



Department of Health and Human Services

**Office of
Inspector General**

Work Plan

Fiscal Year 1999

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Inspector General**






Office of Inspector General

MISSION:

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






VISION

WE ARE GUARDIANS OF THE PUBLIC TRUST

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

VALUES

WE VALUE:

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

Department of Health and Human Services

Office of Inspector General



Work Plan for Fiscal Year 1999

INTRODUCTION

The Office of Inspector General (OIG) Work Plan is set forth in five chapters encompassing the various projects to be addressed during Fiscal Year (FY) 1999 by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The first four chapters present the full range of projects planned in each of the Department of Health and Human Services' (HHS) major entities: the Health Care Financing Administration, the Public Health Service agencies, the Administration for Children and Families, and the Administration on Aging. The fifth chapter embraces those projects related to issues that cut across Department programs, including State and local government use of Federal funds, as well as the functional areas of the Office of the Secretary.

In preparing this edition of the OIG Work Plan, we have provided a brief description of the various project areas that we perceive as critical to the mission of the OIG and the Department. Unless otherwise noted, reports on all projects are expected to be issued in FY 1999. However, as the work planning process tends to be ongoing and dynamic, the focus and timing of many of these projects can evolve in response to new information, new issues, and shifting priorities of the Congress, the President, and the Secretary and may be altered over time.

Given these variables, the OIG objective still remains the targeting of available resources on those projects that best identify vulnerabilities in the Department's programs and

activities that have been designed to serve and protect the safety, health, and welfare of the American people and promote the economy, efficiency, and effectiveness of the Department's programs. The Health Insurance Portability and Accountability Act of 1996, strengthened by the Balanced Budget Act of 1997, brought much needed authorities and resources to achieving this objective.

Program Audits

The Office of Audit Services (OAS) conducts comprehensive financial and performance audits of departmental programs and operations to determine whether program objectives are being achieved and which program features need to be performed in a more efficient manner. The OAS also provides overall leadership and direction in carrying out the responsibilities mandated under the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994 relating to financial statement audits.

The audit portion of the OIG Work Plan represents the most significant audit work that will be conducted in FY 1999.

Program Inspections

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

Investigative Focus Areas

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

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

Legal Counsel Focus Areas

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

Internet Address

The FY 1999 OIG Work Plan and other OIG materials, including final reports issued and OIG program exclusions, may be accessed on the Internet at the following address:

<http://www.hhs.gov/progorg/oig>

Department of Health and Human Services

Office of Inspector General



Work Plan for Fiscal Year 1999

TABLE OF CONTENTS

Health Care Financing Administration Projects

Public Health Service Agencies Projects

Administration for Children and Families Projects

Administration on Aging Projects

Departmentwide Projects

Department of Health and Human Services

Office of Inspector General



Health Care Financing Administration Projects

Table of Contents

HOSPITALS

Hospital Quality Oversight	1
Relationship Between Hospital Costs and Revenues	1
Hospital Services Billed Under Arrangement	1
Hospital-Owned Physician Practices: Provider-Based Status	2
Hospital-Owned Physician Practices: Financial Impact	2
Prospective Payment System Transfers	2
Prospective Payment System Transfers During Hospital Mergers	3
Hospital Reporting of Patients Who “Left Against Medical Advice”	3
Same-Day Discharge and Readmission to Same Hospital	4
Updating Diagnosis-Related Group Codes	4
Monitoring Diagnosis-Related Group Coding	4
Outpatient Base Year Costs	5
Outpatient Psychiatric Services	5
Experimental Drug Trials	5
Hospital Closure: 1997	6

HOME HEALTH

Home Health Base Year Costs	6
Payment Based on Location of Service	6
Physician Case Management Billings	7
Access to Home Health Services	7

