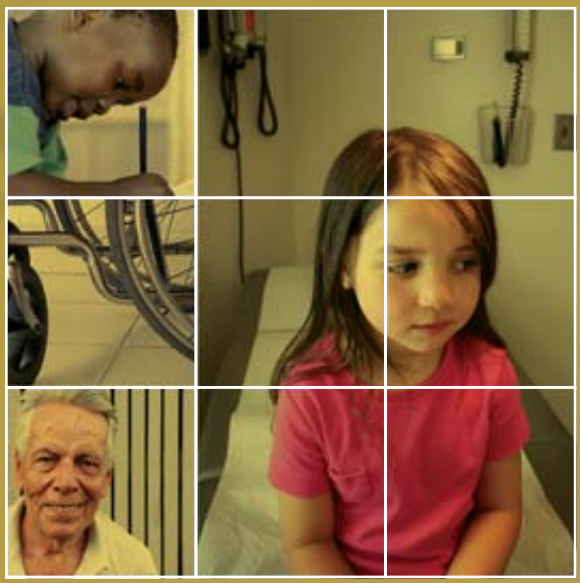
Department of Health and Human Services



Work Plan Fiscal Year 2007

OIG Office of Inspector General

Introduction

The project areas described in this Office of Inspector General (OIG) Work Plan reflect what we believe at the beginning of each fiscal year best identifies vulnerabilities of Department of Health & Human Services' (HHS) programs and activities, and promotes improvement in their efficiency and effectiveness.

OIG work planning does not end with publication of the plan. It is a dynamic, year-round process, adjusting to new issues, new information, and shifts in the priorities of Congress, the President, and the Secretary.

To ensure that our studies do not duplicate existing work and to build on that work, we identify and evaluate the audits, inspections, and studies done by others, such as the Government Accountability Office (GAO), the Centers for Medicare & Medicaid Services (CMS), and the Office of Management & Budget Program Assessment and Rating Tool (PART) process. We also undertake projects designed to determine the effectiveness of management actions to correct deficiencies cited in prior studies.

This document is divided into four sections. The first three consist of the ongoing and proposed work relating to each of the major program operating divisions of HHS: (1) CMS; (2) the seven major public health agencies: Agency for Health Care Research & Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), Indian Health Service (IHS), National Institutes of Health (NIH), and Substance Abuse and Mental Health Services Administration (SAMHSA); and (3) Administration for Children & Families (ACF) and Administration on Aging (AoA). The fourth section contains projects that cut across Department programs, including State and local government use of Federal funds, and the functional areas of the Office of the Secretary.

Mission Activities

The work of the OIG is planned and performed by its four direct mission components: the offices of Audit Services (OAS), Evaluation and Inspections (OEI), Investigations (OI), and Counsel to the Inspector General (OCIG).

Program Audits

OAS conducts financial and performance audits of departmental programs and operations to determine whether objectives are being achieved, which aspects of programs need to be performed more efficiently, and to identify systemic weaknesses that give rise to fraud, waste, or abuse. OAS also provides leadership and direction in carrying out the mandates of the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994 relating to financial statement audits.

Program Inspections

OEI seeks to improve HHS program effectiveness and efficiency by conducting 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, Congress, and the public. The inspections in this work plan focus on programs with significant expenditures of funds, and in which important management issues have surfaced. The results of these inspections should generate useful information on how well the programs are operating and offer specific recommendations to improve their overall efficiency and effectiveness.

Investigative Focus Areas

OI conducts investigations of fraud and misconduct to safeguard the Department's programs and protect its beneficiaries. OI concentrates its resources on criminal investigations, but its activities are also aimed at deterring fraud and abuse by identifying systemic weaknesses and vulnerabilities that can be mitigated through corrective management actions, regulation, or legislation; and by pursuing criminal convictions and recovering damages and penalties through civil and administrative proceedings.

Legal Counsel Focus Areas

OCIG coordinates OIG's role in the judicial and administrative resolution of fraud and abuse cases involving HHS programs, 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 and monitoring of corporate integrity agreements for certain providers that have settled their False Claims Act liability with the Federal Government. It also develops and promotes industry-specific voluntary compliance program guidance. OCIG issues special fraud alerts to the public, special advisory bulletins, and advisory opinions regarding the application of OIG's sanction authorities. OCIG is responsible for developing new, and modifying existing, safe harbor regulations under the anti-kickback statute. Finally, OCIG provides general legal services to OIG, including advice and representation on HHS programs and operations, administrative law issues, and criminal procedure.

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Centers for Medicare & Medicaid Services

Medicare Hospitals

Hospital Capital Payments

We will examine Medicare inpatient capital payments, including the accuracy and appropriateness of the current methodology used to update the capital rates. We will also determine whether hospitals have used capital payments for their intended purposes. Capital payments are a hospital's expenditure for assets such as equipment and facilities.
(OAS; W-00-07-35300; various reviews; expected issue date: FY 2007; new start)

Medicare-Dependent Hospital Program

We will review the appropriateness of fiscal year (FY) 2002 base-year costs for a selected number of Medicare-dependent hospitals (MDH). Under provisions of the Deficit Reduction Act of 2005 (DRA), payment to an MDH is based on its FY 2002 hospital-specific rates for discharges starting on October 1, 2006, if that payment would result in higher Medicare payments than under the Medicare prospective payment system (PPS). MDH's payments would be based on 75 percent of the FY 2002 adjusted hospital-specific costs.
(OAS; W-00-07-35301; various reviews; expected issue date: FY 2007; new start)

Inpatient Rehabilitation Facility Classification Criteria

We will review the extent to which admissions to inpatient rehabilitation facilities (IRF) met specific regulatory requirements and whether the facilities billed for services in compliance with Medicare regulations. The DRA modified the compliance threshold criteria, i.e., the percentage criterion that must be met to be classified as a rehabilitation hospital under the Medicare program. Under the revised criteria, the compliance threshold will be set at 60 percent for cost reporting periods during the 12-month period beginning on July 1, 2006; at 65 percent for cost reporting periods during the 12-month period beginning on July 1, 2007; and at 75 percent for cost reporting periods beginning July 1, 2008.
(OAS; W-00-07-35302; A-04-07-00000; expected issue date: FY 2007; new start)

Adjustments for Graduate Medical Education Payments

We will determine whether audit adjustments for direct and indirect graduate medical education that fiscal intermediaries (FI) make while settling Medicare cost reports were properly reflected in the revised Medicare reimbursement.
(OAS; W-00-06-35189; various reviews; expected issue date: FY 2007; work in progress)

Payments for Observation Services Versus Inpatient Admission for Dialysis Services

We will determine whether payments were made for inpatient admissions for dialysis services when the physicians' orders stated the level of care as admission to observation status. In conjunction with medical reviews conducted by FIs, it was noted that some hospitals admitted patients for dialysis treatment, which lasted from 24 to 48 hours. Medical reviewers determined that the stays were for observation rather than treatment. CMS Intermediary Manual Part 3, Chapter II, section 3112.8, requires the physician's order to clearly state the level of care the patient requires, e.g., "admission to inpatient status" or "admission to observation status."

Observation services are outpatient services that are paid on an hourly basis and can last up to 48 hours. Inpatient services are paid under a diagnosis-related group (DRG) at a much higher rate.
(OAS; W-00-06-35190; A-04-06-07001; expected issue date: FY 2007; work in progress)

Nursing and Allied Health Education Payments

We will determine the appropriateness of payments for provider-operated nursing and allied health (NAH) education programs. The Medicare program makes payments to hospitals for provider-operated NAH programs on a reasonable cost basis. We will perform our work at various FIs and providers to determine the validity of claims for these payments.
(OAS; W-00-05-35123; various reviews; expected issue date: FY 2007; work in progress)

Inpatient Prospective Payment System Wage Indices

We will determine whether hospital and Medicare controls are adequate to ensure the accuracy of the hospital wage data used for calculating wage indices for the inpatient PPS. We believe that the wage indices are vulnerable to inaccuracy because the data used to calculate them for many metropolitan statistical areas (MSA) are significantly influenced by a single hospital. Consequently, a significant hospital that reports incorrect wage data through its Medicare cost report could receive incorrect DRG reimbursement and lead to incorrect wage indices throughout the MSA. We will determine the effect on the Medicare program of incorrect DRG reimbursement caused by inaccurate wage data.
(OAS; W-00-04-35142; various reviews; expected issue date: FY 2007; work in progress)

Inpatient Rehabilitation Facility Compliance With Medicare Requirements

We will continue to review payments to Inpatient Rehabilitation Facilities (IRF) under the PPS to determine the extent to which they were made in accordance with Medicare requirements. For example, we will determine the extent to which admissions to IRFs met Medicare requirements and whether a claim paid as a discharge should have been paid as a transfer. We will also review outlier claims.
(OAS; W-00-04-35103; W-00-04-35127; expected issue date: FY 2007; work in progress)

Inpatient Rehabilitation Payments - Late Assessments

We will determine the accuracy of Medicare payments for inpatient rehabilitation stays when patient assessments are entered late. Under the inpatient rehabilitation facility PPS, admission and discharge assessments must be entered and transmitted within defined time limits or payment is reduced. We will determine how FIs make these adjustments and confirm that payments are accurate.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Organ Procurement Organizations

We will examine Medicare payments made to organ procurement organizations and will identify and review controls and cost containment practices used by organ procurement organizations to acquire organs for transplant.
(OAS; W-00-06-35083; W-00-06-35152; A-09-06-00034; expected issue date: FY 2007; work in progress)

Inpatient Hospital Payments for New Technologies

We will review payments made to hospitals for new services and technologies. New technology payments consist of payments for new medical services and technologies meeting the clinical definition of "new" that are demonstrated to be inadequately paid otherwise under the DRG system. We will examine the costs associated with the new devices and technologies to determine whether the reimbursement is appropriate.
(OAS; W-00-06-35191; various reviews; expected issue date: FY 2007; work in progress)

Inpatient Psychiatric Facilities

We will review payments to psychiatri9c facilities under the inpatient psychiatric facility PPS to determine the extent to which they were made in accordance with Medicare laws and regulations. We will review outlier payments made to psychiatric facilities, as well as payments made for interrupted stays.
(OAS; W-00-06-35192; various reviews; expected issued date: FY 2007; work in progress)

Long Term Care Hospital Payments

We will review payments under the long term care hospital (LTCH) PPS to determine the extent to which these payments were made in accordance with Medicare laws and regulations. We will review the appropriateness of early discharges to home and interrupted stays.
(OAS; W-00-04-35128; W-00-04-35188; various reviews; expected issue date: FY 2007; work in progress)

Long Term Care Hospital Admissions

We will determine the extent to which LTCHs admit patients from a sole acute-care hospital. LTCHs have grown more rapidly than any other postacute setting. Medicare began paying LTCHs under a PPS in 2002. However, CMS applies a larger base payment and different relative weights to the LTCH DRGs than inpatient DRGs. We will examine whether LTCHs may be receiving most of their patients from a single acute care hospital, thus effectively functioning as units of those hospitals.
(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Long Term Care Hospital Classification

We will determine whether hospitals currently reimbursed as LTCHs are in compliance with the average length of stay criteria. In general, to qualify as a long term care hospital, a hospital must have an average Medicare inpatient length of stay greater than 25 days. Typically, if a hospital does not meet this requirement, it will be reimbursed as an acute care hospital. Typically, acute care hospitals are reimbursed at a lower rate.
(OAS; W-00-07-35303; A-04-07-00000; expected issue date: FY 2007; new start)

Critical Access Hospitals

We will review critical access hospital (CAH) cost reports to examine the administrative and other costs incurred by CAHs for inpatient and outpatient services before and after their conversion to CAH status. The Medicare Rural Hospital Flexibility Program, established in 1997, designated certain limited service hospitals as CAHs. The Medicare statute provides that CAHs be reimbursed reasonable costs for their inpatient and outpatient services.
(OAS; W-00-06-35101; A-06-00-00000; expected issue date: FY 2007; work in progress)

Rebates Paid to Hospitals

We will determine whether hospitals are properly identifying purchase credits rebates as a separate line item in their Medicare cost reports. We will visit several large vendors and determine the amount of rebates paid to hospitals in a given year. We will then examine a sample of Medicare hospital cost reports to determine whether the rebates were properly credited on the Medicare cost reports.
(OAS; W-00-05-35161; various reviews; expected issue date: FY 2007; work in progress)

Outpatient Outlier and Other Charge-Related Issues

We will determine whether outlier payments to hospital outpatient departments and community mental health centers were in accordance with Medicare laws and regulations.
(OAS; W-00-04-35105; various reviews; expected issue date: FY 2007; work in progress)

Outpatient Department Payments

We will review payments to hospital outpatient departments under the outpatient hospital PPS to determine the extent to which they were made in accordance with Medicare laws and regulations. We will review the appropriateness of payments made for multiple procedures, repeat procedures, and global surgeries.
(OAS; W-00-06-35193; W-00-06-35065; various reviews; expected issued date: FY 2007; work in progress)

Unbundling of Hospital Outpatient Services

We will determine the extent to which hospitals and other providers have been submitting claims for services that should be bundled into outpatient services. The unbundling of services could lead to inappropriate Medicare expenditures.
(OEI; 00-00-00000; expected issue date: FY 2008; new start)

"Inpatient Only" Services Performed in an Outpatient Setting

We will determine if Medicare payments are appropriately denied for "inpatient only" and related services performed in an outpatient setting and assess the extent to which Medicare beneficiaries are held liable for denied inpatient claims for these services. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 established and refined the Hospital Outpatient PPS, which went into effect August 1, 2000. We will also assess whether CMS claims processing edits are in place to ensure that appropriate payments are made.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Medical Appropriateness and Coding of Diagnosis Related Group Services

We will analyze inpatient hospital claims to identify providers who exhibit high or unusual patterns for selected DRGs. We will then determine the medical necessity, the appropriate level of coding, and reimbursement for a sample of services billed by these providers. In 2005, Medicare reimbursed hospitals approximately $110 billion for inpatient care. In earlier work, we have found the DRG system vulnerable to abuse by providers who wish to increase reimbursement inappropriately thorough upcoding.
(OEI: 00-00-00000; expected issue date: FY 2008; new start)

Medicare Rural Hospital Flexibility Program

We will determine the extent to which hospitals in the Rural Hospital Flexibility Program (RHFP) serve beneficiaries from rural areas and examine CMS oversight of State compliance with program requirements. The RHFP, authorized by the Balanced Budget Act of 1997, was created to ensure that rural beneficiaries have access to essential health care services. A rural health network in the Medicare RHFP must be initiated through a State plan and is defined as an organization consisting of at least one critical access hospital (CAH) and at least one full-service hospital. To be designated as a CAH, a facility must meet certain criteria (e.g., located more than 35 miles from another hospital, have no more than 25 inpatient beds). CAHs are paid on a reasonable cost basis. We will obtain facility specific information for a sample of RHFP facilities to determine whether the number of beds and distance between facilities meets minimum requirements.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Inappropriate Payments for Diagnostic X-rays in Hospital Emergency Departments

We will determine the extent of inappropriate payments for diagnostic x-rays performed in hospital emergency departments. In 2004, more than 2.5 million diagnostic x–rays were performed in Medicare-certified hospitals with emergency departments. Interpretations by emergency room physicians of diagnostic x-rays should not be billed separately. We will assess the extent to which Medicare is inappropriately paying for diagnostic x-rays interpreted by emergency room physicians.
(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Oversight of Specialty Hospitals

We will assess CMS oversight of physician-owned specialty hospitals to ensure patient safety and quality of care at these hospitals. Concerns over the dynamic growth of specialty hospitals led Congress to impose an 18-month moratorium on the construction of new physician-owned specialty hospitals in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). As part of this review, we will also examine policies related to staffing requirements at these hospitals.
(OEI; 02-06-00310; expected issue date: FY 2007; work in progress)

Medicare Home Health

Home Health Outlier Payments

We will determine whether outlier payments to home health agencies (HHA) were in compliance with Medicare laws and regulations. Medicare makes outlier payments as a loss-sharing mechanism for costly cases in which the estimated cost exceeds a threshold amount for each case-mix group. We will evaluate the frequency of outliers and whether they cluster in certain home health resource groups (HHRG) or geographical areas. We also plan to determine whether the current outlier methodology is equitable to all HHAs.
(OAS; W-00-04-35107; various reviews; expected issue date: FY 2007; work in progress)

Enhanced Payments for Home Health Therapy

We will determine whether HHAs' therapy services met the Medicare regulations threshold for higher payments. We will analyze the number and duration of therapy visits provided per episode period.
(OAS; W-00-04-35108; various reviews; expected issue date: FY 2007; work in progress)

Cyclical Noncompliance in Medicare Home Health Agencies

We will examine trends and patterns in HHA survey and certification deficiencies. The Social Security Act requires that CMS survey the quality of care and services furnished by HHAs, as measured by indicators of medical, nursing, and rehabilitative care, every 36 months. We will also identify whether any HHAs show patterns of cyclical noncompliance with certification standards and whether CMS applies appropriate sanctions to noncompliant HHAs.
(OEI; 09-06-00040; expected issue date: FY 2007; work in progress)

Accuracy of Data on the Home Health Compare Web Site

We will determine to the extent to which the Home Health Compare Web site includes accurate and complete information on Medicare-certified home health agencies. The CMS maintained Web site provides beneficiaries and their families with information on all home health agencies certified by Medicare as of January 2003. We will also examine how CMS identifies and updates missing and incorrect information on the database.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Accurately Coding Claims for Medicare Home Health Resource Groups

The review will determine the extent to which Medicare HHAs accurately code the HHRG in the Outcome and Assessment Information Set. We will also determine the extent to which providers improperly code HHRGs and the level of inappropriate payments made as a result of any miscoding.
(OEI; 00-00-0000; expected issue date: FY 2008; new start)

Home Health Rehabilitation Therapy Services

This review will determine the extent to which rehabilitation therapy services provided by HHAs were provided by appropriate staff and were medically necessary. We will determine the extent to which patients' plans of care identified the need for the amount and level of therapy they received. We will also determine the amount of reimbursement that providers received due to medically unnecessary HHA therapy.
(OEI; 00-00-0000; expected issue date: FY 2008; new start)

Medicare Nursing Homes

Skilled Facility Rehabilitation and Infusion Therapy Services

Through medical review, we will analyze whether rehabilitation and infusion therapy services provided to Medicare beneficiaries in skilled nursing facilities (SNF) were medically necessary, adequately supported, and actually provided as ordered. SNFs provide infusion and rehabilitation therapy services to Medicare beneficiaries for a variety of medical and postsurgical conditions. These services are ordered by a physician and are administered onsite by the SNFs' nursing staff.
(OAS; W-00-04-35110; W-00-04-35130; various reviews; expected issue date: FY 2007; work in progress)

Skilled Nursing Facilities' Involvement in Consecutive Inpatient Stays

We will determine whether SNF care provided to Medicare beneficiaries with consecutive inpatient stays was medically reasonable and necessary. An inpatient hospital stay must precede all SNF stays. This study will focus on beneficiaries who experience three or more consecutive stays, including at least one SNF facility stay. We will also examine the extent and nature of consecutive Medicare hospital inpatient stays.
(OEI; 07-05-00340; expected issue date: FY 2007; work in progress)

Enforcement Actions Against Noncompliant Nursing Homes

We will continue our work in examining the effectiveness of CMS and State enforcement actions taken against noncompliant nursing homes. Under contracts with CMS, States conduct surveys at least every 15 months to certify that nursing facilities meet the required standards for the Medicare and Medicaid programs. We will assess whether CMS and its fiscal intermediaries appropriately process denial of Medicare payment remedies for facilities noncompliant with Federal program standards.
(OEI; 06-03-00390; expected issue date: FY 2007; work in progress)

Skilled Nursing Facility Payments for Day of Discharge

Medicare regulations state that the day of discharge is not a day of billable services for SNFs. We will determine whether Medicare is inappropriately paying SNFs for services on the day of discharge.
(OAS; W-00-06-35194; various reviews; expected issue date: FY 2007; work in progress)

Skilled Nursing Facility Consolidated Billing

We will determine whether controls are in place to preclude duplicate billings under Medicare Part B for services covered under the SNF PPS and assess the effectiveness of Common Working File edits established in 2002 to prevent and detect improper payments. Under the PPS, the SNF has the Medicare billing responsibility for virtually all of the Medicare-covered services that its residents receive. As a result, the outside supplier must receive payment from the SNF, rather than the Medicare Part B carrier. Prior OIG work identified improper payments associated with outpatient hospital, ambulance, laboratory, and radiology services during 1999 and 2000. We will identify any additional improper payments for services during calendar years 2001,

2002, and 2003 and also determine whether the Common Working File edits are effective in detecting and preventing improper payments.
(OAS; W-00-05-35185; W-00-05-35097; various reviews; expected issue date: FY 2007; work in progress)

Nursing Home Residents' Minimum Data Set Assessments and Care Planning

We will examine the type, frequency, and severity of nursing home deficiencies related to Minimum Data Set assessments and care planning. In previous studies, we identified increases in deficiencies related to comprehensive assessments, care planning, and the provision of services in accordance with the care plan. We will also examine methods the State survey agencies use in identifying assessments and care plans that do not address individualized needs of residents.
(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Imaging and Laboratory Services in Nursing Homes

We will determine the extent and nature of any medically unnecessary or excessive billing for imaging and laboratory services provided to nursing home residents. Medicare pays more than $200 million a year for imaging and laboratory services. We will review a sample of services and examine utilization patterns in nursing facilities.
(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Implementation of Medicare Part D in Nursing Facilities

This review will assess the implementation of Medicare Part D in nursing homes. Prior to the implementation of Part D, nursing homes generally contracted with one long term care pharmacy to provide drugs for all of their residents eligible for both Medicare and Medicaid. As part of this study, we will determine how dual eligible nursing home residents are selecting and enrolling in Medicare prescription drug plans and whether these residents are receiving the drugs they need under Part D.
(OEI; 02-06-00190; expected issue date: FY 2008; work in progress)

Submission of Skilled Nursing Facility No-Pay Bills

This review will determine whether SNFs submit "no-pay bills" as required. No-pay bills are submitted to Medicare without a request for reimbursement to track beneficiaries' benefit periods. We will also determine the extent to which failure to submit no-pay bills contributes to inappropriate calculations of Medicare SNF eligible benefit periods, as well as the amount of inappropriate Medicare payments due to this practice. Additionally, we will identify whether measures are in place to ensure that no-pay bills are submitted.
(OEI; 00-00-0000; expected issue date: FY 2007; new start)

Inappropriate Psychotherapy Services in Nursing Facilities

This review will determine the extent to which psychotherapy services are provided and medically necessary for Medicare beneficiaries residing in nursing facilities. In a 2001 report, we found that 50 percent of group psychotherapy services reviewed were inappropriate. We will also determine the extent of inappropriate payments for these services.
(OEI; 06-06-00580; expected issue date: FY 2007; work in progress)

Medicare Hospice

Hospice Payments to Nursing Facilities

We will determine whether hospice payments for services for dually eligible patients/residents residing in nursing facilities are accurate. OIG's previous work in this area indicated that nursing home hospice patients received nearly 46 percent fewer nursing and aide services from hospice staff than hospice patients living at home. OIG also raised concerns about the appropriateness of the arrangements hospices have with nursing facilities to provide services. We will examine what services are provided by hospice, by nursing homes, whether there are any overlaps in these services, and, if so, identify any duplication in reimbursement by Medicare hospice and Medicaid.
(OEI; 02-06-00220; expected issue date: FY 2007; work in progress)

Hospice: Plans of Care and Appropriate Payments

This review will determine if assessments were completed and if the plans of care correctly reflect the assessments for beneficiaries receiving hospice care. We will also determine whether beneficiaries are receiving services billed for and whether hospices are billing for services at the correct level of care. By conducting a medical record review, we will determine if the plans of care accurately reflect each patient assessment, and whether all patients received a plan of care documenting all required services including their location, frequency, and level of care.
(OEI; 00-00-0000; expected issue date: FY 2008; new start)

Medicare Physicians and Other Health Professionals

Billing Service Companies

We will identify and review the relationships between billing companies and the physicians and other Medicare providers who use their services. We will identify the types of arrangements that physicians and other Medicare providers have with billing services and determine the impact of these arrangements on physicians' billings.
(OAS; W-00-05-35162; various reviews; expected issue date: FY 2007; work in progress)

