropractic utilization by Medicare enrollees in managed care organizations. Chiropractic claims have recently become one of the more frequently billed services in Medicare. However, no centralized managed care chiropractic reimbursement data are available. This review will assist HCFA in monitoring managed care organizations' compliance with HCFA policies on chiropractic care.

*OEI; 04-97-00495*

## **Medicare Managed Care Prescription Drug Benefit**

This review will provide information on the coverage and payment of prescription drugs in Medicare managed care plans. Fee-for-service Medicare generally does not pay for outpatient prescription drugs, although some drugs, such as injectables for chemotherapy and medications

used with durable medical equipment, are covered. Medicare managed care plans may offer a capped prescription drug benefit, paying up to \$1,500 per year for drugs. We will examine how this limit is calculated for each beneficiary, which drugs are included, and how drug costs are determined by the managed care plan.

*OEI; 00-00-00000*

### **Managed Care Organization Closings**

This review will determine the impact on beneficiaries of recent closings of Medicare managed care organizations. In the fall of 1998, 42 of 347 risk plans announced that they did not intend to renew their Medicare contracts. Another 52 risk contracts reduced their service areas. Additional managed care organization withdrawals are expected. We will look at the impact of recent withdrawals on beneficiaries' ability to access care and to obtain Medigap policies and their willingness to join or stay in Medicare managed care organizations.

*OEI; 04-99-00170*

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## **MEDICAID MANAGED CARE**

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### **Medicaid Dually Eligible Fee-for-Service Payments**

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

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

### **Emergency Services to Enrollees of Medicaid Managed Care**

This review will assess how Medicaid managed care organizations are implementing the Balanced Budget Act's emergency service requirements. Under the statute, Medicaid managed care beneficiaries have the right to immediately obtain emergency care and services. A managed care organization must pay for the cost of these services, and the services must be covered without regard to prior authorization or the emergency care provider's contractual

relationship with the organization. Coverage of emergency services is to be determined under the “prudent layperson” standard, that is, services qualify as emergencies if a prudent layperson would interpret them that way. This review will evaluate how managed care organizations are interpreting the prudent layperson standard and how frequently this interpretation is questioned.

*OEI; 00-00-00000*

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## **MEDICAID - CHILDREN’S HEALTH INSURANCE PROGRAM**

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### **States' Outreach Efforts to Medicaid Eligibles**

This study will determine the effectiveness of State outreach efforts to Medicaid eligibles as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. State Medicaid agencies are expected to incur additional administrative costs to determine Medicaid eligibility for individuals who no longer receive automatic Medicaid eligibility through cash assistance linkage. These additional expenditures include the costs of outreach to potentially eligible individuals who no longer receive cash assistance. Section 1931(h) of the Social Security Act established a \$500 million enhanced Federal matching fund to cover these expenses. As part of this review, we will examine how States re-engineered outreach efforts to promote Medicaid.

*OEI; 00-00-00000*

### **Performance Measures**

This study will assess the current activities of the Department and the States to measure the effectiveness of the State Child Health Insurance Program and Medicaid expansions authorized by the Balanced Budget Act of 1997. We will address both legislative requirements and Institute of Medicine accountability recommendations. In addition, we will describe the activities currently underway to evaluate the programs regarding health service access, utilization, and health status outcomes of children covered by both programs.

*OEI; 00-00-00000*

## **Involvement of Federally Funded Health Centers in Children's Health**

We will examine the changing role of federally funded health centers in health care delivery to the children covered by State Child Health Insurance Programs and Medicaid expansions. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. The statute allows States to either create a new children's health insurance program or expand the existing Medicaid program. We will study health centers' participation in managed care organizations, their direct contracting with the new and expanded programs, and their formation of networks with other "safety net" providers.

*OEI; 06-98-00320*

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## **OTHER MEDICAID SERVICES**

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

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

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

### **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*

## **State Survey and Certification Costs**

At HCFA's request, we will review selected States' survey and certification costs to verify that costs have been allocated correctly among Medicare, Medicaid, and State licensing agencies and that federally approved indirect cost rates have been applied. We will also study, to the extent possible, variations in survey and certification unit costs from State to State to determine the extent that these variations reflect differences in salary and other costs versus efficiency (e.g., staff-hours allotted to a given type of survey) and other factors.

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

## **Credentialing Medicaid Providers**

This study will identify effective practices used by States in credentialing Medicaid providers. Some States are very careful about who can participate in the Medicaid program. They employ a variety of credentialing practices, including bonding, certification, background checks, and other activities to ensure that providers are reputable, competent, and accountable. We will also assess steps taken by States to credential Medicaid providers and to address the supply and availability of each type of provider within a State.

*OEI; 00-00-00000*

## **HCFA Oversight of Institutions for the Mentally Retarded**

We will review HCFA and State oversight of intermediate care facilities for the mentally retarded. About 7,200 institutions for the mentally retarded receive Medicaid reimbursement. These facilities, which house a total of about 130,000 residents, are surveyed annually by the appropriate State agency. A September 1996 GAO report raised questions about HCFA and State oversight. In response to the GAO report, HCFA regional offices are now to provide oversight of these surveys by accompanying State survey staff on a sample of visits. Recent news articles have raised questions about the quality of care in institutions for the mentally retarded.

*OEI; 00-00-00000*

## **Medicaid Payments to Institutions for the Mentally Retarded**

This follow-up review will examine the extent and causes of variation among States in per resident Medicaid reimbursement rates for large intermediate care facilities for mentally retarded people. In 1996, estimated Medicaid expenditures for such facilities reached \$9.6 billion for approximately 110,000 residents. To be certified to receive Medicaid reimbursement, the intermediate care facilities must annually meet 489 Federal standards.



However, Federal Medicaid rules for reimbursing States for the facilities are not clearly defined. A 1992 OIG report noted that Medicaid reimbursement per facility resident in some States was more than five times greater than that in other States. We also found that a lack of cost controls was correlated to excessive spending.

*OEI; 00-00-00000*

### **Medicaid Outpatient Prescription Drug Pricing**

At HCFA's request, we will update 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-06-00-00000*

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## **MEDICARE CONTRACTOR OPERATIONS**

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### **Comparison of Payment Safeguard Activities**

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

*OEI; 09-99-00080; 05-99-00070*

### **Identifying and Collecting Overpayments**

We will assess the effectiveness of contractor activities to identify and collect Medicare overpayments. Providers are often paid more than the appropriate amount for services they bill. Although contractors use a variety of methods to identify, quantify, and recover overpaid

trust fund amounts, some types of overpayments may never be identified. Further, once overpayments are identified, contractor efforts and success in recovering them vary widely.