Utilization Patterns of Home Health Services	8
Home Health Aides	8

NURSING HOME CARE

State Survey and Certification Process	8
Analysis of State Survey and Certification Data	9
State Resident Abuse Data	9
Nursing Home Survey Results	9
Resident Assessments and Plans of Care	10
Resident Immunizations	10
Skilled Nursing Facility Base Year Costs	10
Ancillary Medical Supplies	11
Nursing Home Implementation of Consolidated Billing	11
Therapy in Nursing Facilities	11
Mental Health Services in Nursing Facilities: A Follow-Up	12

PHYSICIANS

Accuracy and Carrier Monitoring of Physician Visit Coding	12
Physicians at Teaching Hospitals (PATH)	13
Physicians with Excessive Nursing Home Visits	13
Podiatry	13
Automated Encoding Systems for Billing	14
Billing Service Companies	14
Reassignment of Physician Benefits	14
Improper Billing of Psychiatric Services	15
Patient Billing Records	15

MEDICAL EQUIPMENT AND SUPPLIES

Operations of Durable Medical Equipment Carriers	15
Duplicate Billings for Medical Equipment and Supplies	16
Selected Providers	16
Hospice Part B Billings	17
Medical Necessity of Oxygen	17
Orthotic Body Jackets	17
Licensing Requirements for Prescription Drug Suppliers	17

END STAGE RENAL DISEASE

Clinical Laboratory Tests Provided to ESRD Beneficiaries 18
Medical Appropriateness of Tests and Other Services 18
Bad Debts - Nationwide Chain 19

DRUG REIMBURSEMENT

Effect of Average Wholesale Price Discount on Medicare Prescription Drugs . 19
Infusion Therapy Services 19
Medicare Nebulizer Drugs 20

OTHER MEDICARE SERVICES

Excess Payments for Ambulance Services 20
Comparison of Ambulance Reimbursement Policies 21
Partial Hospitalization Services 21
Medicare Reimbursement for Outpatient Psychotherapy 21

MEDICARE MANAGED CARE

General and Administrative Costs 22
Payments Based on Institutional Status 22
Payments for End Stage Renal Disease Beneficiaries 22
Medicare Payments to HMOs for Medicaid-Eligible Beneficiaries Living
in Medicaid Nursing Facilities 23
Physician Incentive Plans in Managed Care Contracts 23
Duplicate Fee-for-Service Billings 23
Investment Income Earned by Risk-Based HMOs 24
National Marketing Guidelines for Medicare Managed Care Plans 24
Assessing Managed Care Health Plan Data 25
Managed Care Additional Benefits 25
Enrollee Access to Emergency Services 25
Services Provided After Disenrolling 26

MEDICAID MANAGED CARE

States' Use of External Quality Review Organizations 26
Impact on Mental Health Services 27
Fraud and Abuse in Medicaid Managed Care 27

MEDICAID - CHILDREN S HEALTH INSURANCE PROGRAM

Best Practices in Medicaid and Children's Health Insurance
Program Outreach 27

Special Needs Children	28
Involvement of Federally Funded and Qualified Health Centers	28
States' Application Procedures	28

MEDICAID REIMBURSEMENT

Coordination of Care for Dual Eligibles	29
Federal Reimbursement for Psychiatric Care	29
Follow-Up on Medicaid Clinical Labs	29

MEDICARE CONTRACTOR OPERATIONS

HCFA Oversight of Medicare Contractors	30
Comparison of Payment Safeguard Activities	30
Factors in Identifying Potentially Fraudulent Providers	31
Excessive Numbers of Billings	31
Mutually Exclusive Medical Procedures	31
Suspension of Payments to Medicare Providers	32
Identifying and Collecting Overpayments	32
Management Service Organizations	32
Contractor Medical Review	33
Medicare Provider Numbers and Unique Physician Identification Numbers ...	33
Provider Billing Numbers Issued to Resident Physicians	34
Medicare Administrative Appeals	34
Preaward Review of Medicare Integrity Program Contract Proposals	34
Preaward Review of Medicare Peer Review Organizations	35
Audit of Peer Review Organization Incurred Costs	35
Claim Processing Contractors' Administrative Costs	35
Unfunded Pensions	36
Pension Segmentation/Charges	36
Pension Termination	36