Physician Pathology Services

We will determine whether the billings for pathology laboratory services comply with Medicare Part B requirements. We will focus on pathology services performed in physicians' offices. Medicare pays more than $1 billion annually to physicians for pathology services. We will also identify and review the relationships between physicians who furnish pathology services in their offices and outside pathology companies.
(OAS; W-00-05-35164; various reviews; expected issue date: FY 2007; work in progress)

Cardiography and Echocardiography Services

We will review Medicare payments for cardiography and echocardiography services to determine whether physicians billed appropriately for the professional and the technical components of the services. Like many physician services, cardiography and echocardiography include both technical and professional components. When a physician performs the interpretation separately, the modifier 26 should be used to bill Medicare.
(OAS; W-00-06-35165; various reviews; expected issue date: FY 2007; work in progress)

Physical and Occupational Therapy Services

We will review Medicare claims for therapy services provided by physical and occupational therapists to determine whether the services were reasonable and medically necessary, adequately documented, and certified by physician certification statements. Physical and occupational therapies are medically prescribed treatments concerned with improving or restoring functions, preventing further disability, and relieving symptoms.
(OAS; W-00-06-35159; various reviews; expected issue date: FY 2007; work in progress)

Payment to Providers of Care for Initial Preventive Physical Examination

We will evaluate the impact of the initial preventive physical examination (IPPE) on Medicare payments and physician billing practices. Section 611 of the MMA provides for coverage under Part B of an IPPE, including a screening electrocardiogram (EKG) for new Medicare beneficiaries, effective January 1, 2005. In addition to the screening EKG, the IPPE must include a measurement of height, weight, and blood pressure; a review of medical and social history; assessment of the potential for depression; and evaluation of functioning ability. For new Medicare beneficiaries with established relationships, the physician is presented with the opportunity to claim a higher payment for the IPPE under a new Healthcare Common Procedure Coding System (HCPCS) code, G0344, for services that may already have been performed in a past evaluation and management visit.
(OAS; W-00-06-35195; A-02-06-01014; expected issue date: FY 2007; work in progress)

Part B Mental Health Services

We will determine whether Medicare Part B mental health services provided in physicians' offices were medically necessary and billed in accordance with Medicare requirements. Payments for mental health services provided in the physician's office setting accounted for approximately 55 percent of the $1.3 billion in Medicare payments for Part B mental health services in 2002. In a prior report, we found that Medicare allowed $185 million in 1998 for inappropriate mental health services in the outpatient setting. We will also determine the financial impact of claims that do not meet Medicare requirements.
(OEI; 09-04-00220; expected issue date: FY 2007; work in progress)

Wound Care Services

We will determine whether claims for wound care services were medically necessary and billed in accordance with Medicare requirements. Medicare-allowed amounts for certain wound care services billed by physicians increased from approximately $98 million in 1998 to $147 million in 2002. We will also examine the adequacy of controls to prevent inappropriate payments for wound care services.
(OEI; 02-04-00410; expected issue date: FY 2007; work in progress)

Evaluation of "Incident to" Services

The purpose of this study is to evaluate the appropriateness of Medicare services performed "incident to" the professional services of physicians. We will identify services performed "incident to" physicians' professional services and will determine the extent to which the services met Medicare standards for medical necessity, documentation, and quality of care.
(OEI; 09-06-00430; expected issue date: FY 2007; work in progress)

Potential Duplicate Physical Therapy Claims

We will assess whether CMS's systems are able to identify and prevent payment for potential duplicate claims for physical therapy submitted by providers. In May 2004, CMS issued a fraud alert regarding physical therapy suppliers switching their submission of claims between Part A and Part B. We will review the current Common Working File operations to determine whether edits are adequately identifying potential duplicate physical therapy claims submitted to Part A and Part B contractors.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Eye Surgeries

We will determine whether Medicare payments for ophthalmology services related to cataract and lasik eye surgery were billed in accordance with Medicare requirements. We will also examine the adequacy of carrier claims processing controls to prevent inappropriate payments for these services.
(OAS; W-00-06-3521; A-05-06-00054; expected issue date: FY 2007; work in progress)

Place of Service Errors

This review will determine whether physicians properly coded the place of service on claims for services provided in ambulatory surgical centers and hospital outpatient departments. Medicare regulations provide for different levels of payments to physicians depending on where the service is performed. Medicare makes higher payments for physician office services.
(OAS; W-00-06-35113; various reviews; expected issue date: FY 2007; work in progress)

Review of Evaluation and Management Services During Global Surgery Periods

We will determine whether (1) physicians received separate payments for evaluation and management (E&M) services provided during the global surgery period and (2) industry practices related to the number of E&M services provided during the global surgery period have changed since the global surgery fee concept was initially developed in 1992. Under the global surgery fee concept, physicians bill a single fee for all their services usually associated with a surgical procedure and related E&M services provided during the global surgery period. E&M services related to the surgery provided during the global period should not be billed for and paid separately by Medicare. The global surgery fee includes payment for a certain number of E&M services provided during the global surgery period.
(OAS; W-00-06-35207; A-05-06-00040; expected issue date: FY 2007; work in progress)

Psychiatric Services Provided in an Inpatient Setting

We will determine whether psychiatric services provided in an inpatient setting are being properly billed to Medicare. Medicare makes payments to physicians and certain nonphysician practitioners for therapy sessions provided to beneficiaries, including individual and group therapy sessions, based on a fee schedule. Because a group therapy session is reimbursed at a lower rate than an individual session, physicians may have an incentive to bill Medicare for an individual session when a group therapy session was provided to receive a higher reimbursement.
(OAS; W-00-07-35304; A-04-07-00000; expected issue date: FY 2007; new start)

Medicare Reimbursement for Polysomnography

This study will determine the factors contributing to the rise in Medicare reimbursement for polysomnography. Medicare reimbursement for polysomnograpy increased nearly 175 percent in 4 years, rising from $62 million in 2001 to $170 million in 2004. The study will also examine the appropriateness of services billed to Medicare.
(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Long Distance Physician Claims Associated with Home Health and Skilled Nursing Facility Services

We will determine if Medicare Part B long distance physician services are inappropriately billed for beneficiaries of home health and skilled nursing facility services. Previous inspections identified instances of physicians ordering or billing for services that would normally require face-to-face examination for beneficiaries who live a significant distance from the physician's office.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Violations of Assignment Rules by Medicare Providers

We will examine the extent to which providers are billing beneficiaries in excess of amounts allowed by Medicare requirements. Providers must accept Medicare's payment and beneficiary copayment, known as the Medicare allowed amount, as payment in full for all covered services. Providers cannot bill beneficiaries for amounts in excess of the Medicare allowed amount. We will also assess beneficiary awareness of their rights and responsibilities regarding potential billing violations and Medicare coverage guidelines.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Advanced Imaging Services in Physician Offices

This review will examine the appropriateness of imaging services provided in physician offices. From 1999 to 2005, utilization of advanced imaging services, such as MRI, PET, and CT scans, has grown on average by 20 percent per year. In 2005 Medicare allowed charges of over $7 billion for these services. This review will examine the nature of the growth of these services over this period including examination of billing patterns in certain geographic areas and practice settings.
(OEI; 01-06-00260; expected issue date: FY 2007; work in progress)

Medicare Medical Equipment and Supplies

Durable Medical Payments for Beneficiaries Receiving Home Health Services

We will review medical records for durable medical equipment (DME) items and supplies furnished to beneficiaries receiving HHA services to determine whether the items and supplies were reasonable and necessary for the beneficiaries' conditions.
(OAS; W-00-07-35196; A-02-07-00000; expected issue date: FY 2007; new start)

Medicare Payments for Therapeutic Footwear

We will determine whether therapeutic footwear furnished by individual suppliers was reasonable and necessary for the beneficiaries to whom it was provided. Under certain circumstances, Medicare covers therapeutic footwear for beneficiaries who have diabetes and at

least one of several related conditions. Medicare payments for therapeutic footwear totaled more than $130 million in 2003. A previous OIG report indicated that a significant percentage of payments made for therapeutic footwear did not have adequate documentation to support the beneficiaries' medical need for the footwear.
(OAS; W-00-05-35187; A-04-05-05033; expected issue date: FY 2007; work in progress)

Medicare Payments for Durable Medical Equipment Claims with ZX, KX, and KS Modifiers

We will determine whether DME suppliers that filed claims with ZX, KX, and KS modifiers appropriately billed Medicare. Under the Medicare program, a DME supplier may use these modifiers to indicate that it has the appropriate documentation on file; upon request, the supplier will provide the documentation to support its claim for payment. Reviews by several CMS DME regional carriers of suppliers who had used the ZX, KX, and KS modifiers found that suppliers had little or no documentation to support their claims. This suggests that many of the claims submitted may have been invalid and should not have been paid by Medicare.
(OAS; W-00-07-35305; A-04-07-00000; expected issue date: FY 2007; new start)

Medical Necessity of Durable Medical Equipment

We will determine the appropriateness of Medicare payments for certain DME items, such as power wheelchairs, wound care equipment, and supplies or orthotics. We will assess whether the suppliers' documentation supports the claim, whether the item was medically necessary, and/or whether the beneficiary actually received the item.
(OEI; various reviews; 00-00-00000; expected issue date: FY 2008; new start)

Medicare Pricing of Equipment and Supplies

We will compare Medicare payment rates for certain medical equipment and supplies with the rates of other Federal and State health care programs, as well as with wholesale and retail prices. Our review will cover such items as wheelchairs, parenteral nutrition, wound care equipment and supplies, and oxygen equipment and supplies.
(OEI; various reviews; 09-04-00420; expected issue date: FY 2007; work in progress)

Medicare Part B Drug Reimbursement

Computation of Average Sales Price

We will evaluate drug manufacturers' methodologies for computing the average sales price (ASP). The calculation is used for determining the Medicare Part B reimbursement of certain classes of drugs. The calculation is a requirement enacted as part of the MMA.
(OAS; W-00-05-35174; various reviews; expected issue date: FY 2007; work in progress)

Review of Part B Drug Reimbursement Methodology

We will determine whether the Federal Government would benefit if CMS reimbursed multi-source Part B drugs based on the ASP of individual National Drug Codes (NDC). CMS calculates the reimbursement amount for a Healthcare Common Procedure Coding System (HCPCS) code, which is often composed of multiple NDCs, by weighting the reported ASPs based on the amount of each NDC sold during the quarter. For multi-source drugs, the inclusion of higher priced brand name drugs in the weighted average may increase the amount of Federal reimbursement. With respect to multiple source Part B drugs, section 1847A(b)(3) requires the

inclusion of all drug products within the same multiple source drug billing and payment code in the calculation of the amount of Federal reimbursement. We will analyze the top 10 multi-source drugs purchased by our sample of oncology practices during the first quarter of 2005 to illustrate the reimbursement differences between the ASPs of individual NDCs within a HCPCS code and the weighted average ASP for a HCPCS code.
(OAS; W-00-07-35197; various reviews; expected issue date: FY 2007; new start)

Medicare Payments for Oral Antiemetic Medications

We will assess Medicare payments for oral antiemetic medications. Medicare covers certain oral antiemetic medications when they are used as a full therapeutic replacement for the intravenous antiemetic medication. The oral antiemetic must replace the intravenous antiemetic medication that would otherwise have been administered immediately before or within 48 hours after chemotherapy treatment.
(OAS; W-00-06-35198; A-04-06-04013; expected issue date: FY 2007; work in progress)

Payments to Independent Dialysis Facilities for Epogen

We will determine whether independent dialysis facilities are billing Medicare for administering the anemia drug Epogen beyond what is medically necessary and ordered by physicians. Epogen is a biologically engineered protein that is used to treat anemia associated with chronic renal failure. Patients who receive Epogen should have a hematocrit level between 30 percent and 36 percent. Medicare policy requires that FIs identify dialysis facilities with an atypical number of patients with hematocrit levels above a 90-day rolling average of 37.5 percent for routine medical review activities. Dialysis facilities are paid a composite rate per treatment for providing dialysis services to patients with end-stage renal disease (ESRD). These facilities receive a separate payment for administering Epogen that is not a part of the composite rate. We will identify for review dialysis facilities that bill Medicare for Epogen and have an atypical number of patients with a 90-day rolling average hematocrit level greater than 37.5 percent.
(OAS; W-00-07-35306; A-03-07-00000; expected issue date: FY 2007; new start)

Review of Botulinum Toxin (Botox) Treatments

We will assess the appropriateness of Medicare payments for Botox treatments provided to Medicare beneficiaries. Section 1862(a)(1)(A) of the Social Security Act prohibits payment of claims for items or services that are not reasonable or necessary for the diagnosis or treatment of illness or injury or improvement of the function of a malformed body part. Medicare coverage for Botox includes specific spastic conditions associated with certain diagnoses that are supported by medical necessity. Use of Botox for conditions other than what is covered by Medicare is unallowable.
(OAS; W-00-07-35318; A-02-07-00000; expected issue date: FY 2007; new start)

Monitoring Part B Drug Prices: Average Sales Price to Widely Available Market Prices

The MMA made significant changes to the way Medicare reimburses for Part B prescription drugs. Beginning in 2005, Medicare generally pays for drugs based on the average sales price (ASP) methodology. The MMA mandates that OIG conduct studies, which may include market surveys, to determine widely available market prices for Part B drugs. The market price will then be compared to the ASP.
(OEI; 00-00-00000; various studies; expected issue date: FY 2007; new start)

Monitoring Part B Drug Prices: Average Sales Price to Average Manufacturer Prices

In 2005, Medicare began paying for most Part B prescription drugs using a new methodology based on the ASP. The MMA mandates the OIG compare ASPs to average manufacturer prices (AMP) for Medicare Part B prescription drugs and notify the Secretary if the ASP for a particular drug exceeds the AMP by a threshold of 5 percent.
(OEI; 00-00-00000; various studies; expected issue date: FY 2007; new start)

Duplicate Payments for Part B Drugs Under the Competitive Acquisition Program

We will determine if there are duplicate payments to physicians for Part B drugs purchased from vendors selected through a competitive bidding process and those directly reimbursed under the average sales price system. We will further evaluate what systems CMS has in place to prevent duplicate payments for Part B drugs.
(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Adequacy of Reimbursement Rate for Drugs Under the Average Sales Price

We will conduct a study that determines whether physicians' practices in the specialties of hematology, hematology/oncology, and medical oncology are able to purchase drugs at Medicare Part B reimbursement amounts, which are based on the ASP. The study will take into account practices of different sizes in determining the adequacy of Medicare reimbursement. The review was developed as a result of a completed congressional mandated review related to ASP adequacy rate, Adequacy of Medicare Part B Drug Reimbursement to Physician Practices for the Treatment of Cancer Patients (A-06-05-00024).
(OAS; W-00-05-35167; various reviews; expected issue date: FY 2007; work in progress)

Intravenous Immune Globulin: Medicare Reimbursement and Availability

We will examine current market prices and product availability for Intravenous Immune Globulin (IVIG). As part of this review, we will assess manufacturer pricing and perspectives on IVIG and will also examine other links in the IVIG supply chain, i.e., distributors, Group Purchasing Organizations, and physicians.
(OEI; 03-05-00400; expected issue date: FY 2007; work in progress)

Medicare Part D Administration

Third Party Liability Safeguards

The MMA requires coordination between CMS, State programs, insurers, employers, and all other payers of prescription drug coverage. We will review safeguards in place to ensure that Medicare Part D does not inappropriately pay for prescription drug claims for which a third party is liable.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Comparisons of Part D Drug Pricing

We will conduct pricing comparisons for Medicare Part D prescription drugs. We will contrast prescription drug prices under Part D with the same drug prices covered under Medicare Part B. We will also compare prices of selected Part D prescription drugs to Medicaid reimbursement amounts.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Medicare Part D: Drug Access Through Prior Authorization and Exceptions
We will examine controls that CMS has instituted to ensure that Medicare Part D prescription drug plans (PDP) implement appropriate prior authorization and formulary exceptions processes. The study will also explore how policies and processes compare across PDPs.
(OEI; 06-06-00340; expected issue date: FY 2007; work in progress)

Monitoring Drug Prices of Medicare Part D Drug Plans
We will examine changes and trends in Medicare Part D prescription drug prices. We will explore to what extent drug plans' prices fluctuated over time to include price variations during the open enrollment period compared to patterns after enrollment closed. We will also assess whether plans show consistent pricing trends and patterns and how trends compare across drug plans.
(OEI; 03-06-00520; expected issue date: FY 2007; work in progress)

Part D Dual-Eligible Demonstration Project
We will review CMS's system to reimburse States participating in the Part D Dual-Eligible Demonstration Project. As part of the transition of beneficiaries into the Part D program, CMS has initiated a demonstration project to reimburse States for their efforts in assisting their dual eligible and low-income subsidy entitled populations in obtaining Medicare Part D coverage and paying for prescriptions for beneficiaries lacking coverage. Medicare will reimburse States for the difference between the drug plan reimbursement and Medicaid costs, as well as certain State administrative costs. We will also review the States' submission of data to determine accuracy of payments.
(OAS; W-00-06-31122; A-03-06-00203; expected issue date: FY 2007; work in progress)

Dually Eligible Hospice Patients
We will determine the propriety of drug claims for individuals that are receiving hospice benefits under Medicare Part A and drug coverage under Medicare Part D. CMS established daily per diem rates to pay for hospice benefits, which include prescription drugs (used for pain relief and symptom control) related to the beneficiary's terminal illness. Hospice providers are paid daily per diem amounts, which include drugs related to a hospice beneficiary's terminal illness. Medicare Part D, which began January 2006, covers prescription drugs for Medicare beneficiaries enrolled in this voluntary benefit. Because the hospice program continues to cover prescription drugs related to a hospice beneficiary's terminal illness, Medicare Part D drug plans may unknowingly duplicate payments for prescription drugs related to a hospice beneficiary's terminal illness. We will identify whether this is a widespread problem and, if so, the controls needed to prevent duplicate drug payments.
(OAS; W-00-07-35307; various reviews; expected issue date: FY 2007; new start)

Medicare Part D Duplicate Claims
We will review CMS's controls to prevent duplicate Part D claims for the same beneficiary, particularly when a beneficiary changes plans, tries to enroll in more than one plan, or tries to enroll in a plan and a retiree-subsidy covered plan. As of January 2006, there were more than 6 million beneficiaries dually eligible for Medicare and Medicaid assigned to a Part D plan. These beneficiaries are allowed to change their enrollment in a prescription drug plan monthly.
(OAS; W-00-07-35308; various reviews; expected issue date: FY 2007; new start)

Coordination and Oversight of Medicare Parts B and D To Avoid Duplicate Payments

We will determine whether there is sufficient coordination and oversight of Medicare Parts B and D to prevent duplicate payments for drugs. Drugs for which payment is available under Medicare Part B will continue to be covered by Part B and should not also be reimbursed under Medicare Part D drug coverage. Proper coordination will be needed to prevent duplicate payments for the same prescription under Part D.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Allocation of Employer Premiums Under the Retirement Drug Subsidy Program

We will assess selected employers' controls to track actual "allowable retiree drug costs" under the Part D retiree drug subsidy (RDS) program. We will also determine whether RDS reported costs are accurate and supportable, determine how closely the interim subsidy payments (based on allocated premium costs) approximated the actual allowable costs, and assess the impact of the difference between the interim payments and final payment to the Medicare program. Under the RDS program, the Secretary must provide a special subsidy payment to the sponsor (a private or governmental employer, labor union, etc.), of a qualified plan for each qualified covered retiree in the plan. For employers with fully insured plans that pay premiums based on expected costs, the Medicare interim subsidy payments may be based on actuarial estimates. However, final cost data must reflect the actual allowable retiree costs attributable to gross retiree plan-related prescription drug costs within the cost limit and the cost threshold.
(OAS; W-00-07-35309; various reviews; expected issue date: FY 2007; new start)

Allowable Costs Under the Retirement Drug Subsidy

We will review employer controls to ensure that only drugs covered under Medicare Part D and related allowable costs are included in the employer interim drug cost submissions. Pursuant to section 1860D-2(e) of the Act, for employer Part D prescription drug plans, gross covered drug costs include nonadministrative costs and costs directly related to the dispensing of the covered Part D drugs. Under the Act, Part D coverage excludes certain drugs, i.e., weight-loss drugs, cosmetic drugs, nonprescription drugs, and drugs covered under Medicare Parts A and B. Also dispensing fees include only costs for mixing drugs, delivery, and overhead.
(OAS; W-00-07-35310; various reviews; expected issue date: FY 2007; new start)

Actuarial Value of Retiree Prescription Drug Coverage

We will review selected employers' RDS plans to identify any material changes to the actuarial value of the plan since the plan's initial approval, which preceded the implementation of the Medicare drug program on January 1, 2006. We will also assess whether any changes affected subsidy payments to the employer and whether the employer provided to CMS the required certification that a qualified retiree's health coverage was at least actuarially equivalent to the standard prescription drug coverage under Medicare Part D.
(OAS; W-00-07-35311; various reviews; expected issue date: FY 2007; new start)

Rebates in the Retirement Retiree Drug Subsidy Program

We will examine employers' controls for developing estimates of expected rebates and other price concessions used for determining interim subsidy payments to determine whether these estimates are reasonable, supported, and consistently applied. An employer participating in the RDS program must provide an estimate of the expected rebates and other price concessions attributable to the plan (based on historical data) upon submission of data for payment.