*OEI; 04-98-00530, -00531, -00532; 03-98-00520*

### **Collecting Medicare Secondary Payer Overpayments**

We will evaluate the Medicare contractors' diligence in collecting Medicare Secondary Payer (MSP) overpayments. By statute, Medicare is the secondary payer to certain types of other insurance plans when medical services are provided to Medicare beneficiaries with other insurance coverage. The HCFA provides administrative funds to Medicare contractors to monitor and collect incorrect primary payments paid on behalf of these beneficiaries. Our review will follow through on the contractors' identification of and early action on potential MSP overpayments. Initially, we will develop and streamline our approach at one contractor before reviewing additional contractors across the Nation. As of March 31, 1999, the MSP accounts receivable (principal only) reported by the Medicare contractors in Region IV totaled over \$225 million.

*OAS; W-00-00-40011; A-04-00-00000*

### **Medicare Provider Numbers and Unique Physician Identification Numbers**

We will determine whether information associated with Medicare provider numbers and unique physician identification numbers is accurate and up to date. A number of OIG reports have identified deficiencies in the issuance of provider numbers for specific areas of the program, such as durable medical equipment providers and independent physiological laboratories. Other studies have noted that unused provider numbers are not deactivated timely and thus constitute a potential fraud vulnerability. In recent years, HCFA has taken a number of actions to standardize Medicare enrollment and has required providers to submit more information to ensure compliance with Social Security Act reporting requirements. We will assess the current condition of this information.

*OEI; 07-98-00410*

### **Billing for Resident Services**

We will assess the extent of improper Medicare billings resulting from the issuance of provider billing numbers to resident physicians at teaching hospitals. In general, Medicare regulations do not allow residents to bill Medicare for their services. The exception is if the billable services are related to "moonlighting" activities unrelated to the resident's training program. Our work at one carrier found that a hospital had requested and received over 40 billing numbers for its residents over a 6-year period. The residents were not involved in "moonlighting" activities, and the hospital used the numbers to improperly bill Medicare for

services provided by the residents. We will determine the extent of this condition at the carrier in this State and at other carriers.

*OAS; W-00-98-30003; A-05-98-00053*

### **Implementation of Therapy Caps**

This review will examine whether HCFA contractors have developed the systems necessary to implement provisions of the Balanced Budget Act related to therapy caps. The act limits Part B physical therapy payments to \$1,500 per year, regardless of the setting in which the therapy is received. Currently, HCFA and the fiscal intermediaries do not have a system for comparing therapy provided in the home and in the nursing home. Such a system will be necessary to ensure that beneficiaries do not receive more than \$1,500 a year in therapy. We will review contractor operations to implement these provisions and determine whether the payment limits have been exceeded.

*OEI; 00-00-00000*

### **Contractors' Year 2000 Remediation Costs**

At HCFA's request, we will determine the allowability, allocability, and reasonableness of the costs reported by approximately 50 fiscal intermediaries and carriers (contractors) for Year 2000 remediation of their Medicare computer systems. The HCFA has provided and is continuing to provide Year 2000 funding to each of its contractors based on budget requests. We will evaluate the contractors' reported expenditures in relation to the funding they have requested and received through HCFA's budget allocation process.

*OAS; W-00-00-30031; Various CINs*

### **Preaward Review of Medicare Integrity Program Contract Proposals**

At the request of HCFA's contracting officer, we will review the cost proposals of various bidders under HCFA's Medicare Integrity Program. The results of these reviews will assist the HCFA contracting office in identifying the most cost-efficient bidders and in negotiating a cost-beneficial contract award.

*OAS; W-00-00-30006; A-00-00-00000*

## **Contract Close-Out Audits of Peer Review Organizations**

At HCFA's request, we will audit the allowability, allocability, and reasonableness of costs incurred by various PROs whose contracts under HCFA's fifth Statement of Work will expire during the fiscal year. Our reports will provide HCFA's contracting officer with recommendations on the amount, if any, of the PROs' claimed costs that should be disallowed.

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

## **Contractors' Administrative Costs**

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

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

## **Unfunded Pensions**

This series of reviews requested by HCFA will determine if unallowable costs were identified and eliminated in computing allowable pension costs charged to the Medicare program. Regulations provide that pension costs not funded for an accounting period, plus interest on the unfunded amounts, are unallowable components of future-year pension costs. These reviews will be performed in conjunction with our pension segmentation audits.

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

## **Pension Segmentation/Costs Claimed**

At HCFA's request, we will determine whether Medicare contractors have fully implemented contract clauses requiring them to determine and separately account for the assets and liabilities of the Medicare segment of their pension plans and to assess Medicare's share of future pension costs on a segmented basis. We will also determine whether contractors use a reasonable method for claiming reimbursement for pension costs under their Medicare contracts.

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

## **Pension Termination**

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

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

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## **GENERAL ADMINISTRATION**

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

We will determine whether Medicare fee-for-service benefit payments are (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 1998, estimated improper payments totaled \$12.6 billion, or 7.1 percent of the \$176.1 billion total spent on Medicare fee-for-service claims.

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

### **Year 2000 Computer Renovation Plans**

We will continue to determine the adequacy of HCFA's planning, management, and assessment of the Year 2000 system compliance problem and assess the risk that HCFA's mission-critical, internal information systems may not operate effectively and efficiently at January 1, 2000. The scope of this review includes the 25 internal systems designated by HCFA as mission-critical, as well as other internal systems and data exchanges with external systems that are essential for the continuity of HCFA's programs and operations. This review is part of our Departmentwide Year 2000 compliance review.

*OAS; W-00-98-40007; A-14-00-00000*

## **Analysis of HCFA Data**

We will analyze existing HCFA data to identify vulnerable beneficiary populations and program benefits, test new methods of detecting high-risk claims and providers, and evaluate the efficiency and effectiveness of current programs and contractors. Through this series of reviews, we will also provide insight into the present health care environment and establish a baseline for observing change. Efficient administration of Medicare depends on making full use of available data for strategic decision-making.

*OEI; 00-00-00000*

## **OIG-Excluded Persons**

We will examine how Federal programs use OIG exclusion data to protect federally funded programs and their beneficiaries from fraudulent or poorly performing health care providers. We will also identify the number of claims submitted by these excluded providers. Every year the OIG excludes 1,200 to 1,500 fraudulent or unqualified practitioners from Medicare and Medicaid participation for various durations. Interested parties are able to identify these excluded providers by virtue of broad dissemination of OIG exclusion data and other means. However, anecdotal indications are that Federal programs other than Medicare and Medicaid do not use this information, even though these providers are potentially harmful to Federal programs and their beneficiaries.