GENERAL ADMINISTRATION

Year 2000 Computer Renovation Plans	37
OIG-Excluded Persons	37
Medicare Secondary Payer	37
Employer Insurance Replies	38
Physician Referrals to Self-Owned Laboratory Services	38
Medicare Part B Billings by State-Owned Facilities	38
Organ Transplant Costs	39
Joint Work with Other Federal and State Agencies	39

INVESTIGATIONS

Medicare Part A 40
Medicare Part B 40
Medicare Part C 41
Medicaid 41
Pneumonia DRG Upcoding Project 41

LEGAL COUNSEL

Compliance Program Guidance 42
Corporate Integrity Agreements 42
Advisory Opinions and Fraud Alerts 43
Anti-Kickback Safe Harbors 43
Patient Anti-Dumping Statute Enforcement 43
Program Exclusions 44
Civil Monetary Penalties 44

HOSPITALS

Hospital Quality Oversight

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

OEI; 01-97-00050

Relationship Between Hospital Costs and Revenues

We will examine the relationship between hospitals' costs and revenues to assess the reasonableness of Medicare payment levels for inpatient services. Under Medicare's prospective payment system, hospitals are paid a predetermined payment rate per discharge for each patient treated. Since hospitals receive millions of dollars annually comprising the largest portion of Medicare Part A reimbursements, it is critical that the predetermined payment rates be set at appropriate levels.

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

Hospital Services Billed Under Arrangement

We will determine the extent to which hospitals purchase services under arrangement and identify the services that hospitals purchase most frequently. We will also assess the fiscal effects of these arrangements. Previous work conducted by the OIG found that Medicare pays substantially more when nursing homes purchase services "under arrangement" from ancillary service providers, such as therapy/rehabilitation agencies and portable x-ray suppliers. "Under arrangement" means that a facility purchases ancillary services from a service provider who bills the facility rather than a Medicare contractor. We found that the facility then included those services as costs on the claims

it submitted to the fiscal intermediary, marking them up as much as 250 percent for overhead and administrative expenses. We will determine if similar problems occur at hospitals.

OEI; 04-98-00230

Hospital-Owned Physician Practices: Provider-Based Status

We will identify the potential vulnerabilities to Medicare arising from the proliferation of provider-based physician practices. Hospitals that meet certain criteria may receive higher reimbursement by having a “provider-based” designation for facilities housing practices they own, such as physician practices. We will review HCFA’s oversight of the process for approving “provider-based” status and for monitoring hospitals that receive the additional benefit. We will also explore any benefits of provider-based facilities to Medicare and its beneficiaries.

OEI; 04-97-00090

Hospital-Owned Physician Practices: Financial Impact

We will review the financial impact of trends in physician-hospital integration. In recent years, hospitals have acquired or become affiliated with physician practices. Medicare reimbursement may be affected, e.g., when a newly acquired physician group becomes a “provider-based” entity for the purposes of enhancing reimbursement through hospital claims for overheard expenses. There may also be an impact on beneficiary copayment responsibilities. We will determine whether and to what extent Medicare expenditures are increased as a result of physician-hospital integration and identify other potential vulnerabilities, such as questionable patient referral practices.

OEI; 05-98-00110

Prospective Payment System Transfers

We will continue to support the Department of Justice’s assistance to the Department in seeking recovery of Medicare overpayments to prospective payment system (PPS) hospitals that incorrectly reported PPS transfers. The transfer payment policy stipulates that when a Medicare patient is transferred between PPS hospitals, the first (transferring)

hospital receives a per diem payment limited to the length of stay, while the hospital receiving the transferred patient is paid a diagnosis-related group payment based on the final discharge code. Incorrect reporting of these transfers allows both hospitals to receive the full payment amount. We also plan to issue a report recommending recovery of overpayments from hospitals that are not covered by the Justice Department's project.