Employers are required to provide an annual reconciliation that includes actual rebates, discounts, or other price concessions received. If rebates and other price concessions for an employer drug plan are not specifically allocated by a manufacturer to the drug spending of a particular qualifying covered retiree, an employer will be permitted to assign the price concessions to qualifying covered retirees using reasonable actuarial principles or other methods specified by CMS. The reconciliations must take place within 15 months following the end of the plan year. As a result of the reconciliation, employers will repay any subsidy overpayments or be paid any subsidy underpayments.
(OAS; W-00-07-35312; various reviews; expected issue date: FY 2007; new start)

Tracking Beneficiaries True Out-of-Pocket Costs for Part D Prescription Drug Coverage
We will examine CMS's oversight of the calculation of beneficiaries' true out-of-pocket (TrOOP) expenses that qualify toward catastrophic coverage. The study will also analyze the accuracy of tracking beneficiaries' TrOOP expenses in the Coordination of Benefits system.
(OEI; 03-06-00360; expected issue date: FY 2007; work in progress)

Prescription Drug Plan Marketing Materials
We will determine whether marketing materials for Medicare prescription drug plans are in compliance with CMS regulations and guidelines. We will also examine whether the prescription drug plans' marketing materials are clear and understandable to Medicare beneficiaries in accordance with CMS guidelines.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Medicare Prescription Drug Benefit Pharmacy Access in Rural Areas
We will measure beneficiary access to retail pharmacies that dispense Medicare Part D covered prescription drugs in rural areas. The study will also assess the extent to which drug plans comply with minimum pharmacy access requirements. The MMA mandates that beneficiaries must have convenient access to retail pharmacies and establishes minimum pharmacy access standards.
(OEI; 05-06-00320; expected issue date: FY 2007; work in progress)

Rural Pharmacy Drug Purchases
We will compare payments made by PDPs to rural pharmacies to the prices the pharmacies are paying for the drugs, including dispensing fees. We will also review provisions of PDP contracts that include rural pharmacies in their networks.
(OAS; W-00-06-35313; expected issue date: FY 2007; work in progress)

Medicare Part D Drug Benefit Payments
To implement the new Part D drug benefit established by the MMA, CMS has established new policies and procedures as well as new computerized payment systems. To determine whether these policies, procedures, and payment systems are working as intended, we will sample Part D beneficiaries' claim files to determine whether controls have been implemented and are working to ensure that (1) benefits are paid on behalf of eligible beneficiaries and (2) Medicare and beneficiaries are paid appropriate amounts for drug coverage.
(OAS; W-00-06-35199; various reviews; expected issue date: FY 2007; work in progress)

State Contribution to Drug Benefit Costs Assumed by Medicare

We will determine States' compliance with laws and regulations related to States' contribution payments toward Medicare Part D. This will include reviews of data used to calculate States' contribution payments, calculation of the States' contribution payments and the States' payment amounts, and CMS and States' controls related to contribution payments. Under the MMA, full-benefit, dual eligible individuals now receive drug coverage under Medicare Part D rather than Medicaid. As of January 2006, each of the 50 States and the District of Columbia are responsible for making monthly payments to the Federal Government to defray a portion of the Medicare drug expenditures for these individuals.
(OAS; W-00-06-35186; various reviews; expected issue date: FY 2007; work in progress)

Medicare Part D Risk-Sharing Payments and Recoveries

We will determine whether CMS and the PDPs have established adequate controls over Medicare Part D risk-sharing payments and recoveries to ensure that (1) the plans submit accurate and timely information to CMS; (2) CMS calculations are performed in accordance with applicable laws and regulations; and (3) payments and recoveries are made in accordance with applicable laws and regulations. Medicare will share a portion of a PDP's losses or profits resulting from expenses that fall either above or below an expected target level. CMS will calculate risk-sharing payments or recoveries based on information that the PDPs provide.
(OAS; W-00-06-35200; various reviews; expected issue date: FY 2007; work in progress)

Other Medicare Services

Laboratory Services Rendered During an Inpatient Stay

We will determine the extent to which laboratory services rendered during an inpatient stay are unallowable. CMS payment for laboratory services that are payable under Part B is based on the clinical diagnostic laboratory fee schedule. Preliminary work indicated that $73 million of laboratory services were rendered in hospital settings during inpatient stays nationwide in calendar year 2001. This was a considerable increase in cost over similar services provided in prior periods. Our review will determine the percentage of these costs that is unallowable.
(OAS; W-00-05-35168; A-01-06-00505; expected issue date: FY 2007; work in progress)

Therapy Services Provided by Comprehensive Outpatient Rehabilitation Facilities

We will determine whether comprehensive outpatient rehabilitation facilities (CORF) provided and billed physical therapy, speech language pathology, and occupational therapy services in accordance with applicable Medicare requirements. A CORF is recognized as a provider of services that is paid under the physician fee schedule for most services. Prior OIG reviews found that Medicare paid significant amounts for unallowable or highly questionable therapy services in outpatient rehabilitation facilities and nursing homes. A majority of these services were not reasonable and necessary for the beneficiary's health condition, or lacked sufficient documentation.
(OAS; W-00-05-35119; various reviews; expected issue date: FY 2007; work in progress)

Emergency Health Services for Undocumented Aliens

We will determine whether the $250 million appropriation enacted by the MMA for emergency health services furnished to undocumented aliens and other specified aliens is appropriately

distributed to States and providers and is used for its intended purpose. The MMA has appropriated $250 million for each of FYs 2005 through 2008 for eligible States and providers. Two-thirds of the funds are to be distributed according to the estimated proportion of undocumented aliens residing in each State; the remaining third is designated for the six States with the highest number of apprehensions of undocumented aliens as reported by the Department of Homeland Security. The new funds are to be paid directly to eligible providers, such as hospitals, physicians, and ambulance services, for emergency medical services furnished to undocumented aliens. We will coordinate with departmental components that are also evaluating these distributions.
(OAS; W-00-05-35170; various reviews; expected issue date: FY 2007; work in progress)

Medicare Reimbursement for End Stage Renal Disease Drugs
We will examine the difference between the Medicare reimbursement amounts for selected separately billable end stage renal disease (ESRD) drugs and the acquisition costs of these drugs for ESRD facilities. We will also assess the variability of acquisition costs among providers. The review will update prior OIG work completed in 2004.
(OEI; 03-06-00590; expected issue date: FY 2007; work in progress)

Separately Billable Laboratory Services Under the End Stage Renal Disease Program
The MMA requires the Secretary to develop a report on a bundled PPS for ESRD services. This bundled PPS would include certain clinical laboratory tests that are currently separately billable to Medicare. The current facility payment (composite rate) includes payments for certain automated multichannel chemistry (AMCC) tests provided routinely at specified frequencies. Any AMCC tests performed in excess of specified frequencies or that are not included in the composite rate payment are billed separately, provided that medical necessity is documented. Prior OIG reviews concluded that providers were paid separately for AMCC tests included in the composite rate. To ensure that the bundled PPS rate is based on valid data, we will review providers' compliance with the current payment policies for AMCC tests furnished to ESRD beneficiaries.
(OAS; W-00-07-35202; A-01-07-00000; expected issue date: FY 2007; new start)

Medicare Pricing of Laboratory Services
We will compare Medicare payment rates for certain laboratory tests with the rates of other Federal and State health programs and private payers. In 2003, Medicare-allowed charges for tests paid under the laboratory fee schedule totaled $3.2 billion. This study will build upon prior OIG work in which we found that Medicare paid significantly higher prices than other payers for certain laboratory tests.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Medicare Duplicate Claims
We will determine whether the Medicare program has made payments for duplicate claims. We will examine the current edit process to determine whether the process is effective in identifying potential duplicate claims and preventing overpayments.
(OAS; W-00-06-35210; various reviews; expected issue date: FY 2007; work in progress)

Medicare Managed Care

Stabilization Fund

We will assess compliance with MMA requirements and CMS regulatory guidance pertaining to the establishment and management of the "Stabilization Fund for CYs 2004 and 2005." We will also examine the adequacy, propriety and timeliness of CMS's review processes for evaluating Medicare Advantage (MA) plan proposals and the awarding of stabilization funds.
(OAS; W-00-05-35171; various reviews, expected issue date: FY 2007; work in progress)

Administrative Costs

Using the Federal Employees Health Benefit Program guidelines, we will examine the administrative amounts currently claimed by MA organizations. Under the MMA legislation, beginning in 2006, MA organizations are paid a monthly amount based on bids that may include amounts to cover administrative costs such as marketing, taxes, depreciation, reinsurance, interest, and other nonmedical costs. In this new arrangement, the Secretary's negotiating authority will be similar to that exercised by the Office of Personnel Management under the Federal benefit program. Congress has expressed interest in how MA organizations determine funding amounts to meet administrative costs, which must be allocable, allowable, reasonable, and limited under the program.
(OAS; W-00-05-35173; various reviews; expected issue date: FY 2007; work in progress)

Accuracy of Medicare Managed Care Payments

Our review will determine whether CMS paid MA organizations pursuant to Federal laws and regulations. At the beginning of each month, CMS makes capitation payments to MA plans for each enrolled Medicare beneficiary. In 2005, the payment was based on a blend of two methodologies: demographic and risk-based. The demographic model considers specific beneficiary factors, i.e., age, sex, and Medicaid status. The risk-based model incorporates the health status of beneficiaries, i.e., inpatient, outpatient, and physician services incurred during previous years. Based on our 2005 CMS Financial Report, CMS made adjustments to MA payments that were processed in the Medicare managed care system. The adjustments were based on prior months' actual payments from the predecessor system without considering other factors that may have caused changes. For our audit, we will review the accuracy of the payments and subsequent adjustments.
(OAS; W-00-06-35209; A-07-06-01027; expected issue date: FY 2007; work in progress)

Managed Care Encounter Data

We will determine the accuracy of encounter data on Medicare beneficiaries. All MA organizations are required to submit these data for CMS's use in developing a portion of each organization's monthly capitation rate. The portion of the monthly rate that relates to the encounter data is the risk-adjusted portion, which made up 10 percent of the rate in 2003. The risk-adjusted portion increased to 50 percent in 2005 and will become 75 percent in 2006. It will eventually be 100 percent of the monthly rate. Thus, incorrect or incomplete encounter data could have a significant impact on future Medicare reimbursement.
(OAS; W-00-05-35078; various reviews; expected issue date: FY 2007; work in progress)

Enhanced Managed Care Payments

We will complete several reviews to determine whether CMS made proper enhanced capitation payments to MA organizations. Medicare provides enhanced capitation payments for beneficiaries who are institutionalized, in ESRD status, or dually eligible for Medicare and Medicaid. Our reviews will focus on the accuracy of controls at both CMS and the MA organizations regarding special status categories warranting these enhanced payments.
(OAS; W-00-06-35054; various reviews; expected issue date: FY 2007; work in progress)

Duplicate Medicare Payments to Cost-Based Plans

We will review selected cost-based (section 1876) health maintenance organizations (HMO) nationwide that have made significant Medicare payments to providers under capitation agreements. We will determine whether any payments have been duplicated under the Medicare fee-for-service payment system. Generally, under capitation arrangements, health care providers are paid for services furnished to an HMO's Medicare enrollees through monthly per capita payments from the HMO. The HMO receives Medicare reimbursement for these payments by claiming them on Medicare cost reports. Accordingly, any Medicare fee-for-service billings that the capitated providers submit for services provided to the HMO's Medicare enrollees would result in duplicate payments. Under CMS regulations, the HMO is responsible for establishing internal controls to detect and prevent such duplicate reimbursement.
(OAS; W-00-06-35122; various reviews; expected issue date: FY 2007; work in progress)

Medicare Capitation Payments to Managed Care Plans After a Beneficiary's Death

We will determine the extent to which payments are made to MA plans for deceased beneficiaries. MA organizations are required to submit information to CMS about the status of their members and report specific beneficiary status changes, including death. We will examine processes and systems used by CMS to identify MA overpayments made after a beneficiary's death. Further, we will assess what proportion of payments is subsequently recovered by CMS.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Medicare Advantage Regional Plans: Availability, Physician Participation, and Beneficiary Enrollment in Rural Areas

We will determine the availability of regional MA plans to beneficiaries residing in rural areas. We will also assess the extent to which Medicare beneficiaries residing in rural areas choose to enroll in MA plans and whether physician practices in rural areas participate in regional MA plans. Historically, Medicare managed care plans have been concentrated in urban areas. The MMA requires the Secretary to establish MA regions so as to maximize the availability of plans to eligible individuals.
(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Medicare Advantage Lock-In Provisions

This review will examine CMS and MA plan communications and beneficiary understanding of lock-in provisions. Recent reforms to the MA program include a lock-in provision that limits the number of times and the time of year that beneficiaries may change health plans. To assist beneficiaries, CMS or MCOs provide written descriptions of rules, procedure, benefits, fees and other charges, services, and other information necessary to make an informed decision about

enrollment. This study will assess how effectively CMS and MA plans are fulfilling this requirement.
(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Medicare Contractor Operations

Preaward Reviews of Contract Proposals

We will review the cost proposals of various bidders for Medicare contracts. The reports produced by these reviews assist CMS in negotiating favorable and cost-beneficial contract awards.
(OAS; W-00-06-35002; various reviews; expected issue date: FY 2007; work in progress)

Contractors' Administrative Costs

We will review administrative costs claimed by various contractors for their Medicare activities, paying special attention to costs claimed by terminated contractors. We will determine whether the costs claimed were reasonable, allocable, and allowable under the terms of the contract with CMS as well as applicable Federal Acquisition Regulations. We will coordinate the selection of contractors with CMS staff.
(OAS; W-00-06-35005; various reviews; expected issue date: FY 2007; work in progress)

Quality Improvement Organizations

We will assess the fiscal integrity of quality improvement organizations (QIO). QIOs receive payments to ensure that medical care is reasonable and medically necessary, is provided in the most economical settings, and meets professionally recognized standards. In FY 2004, QIOs received $367 million annually from CMS and $1.1 billion for their current 3-year contract. We will determine whether Medicare payments in the following areas were reasonable and allowable pursuant to Federal requirements: (1) board member and executive staff compensation and travel, (2) costs relating to legal fees and administrative charges, and (3) equipment. We will also determine whether there were any conflicts of interest in these payments and whether contract modifications were appropriate.
(OAS; W-00-06-35204; various reviews; expected issue date: FY 2007; work in progress)

CMS Contracting Operations

We will review CMS's Office of Acquisition and Grants Management (OAGM) contracting operations to acquire an understanding of the procedures that CMS uses to solicit and manage its contracts, with a view toward examining specific contracts as part of a separate future audit assignment. In FY 2005, OAGM initiated an estimated $1.6 billion in contracts. We will initially document the OAGM operations addressing (1) presolicitation activities; (2) solicitation, evaluation, and award activities; and (3) postaward activities.
(OAS; W-00-06-30003; A-14-06-02207; expected issue date: FY 2007; work in progress)

Contractors' Incurred Cost Audits

We will review the incurred costs claimed by various organizations on contracts awarded by CMS. We will determine whether the costs claimed were reasonable, allocable, and allowable under the terms of the contract with CMS, as well as applicable Federal Acquisition Regulations.
(OAS; W-00-07-35314; various reviews; expected issue date: FY 2007; new start)

Contractors' Accounting System Audits

We will review prospective Medicare contractors' accounting systems to determine whether the system is capable of identifying, gathering, segmenting, and reporting costs by project and whether it complies with applicable Federal Acquisition Regulations.
(OAS; W-00-07-35315; various reviews; expected issue date: FY 2007; new start)

Contractors' Provisional Billing Rates

We will review contractors' indirect cost rate proposals to determine whether the costs claimed were reasonable, allocable, and allowable, and can be used for provisional billing purposes.
(OAS; W-00-07-35316; various reviews; expected issue date: FY 2007; new start)

Pension Segmentation

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 segments of their pension plans. We will also assess Medicare's share of future pension costs on a segmented basis.
(OAS; W-00-06-35094; various reviews; expected issue date: FY 2007; work in progress)

Pension Costs Claimed

We will determine whether Medicare contractors have calculated pension costs claimed for reimbursement in accordance with their Medicare contracts and cost accounting standards. We will also determine whether the costs claimed were allocable and allowable under the Medicare contracts.
(OAS; W-00-06-35067; various reviews; expected issue date: FY 2007; work in progress)

Unfunded Pension Costs

We will determine whether Medicare contractors identified and eliminated unallowable costs when computing pension costs charged to the Medicare program. Additionally, we will determine whether pension costs that would have been tax deductible had they been funded were reassigned to future periods.
(OAS; W-00-06-35148; various reviews; expected issue date: FY 2007; work in progress)

Pension Segment Closing

We will review Medicare carriers and FIs 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 each Medicare segment as of the segment closing date. Regulations and Medicare contracts provide that pension gains that occur when a Medicare segment closes should be credited to the Medicare program.
(OAS; W-00-06-35067; various reviews; expected issue date: FY 2007; work in progress)

Postretirement Benefits and Supplemental Employee Retirement Plan Costs

We will review the postretirement health benefit costs and the supplemental employee retirement plans of FIs and carriers. Our reviews will determine the allowability, allocability, and reasonableness of the benefits and plans, as well as the costs charged to Medicare contracts.
(OAS; W-00-06-35095; various reviews; expected issue date: FY 2007; work in progress)

Program Safeguard Contractor Performance

We will examine the effectiveness of CMS program safeguard contractors in identifying fraud and abuse. In 2000, CMS began transferring benefit integrity functions from carriers and fiscal intermediaries to specialized entities called program safeguard contractors. We will also evaluate whether program safeguard contractors effectively coordinate information with CMS and its other contractors, determine whether inefficiencies result from any duplication of effort, and examine CMS oversight of these entities.
(OEI; 03-06-00010; various reviews; expected issue date: FY 2007; work in progress)

Accuracy of the Provider Enrollment, Chain, and Ownership System

We will assess the accuracy of the provider enrollment information in the Provider Enrollment, Chain, and Ownership System and determine whether it contains providers that should have been deactivated in the system. The purpose of the system is to enable Medicare contractors to ensure that only qualified providers and suppliers are enrolled and eligible for Medicare payments. In prior reports, both the Government Accountability Office and OIG have found problems with contractors not verifying enrollment information and not removing unused provider numbers. We will also determine whether the new system has simplified the enrollment process.
(OEI; 07-05-00100; expected issue date: FY 2007; work in progress)

Handling of Beneficiary Inquiries

We will assess Medicare beneficiaries' experiences accessing information from Medicare-funded call centers. In July 2004, all calls to Medicare-funded call centers began routing through a single phone number: 1-800-Medicare. As changes have occurred in Medicare coverage and delivery options as a result of the MMA, beneficiary calls to the call centers have increased. Prior OIG work found that some beneficiaries had difficulty obtaining needed information from Medicare-funded call centers.
(OEI; 07-06-00530; expected issue date: FY 2007; work in progress)

Medicare Appeals Process

We will update our prior work in which we identified significant problems in the Medicare appeals process, which resulted in the system being backlogged and untimely. Several recommendations in these reports have subsequently been addressed by legislation, including the transfer of the Administrative Law Judge (ALJ) function from the Social Security Administration to the Department of Health and Human Services and modifying the timeframes for the various levels of appeals to provide adequate time for fair and effective processing, while still ensuring timely and efficient resolution of appeals. In a series of reviews, we will examine the early implementation of these changes to the entire appeals process, including the transfer of ALJs to HHS, the use of video conferencing in ALJ hearings, and the creation of Qualified Independent Contractors. We will also evaluate the impact of these changes on the process, including examining the timeliness and outcomes of appeal processing at the various levels.
(OEI; 02-06-00110; 06-06-00500; various reviews; expected issue date: FY 2007; work in progress)

Payment Suspensions for Medical Equipment Suppliers

This study will determine whether Medicare is vulnerable to suppliers who continue to do business with Medicare after holding suppliers' numbers that become suspended, revoked, or

inactive. This study will also determine if such suppliers exhibit aberrant billing patterns.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Contractor Provider Education and Training Efforts

We will assess the provider education and training efforts conducted by Medicare contractors. Section 921 of the MMA prioritized the need to improve contractor's provider education and training efforts in order to improve the accuracy of Medicare claims payments. The Comprehensive Error Rate Testing program is one measure used by CMS to determine the effectiveness of a contractor's provider education and training program. In prior work, OIG found problems with CMS's oversight and monitoring of contractor provider education and training efforts.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Medicaid Hospitals

Hospital Outlier Payments

We will determine whether Medicaid State agencies' methods of computing inpatient hospital cost outlier payments result in reasonable payments. Prior OIG work involving Medicare claims for hospital outliers identified vulnerabilities in the Medicare payment methodology.
(OAS; W-00-04-31069; W-00-05-31069; various reviews; expected issue date: FY 2007; work in progress)

Disproportionate Share Hospital Payments

We will review several States' disproportionate share hospital (DSH) payments to selected hospitals to verify that the States calculated the payments according to 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 section 1923(g) of the Social Security Act, DSH payments to an individual hospital may not exceed that hospital's uncompensated care costs. In addition, in subsequent years, we plan to review States' implementation of the new requirement that DSH claims be audited on an annual basis.
(OAS; W-00-04-31001; W-00-05-31001; W-00-05-39023; various reviews; expected issue date: FY 2007; work in progress)

Hospital Eligibility for Disproportionate Share Hospital Payments

We will determine whether States are appropriately determining hospitals' eligibility for Medicaid DSH payments. Section 1923 of the Social Security Act requires hospitals to meet certain criteria before being deemed eligible to receive DSH payments. During several prior reviews, we found that States were making DSH payments to hospitals that did not meet the eligibility standards.
(OAS; W-00-05-31084; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Long Term and Community Care

Billing for Medicaid Nursing Home Patients Transferred to Hospitals

We will examine States' Medicaid claims data to determine whether Medicaid made duplicate payments to nursing facilities and hospitals for the same patients and whether hospitals are receiving payments for Medicaid patients who have been discharged. During prior audit work, we found that some States were making Medicaid nursing facility payments for individuals who had transferred to hospitals. These States were also making Medicaid payments to hospitals for patients who had been discharged.
(OAS; W-00-07-31201; various reviews; expected issue date: FY 2007; new start)

Community Residence Claims

We will determine whether States have improperly claimed Federal financial participation under the Medicaid program for beneficiaries who reside in community residences for people with mental disabilities. OIG work in one State indicated that some providers were improperly claiming Medicaid reimbursement for beneficiaries who had changed living arrangements and were no longer living at the community residences.
(OAS; W-00-07-31087; various reviews; expected issue date: FY 2007; new start)

Assisted Living Facilities

In several States, we will determine whether providers were improperly reimbursed for services provided to residents of assisted living facilities and determine the associated financial impact on the Medicaid program. In some States, assisted living facilities receive a daily Medicaid rate for their residents' home care services. Outside providers should not submit separate claims for home care services because these services are included in the Medicaid rates paid to the assisted living facilities.
(OAS; W-00-04-31076; W-00-05-31076; various reviews; expected issue date: FY 2007; work in progress)

Targeted Case Management

We will determine whether Medicaid payments claimed by States for targeted case management services were in accordance with Federal requirements. Section 1915(g)(2) of the Social Security Act defines case management as services that assist individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred. Payments for case management services may not duplicate payments made to public agencies under other program authorities for the same service.
(OAS; W-00-05-31082; W-00-06-31082; various reviews; expected issue date: FY 2007; work in progress)

Home and Community Based Services Administrative Costs

We will determine whether one State claimed costs for home and community based services in accordance with Federal and State regulations and whether the State properly monitored compliance with the requirements of the program. Waivers under section 1915(c) of the Social Security Act allow States to provide health care services and personal care in the home and

community to help individuals avoid or delay the need to enter an institution. In one State, we will review how a developmental disabilities agency administers services under a waiver.
(OAS; W-00-03-39003; W-00-04-39003; A-04-03-03025; A-04-03-03026; A-04-04-04006; expected issue date: FY 2007; work in progress)

Home and Community Based Services: Erroneous Medicaid Payments After a Beneficiary's Death

In the last 6 years, Medicaid long term care programs have seen a 110 percent increase in health care services paid under Home and Community Based Services (HCBS) waivers. In a 1997 study, we found that a substantial amount of erroneous Medicare payments were made after the beneficiary's death. This review will determine the extent to which Medicaid paid for HCBS provided after beneficiaries' dates of death.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Home and Community Based Services: Erroneous Medicaid Payments During a Beneficiary's Institutionalization

This review will determine the extent to which Medicaid paid for HCBS during beneficiaries' institutionalizations in a hospital, nursing home, or intermediate care facility. In 2003, a GAO report on long term care and HCBS waivers found that CMS did not adequately monitor State HCBS waivers. Without adequate monitoring, States may be making Medicaid payments for HCBS provided after beneficiaries' dates of institutionalization.
(OEI; 000-00-00000; expected issue date: FY 2007; new start)

Preadmission Screening and Resident Review for Younger Nursing Facility Residents with Serious Mental Illness and Mental Retardation

We will assess the Preadmission Screening and Resident Review (PASRR) program for Medicaid nursing facility residents aged 22 to 64 with serious mental illness or mental retardation. The Omnibus Budget Reconciliation Act of 1987 requires preadmission screening for mental illness and mental retardation. In a 2001 report, we found that the PASRRs did not comply with Federal requirements. We will update this previous work. The review will evaluate CMS's oversight of States' PASRR programs, State Medicaid agencies' oversight of the process, and the extent to which nursing facilities comply with the PASRR requirements.
(OEI; 05-05-00220; 07-05-00230; expected issue date: FY 2007; work in progress)

Medicaid Payments for Medicare-Covered Home Health Services

Home health services constitute a significant portion of both Medicare and Medicaid expenditures. Medicare pays a prospective payment rate for each 60-day episode of home health coverage for a beneficiary. Most States pay for Medicaid home health services on a fee-for-service basis. This evaluation will determine the appropriateness of Medicaid payments for Medicare-covered home health services.
(OEI; 00-00-00000; expected due date: FY 2007; new start)

Medicaid Mental Health Services

Medicaid for Persons with Mental Disabilities

We will review the methodology under which one State claims costs for services to persons with mental disabilities. In some cases, the State reimburses its providers less than the actual amount

it claims as Federal financial participation on the Medicaid expenditure reports. This may result in the State claiming excess Federal financial participation.
(OAS; W-00-04-39012; A-04-04-04005; expected issue date: FY 2007; work in progress)

Community Mental Health Centers
We will determine whether Medicaid payments to community mental health centers are made in accordance with applicable Federal and State regulation and guidance. Specifically, we will review a proposal for claiming administrative costs in one State to determine whether claims submitted under this proposal were eligible for Federal financial participation. Prior reviews of Medicare payments to community mental health centers identified problems, including payments for noncovered services and payments for services provided to beneficiaries who did not meet eligibility requirements.
(OAS; W-00-04-39020; W-00-05-39035; W-00-05-31099; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Supplemental Mental Health Payments to Prepaid Inpatient Health Plans
We will determine whether prepaid inpatient health plans were paid in accordance with Federal laws and regulations. We will focus on States' Medicaid supplemental mental health payments to prepaid inpatient health plans. Federal law prohibits prepaid inpatient health plans from receiving a supplemental payment that is not part of the actuarially certified capitated rate and is not part of the contract between the State Medicaid Agency and the prepaid inpatient health plans.
(OAS; W-00-06-31098; A-07-06-04067; expected issue date: FY 2007; work in progress)

Medicaid Outpatient Mental Health Services: Appropriateness of Payments
We will identify improper payments and potential cost savings for Medicaid outpatient mental health services. In a Medicare study, we found that one-third of outpatient mental health services provided were medically unnecessary, billed incorrectly, rendered by unqualified providers, undocumented or poorly documented. Through a medical review, this study will determine the extent to which Medicaid services have similar issues.
(OEI; 00-000-00000; expected issue date: FY 2007; new start)