*OEI; 07-98-00380, -00381, -00382*

## **Medicare Secondary Payer**

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

*OAS; W-00-99-30030; A-01-98-00531, A-09-99-00000*

*OEI; 07-98-00180*

## **Joint Work With Other Federal and State Agencies**

To efficiently use audit resources, we will continue our efforts to provide broader coverage of the Medicaid program by partnering with State auditors, State departmental internal auditors and Inspectors General, Medicaid agencies, and HCFA financial managers. Since 1994, active partnerships have been developed with States on such issues as prescription drugs, clinical laboratory services, the drug rebate program, and durable medical equipment. Future joint initiatives will cover managed care issues, hospital transfers, prescription drugs, laboratory services, nonphysician outpatient services, and nursing home services. In addition, we will continue to work with the National State Auditors Association on a joint audit of long-term care in six States. Potential audit areas include evaluating the licensing and inspection of nursing homes and the reimbursement system.

*OAS; W-00-00-30001; 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.

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

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

## **Medicare Part A**

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

## **Medicare Part B**

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

## **Medicare Part C**

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

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

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

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



## **Medicaid**

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

### **Pneumonia Diagnosis-Related Group Upcoding Project**

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

### **Prospective Payment System Transfer Project**

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

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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 all major health care fraud cases, including the imposition of exclusions and civil monetary penalties and assessments. OCIG represents OIG in administrative litigation, such as patient dumping cases 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 the development of OIG regulations, including new safe harbor regulations under the anti-kickback statute. Work planned in FY 2000 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 during the first half of FY 2000 pertaining to Medicare+Choice organizations offering coordinated care plans and to nursing homes and ambulance companies. The adoption and

implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse, and waste in Federal health care plans while furthering the health care industry's fundamental mission to provide quality patient care.

*Expected Completion Date: Ongoing*

### **Corporate Integrity Agreements**

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

*Expected Completion Date: Ongoing*

### **Advisory Opinions and Fraud Alerts**

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

*Expected Completion Date: Ongoing*

### **Anti-Kickback Safe Harbors**

Near the beginning of FY 2000, we will publish final regulations establishing eight new safe harbor exemptions from the anti-kickback statute. Also, we will evaluate comments that the OIG solicited from the public concerning proposals for additional safe harbors. Where appropriate, we will develop proposed and final regulations for additional safe harbors.

*Expected Completion Date: Ongoing*

## **Patient Anti-Dumping Statute Enforcement**

We expect to increase the number of patient anti-dumping cases reviewed, negotiated, and litigated and to resolve approximately 70 such cases in FY 2000. In addition, we plan to continue our efforts to enhance awareness of the statute's requirements and increase the referral of possible violations through an outreach program aimed at State survey agencies, State peer review organizations, and hospital personnel.

*Expected Completion Date: Ongoing*

## **Program Exclusions**

In coordination with the Office of Investigations, we anticipate increasing the number of program exclusions imposed by the OIG. In addition, we intend to issue an advisory bulletin regarding the scope and effect of program exclusions.

*Expected Completion Date: Ongoing*

## **Civil Monetary Penalties**

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

*Expected Completion Date: Ongoing*

**Department of Health and Human Services**

**Office of Inspector General  
Projects**



**PUBLIC HEALTH SERVICE AGENCIES  
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## CENTERS FOR DISEASE CONTROL AND PREVENTION

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### **National Immunization Tracking System**

We will describe how the current national immunization tracking system is functioning. We will specifically address concerns that have been raised about the coordination and tracking of vaccines provided to children in private settings, access to the data base by private providers and other practitioners, and the handling of patient privacy. The Comprehensive Childhood Immunization Act of 1993 was created to improve the Nation's immunization delivery system. The act calls for the Secretary to purchase and provide free vaccines, to establish a national tracking system or registries, to ensure that the National Vaccine Injury Compensation Program remains operational, and to continue vaccine infrastructure enhancements.

*OEI; 05-99-00270*

### **Controls Over Program Budgeting and Accounting**

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

Although most of its funding is provided through a single-line appropriation covering a wide range of activities, CDC receives guidance and direction from the Congress and HHS on establishing budgets for many individual programs. Building on information obtained during our recent review of costs charged to the Chronic Fatigue Syndrome program, we will identify programs for which CDC has received specific budgetary guidance or for which CDC officials have provided the Congress and the Department with detailed data related to program costs. We will then determine whether the costs budgeted and charged to those programs are appropriate and have been properly reported.

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

## **Follow-Up on Chronic Fatigue Syndrome Program Issues**

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

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

## **Controls Over Physical Security**

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

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

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# **FOOD AND DRUG ADMINISTRATION**

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## **State Accountability for Ensuring Food Safety**

We will assess how well the Food and Drug Administration (FDA) holds States accountable for food safety inspections. While FDA has authority over food firms engaging in interstate commerce, approximately 3,000 State and local jurisdictions also have authority over food firms within their boundaries, whether or not interstate commerce is involved. Both FDA and the States conduct food safety inspections, and in recent years, FDA has delegated certain inspections work to many States for a limited number of food products. As FDA and other Federal and State agencies responsible for food safety work toward developing a "seamless" regulatory system for ensuring the safety of the Nation's food supply, accountability will become an increasingly important issue.

*OEI; 01-98-00400*

## **Biennial Inspection Requirement**

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

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

## **Effectiveness of MedWatch**

We will evaluate the effectiveness of MedWatch, FDA's medical products safety reporting program. The FDA is responsible for ensuring the safety and efficacy of all regulated, marketed medical products, including drugs, biologics, medical and radiation-emitting devices, and special nutritional products. Created in 1996, MedWatch was designed to (1) educate health professionals about the importance of monitoring for and reporting adverse reactions and other problems to FDA and/or the manufacturer, (2) enhance the effectiveness of postmarketing surveillance of medical products, and (3) ensure that safety and labeling changes are rapidly communicated to the medical community, thereby improving patient care.

*OEI; 00-00-00000*

## **Recruiting Human Subjects for Industry-Sponsored Clinical Trials**

We will assess sponsor and investigator efforts to recruit human subjects for clinical trials on a timely basis. To gain FDA approval to market new drugs, pharmaceutical companies must document the drug's safety and effectiveness through clinical trials. Recruiting an adequate number of human subjects for these trials is a large hurdle and has been blamed for 25 percent of the delays in development of 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; 01-97-00195*

## **Clinical Investigations of Human Drugs**

This review will evaluate FDA's monitoring of clinical research conducted in support of new drug applications. The FDA audits clinical investigations of human drugs to ensure that the research data submitted by drug manufacturers are valid and scientifically sound and that investigators have adequately protected research subjects. Clinical studies selected for audit generally are those for which safety and efficacy data have been determined as pivotal in the



decision to approve a new drug for marketing. Audits are also conducted in situations of possible scientific misconduct, suspicion of fraudulent data, or potential lack of human subject protection by clinical investigators. Recent media reports disclosed two cases in which clinical investigators falsified research data submitted to pharmaceutical companies to support new drug approvals.