OAS; W-00-98-30010; A-06-98-00010, A-06-98-00024

Prospective Payment System Transfers During Hospital Mergers

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

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

Hospital Reporting of Patients Who Left Against Medical Advice

We will identify prospective payment system (PPS) hospitals that routinely report that Medicare patients left the hospital against medical advice (self-discharged). Such reporting may indicate that facilities are trying to circumvent the PPS transfer payment policy, which exempts situations in which the patient left the first PPS hospital against medical advice. A significant increase in the reporting of "left against medical advice" transfers has occurred since the OIG's first PPS transfer recovery project (January 1986 through November 1991).

OAS; W-00-98-30010; A-02-98-01016, A-06-98-00013

Same-Day Discharge and Readmission to Same Hospital

This review will examine Medicare claims for beneficiaries who were discharged and subsequently readmitted on the same day to the same prospective payment system hospital. We will review procedures in place for these readmissions at selected hospitals, fiscal intermediaries, and peer review organizations. With the assistance of medical review staff, we will determine if these claims were appropriately paid. We will also review claim processing procedures to determine what system edits are used to identify and review readmissions.

OAS; W-00-98-30010; A-01-98-00504

Updating Diagnosis-Related Group Codes

We will evaluate the process by which HCFA updates diagnosis-related group codes. The basis for payments to hospitals is the diagnosis-related group code for each discharge under the prospective payment system. Each diagnosis-related group represents the average resources required to care for cases in that particular diagnosis-related group relative to the average resources used to treat cases in all diagnosis-related groups. Resources required to care for hospitalized Medicare beneficiaries can increase over time due to changes in the distribution of cases among diagnosis-related groups and increases in the average resource requirements of cases assigned to specific groups. We will assess the adequacy of the data used in recalibrations and reclassifications and examine how new technologies and treatments are incorporated into diagnosis-related groups.

OEI; 00-00-00000

Expected Issue Date: FY 2000

Monitoring Diagnosis-Related Group Coding

We will assess the extent and quality of HCFA's monitoring of diagnosis-related group coding by hospitals. In a medical record abstraction of 1996 hospital discharges done by the data abstraction contractors, the contractors found a variation of 8 to 10 percent between initial hospital coding and the data abstraction contractor coding. The OIG also found significant coding error rates in a recent sample of hospital medical records. This

current study will explore reasons why these errors are occurring and what HCFA does to monitor and correct the errors.

OEI; 00-00-00000

Expected Issue Date: FY 2000

Outpatient Base Year Costs

In partnership with HCFA, we will conduct a series of audits of the base year costs used to develop the prospective payment system rates for hospital outpatient department services. The Balanced Budget Act of 1997 required HCFA to implement a prospective payment system for hospital outpatient department services. Our audits will help determine if the prospective outpatient rates are reasonable.

OAS; W-00-99-30026; A-14-99-00000, A-01-98-00519

Outpatient Psychiatric Services

This review will determine whether psychiatric services rendered on an outpatient basis are billed and reimbursed in accordance with Medicare regulations. The regulations require that payments be limited to covered services that are supported by medical records. We have indications from one fiscal intermediary that some services rendered in outpatient hospital settings were not documented, not ordered by a physician, or not covered services. We will determine if this is also a problem at other fiscal intermediaries.

OAS; W-00-98-30010; A-01-98-00503

Experimental Drug Trials

We will conduct reviews to determine whether hospitals and other providers are inappropriately billing Medicare for items or services provided to beneficiaries as part of research grants and experimental drug trials. Many research projects are funded by the Public Health Service agencies and private foundations, whereas experimental drug trials

are usually paid by pharmaceutical companies. We will determine if claims for these projects are also being paid by Medicare.