Restraint and Seclusion in Children's Psychiatric Residential Treatment Facilities
We will determine whether psychiatric residential treatment facilities for children are in compliance with CMS regulations regarding the use of restraints and seclusion. In January 2001, CMS issued regulations establishing standards for the use of restraints and seclusion for residential treatment facilities serving those under age 21. The standards limit the use of restraints or seclusion to emergency safety situations, and include age-specific time limits for restraints or seclusion orders. States are required to conduct onsite inspection, including reviewing the implementation of these standards, of 20 percent of their residential treatment facilities annually. We will review CMS's oversight of State monitoring activities as well as State oversight.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Early and Periodic Screening, Diagnostic and Treatment of Mental Health in Medicaid Managed Care Plans

This inspection will examine the extent to which Medicaid managed care plans are meeting early and periodic screening, diagnostic, and treatment (EPSDT) program requirements for mental health. Specifically, we will examine how EPSDT programs screen, refer, and provide mental health services to children. The transition from Medicaid fee-for-service to Medicaid managed care has raised concerns about children's access to necessary health screenings and services because managed care plans have incentives to limit services to enrollees. Previous work by OIG found that enrollees in Medicaid managed care often failed to receive required EPSDT services.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Medicaid Outpatient Mental Health Services that Exceed State Utilization Criteria

This study will determine the extent to which Medicaid paid for outpatient mental health services for individual beneficiaries that exceeded State utilization criteria. Many States have established utilization criteria based on type, frequency, and duration of services. This study will identify the types of services that are most vulnerable, trends if any, and the State and Federal expenditures for services that were provided in excess of State utilization criteria.
(OEI; 07-06-00390; expected issue date: FY 2007; work in progress)

Medicaid/State Children's Health Insurance Program

Detecting and Investigating Fraud and Abuse in State Children's Health Insurance Programs

We will determine the extent to which separate State Children's Health Insurance Programs (SCHIP) are in compliance with Federal regulations for detecting and investigating fraud and abuse and examine States' experiences with fraud and abuse. Regulations at 42 CFR § 457.915(a) require States to establish procedures for ensuring program integrity and detecting fraudulent or abusive activity for separate SCHIPs. This study will not only evaluate States' compliance with Federal regulations and their experiences with fraud and abuse, but it will also establish a benchmark for SCHIP fraud and abuse activities for future work in this area.
(OEI; 06-04-00380; expected issue date: FY 2007; work in progress)

Accuracy of State Children's Health Insurance Program Enrollment Data

We will (1) assess States' efforts to ensure the accuracy of the SCHIP enrollment data reported in the Statistical Enrollment Data System, (2) determine whether inaccuracies in enrollment data could cause incorrect claims for Federal reimbursement, and (3) assess CMS's oversight of these activities. States are required to submit enrollment data that distinguish separate and Medicaid-expansion SCHIP children from children who would be eligible for traditional Medicaid. States receive an enhanced Federal match rate for children eligible for the SCHIP. Prior OIG work found that some States had difficulty accurately identifying children enrolled in SCHIP from their traditional Medicaid population. This study will assess States' accuracy in reporting enrollment data to CMS.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

State Children's Health Insurance Program Use of the National Correct Coding Initiative

We will determine (1) the extent to which separate SCHIPs use the National Correct Coding Initiative (CCI) edits or similar prepayment edits, and (2) the extent to which separate SCHIPs paid for services that would otherwise be denied if they had used CCI edits. To identify improper payments, CMS requires Medicare carriers to utilize CCI edits; however, no similar mandate exists for Medicaid or separate SCHIPs. A prior OIG study, "Applying the National Correct Coding Initiative to Medicaid Services," found that State Medicaid agencies paid $54 million in 2001 for services that would have been denied based on CCI edits. If CCI edits could identify services that should not have been paid in both Medicare and Medicaid, applying these edits to SCHIPs could produce similar results.
(OEI; 00-00-0000; expected issue date: FY 2007; new start)

Medicaid Prescription Drugs

Review of the Average Manufacturer Price

We will review selected drug manufacturers to evaluate the methodologies that manufacturers used to calculate their AMPs for the Medicaid drug rebate program and determine whether the methodologies were consistent with statute, their rebate agreements, and CMS Releases. The DRA makes several changes to the Medicaid drug rebate statute. These changes involve revisions to the calculation of the AMP and the best price (BP) that will affect the amounts that pharmaceutical manufacturers report under the Medicaid drug rebate program. CMS uses the AMP and the BP to determine a rebate amount. Manufacturers must pay rebates to the States based on the rebate amount.
(OAS; W-00-07-31202; various reviews; expected issue date: FY 2007; new start)

Review of CMS's Oversight of the Medicaid Drug Rebate Program

We will review CMS's oversight of the Medicaid drug rebate program to determine whether AMP data are accurate and timely. The Omnibus Budget Reconciliation Act of 1990 established the Medicaid drug rebate program. A drug manufacturer must have a rebate agreement with CMS to have its outpatient drugs covered under the Medicaid program and must report its AMP and BP for each drug to CMS on a quarterly basis. CMS uses the AMP and the BP to determine a rebate amount. Manufacturers must pay rebates to the States based on the rebate amount. The DRA makes available to all States on a monthly basis the most recently reported AMP data. Accuracy of the data is important for both the rebate program and for Medicaid reimbursement because the data will be used to set the Federal upper limit on generic drugs, and individual States may use the data for reimbursement purposes.
(OAS; W-00-07-31203; various reviews; expected issue date: FY 2007; new start)

Pharmacies' Ability to Purchase Drugs at Average Manufacturer Price

In several States we will assess pharmacies' ability to purchase Medicaid drugs at or near the AMP. We will also determine the savings that States could achieve if they used the AMP as their reimbursement base. Most States reimburse pharmacies a percentage of average wholesale price (AWP) for participating in the Medicaid drug program. OIG reviews have indicated that the AWP reimbursement methodology is flawed because pharmacies' payments to drug manufacturers are significantly lower than the AWP. Section 6001 of the DRA makes AMP data

available to all States on a monthly basis. Congress expects that this provision will create more transparency and competition in drug pricing.
(OAS; W-00-07-31204; various reviews; expected issue date: FY 2007; new start)

Drug Rebate Reviews in States

We will conduct follow-up reviews to determine whether States have established adequate accountability and internal controls over their Medicaid drug rebate programs. Federal regulations require that financial management systems provide for effective control over and accountability for all funds, property, and other assets. In a prior OIG report summarizing our reviews in 49 States and the District of Columbia, we found that only 4 States had no weaknesses in accountability and internal controls over their drug rebate programs.
(OAS; W-00-07-31205; various reviews; expected issue date: FY 2007; new start)

Medicaid Drug Rebates—Computation of Average Manufacturer Price and Best Price

We will evaluate the adequacy of drug manufacturers' methodologies for computing the AMP and the BP. Both the AMP and the BP reported to CMS by manufacturers are used to determine the drug rebates paid to States. Any inaccuracies in the amounts reported can significantly affect rebate amounts. In addition, we will assess CMS's oversight of drug manufacturers' recalculations of the AMP and the BP. It is critical that CMS effectively oversee the recalculation process to ensure that State Medicaid programs are receiving the appropriate drug rebates.
(OAS; W-00-03-31042; various reviews; expected issue date: FY 2007; work in progress)

Indexing the Generic Drug Rebate

We will analyze generic drug expenditures over a period of time to determine whether pricing substantially increased compared with the consumer price index for urban consumers. For brand-name drugs under the Medicaid rebate program, the AMP is indexed to the consumer price index for urban consumers using a baseline AMP. No such comparisons and indexing are made for rebates for generic drugs, which are simply set at the AMP multiplied by a fixed percentage. Our review will quantify any potential savings from indexing generic drugs.
(OAS; W-00-04-31073; various reviews; expected issue date: FY 2007; work in progress)

Examining Fluctuations in Average Manufacturer Prices

We will determine the extent to which AMPs fluctuate over time. We will examine whether changes in AMPs over a specified period are more evident for brand or generic drugs. We will also examine whether changes differ for the 200 most common Medicaid drugs.
(OEI; 03-06-00350; expected issue date: FY 2007; work in progress)

States Use of New Drug Pricing Data to Establish Medicaid Reimbursement for Prescription Drugs

Effective July 1, 2006, the Deficit Reduction Act of 2005 (DRA) mandates CMS to share average manufacturer price (AMP) data with States. DRA also mandates CMS to share retail sales price (RSP) data with States for use in calculating pharmacy reimbursement beginning January 1, 2007. This study will evaluate the extent to which States are considering the use of new pricing data to establish Medicaid reimbursement for prescription drugs.
(OEI; 03-06-00490; expected issue date: FY 2007; work in progress)

Overprescribing of OxyContin and Other Prescription Drugs

We will analyze Medicaid paid claims data to identify beneficiaries who have received significant amounts of OxyContin and the prescribing physicians. OxyContin is a pain medication with a very high street value. In 1999, various strengths of OxyContin represented three of the four generic drugs with the highest expenditures in the Medicaid program. Through analyses involving medical reviews, the nature of diagnoses, and physician specialties, we will evaluate the appropriateness of the prescriptions. As part of this review, we will examine prescribing patterns for other drugs with potential for abuse, including Hydrocodone, Xanax, Diazepam, and Soma.
(OAS; W-00-06-31075; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Payments for HIV Drugs

There have been reports in one State about potential abuses in the Medicaid drug program related to the high-cost drugs used to treat HIV. These reports indicate that pharmacies have been soliciting referrals from current HIV patients through gifts and other cash incentives. These reports also appear to indicate that Medicaid is paying far too much for HIV drugs. We intend to examine payments for and utilization of HIV drugs to determine whether there is evidence of abuse and whether the State is paying too much for these drugs.
(OAS; W-00-06-31105; various reviews; expected issue date: FY 2007; work in progress)

Zero Dollar Unit Rebate Amounts

We will determine whether States are properly collecting drug rebates for drugs with $0 unit rebate amounts (URA). CMS provides the URA information quarterly to the States; however, this information may contain a $0 URA if a drug labeler (e.g., a manufacturer) did not provide timely information or if the pricing information significantly varies from the previous quarter. The State agency is instructed to invoice the units at $0 and the manufacturer is required to calculate the URA and remit the proper amount with its quarterly payment. Our review will determine whether the rebates for these drugs were properly billed and collected.
(OAS; W-00-07-31106; various reviews; expected issue date: FY 2007; new start)

Dispute Resolution in the Medicaid Prescription Drug Rebate Program

We will assess the extent to which CMS's Dispute Resolution Program has helped to resolve disputes between State Medicaid programs and drug manufacturers. For Medicaid drug rebates, CMS calculates the unit rebate amount for each drug; State Medicaid agencies use this information, along with their own utilization data, to calculate total rebates owed by drug manufacturers. CMS developed a Dispute Resolution Program to address manufacturers' disputes about State utilization data. When disputes are not properly resolved, State Medicaid programs are at risk of not receiving drug rebates. We will review the dispute process and how the program facilitates resolution between the States and the manufacturers.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Assessing the Accuracy of CMS's Drug Type Classification in the Medicaid Drug Rebate Initiative File

We will determine whether drugs are classified correctly for purposes of the Medicaid Drug Rebate Program. Previous OIG work revealed that some manufacturers do not classify their

drugs in accordance with Medicaid rebate law and therefore may not be paying appropriate rebate amounts to State Medicaid agencies.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Potential Medicaid Savings from Timely FDA Approval of Generic Drugs

We will examine potential Medicaid savings if new generic drugs released in 2004 and 2005 had been approved by the Food and Drug Administration (FDA) within the required timeframe. FDA is statutorily required to approve or disapprove applications for generic drugs within 6 months of submission. Generic drugs are, on average, approximately 63 percent less expensive than brand name drugs. It is likely that increased availability of generics may reduce Medicaid prescription drug costs to some extent.
(OEI; 04-06-00600; expected issue date: FY 2007; work in progress)

Reimbursement of Drugs Under the Federal Upper Limit Program

We will determine (1) the number of additional drugs that will be included on the Federal upper limit list under the new criteria enacted by the DRA, (2) how Medicaid Federal upper limit amounts will change as a result of provisions in the DRA, and (3) the availability of drug products for prices at or below the new Federal upper limit amounts.
(OEI; 03-06-00400; 03-06-0041; expected issue date: FY 2007; work in progress)

Other Medicaid Services

Family Planning Services

We will determine whether several States improperly claimed enhanced Federal funding for family planning services and the resulting financial impact on the Medicaid program. States may claim Medicaid reimbursement for family planning services at the enhanced Federal matching rate of 90 percent. Prior work identified services that were not related to family planning that should not have been claimed at the enhanced rate.
(OAS; W-00-04-31078; W-00-05-31078; W-00-06-31078; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Payments for Transportation Services

Federal Medicaid regulations require that States ensure "necessary transportation for recipients to and from providers." Each State can have different Medicaid coverage criteria, reimbursement rates, rules governing covered services, and beneficiary eligibility for services. Expenditures for transportation services rose 48 percent nationally during the 5-year period from 1999 to 2003, reaching $1.5 billion in 2003. We will determine whether State Medicaid agencies make erroneous payments for transportation services.
(OAS; W-00-06-31121; OEI-00-00-00000; various reviews; expected issue date: FY 2007; work in progress)

Improper Pediatric Dental Medicaid Payments

We will identify improper payments and potential cost savings for Medicaid pediatric dental services in five selected States. In 2003, Medicaid expenditures totaled $262.6 billion, of which dental services accounted for $3 billion (approximately 1 percent). Through a medical review,

this study will identify improper payments by addressing medical necessity, correct coding, and documentation of services.
(OEI; 04-04-00210; expected issue date: FY 2007; work in progress)

Medicaid Laboratory Tests

We will (1) determine whether Medicaid payments for chemistry, hematology, and urinalysis tests exceeded amounts recognized by Medicare for the same tests or were duplicated; (2) identify tests that were not grouped together (bundled into a panel or profile) for payment purposes; and (3) determine whether the tests were properly supported by a physician's order.
(OAS; W-00-07-31206; various reviews; expected issue date: FY 2008; new start)

School-Based Health Services

We will determine whether Medicaid payments for school-based health services were in accordance with Federal laws and regulations. States are permitted to use their Medicaid programs to help pay for certain health care services, such as physical and speech therapy, delivered to children in schools. Schools may also receive Medicaid reimbursement for the costs of administrative activities, such as Medicaid outreach, application assistance, and coordination and monitoring of health services.
(OAS; W-00-03-31050; W-00-03-31061; W-00-04-31051; W-00-04-31062; W-00-05-31017; W-00-06-39002; W-00-06-31017; W-00-05-39024; W-00-05-39041; various reviews; expected issue date: FY 2007; work in progress)

Adult Rehabilitative Services

We will determine whether adult rehabilitative services claimed by a selected State met Federal Medicaid reimbursement requirements. Preliminary work related to child rehabilitation services identified numerous claims for services not eligible for Medicaid. We will determine whether similar problems exist in the adult services program.
(OAS; W-00-03-31028; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Adult Day Health Service Payments for Ineligible and Absent Beneficiaries

Previous reviews of Medicaid adult day health services indicate inappropriate payments for these services. Facilities were found to have billed Medicaid for deceased patients, patients who did not require center services and patients who attended facilities for only a fraction of the time required by the State. We will identify Medicaid adult day health payments for services to beneficiaries who were ineligible for services or not in attendance at the facility.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Outpatient Alcoholism and Substance Abuse Services

We will determine whether providers were reimbursed for improper claims for outpatient alcoholism and substance abuse services. Medicaid reimbursement is available for outpatient alcoholism and substance abuse services provided in hospital-based or freestanding clinics. Prior work identified significant noncompliance with Federal and State rules. The applicable Federal rules are 42 CFR §§ 440.20 and 440.90, the State Plan, and OMB Circular A-87. In several States, we will conduct reviews at providers that receive the largest amounts of Medicaid reimbursement.
(OAS; W-00-07-31079; various reviews; expected issue date: FY 2007; new start)

Freestanding Inpatient Alcoholism Providers

We will determine whether States have improperly claimed Federal Medicaid reimbursement for inpatient alcoholism services provided in freestanding facilities. These services are not covered under the Federal Medicaid program. A prior review in one State identified improper claims totaling about $3.8 million in Federal reimbursement.
(OAS; W-00-06-31107; various reviews; expected issue date: FY 2007; work in progress)

Medical Services for Undocumented Aliens

We will review Medicaid payments for medical services rendered to undocumented aliens to determine whether States appropriately claimed Federal funds for allowable medical services. States may claim Federal funds for medical services provided to undocumented aliens only when those services are necessary to treat an emergency condition. Prior OIG survey work revealed that six States claimed more than $1.8 billion annually for medical services rendered to undocumented aliens. We have indications from work in one State and discussions with CMS officials that at least three of the six States have claimed Federal funds for nonemergency medical services.
(OAS; W-00-06-31108; various reviews, expected issued date: FY 2007; work in progress)

Inappropriate Medicaid Payments for Personal Care Services

Medicaid covers personal care services only for individuals who are not inpatients or residents of a hospital, nursing facility, psychiatric institution, or intermediate care facility for persons with mental retardation. We will determine whether States have improperly claimed Federal financial participation for personal care services provided under the Medicaid program.
(OEI; 00-00-00000; expected issue date: FY 2007; new start; OAS; W-00-05-31035; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Payments for Physical and Occupational Therapy Services

This study will analyze claims data to identify patterns of Medicaid payments for physical and occupational therapy services that are not in compliance with State standards. States have established standards and limits governing the circumstances under which Medicaid will pay for physical and occupational therapy services. Such standards and limits could relate to the number of allowable sessions per day per beneficiary, as well as restrictions on specific procedures being billed on the same day. In 2003, State Medicaid programs paid approximately $590 million for therapy services. The study will review State controls for physical and occupational therapy services.
(OEI; 04-06-00410; expected issue date: FY 2007; work in progress)

Medicaid Physical and Occupational Therapy Services: Appropriateness of Payments

We will identify improper payments and potential cost savings for Medicaid physical and occupational therapy services. In past Medicare studies, we found that physical and occupational therapy services provided were medically unnecessary, billed incorrectly, or rendered by unqualified providers. Through a medical review, this study will determine if Medicaid has similar problematic issues.
(OEI; 00-000-00000; expected issue date: FY 2007; new start)

Medicaid Administration

Contingency Fee Payment Arrangements

We will determine the extent to which State Medicaid agencies have contracted with consultants through contingency fee payment arrangements and the impact of these arrangements on the submission of questionable or improper claims to the Federal Government. Some State Medicaid agencies use consulting firms to help identify ways to maximize Federal Medicaid reimbursement. In some cases, States pay the consulting firms a percentage of the increase in Federal Medicaid funding.
(OAS; W-00-04-31045; W-00-05-31045; W-00-06-31045; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Statistical Information Systems Data Reporting

This evaluation will identify (1) the extent to which Medicaid Statistical Information Systems (MSIS) data submitted are complete, (2) barriers to submitting data encountered by the States, and (3) oversight activities conducted by CMS to ensure complete data submission. The MSIS is the only national State Medicaid database available to CMS that includes paid claims and eligibility information.
(OEI-04-06-00380; expected issue date: FY 2007; new start)

Upper Payment Limits – Flow of Funds

We will determine whether States have eliminated the use of inappropriate financing mechanisms involving supplemental payments available under the upper payment limits. CMS has been working with States to halt accounting practices that artificially inflate the Federal share of the Medicaid program. CMS has identified 33 States that were using inappropriate financing mechanisms involving upper payment limits (UPL). According to CMS, 26 of the 33 States have halted the practice.
(OAS; W-00-07-31207; various reviews; expected issue date: FY 2007; new start)

Medicaid Payments for Services Provided Under Section 1115 Demonstration Projects

We will review selected States' section 1115 demonstrations to determine whether services are being provided in accordance with demonstration approval conditions and whether the demonstrations are achieving budget neutrality. Section 1115 of the Social Security Act provides the Secretary with authority to authorize experimental demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. Under this authority, some States have expanded Medicaid eligibility to individuals not otherwise eligible for Medicaid, provided services not typically covered by Medicaid, or used innovative systems to deliver services. In addition, the terms of approved demonstrations require that they be "budget neutral," that is, costing the Federal Government no more than it could have cost in the absence of the demonstration.
(OAS; W-00-07-31208; various reviews; expected issue date: FY 2008; new start)

Medicaid Payments for Services Provided Under Section 1915(b) Managed Care/Freedom of Choice Waivers

We will review selected States' section 1915(b) waivers to determine whether services are being provided in accordance with waiver agreements and whether the waivers are cost effective. Under section 1915(b) of the Social Security Act waiver authority, States may operate managed

care/freedom of choice waivers. These waivers affect service delivery to some or all of the individuals eligible for Medicaid in the State. States may elect to enroll on a mandatory basis beneficiaries in managed care programs, or may "carve out" specialty care. These waivers cannot negatively affect beneficiary access or quality of care or service and must be cost effective; that is, they cannot cost the Medicaid program more than it would have cost to provide services without the waiver. We will also review the effectiveness of CMS's national review protocol for the oversight process.
(OAS; W-00-07-31125; OEI; 00-00-00000; various reviews; expected issue date: FY 2008; new start)

Medicaid Payments for Services Provided Under Section 1915(c) Home and Community Based Service Waivers

We will review selected States' section 1915(c) waivers to determine whether services are being provided in accordance with waiver agreements and whether the waivers are cost effective. Under home and community based service waivers, States may offer a variety of services to beneficiaries, including both traditional medical services and nonmedical services, (i.e., respite care and case management). In addition, if they meet certain requirements, family members may provide services under these waivers. We will also review the effectiveness of CMS's national review protocol for the oversight process.
(OAS; W-00-06-39045; W-00-06-31124; OEI; 00-00-00000; various reviews; expected issue date: FY 2008; new start and work in progress)

Identification of Potential Abusive Claims Volumes

We will analyze claims filed by providers participating in the Medicaid program to identify potentially abusive claims volume. We plan to analyze areas such as outpatient prescription drug claims, home health care services, DME supplies, and psychiatric services, to identify beneficiaries and/or providers' claims that need further review.
(OAS; W-00-07-31209; various reviews; expected issue date: FY 2007; new start)

Upper Payment Limits – State Calculations

We will determine whether selected States have properly calculated UPLs. During prior audits, we identified errors in States' UPL calculations that resulted in a significant amount of unallowable claims for Federal financial participation.
(OAS; W-00-07-31211; various reviews; expected issue date: FY 2007; new start)

Medicaid Payments Made for Ineligible Managed Care Members

We will review Medicaid payments to MCOs in selected States. Some States operate managed care programs for children and families receiving Medicaid and contract with MCOs to provide services. Individuals eligible for both Medicare and Medicaid are typically not eligible for these managed care programs. States must receive Medicare eligibility information timely to avoid making payments on behalf of such individuals. Previous audits have found this to be a problem, and additional reviews will be performed to determine if the problem still exists.
(OAS; W-00-07-31212; various reviews; expected issue date: FY 2007; new start)

Medicaid Third-Party Liability

We will determine whether State agencies are recovering funds from third-party insurers for care and services provided under Medicaid and reimbursing the Federal Government's portion of the

third-party liability recovered. Under the Medicaid program, generally, all other liable third-party insurers are required to meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third-party insurers.
(OAS; W-00-07-31213; A-06-07-00000; expected issue date: FY 2007; new start)

Additional Medicaid Payments to High-Volume Providers

We will determine whether one State is adequately managing its high-volume provider payment program. To recognize significant provider service to its Medicaid program, the State designated certain practitioners as "high-volume" providers. These providers are eligible for additional payments on traditional Medicaid and primary care case management claims.
(OAS; W-00-07-31214; A-06-07-00000; expected issue date: FY 2007; new start)

Medicaid Administrative Charges by Other State Agencies

We will evaluate Medicaid administrative charges by State agencies other than the State Medicaid agency to ensure that the charges meet Medicaid requirements and do not duplicate costs charged to other Federal programs. Administrative services are provided by several State agencies in addition to the Medicaid agency responsible for the Medicaid program. The Medicaid agency reimburses the other State agencies for these services. In one State, a recent OIG review identified significant questionable administrative charges reimbursed to another State agency by the State Medicaid agency.
(OAS; W-00-07-31215; various reviews; expected issue date: FY 2007; new start)