*OAS; W-00-00-50004; A-00-00-00000*

### **Sanctions of Clinical Investigators**

We will assess departmental oversight of clinical investigators subject to FDA regulation. As part of its regulatory function, FDA is authorized to sanction persons who have engaged in research misconduct, such as falsification of research data or repeated violations of regulatory requirements. Sanctioned clinical investigators are not necessarily subject to sanction action by other Federal entities. We will examine whether FDA's use of the disqualification authority adequately protects the public and the clinical research process from dishonest or noncompliant investigators and whether other departmental agencies and programs, such as Medicare, have procedures for protecting their program beneficiaries from FDA-sanctioned researchers who may pose a threat.

*OEI; 05-99-00350*

### **Blood Safety Consent Decrees**

This review will evaluate FDA's oversight of consent decrees involving the two largest blood collection organizations in the United States, which collect over 60 percent of the Nation's blood supply. These decrees resulted from deficiencies identified during FDA inspections. Under the consent decrees, which are legally enforceable documents, the blood inspection organizations have agreed to improve the quality of their operations by implementing a more comprehensive quality assurance program and increasing training for all blood workers; improving data systems and records management; and strengthening policies for investigating and reporting errors, accidents, and adverse reactions.

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

### **Follow-Up of Blood Safety Issues**

This review will examine FDA's efforts to improve its oversight of the safety of the Nation's blood supply. Our work will focus on problems the OIG previously identified regarding the blood error and accident reporting process, the blood recall process, and the inspection process

for plasma fractionators. Our objective will be to determine if FDA has implemented the specific recommendations made in earlier OIG reports.

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

### **FDA's Bioterrorism Program**

At the request of the Subcommittee on Oversight and Investigations, House Committee on Commerce, we will assess FDA's actions to implement its bioterrorism research program. As part of the FY 2000 budget request, FDA is seeking over \$13 million to engage in research on, for example, vaccines and antidotes related to biological terrorism. The Subcommittee has specifically requested that we examine FDA's controls in such areas as safeguarding hazardous materials, securing classified research data, and ensuring that staff have adequate background reviews.

*OAS; W-00-00-50004; A-00-00-00000*

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## **HEALTH RESOURCES AND SERVICES ADMINISTRATION**

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### **State Licensing Boards and Discipline of Physicians**

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

*OEI; 00-00-00000*

### **Training Programs in the Maternal and Child Health Bureau**

We will evaluate training programs funded as "Special Projects of Regional and National Significance" under the Maternal and Child Health Program. The statute provides that about 15 percent of funds appropriated for the Maternal & Child Health block grant be set aside for these special projects. Funding for training has generally been a major portion of the set-aside. In FY 1999, about 160 training grants were funded at a cost of approximately \$42 million. The

training program has never been evaluated. As part of our evaluation, we will look at the process for awarding grants and oversight of grantee performance.

*OEI; 04-98-00090*

### **Ryan White Cost Containment Strategies**

We will examine the various cost containment strategies, such as PHS 340B drug purchasing, used by AIDS drug assistance programs to purchase drugs at the lowest available cost. The Ryan White Comprehensive AIDS Resource Emergency Act requires that States use a portion of their funding to establish a drug assistance program for low-income people living with HIV/AIDS who are uninsured or underinsured and lack coverage for medication. In FY 1998, the Congress appropriated \$285.5 million for drug assistance program use. A 1998 OIG review of five such programs found that they could have purchased an additional 8 percent, or \$4.4 million, of drug therapies had they participated in 340B drug purchasing.

*OEI; 00-00-00000*

### **New York's Use of CARE Act Funding**

We will assess New York State's administration and use of Ryan White Comprehensive AIDS Resource Emergency (CARE) Act funds. We will audit the State's costs (\$78 million for the year ended March 31, 1998) for program services to verify that the expenditures were reasonable and consistent with the purpose of the CARE Act. In addition, we will look at cost sharing (\$38 million for the same year) claimed by the State to determine whether it was program related and met from nonfederal sources. We will also audit subrecipient costs (\$17 million for the year) to test controls over subrecipient programs and to verify that the funds were spent appropriately.

*OAS; W-00-98-50005; A-02-98-02503*

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

We will examine the coordination of HIV/AIDS prevention and treatment services by HRSA's Ryan White programs, CDC, and the Substance Abuse and Mental Health Services Administration (SAMHSA). The Ryan White CARE Act requires the Secretary to ensure that HRSA, CDC, and SAMHSA coordinate the planning and implementation of Federal HIV programs to facilitate the local development of a complete continuum of HIV-related services. The statute also requires the Secretary to submit, no later than October 1, 1996, and biennially

thereafter, a report concerning these coordination efforts, including a statement of whether and to what extent Federal barriers exist to integrating HIV-related programs. The required report has yet to be submitted.

*OEI; 00-00-00000*

### **Organ Donation Referral**

We will review the impact of a recent change in Medicare's conditions of participation that requires all hospitals to refer potential donor families to the local organ procurement organization. About 4,000 people die each year waiting for a transplant. It is estimated that 3,000 to 4,000 donor families are never asked about donation. The new Health Care Financing Administration (HCFA) policy is designed to ensure that hospitals do not overlook suitable donors. Our study will be coordinated with HRSA's organ allocation and donation initiatives.

*OEI; 01-99-00020*

### **Patient Access to Transplantation**

A series of focused reviews, based on recently released data, will examine issues relating to organ waiting lists and access to transplantation. In 1991, we issued a report entitled "The Distribution of Organs for Transplantation: Expectations and Practices." At that time, just over 20,000 people were on transplant waiting lists. In 1999, more than 61,000 people are waiting for a transplant. Our series of reviews will examine a number of issues involving patient access to transplants, including regional differences in waiting times, demographic analysis of patients who are listed at more than one transplant center, and the impact of State "resident-only laws" to ensure that organs donated within a State will be transplanted to State residents.

*OEI; 01-99-00210*

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## **INDIAN HEALTH SERVICE**

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### **Impact of Self-Governance on IHS Services**

We will assess the effect of Indian self-governance on the Indian Health Service's (IHS) ability to provide needed health care services to the Indian people. As an increasing number of tribes elect to manage their own health care through self-governance compacts, IHS must ensure that there are no limits or reductions in the direct care it provides to tribes that do not elect to provide their own care. We will determine (1) if there are adequate controls to ensure that needed health care services are provided with compacting funds and (2) the impact on

nearby IHS facilities should compacting tribes be unable to adequately or fully meet the health care needs of their members.

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

### **Tribal Self-Governance Compact Award Process**

We will examine the process used by IHS to award compacts to tribes under the Tribal Self-Governance Demonstration Project. With nearly 20 percent of the IHS budget provided to Indian tribes through the compact mechanism, the agency needs to ensure that it has implemented the demonstration project as the Congress intended and has effectively used the authorities available to it. Our review will focus on project compliance with key tenets of the legislative mandate and the use of project management and evaluation tools in support of agency oversight responsibilities.