OAS; W-00-98-30010; A-03-98-00000

Hospital Closure: 1997

This will be the 11th in a series of reports on hospital closure, examining the extent, characteristics, reasons for, and impact of closures in 1997. In the mid to late 1980s, closure of general, acute care hospitals generated considerable public and congressional interest. Our first report on closures in 1987 showed that the problem was not as severe as generally believed. Few hospitals had closed, most were small and had low occupancy, and few patients were affected. The closure of hospitals is continuing in a downward trend. Nevertheless, there is continuing interest in this issue, and our annual reports have become a standard reference on it.

OEI; 04-98-00200

HOME HEALTH

Home Health Base Year Costs

Working with HCFA, we will perform a series of audits of the base year costs used in developing prospective payment system rates for home health agencies. The implementation of this prospective payment system was required by the Balanced Budget Act of 1997. Our audits will help evaluate the reasonableness of the prospective rates.

OAS; W-00-98-30009; A-14-98-00410, A-04-99-00000

Payment Based on Location of Service

We will evaluate the implementation of a recent change in paying for home health care. Effective October 1997, home health services are to be paid based on the location where

the service is provided (in the patient's home), rather than where the service is billed (typically the urban location of the parent home health agency).

OAS; W-00-99-30009; A-00-99-00000

Physician Case Management Billings

We will review the reasonableness of physician claims for home health care. Among other things, this review will determine if, after a regional home health intermediary denies a home health claim, the Part B carrier also denies any related payments submitted by the physician for oversight of the plan of care. Payment to physicians for plan care oversight is to be recovered when a claim does not meet Medicare criteria for home health services. The intermediaries and carriers should be interacting with regard to such claims.

OAS; W-00-99-30009; A-06-99-00000

Access to Home Health Services

We will assess the effect of the Medicare home health interim payment system on beneficiary access to home health services. In response to rapidly rising Medicare home health costs, the Balanced Budget Act of 1997 made significant changes in the way home health agencies will be paid. Effective October 1, 1999, cost-based reimbursement will be replaced with a prospective payment system under which Medicare pays agencies a predetermined amount per unit of service. In the meantime, for cost report periods beginning on or after October 1997, the Balanced Budget Act reduces the per visit limit to 105 percent of median national costs for each type of visit (instead of the 112 percent of the mean as under the previous method) and establishes a per beneficiary limit based on 1994 costs. We will examine how home health agencies have responded to the new interim payment system and what effect this has had on beneficiary access to home health services.

OEI; 00-00-00000

Utilization Patterns of Home Health Services

This study will determine if recent reimbursement changes to certain hospital discharges has altered the use of home health services. We will specifically determine whether home health services have increased 3 days after certain inpatient discharges. Under the provisions of the Balanced Budget Act, certain hospital discharges to home health agencies and to skilled nursing facilities will be reimbursed under a formula that treats these discharges as transfers, effective January 1, 1999. Regulations implementing this provision have specified that for the selected discharges, a beneficiary's use of home health services will cause the discharge to be reimbursed under the transfer methodology. Use of home health services after the 3-day period will result in reimbursement based on the current discharge methodology.

OEI; 00-00-00000

Home Health Aides

We will examine claims for home health aide services provided to Medicare beneficiaries in residential care facilities in one State. The State requires such facilities to provide assisted living services, such as meal preparation, room cleaning, and bathing in order to be licensed. The residents pay the facilities for these services. It has been alleged that in some situations home health aides (via home health agencies) claimed Medicare reimbursement as though they--not the resident care facilities--provided the services to beneficiaries.

OAS; W-00-98-30009; A-09-98-00056

NURSING HOME CARE

State Survey and Certification Process

We will examine the variation in State nursing home survey and certification processes. The Omnibus Reconciliation Act of 1987 established requirements for surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation in the Medicare and Medicaid programs and for certifying compliance or noncompliance. We will examine process issues, such as how often States conduct

surveys, number of surveyors, surveyor training, time spent at each facility, and sampling techniques. This review is at congressional request and is one in a series of reviews examining the quality of care in nursing homes.