Medicaid Provider Tax Issues

We will examine State and health care-related taxes imposed on various Medicaid providers to determine whether those taxes comply with applicable Federal regulations and are being used for the stated purposes. The Social Security Act limits Federal financial participation in States' medical assistance expenditures when the States receive funds from other sources, including impermissible health-care related taxes. Prior OIG work has raised concerns regarding States' use of health-care related taxes, including whether taxes received by States adversely affect the providers required to pay the taxes.
(OAS; W-00-04-39019; W-00-06-39019; W-00-06-31094; various reviews; expected issue date: FY 2008; work in progress)

State-Employed Physicians and Other Practitioners

We will review Medicaid payments to physicians and other health care practitioners who are State employees. Recently, several States submitted State plan amendments to CMS requesting that enhanced payments be made to State-employed physicians. Often, these payments were supplemental values based on a relationship between regular physician payments and the physician's customary charges. One State has begun claiming Federal Medicaid reimbursement under such a State plan amendment.
(OAS; W-00-04-31081; W-00-06-31081; W-00-06-39030; various reviews; expected issue date: FY 2007; work in progress)

Skilled Professional Medical Personnel

We will determine whether States have improperly claimed enhanced Federal funding for skilled professional medical personnel. For these professionals, States may claim Federal funds at the enhanced rate of 75 percent.
(OAS; W-00-05-31077; W-00-06-31077; various reviews; expected issue date: FY 2007; work in progress)

Physician Assistant Reimbursement

We will determine whether improper or ineligible claims for physician assistant reimbursement have been made to Medicaid. Many doctors' offices employ physician assistants, often in areas where doctors are difficult to recruit. Survey work in one State showed that, to claim Medicaid reimbursement, physician assistants must be enrolled as nonbilling providers and have their claims submitted by the employing physician or physician group. Among other requirements, the employing physician or physician group must directly supervise the physician assistants, and no duplication or increase in Medicaid charges may be made by the physician for a service solely because assistance has been provided by a physician assistant.
(OAS; W-00-07-31089; various reviews; expected issue date: FY 2007; new start)

Medicaid and State Children's Health Insurance Program Payment Error Rate Measurement

We will determine whether CMS can produce a valid and reliable error rate estimate for Medicaid fee-for-service. As part of our review, we will evaluate CMS's oversight of the Payment Error Rate Measurement (PERM**)** process and CMS's analysis and use of PERM results. The Improper Payments Information Act of 2002 (IPIA) requires Federal agencies to annually develop a statistically valid estimate of improper payments made under programs with a significant risk of erroneous payments. Medicaid and SCHIP have been identified as programs with significant risks and programs which OMB has requested improper payment information. To be compliant with IPIA, CMS developed PERM for measuring improper payments in Medicaid and SCHIP. PERM sets forth requirements for conducting fee-for-service, managed care, and eligibility reviews. PERM will be implemented for Medicaid fee-for-service in FY 2007 and fully implemented in FY 2008. In FY 2008, OIG will monitor and oversee CMS's implementation of PERM.
(OAS; W-00-07-31216; various reviews; expected issue date: FY 2007; new start)

Medicaid Accounts Receivable

We will examine States' procedures for identifying, recording, and collecting Medicaid overpayments from providers. We will also determine whether States have refunded the Federal share of collected overpayments to the Federal Government, including Medicaid recoveries resulting from fraud and abuse collection efforts. Prior reviews have determined that States have written off or "not recovered overpayments" without reporting these amounts to CMS. In such cases, the State may have failed to repay the Federal share of overpayments.
(OAS; W-00-04-31047; W-00-05-31047; W-00-06-31047; various reviews; OEI; 00-00-00000; expected issue date: FY 2007; work in progress)

Impact on the Medicaid Program of Certified Public Expenditures

We will determine whether States are complying with Federal regulations for claiming certified public expenditures (CPE). CPEs are normally generated by local governments as part of their contribution to the coverage of Medicaid services. States may claim CPEs to provide the State's

share in claiming Federal reimbursement as long as the CPEs comply with Federal regulations (42 CFR § 433.51) and are being used for the stated purposes.
(OAS; W-00-06-31110; various reviews; expected issue date: FY 2007; work in progress)

Edits on Medicaid Payment

We will determine whether States have turned off or overridden edits in Medicaid claims payment systems. Specifically, we will identify for selected States their most critical payment edits and determine State procedures to control the override or turn off of these payment edits. We will also review paid claims to determine the effect on the Federal Government of any overridden payment edits.
(OAS; W-00-07-31111; various reviews; expected issue date: FY 2007; new start)

Medicaid Asset Transfers and Estate Recovery Provision for Nursing Home Care

We will determine whether States have adequate procedures for determining the appropriateness of beneficiary eligibility for Medicaid nursing home care. States are required to impose penalties on individuals who transfer assets at less than fair market value within a specific time period of applying for Medicaid benefits. States are also required by Federal law to seek recovery of amounts incorrectly paid by the State for certain Medicaid beneficiaries. We will also review State procedures for seeking recovery of payment from individual estates to determine whether States are complying with applicable Federal laws and requirements.
(OAS; W-00-06-31113; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Payments for County Administrative Services

At CMS's request, we will review selected States' claims for county administrative services. Our reviews will determine whether Medicaid expenditures for county administrative services were allowable, allocable, and in accordance with applicable Federal laws, regulations, and guidelines and the State plan.
(OAS; W-00-05-39025; W-00-05-39026; W-00-05-39037; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Buy-In

We will review selected States' Medicaid buy-in programs of Medicare Parts A and B. Our reviews will determine whether States had adequate controls to ensure that only Medicare premiums are paid for individuals eligible for State buy-in coverage of Medicaid services.
(OAS; W-00-05-39027; W-00-07-00000; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Eligibility in Multiple States

We will determine the appropriateness of Medicaid payments for beneficiaries with Medicaid eligibility in multiple States. Federal regulations (42 CFR § 435.403) require States to provide Medicaid to eligible residents, including residents who are absent from the State. We have determined that individual beneficiaries are eligible in more than one State during a specific period. Initial survey work has confirmed that payments are made to providers in different States, for a specific beneficiary, for identical or overlapping dates of service.
(OAS; W-00-06-31114; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Administrative Costs

We will determine whether the administrative costs claimed by several States were properly allocated or directly charged to the Medicaid program and claimed in accordance with applicable Federal and State requirements. The Federal share of Medicaid administrative costs is typically 50 percent, with enhanced rates for specific types of costs. Prior reviews in one State noted problems in this area.
(OAS; W-00-06-39044; W-00-06-31123; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Provider Enrollment Standards

We will examine Medicaid provider enrollment controls for DME providers. We will identify and verify State standards and determine if these standards are followed at enrollment and reenrollment.
(OEI; 04-05-00180; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Pricing Comparisons

We will compare Medicaid payment rates for certain medical equipment and supplies among State Medicaid programs. Our review will cover DME, prosthetics, orthotics, and supplies and primarily examine payment variation among States.
(OEI; 04-05-00290; expected issue date: FY 2007; work in progress)

Payments to Medicaid Durable Medical Equipment Providers

Some States require that Medicaid DME providers maintain active Medicare enrollment as a condition of participation in the State Medicaid DME program. For States with this requirement, this study will determine the extent to which Medicaid providers who are not maintaining Medicare enrollment are receiving Medicaid payments for DME, contrary to State standards. We will also assess the extent to which State Medicaid programs work with the Medicare program to obtain changes in the enrollment status of Medicare DME providers.
(OEI; 04-06-00480; expected issue date: FY 2007; work in progress)

Medicaid Fee-for-Service Payments for Beneficiaries Enrolled in Managed Care

We will assess the extent to which Medicaid fee-for-service payments are made for beneficiaries who are enrolled in capitated Medicaid managed care health plans. We will also analyze what controls States have in place to detect if improper fee-for-service payments are being made for beneficiaries enrolled in Medicaid capitated health plans.
(OEI; 07-05-00320; expected issue date: FY 2007; work in progress)

Effect of State Medicaid Financing Arrangements on the Federal Share of Program Expenditures

Many States have taken advantage of loopholes in the Medicaid regulations to devise various financing schemes such as upper payment limits certified public expenditures, intergovernmental transfers, and provider taxes to generate additional Federal revenues for their Medicaid programs without an associated increase in State payments. We will focus on several States to determine the overall effect of various Medicaid financing arrangements on the Federal share of actual program expenditures. We will determine the benefit of each financial mechanism employed to maximize the Federal share of Medicaid expenditure.
(OAS; W-00-07-31115; various reviews; expected issue date: FY 2007; new start)

OIG Medicaid Exclusions – State Agency Referrals

This study will evaluate the extent to which State Medicaid agencies and State licensing boards are referring final disciplinary actions taken against health care practitioners to OIG for exclusion consideration. OIG exclusion authorities are intended to protect Federal health care programs and their beneficiaries from unfit health care providers (i.e., individuals and entities whose actions have demonstrated that they pose a risk to beneficiaries or to the integrity of these programs).
(OEI; 01-06-00300; expected issue date: FY 2007; new start)

Medicaid and SCHIP Eligibility Determinations

We will conduct pilot reviews in three States to determine whether statistically valid error rates can be developed to project the number of beneficiaries who were not eligible for Medicaid and for SCHIP benefits during the period selected for review. If appropriate, the dollar value of Federal monies associated with the number of ineligible beneficiaries will also be estimated. The review will cover the States' policies, procedures, and controls for verifying and redetermining eligibility.
(OAS; W-00-05-31100; W-00-06-31100; various reviews; expected issue date: FY 2007; work in progress)

Medicaid Encounter Data: Completeness and Accuracy of Medicaid Managed Care Encounter Data

Recently, States have been moving increasing numbers of Medicaid beneficiaries into managed care programs. This study will determine the extent to which encounter data reported by providers, managed care entities, and Medicaid State agencies is complete, accurate and reported timely in accordance with contractual requirements and Federal regulations.
(OEI; 07-06-00540; expected issue date: FY 2007; work in progress)

Ensuring External Quality Review Organizations Meet Federal Requirements

We will evaluate the extent to which the External Quality Review (EQR) process for Medicaid MCOs is meeting Federal requirements. EQR standards were developed to ensure that beneficiaries receive services that are accessible, timely, and have quality outcomes. As States search for ways to curb escalating Medicaid costs, the number of beneficiaries enrolled in managed care and the number of services provided through managed care arrangements are expected to continue to rise. We will determine the extent to which CMS and the States ensure that MCOs meet EQR standards.
(OEI; 01-06-00510; expected issue date: FY 2007; work in progress)

Information Systems Controls

Annual IG Reports to Congress on Medicare Contractor Information Systems Security Programs (MMA Section 912)

We will review independent evaluations of information systems security programs of Medicare FIs, carriers, and administrative contractors (MAC). We will assess the scope and sufficiency of these evaluations and provide a report to Congress on the results of our assessment. Section 912 of the MMA imposes requirements for annual independent evaluation of FIs, carriers, and MAC security programs and for a subsequent OIG assessment of these evaluations. We are required to

report the results of our assessments to Congress annually. Our report to Congress includes our assessment of the scope and sufficiency of the evaluations performed and our summary of the results of independent evaluation of security programs across Medicare fee for service.
(OAS; W-00-06-41008; expected issue date: FY 2007; work in progress; W-00-07-000008; expected issue date: FY 2008, new start)

Federal Information Security Management Act of 2002 and Critical Infrastructure Protection FY 2007

We will assess CMS's compliance with the Federal Information Security Management Act (FISMA) of 2002 and critical infrastructure protection requirements. The FISMA and OMB Circular A-130, Appendix III, require that agencies and their contractors maintain programs that provide adequate security for all information collected, processed, transmitted, stored, or disseminated in general support systems and major applications. As part of our review, we will follow up on the unresolved findings from other relevant audit reports on information systems controls. The work at CMS is part of an HHS-wide review.
(OAS; W-00-07-41020; A-18-07-0000; expected issue date: FY 2007; new start)

Plan Compliance and Sufficiency of Information Systems Controls Supporting MMA Titles I and II

With contractor support, we will assess the sufficiency of CMS's project planning and monitoring in the development and implementation of information systems to support MMA Title I (Prescription Drug) and Title II (Medicare Advantage). These new parts of the Medicare program entail development and implementation of many new and/or enhanced information systems to be deployed not only at CMS, but also at PDPs, Medicare Advantage plans, and other locations; for example, existing Medicare data centers, where MMA-related Medicare data may be processed.
(OAS; W-00-05-41010; various reviews; expected issue date: FY 2007; work in progress)

Information Technology Planning To Support Medicare Fee-for-Service Contractor Reform

With contractor support, we will assess how CMS is addressing internal control issues in its plans for Medicare contractor reform. Section 911(d)(1)(C) of the MMA establishes a deadline for competitive bidding for annual contract periods that begin on or after October 1, 2001. This effectively results in the need for the phased replacement of the 33 corporate entities that currently serve as FIs, including regional home health intermediaries (RHHIs) and/or carriers, including DMERCs, with new MACs by 2011. Section 911 also required the Secretary to submit to Congress a plan for accomplishing the transition. The HHS plan, which CMS is implementing, calls for consolidating all existing FI/carrier/DMERC contracts into 15 regional A/B MACs, 4 regional DMERCs, and 4 regional RHHIs. The HHS plan further calls for consolidating the existing 16 Medicare data centers where claims are processed into four centers and the streamlining of current fee-for-service processing information systems, (Shared Systems, Common Working File, and National Claims History) into a single integrated claims processing system.
(OAS; W-00-05-41011; various reviews; expected issue date: FY 2007; work in progress)

Smart Card Technology

We will assess the use of "smart card" technology in Medicare demonstrations as a means of creating portable electronic patient medical records. Our review will focus on information security, data privacy, and program integrity concerns. The Secretary's Advisory Commission

on Regulatory Reform recommended that HHS establish a multidisciplinary panel to evaluate the use of this technology in the Medicare program and that OIG provide technical assistance to prevent fraud and abuse. We plan to determine the current state of the technology; identify risk assessments performed by information security, data privacy, and insurance fraud experts; and provide recommendations on the suitability of using smart cards in Medicare health care demonstration projects, as well as measures to mitigate potential risks.
(OAS; W-00-06-41005; A-18-06-02502; expected issue date: FY 2007; work in progress)

Health Information Technology in Medicare and Medicaid—Privacy and Security Issues

We will review the experience with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification privacy and security implementation in Medicare and Medicaid to identify key issues that may be relevant to the Department's health information technology (IT) initiative. The Department's health IT initiative has a primary objective of fostering the use of electronic medical records throughout the health industry to promote economy and efficiency in the delivery of health services and to enhance patient safety. Towards those ends, HHS is also considering whether it may provide, and possibly how best to provide, personal health records to beneficiaries of its health programs for their use as informed customers of health care services. These efforts build on industry's implementation of other health IT standards, such as the HIPAA administrative simplification rules for identifiers, transaction standards, privacy, and security and related security guidance from the National Institute of Standards and Technology. The wider use of electronic medical records and personal health records raises concerns over privacy and security of patient data.
(OAS; W-00-07-41021; various reviews; expected issue date: FY 2007-2008; new start)

State-Based Controls Over Medicaid Payments and Program Eligibility

We will evaluate State-based information systems controls over Medicaid claim processing and program eligibility. In selected States, we will review: (1) entitywide security program planning and management, (2) access controls, (3) application software development and change controls, (4) system software, (5) segregation of duties, and (6) service continuity. In addition, we will follow up on unresolved findings from self-assessments and any other relevant audit reports on information systems controls.
(OAS; W-00-04-40019; W-00-07-00000; various reviews; expected issue date: FY 2007; work in progress and new start)

Medicare Contractor Information Technology Closeout Audits

We will (1) review CMS policies, instructions, and procedures in place to ensure adherence to Federal data privacy, information security, and contractual requirements and (2) conduct IT closeout audits at Medicare contractors leaving the program in 2007–2008 to ensure compliance with all applicable Federal requirements. Section 911 of the MMA required the Secretary to submit a plan to Congress outlining a strategy for accomplishing the replacement of current FIs and carriers with MACs no later than 2011. The plan that the Secretary submitted to Congress called for the establishment of 23 new administrative contracts by 2009. It also included steps to consolidate the number of contracted data centers from 16 to no more than 4. Consequently, over the next 5 years, a number of contractors will leave the program. Our experience with previous workload transitions suggests that problems could arise with the disposition of Government systems and data when contractors leave Medicare. Also, these contractors' access

rights to Medicare shared systems, the Common Working File system, and Medicare banking records need to be terminated as soon as the contractors' performance periods end.
(OAS; W-00-07-41022; various reviews; expected issue date: FY 2007-2009; new start)

Contractor Development of Medicare Part D Systems—Eligibility Query Transaction (E1) and Systems for Tracking True Out-of-Pocket Beneficiary Costs

We will review the development by a CMS contractor of the E1 (eligibility query transaction) for Medicare Part D. We will also review development of other systems by that contractor to meet the MMA Title I requirement to accurately track true out-of-pocket (TrOOP) beneficiary costs. We want to determine whether these systems meet program needs and their possible shortcomings. We also want to examine what processes and procedures have been established for transferring information on TrOOP between plans and for beneficiaries who become Medicaid eligible during the course of the year.
(OAS; W-00-07-41023; expected issue date: FY 2007; new start)

Selected Medicare Part D General and Application Controls for Systems That Track TrOOP.

We will review selected Medicare Part D general and application controls placed into operation since January 1, 2006, the effective date of Part D, at the CMS contractor responsible for collecting information on TrOOP from payers secondary to Medicare Part D. With respect to general controls, we will focus on continuity of service planning and software development change controls. We will also review the application controls, including the accuracy and completeness of standard transactions generated at the CMS contractor for covered prescriptions and documenting payers secondary to Medicare. These transactions are transmitted by the CMS contractor to the applicable plans and CMS, where they are used to compute beneficiary TrOOP for covered prescription drugs. TrOOP calculations are critical in the Medicare Part D payment process because they affect how much the beneficiary pays for drugs and the adjustments to plan payments.
(OAS; W-00-07-41024; A-00-07-00000; expected issue date: FY 2007; new start

Review of the Implementation of Medicare Part D at Small and Medium Size Plans and Plans New to Medicare

We will review implementation of Part D at Medicare Advantage PDPs and PDPs run by small to medium size sponsor organizations and other sponsor organizations with little or no previous involvement in the Medicare program. We want to determine whether and how such plans are in compliance with Medicare Part D contractual requirements, CMS instructions, and HIPAA security and privacy requirements.
(OAS; W-00-07-41025; various reviews; expected issue date: FY 2007-2008; new start)

Wellpoint's Point of Sale System for Handling Emergency Billing Under Medicare Part D

We will review Wellpoint's system for handling emergency billing for potential dual eligibles not identified as enrolled in Part D. CMS contracted with Wellpoint to provide a system for paying pharmacies for prescriptions for individuals who present evidence of dual (Medicare and Medicaid) eligibility but for whom a query by the pharmacy to the Medicare Part D eligibility database returns a negative response. We also plan to review the process for reversing payments and billing the appropriate plan once correct enrollment status has been determined.
(OAS; W-00-07-41026; expected issue date: FY 2007; new start)

Oversight of System Conversions, Redesigns, and Transitions of State Medicaid Management Information Systems

We will review the nature of oversight, guidance, and assistance that CMS provides to the States to help ensure that these systems initiatives are appropriately focused, risks are reduced, and successful implementation of new systems is achieved. Pursuant to Title XIX of the Social Security Act, States receive 90 percent Federal financial participation for costs covering converting, redesigning, or transitioning their MMIS.
(OAS; W-00-07-41027; various reviews; expected issue date: FY 2007-2008; new start)

Medicaid Management Information System—Business Associate Agreements

We will review State MMISs to determine if they have controls in place to assure that business associate agreements have been properly executed to protect beneficiary information, including safeguards implemented pursuant to HIPAA standards. States' MMISs process and pay claims for Medicaid health benefits. Business associates of States' MMISs typically include support organizations, such as data processing services and medical review services. State Medicaid agencies must comply with the HIPAA Privacy and Security Final Rules, which stipulate minimum requirements that contracts with business associates must include to protect the privacy and security of certain individually identifiable health information.
(OAS; W-00-07-41028; various reviews; expected issue date: FY 2007-2008; new start)

Security Planning for CMS Systems Under Development

We will determine whether CMS has an effective process in place to ensure that information systems security requirements are addressed adequately as major new systems are designed, developed/acquired, and implemented. Federal law and departmental policy require that information security be practiced throughout the life cycle of each system. We will also review security plans and related internal control deliverables for major new systems and databases, such as the Health Insurance General Ledger Accounting System, the Common Working File System Redesign, and the Integrated Data Base to determine whether they conform to Federal guidelines and incorporate best practices from the public and private sectors.
(OAS; W-00-06-41001; various reviews; expected issue date: FY 2007-2008; new start)

Duplicate Payments For Medicaid Services

We will determine if States have effective controls in place to preclude duplicate payments. Under the Medicaid program, Federal financial participation is available for design, development, installation, and operation of State mechanized Medicaid claims processing and information retrieval systems. Federal regulations require that States conduct prepayment claims reviews to prevent duplicate claims. A prior review disclosed that duplicate payments were made as a result of ineffective claims resolution.
(OAS; W-00-06-31109; various reviews; expected issue date: FY 2007; new start)

Use of Health Information Technology in State Medicaid Programs

We will assess State Medicaid Agencies' use of health information technology. Medicaid is the second largest payer of health care in the U.S., with expenditures totaling $291 billion in fiscal year 2004. Current literature suggests that health IT could result in cost-savings for health payers, increase efficiencies in general, reduce fraud, and improve the quality of care provided. These potential benefits of health IT have implications for State Medicaid agencies. To date, however, little is known about State Medicaid agencies' use of health IT. This study will

identify State Medicaid agencies' health IT initiatives and describe States' experiences with implementing these initiatives. As State Medicaid agencies continue to pursue and implement health IT, the information contained in this report may be a valuable resource for both State and Federal agencies involved in health IT efforts.
(OEI; 02-06-00270, expected issue date: FY 2007; work in progress)

Accuracy of the Fraud Investigation Database

We will determine the uses, accuracy, and reliability of CMS's Fraud Investigation Database. The database was developed in 1996 to assist CMS in the prevention, detection, and deterrence of fraudulent activity in the Medicare and Medicaid programs. With increased use of computerized data to identify Medicare and Medicaid program vulnerabilities, the integrity of this database is essential.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

General Administration

Medicare Secondary Payer

We will review 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. We will assess the effectiveness of current procedures in preventing inappropriate Medicare payments. For example, we will evaluate procedures for identifying and resolving credit balance situations, which occur when payments from Medicare and other insurers exceed the providers' charges or the allowed payment amount.
(OAS; W-00-07-35317; various reviews; expected issue date: FY 2007; new start)

FY 2006 Medicare Error Rate Estimate

In this annual review, we will determine whether CMS has produced a valid and reliable Medicare fee-for-service paid claims error rate estimate for FY 2006. FY 2006 will be the fourth year that CMS has developed the error rate and the third year that the projection will include data on all provider types for a full year. We will examine whether CMS has adequately implemented its comprehensive error rate testing program to review all Medicare fee-for-service claims except PPS inpatient claims, and we will examine the hospital payment monitoring program to produce an error rate for PPS hospitals.
(OAS; W-00-06-40011; A-17-00-00000; expected issue date: FY 2007; new start)

Contractual Arrangements With Suppliers

We plan to evaluate contractual arrangements in which a supplier, such as a laboratory or DME company, agrees to operate the service on behalf of a physician's practice or a hospital. We will review the structure of financial arrangements and will determine whether these arrangements are having an effect on the Medicare program.
(OAS; W-00-05-35172; various reviews; expected issue date: FY 2007; work in progress)

Payments to Psychiatric Facilities Improperly Certified as Nursing Facilities

We will determine whether psychiatric facilities have been improperly certified as nursing homes and quantify any resulting inappropriate Medicare and Medicaid expenditures. Medicare is prohibited by statute from certifying any nursing facility that is "primarily for the care and

treatment of mental diseases." We will identify nursing facilities that operate primarily as psychiatric facilities, examine their State certification, and determine the amount of any inappropriate Medicare and Medicaid reimbursement.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Quality Concerns Identified Through Quality Improvement Organizations' Medical Record Reviews

Over the past 20 years, CMS has shifted the primary focus of the QIO program from identifying and taking action against poorly performing health care providers to increasing the overall quality of care provided within the Medicare program. In this review we will determine the extent to which QIOs identify quality-of-care concerns through medical record reviews and what interventions QIOs take in response to confirmed concerns.
(OEI; 01-06-00170; expected issue date: FY 2007; work in progress)