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

### **Medicare Pricing for Contract Health Services Program: Outpatient Services**

We will analyze the potential cost savings to the IHS Contract Health Services Program if legislation is enacted that requires outpatient health service providers to accept rates similar to Medicare's. This program pays outpatient providers \$44 million annually to care for eligible beneficiaries living outside IHS' direct care boundaries or for those requiring specialty care. These health services are currently purchased using negotiated contracts, which generally do not reflect competitive rates.

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

### **IHS Audit Resolution Process**

We will determine whether and to what extent the IHS audit resolution process meets legislative and regulatory requirements. The Office of Management and Budget (OMB) Circular A-133 requires awarding agencies to (1) ensure that Indian tribes that receive Federal funds of \$300,000 or more submit annual audits required by the Single Audit Act (as amended in 1996) and (2) resolve annual audit findings applicable to their programs. In FY 1999, IHS will award over \$900 million to Indian tribes with a projected increase in FY 2000 to \$1 billion (42 percent of the IHS budget).

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

## **Equal Employment Opportunity Program**

We will review IHS' Equal Employment Opportunity program. The IHS employs over 14,000 individuals to administer, deliver, and facilitate the provision of health care to Native Americans and Alaska Natives. This review, requested by the Director of IHS, will cover management practices and issues of timeliness, delegations of authority, training, conflict of interest, and confidentiality.

*OEI; 05-99-00290*

## **IHS Facilities**

The IHS, which is the largest property owner in the Department, asked OIG to examine the condition of its existing health care facilities compared with that of similar structures owned by the Federal Government and the private sector. According to IHS officials, the agency's buildings are old and costly to repair and could affect the quality of care provided to beneficiaries of their programs.

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

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# **NATIONAL INSTITUTES OF HEALTH**

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## **Superfund Financial Activities for Fiscal Year 1999**

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 the Superfund. 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 1998, agency obligations and disbursements of Superfund resources amounted to \$61.2 million and \$55.8 million, respectively.

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

## **Cooperative Agreements With the Pharmaceutical Industry**

We will review the National Cancer Institute's (NCI) collaboration with the pharmaceutical industry in developing new drugs to assess the costs and benefits to the Federal Government and the taxpaying public. When NCI develops new drugs, it enters into cooperative research and development agreements with pharmaceutical companies to test the drugs and to submit the data to FDA for marketing approval. Because these cooperative agreements afford the

pharmaceutical industry benefits from the Federal investment in NCI's research, it is important to ensure that the Government's and taxpayers' interests are safeguarded. Preliminary work indicates that NCI is collaborating with the pharmaceutical industry on over 90 investigational cancer drugs.

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

### **Grantee Adherence to the Bayh-Dole Act**

We will determine whether selected grantee institutions followed certain provisions of the Bayh-Dole Act of 1980 in regard to medical devices and drugs recently brought to market and developed with the assistance of Federal grant funds. The act transfers title and ownership of inventions developed with Federal grant funds to the grantee institutions. In return, the grantees must adhere to certain reporting requirements regarding the inventions, and any patents that may result from them, and agree to substantially manufacture any invented products in the United States. We will also determine if the grantee institutions give the Government a license to use the inventions and the right to purchase them at royalty-free prices.

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

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

We will determine whether the National Institutes of Health (NIH) is in compliance with HHS and Department of Transportation regulations on the handling, storage, and disposal of equipment exposed to hazardous materials. The NIH uses hazardous materials in its hospitals, clinics, and research. If not properly handled, equipment exposed to hazardous material can contaminate individuals and resources. We reported in the 1980's that NIH had surplused some contaminated equipment before decontamination.

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

### **Security of NIH Laboratories**

This review will determine whether the NIH master plan for a security system at its laboratories complies with the President's June 1995 directive that all Federal agencies upgrade security at their facilities to meet minimum standards recommended by the

Department of Justice. The minimum standards are categorized under perimeter security, entry security, interior security, and security planning.

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

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

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### **External Oversight of Inpatient Psychiatric Units and Facilities**

We will assess the external quality review of prospective payment system-exempt inpatient psychiatric units in acute care hospitals that participate in the Medicare program. Because of the number of deaths associated with the use of restraints and seclusion, SAMHSA has recently raised concerns echoed by the OIG, the Congress, and advocacy groups for the mentally ill about the quality of care in psychiatric facilities. The SAMHSA-funded State protection and advocacy organizations are the only federally funded agencies with authority to investigate reports of abuse and neglect in psychiatric facilities. We will examine their role and the roles of the other major entities that the Federal Government relies on to ensure that psychiatric hospitals meet the minimum standards for participation in Medicare. Bills have been introduced in both the House and the Senate to address the inappropriate use of restraints and seclusion in psychiatric facilities.

*OEI; 01-99-00160*

### **Patient Abuse Reporting - Psychiatric Hospitals**

To profile quality of care problems in psychiatric hospitals, as discussed above, we will describe what current data systems can tell us about abuse and death of patients. We will conduct a systematic analysis of data reporting systems which will encompass all agencies and entities that have a role in patient abuse reporting, with special emphasis on the incidence of problems associated with the use of restraints and seclusion. Our analysis will include data systems maintained by the SAMHSA-funded State protection and advocacy organizations, which are the only agencies receiving Federal funds that are authorized to investigate reports of abuse and neglect in facilities that care for or treat persons with mental illness.

*OEI; 04-99-00150*



## **Substance Abuse Treatment Needs of Welfare Recipients**

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

*OEI; 00-00-00000*

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## **PHS AGENCIES-WIDE ACTIVITIES**

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### **Year 2000 Computer Renovation Plans**

We will continue to evaluate the efforts of the Public Health Service (PHS) operating divisions, as well as those of the Program Support Center, to meet Year 2000 computer renovation and validation goals. The Federal Government's Year 2000 project strategy regarding computer systems places emphasis on ensuring that agencies' mission-critical systems are Year 2000 compliant before December 31, 1999, to avoid widespread system failures. Our work will focus on ensuring that the most critical systems have business continuity plans in place in the event of Year 2000 systems failures. This review is part of our Departmentwide Year 2000 compliance review.

*OAS; W-00-98-40007; A-15-98-80002*

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

The OMB Circular A-21, revised May 8, 1996, requires that colleges and universities disclose their cost accounting practices by filing disclosure statements. The statements are designed to promote uniformity and consistency in the cost accounting practices followed by colleges and universities and to ensure that only allowable costs are claimed and that costs are equitably allocated to Federal projects. Our continuing reviews will determine whether disclosure statements are complete and accurate, reflect current practices, and comply with cost accounting standards and pertinent cost principles.

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

## **Recipient Capability Audits**

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

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

## **Reimbursable Audits**

We will conduct a series of audits in accordance with OMB Circular A-133, which assigns audit cognizance for approximately 95 percent of the Nation's nearly 3,000 colleges and universities to the Inspector General of HHS. Audit cognizance requires that we perform 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 recently incorporated in OMB Circular A-21.