OEI; 02-98-00330

Analysis of State Survey and Certification Data

We will examine trends in State survey and certification data and the extent to which the data indicates quality of care problems in nursing facilities. The Online Survey Certification and Reporting System is a national HCFA database comprised of information entered by State survey agencies during periodic inspection and/or certification of Medicare and Medicaid facilities. The database includes basic demographic and deficiency information on facilities. We will analyze the data for a sample of States. This review is at congressional request and is one in a series of reviews examining the quality of care in nursing homes.

OEI; 02-98-00331

State Resident Abuse Data

We will examine trends in nursing facility patient abuse reports to State agencies. The law requires that all alleged patient abuse incidents be reported immediately to the facility administrator and to State officials in accordance with State law. Further, following a thorough investigation of each incident, the results of all investigations must be reported to the administrator and to State officials in accordance with State law within 5 working days of the incident. We will examine types of reports received, investigations, and confirmations of abuse. This review is at congressional request and is one in a series of reviews examining the quality of care in nursing homes.

OEI; 06-98-00340

Nursing Home Survey Results

We will examine the manner in which States and HCFA make survey results public. Federal law requires States and HCFA to make public (upon request) all information concerning survey and certifications of skilled nursing facilities and nursing facilities, a

service for which the States and HCFA may charge. States require that survey results be posted in the nursing home. We will determine how easily the public can obtain survey results, comprehend the information, and compare quality among facilities.

OEI; 06-98-00280

Resident Assessments and Plans of Care

We will determine whether quality of care concerns exist with resident assessments and plans of care and whether Medicare and Medicaid payment levels are correct. Federal law requires nursing facilities to conduct initial and periodic assessments of each resident's functional capacity that are comprehensive, accurate, and standardized and then to develop a comprehensive plan of care based on the assessment. The assessment information is also used to determine the level of Medicare and Medicaid payments to nursing facilities.

OEI; 00-00-00000

Resident Immunizations

We will examine the obstacles to immunizing Medicare-eligible nursing home residents against influenza and pneumococcal disease. The Centers for Disease Control's Advisory Committee on Immunization Practices recommends that all persons aged 65 and older and residents of nursing homes be vaccinated for these diseases. The Healthy People 2000 objective is to increase the immunization level for influenza and pneumococcal disease to 80 percent for institutionalized, chronically ill, or older people. Recent evidence suggests that many nursing home residents do not receive both vaccinations, and some data indicates a dual vaccination rate as low as 21 percent. Medicare Part B pays for both vaccinations.

OEI; 00-00-00000

Skilled Nursing Facility Base Year Costs

In conjunction with HCFA, we will perform a series of audits of the base year costs used in developing the prospective payment system rates for skilled nursing facilities.

Implementation of this prospective payment system was required by the Balanced Budget Act of 1997. Our work will help evaluate the reasonableness of the prospective rates.

OAS; W-00-98-30014; A-01-98-00519

Ancillary Medical Supplies

These ongoing reviews will determine if skilled nursing facilities have claimed unallowable costs for ancillary medical supplies. Pre-PPS Medicare reimbursement rules describe those items and services that are allowable as ancillary costs. Reviews conducted in two States have identified items and services that are unallowable as ancillary costs.

OAS; W-00-98-30015; A-09-98-00076

Nursing Home Implementation of Consolidated Billing

We will examine the early implementation of consolidated billing in nursing homes. The Balanced Budget Act legislated a new billing method for all Part B services provided to Medicare beneficiaries residing in nursing homes, effective July 1, 1998. For nursing home stays not paid by Medicare Part A, nursing facilities will be responsible for submitting bills to Medicare contractors for most Part B services. Outside entities will no longer be able to directly bill the program. This is known as consolidated billing. We will examine nursing homes' response to the consolidated billing requirements and the guidance HCFA provided to nursing homes on implementing consolidated billing.