Medicare/Medicaid Hurricane Response

Billing for Durable Medical Equipment in Hurricane-Affected Areas

We will examine payments for DME supplies and equipment in the areas affected by the recent hurricanes. According to DMERC officials, suppliers in the hurricane-affected areas were not to bill for equipment until they could make contact with the beneficiary to be sure the equipment was still medically necessary and that the beneficiary had the equipment in use.
(OAS; W-00-07-35165; various reviews; expected issue date: FY 2007; new start)

Medicaid Services and Payments under Hurricane Katrina Waivers

We will study services and payments made under Medicaid waivers for Hurricane Katrina evacuees. We will also examine the services provided and payments made to health care providers enrolled in Medicaid under Hurricane Katrina public health waivers. During Hurricane Katrina, CMS developed a template for States to create emergency section 1115 waivers. These waivers provided access to health care by simplifying eligibility requirements and waiving the employment and income verification requirements. These waivers also created uncompensated care pools, which allow providers to be compensated for care provided to evacuees regardless of eligibility status or services normally covered under Medicaid.
(OEI; 05-06-00140; expected issue date: FY 2007; work in progress)

Hurricane-Related Waiver of Final Claim Requirements for Home Health RAP Payments

We will review the appropriateness of requests for anticipated payments (RAP) made by HHAs. At the beginning of a 60-day home health episode, the HHA submits on RAP. The contractor processes the RAP and submits a partial payment to the HHA for the episode. The beneficiary's condition may worsen or improve significantly during the 60-day episode. To adjust for these changes, the provider must submit a final claim to the contractor. The contractor then adjusts the original payment, either by making an additional payment or by recouping any overpayment. Ordinarily, if the final claim is not submitted by a certain time, the RAP is canceled. However, as a result of the hurricanes, the deadline for filing final claims was extended. We will determine whether CMS canceled outstanding RAPs with no final claim file by the extended deadline.
(OAS; W-00-07-35166; various reviews; expected issue date: FY 2007; new start)

Hurricane-Related Extraordinary Capital Expenditure Payments to PPS Hospitals
We will review the appropriateness of payments made to PPS hospitals for extraordinary capital expenditures made as a result of the hurricanes. Hospitals were required to submit a request for reimbursement to CMS within 180 days of the event causing the unanticipated expenditures, with documentation of why the unanticipated expenditures occurred and the sources and amounts of anticipated reimbursements from other sources such as Federal Emergency Management Agency (FEMA), insurance, or litigation.
(OAS; W-00-07-35167; various reviews; expected issue date: FY 2007; new start)

Hurricane-Related Accelerated/Advance Payments to Providers
We will determine what steps Medicare contractors took to (1) ensure that providers/suppliers met the CMS requirements for accelerated payments/advance payments and (2) recoup accelerated/advance payments. CMS made "accelerated payments" under Part A and "advance payments" under Part B to providers and suppliers that experienced cash flow disruptions because of hurricanes. These payments were to be recouped by offsetting future payments.
(OAS; W-00-07-35168; various reviews; expected issue date: FY 2007; new start)

Hurricane Katrina – Duplicate Medicaid Payments to Providers
We will determine whether providers are submitting claims to and receiving Medicaid payments for the same service from the evacuee's home State and the State in which the evacuee is residing.
(OAS; W-00-06-31117; various reviews; expected issue date: FY 2007; work in progress)

Hurricane Katrina – Medicaid Payments for Evacuees
We will review controls that State Medicaid agencies use to help ensure that Medicaid claims submitted for 100 percent Federal financial participation are appropriate. The DRA provides funding to CMS to pay for the State share of services provided to evacuees of the affected areas. Other Medicaid claims for beneficiaries who are not evacuees should be submitted at the regular matching rate.
(OAS; W-00-07-31216; various reviews; expected issue date: FY 2007; new start)

Hurricane Katrina – Uncompensated Care Costs
We will review controls used by State Medicaid agencies that received CMS approval for Federal funding for an uncompensated care pool to ensure that funds are appropriately spent. CMS approved Federal funding for an uncompensated care pool to cover medical services furnished to low-income individuals who do not meet eligibility requirements for Medicaid or SCHIP.
(OAS; W-00-07-31219; various reviews; expected issue date: FY 2007; new start)

Hurricane Katrina – Duplicate Medicaid Payments to Managed Care Organizations
We will determine whether States affected by Hurricane Katrina have continued to make Medicaid payments to MCO beneficiaries who have been evacuated to other States. Our work will focus on whether State Medicaid agencies are making duplicate payments for the same beneficiary: once through a capitation payment in the "home" State and another through fee-for-service in the "host" State.
(OAS; W-00-07-31217; various reviews; expected issue date: FY 2007; new start)

Investigations

The OIG Office of Investigations conducts investigations of fraud and misconduct to safeguard the Department's programs and to protect the beneficiaries of those programs. Investigative activities are designed to prevent waste, fraud, and abuse in departmental programs by identifying systemic weaknesses in vulnerable program areas. These weaknesses can be eliminated through corrective management actions, regulations, or legislation; by pursuing criminal convictions and program exclusions; and by recovering damages and penalties through civil and administrative proceedings. Each year, thousands of complaints from various sources are brought to OIG's attention for development, investigation, and appropriate conclusion. This work plan identifies investigative focus areas in which we will concentrate our resources, subject to the demands of current case referrals.

Health Care Fraud

OIG devotes significant resources to the investigation of allegations of fraud committed against the Medicare and Medicaid programs and their beneficiaries. OIG conducts many investigations in conjunction with other law enforcement agencies, such as the Federal Bureau of Investigation, the United States Postal Inspection Service, the Internal Revenue Service, and the various State Medicaid Fraud Control Units.

OIG will investigate individuals, facilities, or entities that bill Medicare and/or Medicaid for services not rendered, claims that manipulate payment codes in an effort to inflate reimbursement amounts, claims for care not provided to nursing home residents, and other false claims submitted to obtain program funds. We will also investigate business arrangements that may violate the Federal health care anti-kickback statute.

With the initiation of the Part D drug benefit, OIG invested in efforts to understand thoroughly the various aspects of the laws and regulations, prepare to conduct investigations related to drug benefit fraud, and assist CMS in identifying program vulnerabilities. OIG provided training to special agents and others on the intricacies of the Part D benefit to build our capacity to conduct investigations. OIG is currently investigating potential violations, including enrollment and marketing schemes and prescription shorting.

Working jointly with other law enforcement partners at the Federal, State, and local levels, OIG will continue to identify and investigate illegal schemes to market, obtain, use, and distribute prescription drugs. The goals of these investigations are to ensure the integrity of the Medicare and Medicaid payments for pharmaceuticals, deter the illegal use of prescription drugs, and curb the danger associated with street distribution of highly addictive medications. We are also working to protect Medicare beneficiaries from scams involving identity theft related to the prescription drug discount card program.

OIG will also increase its attention to quality-of-care issues for beneficiaries residing in nursing facilities. The demand for long term care services will continue to increase as our population ages. All too often, Medicare and Medicaid programs are improperly billed for medically unnecessary services and for services either not rendered or not rendered as prescribed. The investigation of claims submitted for nursing or support services not rendered to nursing home

patients sometimes includes allegations of patient abuse or neglect. OIG will work jointly with Federal, State, and local law enforcement and regulatory agencies to resolve allegations of patient abuse or neglect.

OIG closes complaints alleging that individuals, facilities, or entities merely commit errors or mistakes on claims submitted to the Medicare or Medicaid programs. CMS and its contractors address claims errors and mistakes. OIG works with CMS program safeguard contractors to identify specific patterns of misconduct by reviewing a compilation of integrated Medicare Part A, Part B, and Part C, as well as Medicaid claims.

Provider Self-Disclosure

To encourage health care providers to promptly self-disclose improper conduct that threatens Federal health care programs, including Medicare and Medicaid, OIG has made a concerted effort to educate providers on the advantages of self-disclosure. In October 1998, OIG announced a flexible self-disclosure protocol for use by all health care providers doing business with Federal health care programs. The protocol offers health care providers specific steps, including a detailed audit methodology, that they may undertake if they wish to work openly and cooperatively with OIG to resolve potentially fraudulent conduct. Numerous providers have been accepted under this protocol. These providers range from hospitals to laboratories to physicians. Both the Federal Government and the providers benefit from this program.

The self-disclosure protocol is designed only for providers that believe a potential violation of the law has occurred. Matters exclusively involving overpayments or errors that do not indicate violations of the law should be brought directly to the attention of the entity responsible for claim processing and payment.

Legal Counsel

In addition to providing day-to-day internal legal advice and representation to OIG, the Office of Counsel to the Inspector General (OCIG) coordinates OIG's role in the resolution of civil and administrative health care fraud cases, including the litigation of program exclusions and civil monetary penalties and assessments. OCIG also negotiates and monitors corporate integrity agreements. OCIG issues special fraud alerts, special advisory bulletins, and advisory opinions regarding the application of OIG's sanction authorities and is responsible for developing OIG regulations, including new safe harbor regulations under the anti-kickback statute. Work planned in FY 2007 includes the following:

Resolution of False Claims Act Cases and Negotiation of Corporate Integrity Agreements

We will continue to work closely with OIG investigators and auditors and with prosecutors from the Department of Justice (DOJ) to develop and pursue False Claims Act cases against individuals and entities that defraud the Government, where adequate evidence of violations exists. We will provide further assistance to DOJ prosecutors in litigation and in settlement negotiations arising from these cases. We also will continue to consider whether to implement OIG's exclusion authority based on these defendants' conduct. When appropriate and necessary, we will continue to require these defendants to implement compliance measures, in the form of

integrity agreements, aimed at ensuring future compliance with Federal health care program requirements.

Providers' Compliance with Corporate Integrity Agreements

We will continue to assess the compliance of providers with the terms of corporate integrity agreements (and settlements with integrity provisions) into which they entered as part of the settlement of fraud and abuse allegations. We will continue to conduct site visits to entities that are subject to the integrity agreements to verify compliance efforts, to confirm information submitted by the entities to OIG, and to assist with compliance generally. Included in this monitoring process will be systems reviews to determine whether a provider's compliance mechanisms are appropriate and to identify any problem areas and establish a basis for corrective action. Where appropriate, we will continue to impose sanctions, in the form of stipulated penalties or exclusion, against providers that breach their integrity agreement obligations.

Advisory Opinions and Fraud Alerts

As part of OIG's ongoing efforts to foster compliance efforts by providers and industry groups, 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 business arrangements or practices. We will also issue special fraud alerts and advisory bulletins, as warranted, to inform the health care industry more generally of particular practices that we determine are suspect.

Patient Anti-Dumping Statute Enforcement

We expect to continue to review and, when appropriate evidence exists, continue the negotiation, settlement, and litigation of cases involving violations of the patient anti-dumping statute, the Emergency Medical Treatment and Labor Act.

Program Exclusions

Based on cases developed by OIG, we anticipate reviewing and implementing the exclusion of several thousand providers from participation in Federal health care programs. When warranted, we also expect to affirmatively initiate program exclusions against individuals and entities that submitted false or fraudulent claims, failed to provide services that met professionally recognized standards of care, or otherwise engaged in conduct actionable under section 1128 of the Social Security Act or other statutes authorizing exclusions by OIG.

Civil Monetary Penalties

We will continue to pursue civil monetary penalty cases, when supported by appropriate evidence, based on the submission of false or fraudulent claims; the offer, payment, solicitation, or receipt of remuneration (kickbacks) in violation of section 1128B(b) of the Social Security Act; and other offenses actionable under section 1128A of the Act and other civil monetary penalty authorities delegated to OIG.

Review of State False Claims Laws

We published criteria by which OIG will assess whether State false claims laws meet criteria set forth in the Deficit Reduction Act of 2005 (DRA), and in consultation with DOJ, will begin assessing State laws for compliance with those criteria. Section 6031 of the DRA provides that States with qualifying false claims laws will retain an enhanced portion of recoveries generated by enforcement actions under those state statutes. The provisions take effect in January 2007.

Public Health Agencies

Centers for Disease Control and Prevention

Strategic National Stockpile: Security, Product Integrity, and Control of Regulated Products

We will examine the Strategic National Stockpile, which is managed by the Centers for Disease Control and Prevention (CDC), in three areas: security, product integrity, and controls for regulated products. The stockpile is the Federal Government's primary resource to help State and local governments respond to public health emergencies such as bioterrorist attacks and influenza outbreaks. In the area of security, we will evaluate 10 stockpile sites and assess departmental and CDC efforts to identify, monitor, and resolve security weaknesses throughout the stockpile system. In the area of product integrity, we will determine whether CDC has met the requirement to maintain the stockpile according to current Good Manufacturing Practices, 21 CFR Parts 210 and 211. These practices, issued by the Food and Drug Administration, are intended to ensure that finished products, such as drugs, have the identity, strength, quality, and purity characteristics that they are represented to have. In the area related to control of regulated products, we will determine whether CDC has complied with Drug Enforcement Administration (DEA) requirements (21 CFR Parts 1301 and 1304) for pharmaceutical products stored at stockpile sites. The stockpile contains DEA-regulated pharmaceutical products known as controlled substances, i.e., drugs that have a high potential for abuse.
(OAS; W-00-05-52001; W-00-07-52001; W-00-07-52002; W-00-07-52003; various reviews; expected issue date: FY 2007; work in progress and new start)

Implementation of Select Agent Regulations by Private and State Laboratories

We will assess State and private laboratories' implementation of select agent regulations (42 CFR Part 73) in the areas of security, accountability, and access. This effort follows our reviews at university laboratories, where we made recommendations aimed at strengthening control of select agents.
(OAS; W-00-05-52006; multiple reviews; expected issue date: FY 2007; work in progress)

CDC's Management of the Select Agent Oversight Program

We will assess CDC's management of the select agent oversight program. CDC is responsible for regulating entities that possess dangerous substances, known as select agents. Earlier OIG work showed that CDC needed to improve its program in such areas as onsite inspections, written procedures, and data management. We will (1) determine whether CDC has implemented recommendations from our earlier review; and (2) assess CDC's progress overseeing entities' implementation of recent, more stringent regulatory requirements for select agent security, accountability, and access.
(OAS; W-00-07-52022; expected issue date: FY 2007; new start)

Investigations of Violations of Select Agent Requirements

OIG continues to receive requests for information and investigations of alleged terrorist and bio-terrorist activities relating to select agents. On December 13, 2002, HHS issued an interim final rule on Possession, Use, and Transfer of Select Agents and Toxins (42 CFR Part 73). We are continuing to coordinate efforts with CDC, the FBI, and the Department of Agriculture to

investigate potential violations of the statute governing the registration, storage, and transfer of select agents and toxins.

Deemed Exports at CDC

We will determine whether CDC obtained licenses as required by the Department of Commerce export control regulations, for foreign nationals who work at CDC and had access to equipment. Pursuant to the Export Administration Act of 1979 and other laws, the Federal Government controls the export of certain goods and technologies for reasons of national security. Release of covered goods and technologies to a foreign national constitutes a "deemed export" and requires a license.
(OAS; W-00-07-52023; expected issue date: FY 2007; new start)

CDC Pandemic Flu Preparedness Grants

We will review the State and local government expenditure of pandemic influenza preparedness grant funds, awarded by the Department as part of the Administration's effort to prepare for an influenza pandemic. In FY 2006, the Department made initial grant awards totaling $100 million and plans to allocate an additional $250 million. We will determine whether expenditures met Federal cost requirements (OMB Circular A-87) and HHS program guidance, such as the HHS State and Local Influenza Planning Checklist which defines specific actions that jurisdictions must take to ensure their pandemic influenza plans are integrated with the National Response Plan.
(OAS; W-00-07-52020; various reviews; expected issue date: FY 2007; new start)

Pandemic Flu Registry and System

We will assess CDC's progress in deploying a pandemic flu system. In FY 2007, CDC plans to develop and deploy a means to track and manage the distribution of influenza vaccine and other measures from the point of manufacture to the point of delivery.
(OAS; W-00-07-52021; A-04-07-00000; expected issue date: FY 2007; new start)

Health Department Testing of Pandemic Influenza Preparedness Plans

We will determine the extent to which State and local health departments have tested and improved emergency preparedness plans, such as the required testing of pandemic influenza plans, and determine if these plans have been integrated into the National Response Plan. In 2005, the CDC's Public Health Preparedness Cooperative Agreement (Cooperative Agreement) was funded at $862 million. In 2005, the Secretary of HHS announced that the Department would provide $350 million as a supplement to health departments for pandemic influenza preparedness. In March 2006, CDC released the first installment of $100 million to 62 State, local, and territorial jurisdictions as a supplement to Cooperative Agreements to test their influenza preparedness plans and report on several performance measures.
(OEI; 00-00-00000, expected issue date: FY 2007; new start)

Implementation of Early Event Detection Technology

We will review the implementation and current status of early event detection technology among the States. CDC's Public Health Information Network (PHIN) Preparedness initiative strives to implement, at an accelerated pace, a consistent and capable national network of preparedness systems that can be used to effectively detect, track, and respond to public health threats. In particular, the PHIN Preparedness Initiative has set forth functional requirements for early event

detection (EED) systems used by public health partners. We will look at what systems State health partners are implementing to address EED functional requirements, and identify both successes and potential barriers to future implementation.
(OEI; 04-06-00560, expected issue date: FY 2007; work in progress)

State Public Health Laboratories' Bioterrorism Preparedness

We will determine the extent to which laboratories that confirm the presence of bioterror agents are prepared to handle increased testing in a bioterrorism event or public health emergency. We will assess the extent to which these laboratories are receiving support from CDC to strengthen their testing capacity. Since 1999, CDC has funded State public health laboratories to assist them in building up their own capacity, as well as to help strengthen collaboration among laboratories through the formation of the Laboratory Response Network. A recent OIG review, "States' Laboratory Response Programs for Bioterrorism: Level A Laboratory Participation," examined the coordination between sentinel laboratories and reference laboratories, and found that although some coordination is occurring between them, many were overwhelmed during the 2001 anthrax events. This study will address whether reference laboratories are now better prepared to handle a bioterror event.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Coordination Between Grants Officers and Project Officers in CDC Grant Programs

We will determine the extent to which grants officers and project officers in CDC coordinate their grant monitoring activities. Grant monitoring activities are shared between grants officers and project officers. Grants officers monitor a grantee's financial activities, while project officers monitor a grantee's programmatic performance. As specified in departmental grants policies, these roles can be carried out in a responsible manner only when there is effective interaction between the grants officer and project officer.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Food and Drug Administration

FDA Accountability for Human Subject Files

We will assess whether the files of three studies involving human subjects, that were conducted, funded, or supported by the Food and Drug Administration (FDA), could be accounted for and were adequately safeguarded. Federal regulations require that institutions conducting human subject research ensure adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data. Previous OIG work, requested by FDA management, revealed that the agency could not account for lost human subject files for one of its studies.
(OAS; W-00-05-53100; A-03-05-00350; expected issue date: FY 2007; work in progress)

Pandemic Flu Activities

We will assess FDA's progress in undertaking such planned activities as assessing/inspecting vaccine manufacturing processes; developing and assessing new technologies; and monitoring, via improved information and reporting systems, the safety/effectiveness of pandemic vaccines that have been administered.
(OAS; W-00-07-53200; expected issue date: FY 2007; new start)

Implementation of Clinical Trials Data Bank

Section 113 of the 1997 Food and Drug Administration Modernization Act directs the Secretary of HHS (through NIH) to establish and operate a data bank containing information on clinical trials for drugs to treat serious or life-threatening diseases or conditions. To assess the integrity of this data bank, we will examine the completeness of individual registration records, what barriers may exist that prevent complete information from getting to the clinical trials data bank, and what problems, if any, the Department faces in managing the data bank. Effective March 2002, FDA issued guidance that requires drug sponsors to submit clinical trial protocol information to the clinical trials data bank Web site, including descriptive information on the trial, recruitment information, location/contact information, and administrative data (protocol number/study sponsor). FDA estimated that drug companies would submit about 1,600 protocols annually. We will assess the Department's efforts and identify reasons that submissions are less than expected.
(OEI; 00-00-0000; expected issue date: FY 2007; new start)

State Licensure of Wholesale Drug Distributors

We will determine how and to what extent FDA and States ensure that wholesale drug distributors are carrying out their licensing responsibilities as required by the Prescription Drug Marketing Act of 1987. The Act requires a wholesale distributor of prescription drugs to be State licensed and requires FDA to establish minimum requirements for State licensing. We will determine whether and the extent to which FDA ensures that States' rules meet or exceed the minimum Federal requirements for licensure of drug wholesalers. We will also determine the extent to which States are implementing the model rules for wholesale drug distributors licensure developed by the National Association of Boards of Pharmacy and endorsed by FDA and the extent to which FDA has followed up on its 2004 Counterfeit Drug Task Force recommendation to work with States in implementing these model rules.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Adverse Event Reporting for Medical Devices

We will determine how and to what extent manufacturers and user facilities comply with mandatory Federal reporting requirements for adverse events associated with medical devices. FDA requires medical device manufacturers to report deaths, serious injuries, and device malfunctions to FDA within 30 calendar days or within 5 working days if the event requires remedial action to prevent substantial harm to the public. Device reporting is a key part of FDA's oversight of new medical devices, providing an early warning of problems with devices after they reach the market. We will also evaluate how and to what extent FDA uses medical device adverse event reports to identify and address safety concerns.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

FDA Financial Disclosure Requirements for Clinical Investigators

We will assess the nature of financial interests disclosed by clinical investigators to FDA; the extent to which drug, biologic, and device applicants monitor their clinical investigators for conflicting financial interests; and the extent to which FDA monitors the financial interests disclosed by clinical investigators.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Traceability in the U.S. Food Supply Chain of FDA-Regulated Food Products

We will review the effectiveness of the immediate previous sources and immediate subsequent recipients of food traceability model (known as "one-up, one-back") as a response to a deliberate attack on the nation's food supply. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 requires food facilities regulated by the FDA to maintain records that identify the immediate previous sources and immediate subsequent recipients of food. Compliance with this requirement allows FDA to trace back through the supply chain any food products found to be contaminated, and to trace forward through the food chain to alert facilities of contaminated food stock.
(OEI; 02-06-00210; expected issue date: FY 2007; work in progress)

FDA Processes to Address Serious Deficiencies in Foreign Drug and Medical Device Manufacturing

Pursuant to 21 CFR Parts 211, 808, 812, and 820, we will review how FDA determines enforcement actions after it has detected serious deficiencies during an inspection of a foreign drug or medical device firm. We will also review the extent to which FDA ensures that foreign firms comply with enforcement actions. Over the past decade, the number of FDA-regulated imports has grown from 2 million to over 11 million. Drugs and medical devices comprise approximately one quarter of these products. In 1998, GAO found that FDA verified foreign drug firms' corrective actions in only half of those found to have deficiencies.
(OEI; 00-00-0000; expected issue date: FY 2007; new start)

FDA Domestic Compliance Inspections

We will review the extent to which FDA conducts compliance inspections of drug manufacturers who have been cited for manufacturing deficiencies. The Federal Food, Drug and Cosmetic Act requires FDA to conduct comprehensive inspections of all aspects of the production and distribution of drugs and drug products; FDA has established Current Good Manufacturing Practices (CGMP) to ensure that drug manufacturers meet all mandated safety requirements. If FDA identifies a major deficiency in the manufacturing process during a routine CGMP inspection, the Agency must conduct a follow-up survey, or "compliance inspection," to verify that the firm has taken corrective action.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

FDA Generic Drug Approval Process

We will determine the extent to which FDA reviews applications for generic drugs in a thorough and timely manner within statutory requirements. FDA is required by law to approve or disapprove applications for generic drugs within 180 days of submission. However, average review time exceeds 20 months, and as of 2006, the agency had a backlog of approximately 1000 generic drug applications, 250 of which had exceeded the 180-day statutory time limit.
(OEI; 04-06-00610; expected issue date: FY 2007; work in progress)

Reuse of Single Use Medical Devices

We will review the extent to which hospitals use reprocessed single-use medical devices (SUD) or reprocess SUDs themselves and determine the extent to which hospitals comply with Federal law governing reprocessing. We will also assess FDA's oversight of hospitals using and/or reprocessing SUDs. Due to increased health care costs, hospitals are opting to use less expensive, reprocessed SUDs more frequently. An FDA hospital survey in 2001 found that