*OAS; W-00-00-50012; 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 have reviewed such issues as library allocations, medical liability insurance, internal service funds, fringe benefit rates, and space allocation. These assist audits have helped to substantially reduce indirect cost rates at the institutions reviewed.

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

## **Follow-Up 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 group has identified certain prior audits by nonfederal auditors as having circumstances that need further investigation.

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

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## INVESTIGATIONS

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

As a result of a closer relationship being forged between the OIG's Office of Investigations (OI) and the Office of Research Integrity (located in the Office of the Assistant Secretary for Health), OI expects to investigate more scientific misconduct cases referred by that Office. These matters may involve allegations of fiscal improprieties, such as embezzlement or misappropriation of funds, that cannot be addressed by the Office of Research Integrity because it lacks such authority.

**Department of Health and Human Services**

**Office of Inspector General  
Projects**



**ADMINISTRATIONS FOR CHILDREN,  
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## WELFARE REFORM

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### **AFDC Overpayment Collections**

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

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

### **Technical Assistance to States**

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

*OEI; 00-00-00000*

### **Work Participation Data**

We will examine the quality and uniformity of State data reported to ACF on TANF recipients' work participation rates. The ACF uses these data to monitor program performance and, specifically, to determine if States have met their federally defined work participation target rates. The Personal Responsibility and Work Opportunity Reconciliation Act imposes financial penalties if States do not meet target rates.

*OEI; 00-00-00000*

*Expected Issue Date: FY 2001*

### **Performance Bonuses**

We will determine whether States that received bonus funds reported reliable and accurate performance data. Recent amendments to the Social Security Act made \$1 billion available

over a 5-year period to reward States that achieved high performance levels under TANF. The first award of \$200 million will be made based on performance during Fiscal Year (FY) 1999.

*OAS; W-00-00-20016; A-06-00-00000, A-07-00-00000*

### **Recipient Sanction Policies**

We will describe how States implemented recipient sanctions under the TANF program. The sanctions, which may be imposed for failure to meet program requirements, are one tool in moving welfare recipients into the work force. The extent to which they are used appropriately and support this goal is important for the success of the program. The number of recipients sanctioned has increased over the past 2 years.

*OEI; 09-98-00290*

### **Use of TANF Funds**

This joint review will examine how States have used TANF funds and their strategies for using unobligated balances. In selected States, we will determine whether TANF funds were allocated and spent in accordance with applicable policies and procedures. Also, many States have a considerable surplus resulting from a significant caseload decrease. We will determine if there are other major factors influencing the surplus. This review will assist ACF in responding to a recent Office of Management and Budget (OMB) request for information on the States' use of TANF funds.

*OAS; W-00-00-20016; A-05-00-00000, A-06-00-00000*  
*OEI; 00-00-00000*

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## **CHILD CARE**

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### **Child Protective Service Effectiveness**

We will determine whether State Child Protective Service referrals were properly prioritized and whether any service delays could result in further occurrences of child abuse and/or neglect. We will also examine recidivism rates and the extent of State outreach efforts to alert the community to the problem of child abuse.

*OAS; W-00-99-20018; A-04-99-00130*

## **Technical Assistance for Quality Child Care**

We will examine the ACF Child Care Bureau's regional offices' experiences with the technical assistance they receive for supporting State child care agencies. The ACF contracts with private entities to coordinate technical assistance to States and regions. As States experience an increasing number of children in child care as a result of welfare reform, the technical assistance provided through these contracts will be critical to assist regions in supporting State agencies.

*OEI; 07-97-00422*

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## **CHILD SUPPORT**

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### **Interstate Case Collections**

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

*OEI; 00-00-00000*

### **Earnings of Noncustodial Parents**

At the request of the Office of Child Support Enforcement and the Assistant Secretary for Planning and Evaluation, we will examine the earnings of a sample of noncustodial parents, review child support agency actions to collect sums owed, and determine increased collection opportunities. Nationally, child support collections are low; only about 30 percent of custodial families receive regular child support. Little empirical information exists on the actual earnings or earnings potential of noncustodial parents.

*OEI; 05-99-00390*

### **Welfare Recipient Cooperation**

We will review State processes used to determine welfare recipient cooperation in establishing child support orders, including provisions that release recipients from cooperation obligations. In an effort to maximize child support collections, custodial parents receiving public assistance



are required to cooperate with authorities in locating absent parents for payment of child support. Cooperation includes providing the name of the father and any other information that was known by, or could be reasonably obtained from, the mother. Under welfare reform, child support offices take a more active role in obtaining cooperation.

*OEI; 06-98-00040*

### **Support Program for Noncustodial Parents**

This review will assess State and local programs to provide group support, training, and incentives for unemployed and underemployed noncustodial parents and the programs' impact on preventing or reducing arrearages. An effective program could benefit custodial parents and States by increasing child support collections and decreasing enforcement costs.

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

### **State Child Support Fees**

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

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

### **Penalties for Failure to Report New Hires**

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

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

## **Federal Parent Locator Service**

We will examine implementation of the expanded Federal Parent Locator Service, a computerized national location network operated by the Office of Child Support Enforcement. The Personal Responsibility and Work Opportunity Reconciliation Act expanded the existing Locator Service by requiring ACF to develop a National Directory of New Hires and a Federal Case Registry of Child Support Orders. As a result, enhanced coordination among State new hire directories, case registries, and ACF will be necessary.

*OEI; 00-00-00000*

*Expected Issue Date: FY 2001*

## **Privatization of State IV-D Agency Services**

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

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

## **State Systems Operation and Maintenance Contracts**

This review will examine the adequacy of States' procurement of operation and maintenance services for their child support management information systems. We also will determine whether States properly monitored contracts to ensure that deliverables were timely and met Federal standards. The ACF has encountered some difficulty in having States pursue full, open competition.

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

## **Court Administration Charges**

To assist ACF, we will determine whether the costs claimed by a State Office of Court Administration, which provides child support enforcement services, are allowable, allocable, and reasonable. Costs associated with court filing fees; compensation of judges; and travel, training, and related office costs incurred by judges are not allowable for Federal reimbursement. From April 1, 1996, through March 31, 1997, the Office of Court

Administration claimed \$24.3 million for services related to the child support enforcement program. These costs have not previously been reviewed by State or Federal entities.

*OAS; W-00-00-20005; A-02-00-00000*

### **Medical Insurance Coverage: Detection and Coordination with Medicaid**

We will determine the progress State child support enforcement agencies have made in detecting available dependent health insurance and coordinating the information with State Medicaid agencies. By law, Medicaid pays secondary to other insurance which may exist for beneficiary health care. This also pertains to dependents of absent parents for whom a court order requires that medical insurance be provided. Under a recent requirement, all child support orders enforced under the law must include a provision for health care coverage. If the absent parent changes jobs and the new employer provides health care coverage, the State must send notice of coverage (which serves to enroll the child in the health plan) to the new employer.