OEI; 00-00-00000

Therapy in Nursing Facilities

A series of OIG reviews will evaluate the reasonableness of and costs associated with therapy services provided in skilled nursing facilities. The Medicare skilled nursing facility benefit is intended to provide post-hospital care to persons requiring intensive skilled nursing and/or rehabilitative services. These rehabilitative services may include physical and occupational therapy which may be paid by either Medicare Part A or

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

OAS; W-00-98-30014; A-04-98-00000
OEI; 09-97-00121

Mental Health Services in Nursing Facilities: A Follow-Up

We will determine whether mental health services in nursing facilities continue to be inappropriately billed. A 1996 OIG study found that medically unnecessary or questionable mental health services in nursing facilities were charged to Medicare, in addition to a number of other vulnerabilities. We recommended that HCFA take steps to prevent inappropriate payments, such as developing guidelines for carriers, developing screens to implement those guidelines, conducting focused medical review, and providing physician educational activities.

OEI; 00-00-00000

PHYSICIANS

Accuracy and Carrier Monitoring of Physician Visit Coding

We will assess whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding. In 1992, Medicare began using new visit codes that were developed by the American Medical Association for reimbursing physicians for evaluation and management services. Generally, the codes represent the type and complexity of services provided and patient status, such as new or established. Previous work by the OIG has found that physicians do not accurately or uniformly use visit codes. Our analysis will build upon this previous work and add more definitive data on the accuracy of physician visit coding.

OAS; W-00-98-30021; A-04-98-00000

Physicians at Teaching Hospitals (PATH)

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

OAS; W-00-99-30021; A-04-99-00000

Physicians with Excessive Nursing Home Visits

We will identify and audit billings of physicians with excessive visits to Medicare patients in skilled nursing facilities. A past OIG nursing home project identified trends in Medicare and Medicaid payments and populations and identified aberrant providers of nursing home services by type of service. Using this data, as well as other computer screening techniques, we identified physicians with aberrant billing patterns for visits to nursing home patients, such as an excessive number of visits in a given day and excessive visits to the same beneficiaries. We also plan to determine how Medicare carriers could better identify and prevent such billings.

OAS; W-00-99-30021; A-03-99-00000

Podiatry

We will assess whether podiatry services paid by Medicare were medically necessary and met HCFA coverage policy. From 1992 through 1995, Medicare expenditures for nail debridement increased 46 percent while Medicare expenditures for all other Part B services increased only 18 percent. Total Medicare allowances for foot care totaled almost \$300 million in 1995. We will select a random sample of paid claims for podiatry services and, with the assistance of medical staff, conduct a medical review of these services.

OEI; 00-00-00000

Automated Encoding Systems for Billing

We will determine if errors found in Medicare billings for physician services are associated with providers' use of automated encoding software. Using billing errors identified in recent audits of HCFA's financial statements, we will contact providers to determine if automated software was used to prepare the billing. By comparing providers known to have submitted erroneous records with those that did not, we can take a first step in identifying any adverse effect of this software. Results of this work may lead to further reviews.

OEI; 00-00-00000

Billing Service Companies

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

OAS; W-00-97-30021; A-06-98-00029

Reassignment of Physician Benefits

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

This practice shifts the accountability and liability for billing abuses away from the physician to the clinics. We will examine past reassignment abuses to determine specific vulnerabilities.

OEI; 00-00-00000

Improper Billing of Psychiatric Services

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

OAS; W-00-97-30021; A-06-98-00009

Patient Billing Records

In one State, we will review a sample of physicians' patient billing records to identify and obtain refunds for Medicare and Medicaid overpayments. Should we detect significant problems in this State, we will expand the review to include other geographical areas and other types of providers.