24.2 percent of all US hospitals reused SUDs and that in many instances, hospitals are reprocessing SUDs themselves. The same survey found that 15.4 percent of hospitals that reused SUDs had reprocessed at least some in-house.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

FDA Oversight of Clinical Trials Through Its Inspection Processes

We will determine the extent to which FDA conducts inspections of clinical trials and assess FDA's processes for inspecting clinical trials. Recent incidents concerning clinical drug trials have raised questions about the potential vulnerabilities surrounding the protection of human research subjects. This study will build upon prior OIG work that identified problems with Institutional Review Board and clinical trial oversight.
(OEI; 01-06-00160; expected issue date: FY 2007; work in progress)

Health Resources and Services Administration

Management of Unspent Ryan White CARE Act Title I Funds

We will examine how the Health Resources and Services Administration (HRSA) has managed Ryan White CARE Act Title I funds that have not been spent by grantees at the end of the grant period. The Ryan White CARE Act Title I program provides annual funding to large metropolitan areas for HIV/AIDS health-related services. We previously identified issues regarding unspent funds in the CARE Act Title II program.
(OAS; W-00-05-54250; A-02-03-02006; expected issue date: FY 2007; work in progress)

Ryan White CARE Act Title II: Payer of Last Resort

We will determine whether States have used Ryan White CARE Act Title II funds only as a last resort. The Act, which is administered by HRSA, requires States and Territories to use grant funds awarded under Title II only as a last resort, i.e., only after seeking reimbursement from other parties such as insurers or other State/Federal health benefit programs. Previous OIG work has shown that some States had used CARE Act funds to purchase HIV drugs and services without first seeking reimbursement from other insurers or programs. In cases for which this requirement was not followed, we will determine the amount owed to HRSA.
(OAS; W-00-07-54260; multiple reviews; expected issue date: FY 2007; new start)

Ryan White CARE Act Title II: Follow-Up Review

We will conduct a follow-up review to determine the portion of HIV drug costs that a Ryan White CARE Act Title II grantee should have sought from other payment sources and must pay back to HRSA. A previous OIG review showed that the grantee did not have a system to bill third parties for HIV medications and used Title II grant funds to cover the cost of all HIV medications dispensed to program clients.
(OAS; W-00-06-52003; A-02-06-02000; expected issue date: FY 2007; work in progress)

Oversight of Organ Procurement and Transplantation Network

We will assess the nature and extent of the Department's oversight of the Organ Procurement and Transplantation Network. The National Organ Transplant Act of 1984 established the network, which is charged with operating and monitoring an equitable system for allocating organs, maintaining a waiting list of potential recipients, matching potential recipients with

donors, and increasing donation. All transplant centers and organ procurement organizations must be network members to receive Medicare reimbursement. HRSA contracts with the United Network for Organ Sharing for administration of the network. In 1999, the Institute of Medicine found that Federal oversight of the organ transplantation system could be improved. Our assessment will encompass the Department's response to the Institute's recommendations.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Quality of Care at Health Centers

We will assess the quality of care provided by health centers funded by HRSA, taking into account the 14 clinical quality measures that HRSA has established for assessing patient care. HRSA's strategic plan calls for improving the quality of health care and health outcomes. In addition, we will assess the degree to which these measures are collectible by health centers and any barriers health centers may face collecting this information. In FY 2006, HRSA will provide $2.04 billion to 3,650 health center sites, which include community health centers, migrant health centers, health care for the homeless centers, and primary care public housing centers. Health centers are currently operating under a Presidential initiative to increase the number of new sites and the capacity of existing sites so that the number of clients served grows from 10.3 million to 15.84 million for calendar year 2007. Approximately 36 percent of health center patients are covered by Medicaid, and approximately 8 percent are covered by Medicare.
(OEI; 09-06-00420; expected issue date: FY 2007; work in progress)

Indian Health Service

Securing and Accounting for Controlled Substances

We will evaluate controls implemented in Indian Health Service (IHS) facilities to secure and account for highly addictive pharmaceutical products controlled by DEA. Using criteria established by DEA and IHS, we will assess IHS's practices for securing and accounting for these pharmaceuticals.
(OAS; W-00-05-55100; multiple reviews; expected issue date: FY 2007; work in progress)

Accounting for Medication Inventory

We will determine whether pharmacies in IHS facilities have implemented controls to ensure accountability for their medication inventory. Although IHS is required to implement inventory procedures for drugs controlled by DEA, it is not required to follow these procedures for inventories of non-DEA controlled drug products, which account for most of the drugs on hand. Our review will rely upon criteria provided by OMB Circular A-123, Section II, Reasonable Assurance and Safeguards, which requires Federal managers to implement controls to provide reasonable assurance that assets are safeguarded against waste, loss, unauthorized use, or misappropriation.
(OAS; W-00-07-55001; A-06-07-00000; expected issue date: FY 2007; new start)

Background Investigations

We will determine whether IHS and tribal organizations have complied with the Indian Child Protection and Family Violence Prevention Act (Public Law 101-630). This law requires that all IHS employees and contractors with potential direct or unobserved contact with Indian children be investigated for any history of criminal acts against children. Previous OIG work at facilities

providing health care to Native Americans found inconsistent practices regarding staff background investigations.
(OAS; W-00-07-55002; A-06-07-00000; expected issue date: FY 2007; new start)

Tribal Governments' Third Party Collections in Emergency Medical Services Programs

We will evaluate the effectiveness of tribal governments' efforts to collect third party payments for their Emergency Medical Services Programs (EMS). Under statutory requirements, IHS is a payor of last resort. Third party collections are important to IHS and tribal governments because the money augments congressional appropriations and collected funds can be used for such activities as enhancing infrastructure and expanding services. There is no specific line item for EMS in the IHS budget at either the IHS or tribal level. An IHS study in 2001 found wide variation in tribal collection capabilities.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

National Institutes of Health

Securing and Accounting for Controlled Substances

We will evaluate controls implemented in National Institutes of Health (NIH) intramural clinical settings to secure and account for highly-addictive pharmaceutical products controlled by DEA. Using criteria established by DEA and NIH, we will assess NIH's practices for securing and accounting for these pharmaceuticals.
(OAS; W-00-07-56020; expected issue date: FY 2007; new start)

Level of Commitment and Effort Reporting

We will determine whether salary charges to NIH grants accurately reflect the portion of researchers' efforts spent on those grants and are otherwise compliant with Federal requirements. OMB Circular A-21 recognizes that, in an academic setting, teaching, research, and service administration are often inextricably intermingled. Accordingly, OMB Circular A-21 provides some flexibility to institutions in accounting for the distribution of researchers' effort. Despite this flexibility, the growing number of settlements under the False Claims Act regarding this issue indicates that some major research universities continue to engage in practices that do not result in an equitable distribution of their employees' activities, resulting in overcharges to NIH grants and a reduction in funds available for other research costs.
(OAS; A-00-07-56021; various reviews; expected issue date: FY 2007; work in progress and new start)

University Administrative and Clerical Salaries

We will determine whether colleges and universities have appropriately charged administrative and clerical salaries to federally sponsored grants and cooperative agreements. OMB Circular A-21 provides that such costs should usually be treated as indirect costs. However, direct charging of these costs may be appropriate when the nature of the work performed under a particular project requires extensive administrative or clerical support.
(OAS; W-00-05-56009; various reviews; expected issue date: FY 2007; work in progress and new start)

Cost Transfers

We will determine the allowability of cost transfers at NIH grantees. We will assess whether the transfers are supported by documentation that fully explains how errors occurred and whether responsible grantee officials certify the correctness of the new charges. Onsite visits by NIH during FYs 2000 through 2002 found that cost transfer policies and procedures tend to be nonexistent, incorrect, or confusing. Prior OIG work also found that cost transfers were unallowable and/or not appropriately documented. The potential effect of unreasonable, unallocable, or unallowable cost transfers is substantial, considering that the value of NIH grant funds awarded each year is approaching $20 billion and increasing.
(OAS; W-00-05-56012; various reviews; expected issue date: FY 2007; work in progress and new start)

Superfund Financial Activities for Fiscal Year 2006

As required by Superfund legislation, we will conduct this annual financial audit of payments, obligations, reimbursements, and other uses of Superfund monies by the National Institute of Environmental Health Sciences. The Institute's Superfund activities carried out by its own staff and through cooperative agreements, include training for people engaged in hazardous waste activities and studying the effects of exposure to specific chemicals. During FY 2005, agency obligations and disbursements of Superfund resources amounted to $78.3 million and $80.2 million, respectively.
(OAS; W-00-07-56001; expected issue date: FY 2007; new start)

Compensation of Graduate Students Involved in NIH-Funded Research

We will determine whether compensation for graduate student researchers who receive tuition remission as a component of compensation charged to NIH grants is consistent with NIH guidelines. Tuition remission is expressly allowed as a component of compensation under OMB Circular A-21. NIH, however, limits total compensation for graduate student researchers to the amount paid to a postdoctoral researcher doing comparable work at the same institution. Congress has requested this review because of concerns that some research universities may provide compensation to graduate student researchers that exceeds NIH guidelines.
(OAS; W-00-07-56023; A-05-00-00000; expected issue date: FY 2007; new start)

NIH Monitoring of Extramural Conflicts of Interest

We will examine how NIH monitors extramural grantees for potential conflicts of interest. Under 42 CFR Part 50, institutions must certify that they maintain a "written, enforced policy" on conflicting interests. Under the regulations, institutions must also report to NIH the existence of any conflicting interests and assure that the interest has been "managed, reduced, or eliminated." This study will focus on the effectiveness of NIH's oversight, whether conflicts of interest have affected Federal and public interests, and whether the definition of "significant financial interest" effectively protects researchers from perceived conflicts of interest. Conflicts of interest in the scientific community pose especially serious risks to clinical trial subjects and consumers, where a risk of bias can affect the quality of treatment decisions.
(OEI; 03-06-00460; expected issue date: FY 2007; work in progress)

Monitoring of NIH Research Grants

We will review NIH compliance with grants monitoring requirements, including the extent to which NIH evaluates required reports, initiates actions in response to these evaluations, and

ensures grantee responsiveness to action requests. Compliance with grant monitoring requirements will be based on a review of grant files to determine if they are in accordance with Federal regulations (45 CFR Part 74), departmental procedures established by the HHS Office of Grants, and NIH policies and procedures. In FY 2005, an estimated 54 percent of NIH's $28.8 billion budget was disbursed via more than 39,000 research program grants.
(OEI; 00-00-00000, expected issue date: FY 2007; new start)

Substance Abuse and Mental Health Services Administration

Early Implementation Review of Access to Recovery Grant Program

We will assess how States have implemented the Access to Recovery Program, including a review of program integrity controls currently in place. This program enables States which are the grantees to offer vouchers that pay for a range of community based services to people seeking drug and alcohol treatment. Service providers eligible for this program include: public and private, nonprofit, proprietary, and faith-based organizations, as approved by the State. Funded grantees have identified target populations that include youth, individuals involved with the criminal justice system, women, individuals with co-occurring disorders, and homeless individuals. The FY 2006 appropriation was $98 million; the President requested the same amount for FY 2007. We will also assess how States have met the accounting requirements related to funding received as part of this new initiative.
(OEI; 00-00-00000, expected issue date: FY 2007; new start)

Cross-Cutting Public Health Activities

Implementation of Select Agent Regulations by Departmental Laboratories

At laboratories operated by CDC, FDA, and NIH we will assess the implementation of select agent regulations (42 CFR Part 73) in the areas of security, accountability, and access. This effort continues our previous reviews at university, State, and private laboratories, for which we have made recommendations aimed at strengthening control of select agents.
(OAS; W-00-07-58200; various reviews; expected issue date: FY 2007; new start)

Export of Biological Materials

We will determine whether HHS agencies that ship biological materials, such as select agents, have implemented controls to ensure compliance with the Commerce Department's export administration regulations. These regulations require that a license be obtained for certain shipments of biological materials outside the United States. For such shipments, we will determine whether the agency (1) had sufficient documentation for making licensing determinations and (2) obtained licenses or exemptions as necessary.
(OAS; W-00-07-58201; A-04-07-00000; expected issue date: FY 2007; new start)

Use of Bioterrorism Emergency Preparedness Grants in Selected Gulf Coast States

We will audit the use of HHS bioterrorism emergency preparedness grant funding in the Gulf Coast States. We will determine whether such funding, which is provided annually by CDC and HRSA, has been applied for approved purposes and whether items funded by these grants were

effective in the hurricane response and recovery efforts. Reviews will be performed in Florida, Alabama, Louisiana, Texas, and Mississippi.
(OAS; W-00-07-58202; expected issue date: FY 2007 new start)

Use of Data and Safety Monitoring Boards in Clinical Trials

We will determine how and to what extent NIH is ensuring that grantees comply with NIH policy for data and safety monitoring boards (DSMB) in multi-site clinical trials and how and to what extent sponsors use these boards for multisite clinical trials under FDA's purview. A DSMB is a group of individuals with pertinent expertise that reviews, on a regular basis, accumulated data from one or more ongoing clinical trials to ensure the safety of participants in the trials and the validity and integrity of the scientific data generated. NIH sets minimum standards that Institutes or Centers (IC) must meet in ensuring that data and safety monitoring by grantees takes place. Further, it delegates responsibility for overseeing data and safety monitoring to the ICs. In December 2005, FDA released draft guidance for clinical trial sponsors to assist them in determining when a DSMB may be useful for study monitoring, and how such committees should operate.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

State and Local Government Progress Toward Meeting Bioterrorism Incident Management Requirements

We will assess State and local reporting of progress and actual achievements toward meeting the incident management benchmark, the first of six benchmarks common to the bioterrorism cooperative agreements through which CDC and HRSA support bioterrorism preparedness efforts in 62 jurisdictions. Coordination of both preparedness and response efforts to an actual bioterrorism event are essential to successfully protect citizens. In FYs 2004 and 2005, HHS allocated more than $2 billion to CDC and HRSA for these cooperative agreements, which are focused on improving the public health infrastructure and hospital preparedness. Because of the overlapping nature of the two cooperative agreements, CDC and HRSA identified six cross-cutting benchmarks. The incident management benchmark is intended to help States and local governments achieve participation in the National Incident Management System (NIMS). Beginning in FY 2005, NIMS participation is required for awardees receiving Federal preparedness assistance through grants, contracts, or other activities.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Emergency Response to Hurricane Katrina: Use of the International Merchant Purchase Authorization Card

We will determine whether the use of the International Merchant Purchase Authorization Card (IMPAC) to make purchases related to Hurricane Katrina was legitimate and appropriate, and identify what can be learned from Hurricane Katrina purchases to assist in the administration of the IMPAC program during future emergency situations. We will examine what types of purchases were made and how procedures during the emergency differed from established HHS guidelines and agency procedures, particularly concerning the raising and lowering of card limits. We previously conducted a departmentwide review of IMPAC purchases in 2003.
(OEI; 07-06-00150; expected issue date: FY 2007; work in progress)

Legal Counsel

In addition to providing day-to-day internal legal advice and representation to OIG, the Office of Counsel to the Inspector General coordinates OIG's role in the resolution of civil and administrative fraud cases and promotes compliance measures by recipients of HHS grant funding. Work planned in FY 2007 includes the following:

Resolution of False Claims Act Cases

We will continue to work closely with OIG investigators and auditors and with prosecutors from the Department of Justice (DOJ) to develop and pursue False Claims Act cases against institutions that receive grant funds from NIH and other PHS agencies. We will provide further assistance to DOJ prosecutors in litigation and in settlement negotiations arising from these cases.

Administration for Children and Families; Administration on Aging

Child Support

Undistributable Child Support Collections

We will examine undistributable child support collections and determine whether the Federal Government received its share of any program income earned in interest-bearing accounts or for undistributed balances written off by States. Historically, States have had difficulty in distributing sizable amounts of support payments because certain identifiers, such as custodial parents' addresses, were not current or the case numbers were omitted from collection receipts.
(OAS; W-00-06-23080; various reviews; expected issue date: FY 2007; work in progress and new start)

Child Support Enforcement Program Costs

We will determine whether Federal reimbursement for State administrative and program costs claimed for child support enforcement activities were allowable and appropriately allocated to the Child Support Enforcement Program. The Federal Government reimburses States for 66 percent of all expenditures for the administration and operation of the States' Child Support Enforcement Programs. Prior OIG work in various States has identified 30- to 70-percent increases in costs claimed over the past 5 years.
(OAS; W-00-06-23004; expected issue date: FY 2007; new start)

Debt Compromise

We will assess the extent to which States are using debt compromise programs to reduce child support debt, the types of child support cases involved, and measure the extent to which payment of current support changed following debt compromise. Title IV-D of the Social Security Act gives States the option of reducing child support debt by allowing it to be treated with the "full force, effect and attributes of a State judgment," but Federal regulation does not require States to implement debt compromise programs or specify how they should be administered. In 1999, Office of Child Support Enforcement (OCSE) issued a policy statement clarifying the statutory availability of debt compromise and encouraging States to utilize the practice as a means of bringing noncustodial parents who owe large child support arrearages back into compliance and possibly reunite them with their children. Not all States have initiated debt compromise programs and little is known about the operations of those that exist.
(OEI; 06-06-00070; expected issue date: FY 2007; work in progress)

Use of Financial Institution Data Match

This study will determine how effectively States are using the Financial Institution Data Match to collect payment of arrears and ongoing support obligations. Since its inception in 1999, the Financial Institution Data Match (FIDM) has led to collection of billions of dollars in past-due and current support. As an enforcement tool, FIDM is targeted primary at increasing the collection of arrears, a performance indicator in OCSE's FY2005-2009 Strategic Plan. However, stakeholders speculate that payment of arrears through FIDM may also reestablish contact between States and noncustodial parents and result in increases in ongoing support. An

evaluation of FIDM would provide a means of identifying factors inhibiting its maximum effectiveness in increasing collections and reducing arrears.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Investigations Under the Child Support Enforcement Task Force Model

Project Save Our Children is a coordinated effort to identify, investigate, and prosecute criminal nonsupport cases. This project brings together OI, the U.S. Marshals Service, DOJ, State and local law enforcement, local prosecutors, State child support agencies, and other interested parties in working to enforce Federal and State criminal child support statutes. For FY 2004, the most recent year with complete statistics, OI reported 169 criminal convictions and over $8 million in court ordered fines, penalties, and restitution. For FY 2007, we plan to continue our efforts to encourage and coordinate the efforts in the States, particularly in States that have not pursued prosecutions of individuals who failed to meet their child support obligations.

Child Welfare

Allocation of Foster Care Costs

We will determine whether a State is properly allocating costs to the Title IV-E program. The ratio of Title IV-E eligible children to the total number of children in foster care, referred to as the penetration rate, is used to allocate costs. Survey work identified unusual variances in data used to set penetration rates used in allocating costs to the program. Our work will focus on determining whether procedures in place adequately address issues of eligibility and candidacy in accordance with program requirements.
(OAS; W-00-07-24020; A-06-07-00000; expected issue date: FY 2007; new start)

Foster Care and Adoption Assistance Training and Administrative Costs

In these reviews of foster care and adoption assistance training and other administrative costs claimed under Title IV-E, we will focus on determining whether (1) current and retroactive claims were allowable, reasonable, and supported in accordance with laws and regulations; and (2) costs were properly allocated between Federal and State programs. Title IV-E training and other administrative costs have risen dramatically in relation to maintenance payments in recent years. Prior OIG reviews have found that unallowable costs were claimed, costs were improperly allocated, and/or costs were otherwise unsupported.
(OAS; W-00-06-20008; various reviews; expected issue date: FY 2007; work in progress and new start)

Foster Care Level-of-Care Classification

We will determine whether the level-of-care needs of foster children are (1) periodically reassessed and appropriate reclassifications made to ensure that children are receiving the required services, and (2) indicated at a higher level than necessary by providers to obtain a higher foster care payment. If the level-of-care needs are not appropriately set and periodically reassessed, States may be providing and paying for more or fewer services than a child requires, resulting in an improper payment. Foster children may also be affected by not receiving needed services or having a reduced chance of adoption.
(OAS; W-00-06-24006; various reviews; expected issue date: FY 2007; work in progress and new start)

Costs Billed by Child Placing Agencies

We will determine whether State Title IV-E agencies properly excluded child placing agencies' administrative costs when they requested Federal reimbursement for maintenance payments. By statute, foster care maintenance payments cover a child's basic needs, such as food, clothing, shelter, and personal incidentals, but not administrative costs. Preliminary work in one State identified administrative costs included in the State's maintenance payment claims. We will review the State's procedures for reimbursing child-placing agencies' maintenance payments and determine whether administrative costs were paid.
(OAS; W-00-06-24007; A-01-07-00000; expected issue date: FY 2007; new start)

Group Home and Foster Family Agency Rate Classification

We will determine whether foster care payment rates made for group homes and/or foster family agency treatment programs are accurate. The foster care payment amount correlates to the rate classification level. The rate classification level is based on factors such as the number of weighted eligible hours per child per month of childcare services, social work activities, and mental health treatment services. Payments are initially established at a provisional rate. The State subsequently conducts an audit to establish the actual rate classification level. There have been changes in State regulations regarding rate renewal applications and rate application documentation requirements. Also, a reduction of State personnel and redirection of resources in the State foster care audits branch may lessen timely changes to the actual rate classification levels, resulting in overcharges to the Federal Government.
(OAS; W-00-06-24008; A-09-07-00000; expected issue date: FY 2007; new start)

Adoption Assistance Subsidies

We will determine whether claims for Federal reimbursement of adoption assistance subsidies complied with eligibility requirements. A Federal subsidy payment is provided to families to ensure that they have the necessary services and financial resources to meet the special needs of some adopted children. An OIG review of adoption assistance subsidies in one State identified payments to families that did not meet eligibility requirements.
(OAS; W-00-06-24009; A-01-06-02506, expected issued date: FY 2007; work in progress and new start)

Accountability Over Child Welfare Funds

At the request of the Administration for Children and Families (ACF), we will determine whether a State agency is properly accounting for child welfare funds. ACF has long-standing concerns because of unreliable data on financial reports and funds returned unspent. We will review the State agency's cash management, internal controls, use of Federal funds, and compliance with Federal regulations.
(OAS; W-00-06-24010; A-06-07-00000; expected issue date: FY 2007; new start)

Case Management/Case Supervision Claims

We will determine whether Title IV-E Case Management/Case Supervision claims filed by a State were accurate, adequately supported, and complied with Federal eligibility requirements. A previous OIG review found that the State required contractors to submit claims monthly for case management and case supervision services for each client in foster care, but only minimally

reviewed any documentation of provision for these services. We will also determine whether the case manager was involved in the direct provision of services.
(OAS; W-00-06-24011; A-07-06-03070; expected issue date: FY 2007; work in progress)

Foster Care Candidate Costs
We will review several States with high ratios of foster care candidate costs to total Title IV-E administrative costs to determine whether candidates were properly documented and their costs were properly claimed. A candidate for foster care is a child who is at serious risk of removal from his/her home. Costs of some preplacement activities on behalf of children meeting Federal requirements for candidates of foster care can be claimed as Title IV-E administrative costs.
(OAS; W-00-06-24012, various reviews; expected issue date: FY 2007; new start)

Foster Children Over 19 Years Old
We will determine whether foster care maintenance payments were made on behalf of children over the age of 19. Children over 19 years old are ineligible. The ACF Adoption and Foster Care Analysis and Reporting System database listed over 10,000 of 532,000 children that were over 19 years as of September 30, 2002.
(OAS; W-00-06-24013, A-03-06-00575; expected issue date: FY 2007; work in progress)

Therapeutic Foster Care
We will determine whether children in therapeutic foster care (also called specialized or treatment foster care) receive enhanced care consistent with State guidelines. Therapeutic foster care (TFC) involves enhanced services and increased maintenance payments for children with multiple physical and/or mental problems. In one State, for example, the daily maintenance rate in FY 2004 was $20; for TFC the rate was $45 daily. Enhanced services can include: specialized, intensive training for foster parents; a comprehensive and flexible array of services including medical, special education, and counseling; decreased caseload for child welfare workers managing these cases; and respite care and aftercare.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

State Investigations of Abuse and Neglect
We will determine how States investigate allegations of abuse and neglect of Title IV-E foster care children and whether they take appropriate action to prevent further harm. Our primary focus will be on the timeliness and thoroughness of the investigation of incidents occurring after the child had been placed in foster care. We will consider whether the investigations included factors such as the previous history of the alleged abuser, whether a background check was performed on members of the foster care household or provider, and how well caseworkers monitored the child and family/provider. We will be looking for root causes that have contributed to any identified weaknesses.
(OAS; W-00-07-24020; A-09-07-00000; expected issue date: FY 2007; new start)