*OEI; 07-97-00500*

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## **INVESTIGATIONS**

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

The OIG's Office of Investigations and the Office of Child Support Enforcement developed a task force model that is currently being implemented in Columbus, Ohio, and Baltimore, Maryland. It calls for the Office of Investigations, U.S. Marshals, U.S. Attorney Offices in 15 districts, local law enforcement, local prosecutors, State child support agencies, and other interested parties to join forces in creating a coordinated effort to identify, investigate, and prosecute criminal nonsupport cases in seven States — Illinois, Ohio, Michigan, Maryland, Virginia, Delaware, and Pennsylvania — and the District of Columbia.

The task forces investigate intrastate as well as interstate cases, making the involvement of local law enforcement and prosecutors critical. The task force model will be exported to three other areas of the country during the fiscal year.

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## FOSTER CARE

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

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

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

### **State Oversight of Residential Foster Care**

We will describe and evaluate State licensing and monitoring of residential foster care — 24-hour group care of children provided by paid staff unrelated to the children. Child welfare experts estimate that about 17 percent of all “out-of-home” care is provided by residential facilities. These experts have also raised concerns about the variance in State oversight of these institutions. This review is of interest to both ACF and the Child Welfare League of America.

*OEI; 00-00-00000*

### **Licensing and Oversight of Group Homes**

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

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

### **Therapeutic Foster Care Per Diem Rates**

We will evaluate the criteria used to determine whether therapeutic foster care is needed and whether the need for continued care at that level is adequately supported. Children who are considered to be emotionally disturbed and who cannot be properly cared for in regular foster

care homes are placed in therapeutic foster care homes. Because these children require intensive monitoring and counseling, their per diem rates are considerably higher than rates for regular foster care. Our survey work in one State indicates that many children remained in therapeutic foster care homes after they no longer needed intense monitoring and counseling.

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

### **Cost Shifting of Juvenile Justice Costs**

We will determine whether Title IV-E funds have been misused to pay for children in detention facilities, forestry camps, training schools, or other facilities operated primarily for the detention of children determined to be delinquent. Title IV-E funds are not authorized for such purposes. During our review of one State's emergency assistance program, we learned that the State had received Title IV-E foster care maintenance payments on behalf of children living in detention facilities.

*OAS; W-00-00-20008; A-03-00-00000*

### **Foster Care Claims Filed by States**

We will determine whether Title IV-E claims filed by States are accurate, adequately supported, and comply with Federal eligibility requirements. We will review both retroactive and current claims. Previous work identified \$6.4 million in a State's prior-quarter adjustments that could not be supported. Similarly, an ACF review of a State's foster care claims determined that 42 percent of the cases and 46 percent of the dollars reviewed were ineligible in 1994. We believe that similar situations may exist in other States.

*OAS; W-00-98-20008; A-04-98-00123, -00126*

### **Use of Consultants to Maximize Revenue**

We will review one State's use of contracts with consultants to maximize State revenue, such as that available through Federal grants. The consultants receive compensation based on a percentage of the new revenues they help to obtain. We will evaluate whether the costs of such services are inappropriately charged to the foster care program, either directly or indirectly, and the impact of such services on the program.

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

## **Barriers to Freeing Children for Adoption: Follow-up**

We will review the progress child welfare programs have made in facilitating adoptive placements. The OIG's February 1991 report entitled "Barriers to Freeing Children for Adoption" (OEI-6-89-01640) focused on children in foster care who could not return to their families. The report identified a number of problems in the process of terminating parental rights which delayed or prevented children from leaving foster care and entering permanent adoptive homes. Since our report was issued, the Department has developed the Adoption 2002 initiative and the Congress has passed the Adoption and Safe Families Act of 1997, both of which are designed to facilitate the adoption of foster children.

*OEI; 00-00-00000*

## **Adoption and Foster Care Analysis and Reporting System**

We will review State implementation of the Adoption and Foster Care Analysis and Reporting System. Under this management information system, States are required to collect case-specific data on all children in foster care for whom the State child welfare agency has responsibility for placement, care, or supervision. Also, States are required to collect data on all adopted children who were placed by the State child welfare agency and report semiannually. The Department provides over \$4 billion annually to States to support foster care programs. Reliable management data has become critical in measuring caseload activities.

*OEI; 00-00-00000*

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## **HEAD START**

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### **Construction of Head Start Facilities**

This review, requested by the ACF Region IX Administrator, will examine the implementation of Head Start program provisions for constructing Head Start facilities. It will include a review of ACF procedures for reviewing and approving grantees' applications for construction funds to ensure Head Start use of facilities after they are constructed. This review will follow up on a previous OIG review entitled "Review of Facility Purchases by the Head Start Program During Fiscal Years 1993 and 1994" (A-09-94-00085), issued in June 1996.

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

## **Renovation Costs of Head Start Facilities**

This review will assess the Head Start program process for reviewing, negotiating, approving, and monitoring grantees' applications and funding of major facility renovations. The OIG's 1996 report on the acquisition of Head Start facilities (A-09-94-00085) noted that a major part of acquisition costs involved substantial renovations to the purchased facilities to bring them into compliance with program performance standards. It also noted the lack of program regulations and guidance in this area. Other OIG reviews also noted that grantees did not always obtain complete and professional estimates of the cost of such renovations, which affected their ability to complete the work on time and within budgeted costs.

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

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## **DEVELOPMENTAL DISABILITIES**

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### **Criminal Background Checks on Caretakers of Individuals With Disabilities**

We will determine whether States should require background checks of individuals working as caretakers of individuals with disabilities. Two previous reviews, one on elderly care providers and the other on child care providers, identified instances in which arrested and convicted individuals were employed as caregivers. Recent media reports on the deaths of mental health patients, along with requests by advocacy groups to look into the misuse of restraints and seclusion, have raised questions about the hiring practices of facilities that care for the disabled.

*OAS; W-00-00-20010; A-01-00-00000*

*Expected Issue Date: FY 2001*

### **Safeguarding Persons With Disabilities**

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

*OAS; W-00-99-20002; A-01-99-02500*

### **Employment of People With Developmental Disabilities**

As requested by the Administration on Developmental Disabilities, we will describe promising approaches and barriers to employment programs for people with developmental disabilities. The Administration on Developmental Disabilities funds State developmental disability

councils whose mission includes enhancing employment opportunities for such people. These councils carry out this work along with other State agencies and private employers.

*OEI; 07-98-00260*

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## **OTHER ISSUES**

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### **Year 2000 Computer Renovation Plans**

We will continue to evaluate ACF's efforts to meet Year 2000 computer renovation and validation goals. The Federal Government's Year 2000 strategy regarding computer systems places emphasis on ensuring that agencies' mission-critical systems are Year 2000 compliant before December 31, 1999, to avoid widespread system failures. This review is part of our Departmentwide Year 2000 compliance review.