Kinship Placements in One State
We will determine whether a State (1) used different standards for approving foster care placements in relatives' homes versus nonrelatives' homes and (2) used Federal funds for approved relative foster homes that did not meet the State's licensing standards. Section 472(c) of the Social Security Act requires that the same standards be used in the approval process for

foster homes of relatives as those that are used in the licensing process for foster homes of nonrelatives.
(OAS; W-00-04-24005; A-09-06-00023; expected issue date: FY 2007; work in progress)

Costs for Statewide Automated Child Welfare Information System

We will examine one State's escalating costs for operating its Statewide Automated Child Welfare Information System. The review will determine whether (1) prior Federal approval was obtained for acquisition of products and services and (2) costs claimed were allowable and allocable to the system. The Omnibus Budget Reconciliation Act of 1993 provided Federal funds at a 50-percent matching rate to operate statewide systems. The intent for comprehensive statewide systems is to provide effective automated capability to support the administration of services under child welfare programs.
(OAS; W-00-06-24050; A-09-06-00000; expected issue date: FY 2007; work in progress)

Statewide Automated Child Welfare Information Systems

This study will assess the usefulness of Statewide Automated Child Welfare Information Systems. The Omnibus Budget Reconciliation Act of 1993 provided Federal funds at an enhanced 75-percent matching rate for States to design, develop, and install the systems. Once these systems are implemented, the Federal matching rate will drop to 50 percent to cover operating costs. We will evaluate the outcome of Federal funding for the development and implementation of statewide systems.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Family Assistance

Follow-up Aid to Families With Dependent Children Overpayments

We will determine whether States have reimbursed the Federal Government for their share of Aid to Families with Dependent Children (AFDC) overpayment recoveries. Although the AFDC program has been repealed and replaced with the Temporary Assistance for Needy Families (TANF) program, States must return the Federal share of AFDC overpayment recoveries. Prior OIG reviews identified large recoveries that should have been returned to the Federal Government. Survey work indicated that some States are still collecting AFDC overpayment recoveries. We will determine whether the Federal Government has been reimbursed for its share of these recoveries.
(OAS; W-00-06-24004; A-01-06-02504; expected issue date: FY 2007; work in progress)

TANF Improper Payments

We will determine the extent to which State agencies made TANF basic assistance payments to beneficiaries who did not meet Federal and State eligibility requirements. In its 2005 Performance and Accountability Report, the Department reported that "the extensive flexibility of State TANF operations and the prohibitions on data collection in the TANF legislation have continued to present challenges to identifying an effective and cost efficient methodology for measuring improper payments in the TANF program." The Department, along with OMB, has requested that OIG audit State TANF programs to establish a statistically valid estimate of improper payments. In FY 2007, we will review three of the five States with the largest TANF basic assistance expenditures for Federal FY 2005. We will use the results to establish an

improper payment rate for each State reviewed. The results of our reviews will assist the Department in developing a TANF error rate in FY 2008.
(OAS; W-00-06-21003; expected issue date: FY 2007; work in progress)

Low Income Home Energy Assistance Program: State & Grantee Compliance with Block Grant Requirements

We will assess State and grantee compliance with the 16 Federal assurances addressing programmatic and fiscal integrity. The Low Income Home Energy Assistance Program (LIHEAP) is a $1.9 billion block grant program that assists low-income households in meeting their home energy needs. LIHEAP grants go to all 50 States, the District of Columbia, and 135 Native American tribes. State and tribal grantees make payments directly to an eligible low-income household, or on behalf of such household, to an energy supplier. According to an ACF report to Congress, in FY 2003 the program assisted 4.4 million households with heating assistance, 500,000 households with cooling assistance, 1.1 million households with winter/year round energy crisis intervention, and 100,000 households with weatherization.
(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Head Start/Child Care

Hurricane Relief Payments Made to Head Start Grantees

We will determine whether ACF has adequate controls for: (1) awarding and monitoring Hurricane Katrina funds provided to Head Start programs, and (2) ensuring that the funds are used for intended purposes. Hurricanes Katrina and Rita caused damage to more than 200 Head Start facilities. Nearly 100 of those facilities were significantly damaged and were still closed as of October 4, 2005. Most of these facilities will require replacement or extensive repair. ACF and Head Start grantees worked to develop a facility strategy that would, as quickly as possible, allow grantees to serve Head Start children.
(OAS; W-00-07-25020; A-04-07-00000; expected issue date: FY 2007; new start)

Head Start Grants Unallowable/Unsupported Costs

We will determine whether ACF is properly adjusting grants for unallowable or unsupported costs. In a prior review, we found that an ACF regional office was reducing future grant awards rather than requiring grantees to repay unallowable costs and was not requiring grantees to pay back unallowable or unsupported costs totaling less than $10,000.
(OAS; W-00-07-25021; A-06-07-00000; expected issue date: FY 2007; new start)

Foster Care Claims for the Placement of Delinquent Children

In several States, we will determine whether foster care maintenance costs claimed under Title IV-E for the placement of delinquent children complied with applicable Federal requirements. Maintenance costs include room and board payments to licensed foster parents, group homes, and residential child-care facilities for children who meet Title IV-E program requirements. A prior OIG review found claims were submitted for ineligible children, services not provided, and ineligible services.
(OAS; W-00-07-25023; expected issue date: FY 2007; new start)

Head Start Underenrollment

We will assess underenrollment in the Head Start Program, both nationwide and specifically with respect to Hispanic children. The Office of Head Start has expressed concern that Head Start Programs may be significantly underenrolled (i.e., slots are funded but not filled). A 2003 GAO study found that the extent of underenrollment could not be determined due to substantial inaccuracies in the national enrollment data reporting system, the Program Information Report. However, the GAO analysis suggested that more than half of Head Start grantees might be underenrolled. Additionally, the Head Start Bureau believes that underenrollment often occurs in areas in which there is a substantial Hispanic Head Start eligible population that is not being served.
(OEI; 05-06-00290; OAS; W-00-05-25002; expected issued date: FY 2007; work in progress)

Health and Safety Standards at Child Care Facilities

We will determine compliance with health and safety standards at selected childcare facilities that received Federal funding from the State's Child Care Development Fund Block Grant. A 1994 audit identified numerous instances in which childcare facilities did not comply with States' health and safety standards. It also showed the need for greater Federal oversight to improve the health and safety conditions in childcare facilities.
(OAS; W-00-07-25005; A-04-07-00000; expected issue date: FY 2007; new start)

Other Administration for Children and Families Issues

Cash and Medical Assistance Payments to Refugees

We will determine whether a State has controls in place to prevent the payment of cash and medical assistance benefits after a refugee's period of eligibility has expired. Currently, Federal regulations allow for Federal funds to be used to provide cash and medical assistance for up to 8 months after a refugee's entry into the United States. Over the years, refugees' eligibility for cash and medical assistance has been as long as 36 months. In FY 2004 and prior years, nonfederal audits identified material noncompliance and reportable conditions in the State's administration of the program.
(OAS; W-00-06-2700; 6 A-04-06-00000; expected issue date: FY 2007; work in progress)

Lebanon Repatriation Program

As requested by the Secretary, OIG will report to Congress on the Department's use of funds made available pursuant to The Returned Americans Protection Act of 2006, Public Law 109-250. Our report will include a breakdown of program costs incurred with regard to repatriating individuals from Lebanon, including (1) direct assistance to individuals (such as costs of domestic travel and short-term lodging), and (2) administrative costs (such as for caseworkers, security, and related expenses).
(OAS; W-00-06-23102; expected issued date: FY 2007; work in progress)

Health and Safety of Unaccompanied Alien Children

We will assess the Office of Refugee Resettlement's (ORR) performance with respect to the care, placement, and tracking of unaccompanied alien children. In FY 2007, it is estimated that approximately 11,500 unaccompanied alien children will be apprehended crossing United States borders and placed in the custody of the HHS, Office of Refugee Resettlement. ORR is

responsible for the care, placement, and tracking of unaccompanied alien children placed in its custody. Reports conducted by the Inspectors General for the Departments of Justice and Homeland Security noted concerns with the care, placement, and tracking of these children and made recommendations for improvement.
(OEI; 07-06-00290; expected issue date: FY 2007; work in progress)

Administration on Aging

Aging Programs in One State

We will determine whether aging program grants in a State comply with Federal requirements. HHS, pursuant to the Older Americans Act of 1965, Title III, awards funds to States to develop or strengthen preventive health service and health promotion systems through designated State agencies. These grants also have the objective to maximize informal support to enable senior citizens to remain in their homes and communities and to support nutrition services. Nonfederal audits have identified problems in accounting for funds, unspent funds, and inadequately documented matching contributions.
(OAS; W-00-06-26001; A-02-06-00000; expected issue date: FY 2007; work in progress)

Departmentwide Audits and Other Departmentwide Studies

Financial Statement Audits

The Government Management Reform Act of 1994 seeks to ensure that Federal managers have at their disposal the financial information and flexibility necessary to make sound policy decisions and manage scarce resources. This Act broadened the Chief Financial Officers Act of 1990 (CFO Act) by requiring annual audited financial statements for all accounts and associated activities of HHS and other Federal agencies.

Audits of FY 2006 Financial Statements

The audited consolidated HHS financial statements covering FY 2006 are to be submitted to OMB by November 15, 2006. The following FY 2006 financial statement audits will be completed and reports will be issued during FY 2007:

- The consolidated HHS audit will be performed at all operating divisions, including those that will receive separate audit reports (listed below) and those that will not. Those that will not receive separate audit reports include ACF, HRSA, IHS, CDC, SAMHSA, FDA, AHRQ, NIH (excluding the Service and Supply Fund), AoA, and the Office of the Secretary. (*OAS; W-00-06-40009; A-17-06-00001)*

- CMS *(OAS; W-00-06-40008; A-17-06-02006*)

- Program Support Center *(OAS*; *W-00-06-40003; A-17-06-00004)*

- NIH Service and Supply Fund *(OAS; W-00-06-40013; A-17-06-00005)*

FY 2006 Statement on Auditing Standards 70 Examinations

A Statement on Auditing Standards (SAS) 70 examination reports on the controls of a service organization that may be relevant to the user organizations' internal control structures. The following SAS 70 examinations of HHS service organizations will support FY 2006 financial statement audits and will be issued during FY 2007:

- Center for Information Technology (NIH Computer Center) *(OAS; W-00-06-40012; A-17-06-00010)*

- Program Support Center—Major Administrative Support Services

  - Payment Management System *(OAS; W-00-06-40012; A-17-06-00009)*
  - Division of Financial Operations *(OAS; W-00-06-40012; A-17-06-00011)*
  - Enterprise Support Service *(OAS; W-00-06-40012; A-17-06-00012)*

FY 2006 Financial-Related Reviews

- Payment Management System Agreed-Upon Procedures focus on analyses of grant advances and expenditures, posting of expenditures, and recalculation of the estimated yearend grant accrual.
  (OAS; W-00-06-40012; A-17-06-00013)

- Closing-Package Audit Reports for the Governmentwide Financial Report System are intended to support the preparation of governmentwide financial statements and reports.
  (OAS; W-00-06-40009; A-17-06-00006)

- Intragovernmental Agreed-Upon Procedures for the Closing Package are intended to assist with accounting for and eliminating intragovernmental activity and balances in the preparation of governmentwide financial statements and reports.
  (OAS; W-00-06-40009; A-17-06-00007)

Audits of FY 2007 Financial Statements

The audited consolidated HHS financial statements covering FY 2007 are to be submitted to OMB by November 15, 2007. The following FY 2007 financial statement audits will be completed and reports will be issued during FY 2008.

- The consolidated HHS audit will be performed at all operating divisions, including those that will receive separate audit reports (listed below) and those that will not. Those that will not receive separate audit reports include ACF, HRSA, IHS, CDC, SAMHSA, FDA, AHRQ, NIH (excluding the Service and Supply Fund), AoA, and the Office of the Secretary. *(OAS; W-00-07-40009; A-17-00-00000)*

- CMS *(OAS; W-00-07-40008; A-17-00-00000)*

- Program Support Center *(OAS; W-00-07-40003; A-17-00-00000)*

- NIH Service and Supply Fund *(OAS; W-00-07-40013; A-17-00-00000)*

FY 2007 Statement on Auditing Standards 70 Examinations

A SAS 70 examination reports on those controls of a service organization that may be relevant to the user organizations' internal control structures. The following SAS 70 examinations of HHS service organizations will support FY 2007 financial statement audits and will be issued during FY 2007:

- Center for Information Technology (NIH Computer Center)
  (OAS; W-00-07-40012; A-17-00-00000)

- Information Technology Support Center (Office of the Secretary)
  (OAS; W-00-07-40012; A-17-00-00000)

- Program Support Center—Major Administrative Support Services

  - Payment Management System *(OAS; W-00-07-40012; A-17-00-00000)*
  - Division of Financial Operations *(OAS; W-00-07-40012; A-17-00-00000)*
  - Enterprise Support Service *(OAS; W-00-07-40012; A-17-00-00000)*

FY 2007 Financial-Related Reviews

- Payment Management System Agreed-Upon Procedures focus on analyses of grant advances and expenditures, posting of expenditures, and recalculation of the estimated yearend grant accrual.
  (OAS; W-00-07-40012; A-17-00-00000)

- Closing-Package Audit Reports for the Governmentwide Financial Report System are intended to support the preparation of governmentwide financial statements and reports.
  (OAS; W-00-07-40009; A-17-00-00000)

- Intragovernmental Agreed-Upon Procedures for the Closing Package are intended to assist with accounting for and eliminating intragovernmental activity and balances in the preparation of governmentwide financial statements and reports.
  (OAS; W-00-07-40009; A-17-00-00000)

- Payroll Agreed-Upon Procedures focus on reviewing the official personnel files for selected HHS employees to assist the Department of Defense, OIG in performing the OMB Bulletin 06-03, Audit Requirements for Federal Financial Statements, Section 11 Agreed-Upon Procedures.
  (OAS; W-00-07-40009; A-017-00-00000)

Automated Information Systems

Information Systems Internal Controls—FY 2006

As part of our responsibilities under the CFO Act and the Federal Financial Management Improvement Act (FFMIA), we will oversee and conduct tests of internal controls over HHS information systems. The CFO Act and FFMIA require that OIG, or an independent public accountant chosen by OIG, understand the components of internal controls and conduct sufficient tests to reasonably assess control risk. This work will include nationwide reviews of internal controls in Medicare and Medicaid systems and in other HHS financial systems. The results of this effort will be included in the report on the consolidated HHS FY 2006 financial statements.
(OAS; W-00-05-40017; W-00-05-40019; various reviews; no report)

Information Systems Internal Controls—FY 2007

As part of our responsibilities under the CFO Act and the FFMIA we will oversee and conduct tests of internal controls over HHS information systems. The CFO Act and the FFMIA require that OIG or an independent public accountant chosen by OIG understand the components of

internal controls and conduct sufficient tests to reasonably assess control risk. This work will include nationwide reviews of internal controls in Medicare and Medicaid systems and in other HHS financial systems. The results of this effort will be included in the report on the consolidated HHS FY 2007 financial statements.
(OAS; W-00-06-40017; W-00-06-40019; various reviews; no report)

Information System Security Program

We will document and evaluate the existence and reliability of the Information System Security Program at selected operating divisions. This program helps to protect information resources in compliance with the Federal Information Security Management Act (FISMA) and the directives of OMB and the National Institute of Standards and Technology. To date, limited reviews have been conducted to determine compliance with HHS-mandated security program requirements.
(*OAS; W-00-07-42003; A-18-00-00000; expected issue date: FY 2007; work in progress and new start)*

Federal Information Security Management Act of 2002 and Critical Infrastructure Protection

We will assess various operating divisions' compliance with FISMA and critical infrastructure protection requirements. The FISMA and OMB Circular A-130, Appendix III, require that agencies and their contractors maintain programs that provide adequate security for all information collected, processed, transmitted, stored, or disseminated in general support systems and major applications. As part of our review, we will follow up on the unresolved findings from other relevant audit reports on information systems controls.
(OAS; W-00-0742010; various reviews; expected issue date: FY 2007/08; work in progress and new start)

Payment Management System Controls

We will document and evaluate the existence and reliability of information systems controls over the electronic funds transfer function of the Payment Management System, which supports the Program Support Center's primary mission. As the largest grant payment and cash management system in the Federal Government, the Payment Management System disburses more than $200 billion of the more than $300 billion in annual Federal grant funds and financial assistance awarded each year. The system services the grant programs of all HHS operating divisions and more than 40 other Federal agencies. The National Critical Infrastructure Assurance Office recognizes the system as one of the Department's most important national-level assets.
(OAS; W-00-07-42011; A-18-00-00000; expected issue date: FY 2007; new start)

Grants and Contracts

Requested Audit Services

Throughout the year, Members of Congress and officials from the Department and other Federal departments request that we perform a variety of audit services. Requested audit services include:

- recipient capability audits
- contract and grant closeouts
- indirect cost audits

- bid proposal audits
- other reviews designated to provide specific information requested by management

We will evaluate these requests as we receive them, considering such factors as why the audit is being requested, how the results will be used, when the results are needed, and whether the work is cost beneficial.
(OAS; W-00-07-12345; various reviews, expected issue date: FY 2007; new start)

Incurred Cost Contracts

We will audit selected departmental contracts. Selection will be based on the dollar value of the contract; the significance of contract modifications since the original award; and input from the operating divisions and the offices of the Assistant Secretary for Resources and Technology and the Assistant Secretary for Administration and Management.
(OAS; W-00-07-58055; A-00-00-00000; expected issue date: FY 2007; new start)

State Issues

State Funds

OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments, establishes principles for determining the allowable costs incurred by State and local governments under Federal awards. Federal cost principles are designed to provide that Federal awards bear their fair share of cost but do not allow governmental entities to receive reimbursement for charges in excess of cost or to make a profit. Periodically, OIG conducts reviews in the following areas:

- **Pensions**
  These reviews will determine whether the Federal Government received equitable benefit when State pension funds were withdrawn, transferred to other State funds, or used to cover State expenses.
  (OAS; W-00-07-58050)

- **Excess Fund Reserves**
  We will determine whether internal service, self-insurance, or other State funds that receive Federal Government contributions have accumulated excess reserves.
  (OAS; W-00-07-58052)

- **Uncashed, Canceled Checks**
  We will determine whether States with a large percentage of unclaimed, uncashed checks (escheated warrants) are promptly crediting Federal programs for the checks. Federal regulations require that States refund the Federal portion of unclaimed, uncashed checks.
  (OAS; W-00-07-58053)

Direct Charges to Federal Programs for Unused Leave

We will determine whether a State is complying with OMB Circular A-87 in its treatment of unused leave that is charged to Federal programs. The State auditor identified material

noncompliance with OMB Circular A-87 by a State agency because unallowable payments for unused leave were charged as a direct cost to Medicaid. We will determine whether the State Auditor identified all inappropriate unused leave charges to Medicaid and whether other State agencies may be directly charging unused leave to Federal programs.
(OAS; W-00-07-58057; A-04-07-00000; expected issue date: FY 2007; new start)

Vendors' Rebates Collected

We will determine whether a State is using vendors' rebates received by the State as a result of purchases to reduce federally claimed expenditures as required by OMB Circular A-87. The agency responsible for administering the State's cost allocation plan did not provide information regarding rebates received by the State to the various other State agencies so that they could be used to reduce Federal reimbursement claims. We will review the State's policies, procedures, controls, and practices to determine whether vendors' rebates were used to reduce federally claimed costs.
(OAS; W-00-07-58058; A-04-07-00000; expected issue date: FY 2007; new start)

Joint Work With Other Federal and State Agencies

To use audit resources efficiently, we will continue our efforts to provide broader coverage of HHS programs by partnering with State auditors, State departmental internal auditors and Inspectors General, State agencies, and departmental financial managers. Since 1994, active partnerships have been developed with States on such Medicaid 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, outpatient therapy services, and transportation services.

We will also expand our partnerships to cover ACF State-administered programs. Our Partnership Plan will highlight opportunities for joint reviews in critical areas such as licensing and monitoring child care facilities and foster homes and assessing safeguards for the elderly and people with disabilities. We will also identify areas in which State auditors can help States avoid disallowances and financial penalties due to unallowable costs claimed or noncompliance with Federal program requirements. Based on current OIG work, this planned expansion may also cover such issues as increasing child support collections and reducing undistributed collections; expanding enrollment in the State Children's Health Insurance Program; and improving oversight of State contracting for services, providers, and systems.
(OAS; W-00-07-27002; various reviews; expected issue date: FY 2007; new start)

Other Issues

Annual Accounting of Drug Control Funds

We will determine whether HHS agencies are in compliance with the Office of National Drug Control Policy requirements for annual accounting of drug control funds. Each year, agencies that participate in the National Drug Control Program are required to submit to the Office of National Drug Control Policy a detailed accounting of all prior-year drug control funds, along with an accompanying OIG "authentication." We will make this authentication to express a conclusion on the reliability of the HHS assertions regarding FY 2006 drug control funds.
(OAS; W-00-07-58059; A-03-00-00000; expected issue date: FY 2007; new start)

Non-Federal Audits

Under OMB Circular A-133, State, local, and Indian tribal governments, colleges and universities, and nonprofit organizations receiving Federal awards are required to have an annual organization-wide audit of all Federal money they receive. We will continue to review the quality of these audits by non-Federal 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 upfront technical assistance to non-Federal auditors to ensure that they understand Federal audit requirements and to promote effective audit work. In addition, we analyze and record electronically the audit findings reported by non-Federal 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.

Reimbursable Audits

We will conduct a series of audits as part of the Department's cognizant responsibility under OMB Circular A-133. To ensure a coordinated Federal approach to audits of colleges, universities, and States, OMB Circular A-133 establishes audit cognizance; that is, which Federal agency has lead responsibility for audit of all Federal funds the entity receives. HHS OIG has audit cognizance for all State governments and most major research colleges and universities. Agreements have been reached among many OIG offices to reimburse the cognizant agency for audits performed at their request or the request of their program offices.
(OAS; W-00-06-50012; various reviews; expected issue date: FY 2007; new start)

Open and Inactive Grants in the Payment Management System

We will determine whether HHS agencies should close out more than 32,000 open and inactive grants for which the net remaining obligation balances total $2.3 billion. The Department's Payment Management System charges agencies a fee to maintain open grants.
(OAS; W-00-06-52007; A-02-06-02001; expected issue date: FY 2007; work in progress)

HHS Implementation of Grants.gov

We will assess HHS implementation of "Grants.gov." Grants.gov is a Presidential initiative, the purpose of which is to provide a single, secure Web site to find and apply for more than 1,000 grant programs across the Federal Government. HHS is managing the governmentwide system and is implementing the system for its estimated 300 grant programs. We will examine HHS progress toward such goals as eliminating redundant data collection and standardizing the collection of financial and performance measurement data.
(OAS; W-00-07-58002; A-00-07-00000; expected issue date: FY 2007; new start)

Assessing HHS Hurricane-Related Procurements

Using our risk assessments and guidance provided by the Homeland Security Roundtable of the President's Council on Integrity and Efficiency, we will select the most vulnerable hurricane-related HHS procurements and perform in-depth audits. These audits will specifically focus on

the methods of procurement, cost incurred, and the quantity, quality, and timeliness of deliverables.
(OAS; W-00-06-58008; various reviews; expected issue date: FY 2007; work in progress)

HHS Accounting for FEMA Mission Assignment Funds

We will determine whether HHS is appropriately accounting for FEMA Mission Assignment Funds. As of January 3, 2006, the spending authority for HHS FEMA-requested mission assignments (tasks) totaled $272.8 million. The Department of Homeland Security, Congress, and the public expect HHS to provide timely, accurate, complete, and consistent accounting for Gulf coast-related costs that will be reimbursed by FEMA.
(OAS; W-00-07-58101; A-00-06-00000; expected issue date: FY 2007; work in progress)

HHS Response to the National Response Plan

We will audit HHS's implementation of its responsibilities under the National Response Plan, Emergency Support Function #8 – Public Health and Medical Services. At appropriate departmental, operating division, and staff division levels, we will assess the handling of FEMA-requested mission assignments using established plans, objectives, and other pertinent benchmarks. Our results will be critical for improving departmental processes for future public emergencies.
(OAS; W-00-07-58102; A-00-06-00000; expected issue date: FY 2007; work in progress)