*OAS; W-00-98-40007; A-12-98-02000*

### **Social Services and Targeted Assistance Programs**

We will evaluate the States' administration and operation of the Social Services and Targeted Assistance Programs for refugees. Prior reviews have shown deficiencies relating to States' contracting for employment services, oversight of contractors, and use of funds.

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

### **Verification of Immigrant Status and Citizenship**

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

*OEI; 00-00-00000*



## **Data Used to Support Performance Measures**

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

*OAS; W-00-00-20002; A-03-00-00000, A-07-00-00000*

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

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

*OAS; W-00-00-20002; A-02-00-00000  
OEI; 00-00-00000*

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## **ADMINISTRATION ON AGING**

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### **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 Administration on Aging (AoA) funding to the aging agency network has remained essentially unchanged at about \$850 million for most of the 1990's. In response to level funding and an increased demand for services, State units on aging have sought funding from other Federal sources. We will determine how the additional funding sources have changed the service package offered to the traditional AoA population.

*OEI; 00-00-00000*

# 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 (CFO) Act of 1990 by requiring annual audited financial statements--commencing with Fiscal Year (FY) 1996--for *all* accounts and associated activities of selected Federal agencies, including the Department of Health and Human Services (HHS) and its operating divisions. The audited FY 1999 consolidated HHS financial statements are due to the Office of Management and Budget (OMB) by March 1, 2000.

### **Audits of FY 1999 Financial Statements**

The following audits of FY 1999 financial statements will be completed and reports issued during FY 2000:

**Health Care Financing Administration**

*OAS; W-00-99-40008; A-17-99-01999*

**Administration for Children and Families**

*OAS; W-00-99-40010; A-17-99-00003*

**Health Resources and Services Administration**

*OAS; W-00-99-40013; A-17-99-00005*

**Indian Health Service**

*OAS; W-00-99-40013; A-17-99-00006*

**National Institutes of Health (NIH)**

*OAS; W-00-99-40013; A-17-99-00012*

**Centers for Disease Control and Prevention**

*OAS; W-00-99-40013; A-17-99-00013*

**Food and Drug Administration**

*OAS; W-00-99-40013; A-17-99-00011*

**Substance Abuse and Mental Health Services Administration**

*OAS; W-00-99-40013; A-17-99-00004*

**Program Support Center**

*OAS; W-00-99-40013; A-17-99-00007*

**Consolidated HHS Financial Statements**

*OAS; W-00-99-40009; A-17-99-00002*

**Reviews of HHS Service Organizations to Support  
FY 1999 Financial Statement Audits**

**NIH Computer Center**

*OAS; W-00-99-40012; A-17-99-00015*

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

**Payment Management System**

*OAS; W-00-99-40012; A-17-99-00014*

**Accounting Operations--Division of Financial Operations**

*OAS; W-00-99-40012; A-17-99-00008*

**Payroll Operations**

*OAS; W-00-99-40012; A-17-99-00009*

**Audits of FY 2000 Financial Statements**

Work is expected to begin in FY 2000 on the following audits of FY 2000 financial statements:

**Health Care Financing Administration**

*OAS; W-00-00-40008*

*Expected Issue Date: FY 2001*

**Administration for Children and Families**

*OAS; W-00-00-40010*

*Expected Issue Date: FY 2001*

**Health Resources and Services Administration**

*OAS; W-00-00-40013*

*Expected Issue Date: FY 2001*

**Indian Health Service**

*OAS; W-00-00-40013*

*Expected Issue Date: FY 2001*

**National Institutes of Health**

*OAS; W-00-00-40013*

*Expected Issue Date: FY 2001*

**Centers for Disease Control and Prevention**

*OAS; W-00-00-40013*

*Expected Issue Date: FY 2001*

**Food and Drug Administration**

*OAS; W-00-00-40013*

*Expected Issue Date: FY 2001*

**Substance Abuse and Mental Health Services Administration**

*OAS; W-00-00-40013*

*Expected Issue Date: FY 2001*

**Program Support Center**

*OAS; W-00-00-40003*

*Expected Issue Date: FY 2001*

**Consolidated HHS Financial Statements**

*OAS; W-00-00-40009*

*Expected Issue Date: FY 2001*

**Reviews of HHS Service Organizations to Support  
FY 2000 Financial Statement Audits**

**NIH Computer Center**

*OAS; W-00-00-40012*

*Expected Issue Date: FY 2001*

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

**Payment Management System**

*OAS; W-00-00-40012*

*Expected Issue Date: FY 2001*

**Accounting Operations--Division of Financial Operations**

*OAS; W-00-00-40012*

*Expected Issue Date: FY 2001*

**Payroll Operations**

*OAS; W-00-00-40012*

*Expected Issue Date: FY 2001*

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**PROGRAM INTEGRITY AND EFFICIENCY**

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**Year 2000 Computer Renovation Plans**

We will continue to determine the adequacy of the Department's planning, management, and assessment of the Year 2000 system compliance problem and assess the risk that mission-critical, internal information systems may not operate effectively and efficiently by January 1, 2000. The Year 2000 remediation effort, likely the largest computer system conversion effort ever undertaken, is necessary to ensure that computerized systems can distinguish the Year 2000 from 1900, 2001 from 1901, etc., and that they can correctly handle leap year calculations involving the Year 2000 and beyond. To avoid widespread system failures, the Federal Government's Year 2000 strategy places emphasis on ensuring that agencies' mission-critical systems are Year 2000 compliant before December 31, 1999.

The Department has reported to OMB that it has 289 mission-critical systems. Many of these systems are now being reported as compliant. However, crucial testing with business partners is still underway. Additionally, the Medicare claim processing system will undergo changes before December 31, 1999. These efforts will be closely monitored by HCFA and the OIG. Our review is part of an initiative of the President's Council on Integrity and Efficiency to monitor Year 2000 preparations throughout the executive branch. Our compliance work at the individual operating agencies is noted, where applicable, in the preceding chapters.

*OAS; W-00-98-40007; A-17-00-00000*

**Escheated Warrants**

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

*OAS; W-00-00-40006; Various CINs*

## **State Pensions**

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

*OAS; W-00-00-40006; A-02-00-00000, A-09-00-00000*

## **Preaward and Postaward Contract Audits**

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

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

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

## **Nonfederal Audits**

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

We also provide up-front technical assistance to nonfederal auditors to facilitate a clear understanding of the Federal audit requirements and promote effective audit work. In addition, we identify, analyze, and record electronically the audit findings reported by nonfederal auditors for use by Department managers. Our reviews provide Department managers with assurance about the management of Federal programs and identify significant areas of internal control weaknesses, noncompliance with laws and regulations, and questioned costs that require formal resolution by Federal officials.