OAS; W-00-98-30030; A-03-98-00017, A-09-99-00000

MEDICAL EQUIPMENT AND SUPPLIES

Operations of Durable Medical Equipment Carriers

We will assess whether the establishment of durable medical equipment regional carriers has met its intended objectives. Starting October 1, 1993, HCFA began consolidating claim processing activities for durable medical equipment, prosthetics, orthotics, and

supplies into four regional carriers. The four carriers, replaced more than 30 local carriers which previously received and processed claims for these services. We will assess the effectiveness of these regional carriers with respect to medical guidelines, oversight of claim processing, and detection and referral of fraudulent activity.

OEI; 04-97-00330

Duplicate Billings for Medical Equipment and Supplies

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

OEI; 04-97-00460

Selected Providers

We will review selected providers to determine whether Medicare claims submitted by durable medical equipment providers are proper and in accordance with Medicare requirements. Prior OIG work, as well as additional analytical work, has detected a growth in expenditures and problems with services not rendered, upcoding, improper utilization, and medical necessity questions. Work will be performed in New York State and Puerto Rico.

OAS; W-00-98-30007; Various CINS

Hospice Part B Billings

We will determine the appropriateness of selected durable medical equipment Part B billings on behalf of hospice patients. Separate Part B payments for hospice beneficiaries are appropriate only for conditions unrelated to the patient's terminal illness. A recent nationwide review disclosed significant problems in Part A payments to hospitals and skilled nursing facilities for hospice patients; a similar situation appears to be occurring on the Part B side.

OAS; W-00-98-30015; A-02-98-00000

Medical Necessity of Oxygen

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

OEI; 03-96-00090

Orthotic Body Jackets

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

OEI; 04-97-00390

Licensing Requirements for Prescription Drug Suppliers

We will determine if entities that bill for providing drugs and similar medications to Medicare beneficiaries meet required licensing requirements. Effective December 1, 1996, HCFA issued a new policy requiring these entities to have pharmacy licenses.

Previously, suppliers could bill the Medicare program for providing drugs, even though they did not have pharmacy licenses in accordance with applicable State laws. Many suppliers had agreements with pharmacies to dispense the drugs, but the suppliers did the actual billing. The new policy was developed, in part, because of questionable practices encountered in South Florida.

OEI; 00-00-00000

END STAGE RENAL DISEASE

Clinical Laboratory Tests Provided to ESRD Beneficiaries

This review will identify inappropriate Medicare payments for clinical laboratory tests for end stage renal disease (ESRD) patients. Our survey disclosed that providers are either separately billing for laboratory tests that are included in the monthly composite rate or are providing laboratory tests that do not conform to professionally recognized standards.

OAS; W-00-98-30025; A-01-98-00000

Medical Appropriateness of Tests and Other Services

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

OEI; 00-00-00000

Bad Debts - Nationwide Chain

This review will determine whether home office costs and bad debts reported by a large nationwide chain of dialysis facilities during Calendar Years 1996 and 1997 are allowable and properly allocated in accordance with Medicare's reasonable cost principles and the *Provider Reimbursement Manual*. Under Medicare's composite rate reimbursement system, end stage renal disease (ESRD) facilities are reimbursed 100 percent of their allowable Medicare ESRD bad debts, up to their unreimbursed Medicare reasonable costs. However, if a facility's revenues exceed its costs, it would have no unrecovered cost and would not be eligible to receive payment for Medicare bad debts. Prior reviews have identified significant overpayments.

OAS; W-00-98-30025; A-01-98-00508

DRUG REIMBURSEMENT

Effect of Average Wholesale Price Discount on Medicare Prescription Drugs

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

OEI; 03-97-00291

Infusion Therapy Services

We will assess the impact of infusion therapy suppliers' charges on nursing home cost reports submitted to Medicare. Medicare costs associated with infusion therapy in skilled

nursing facilities increased by 46 percent from 1995 to 1996. In the first 6 months of 1997, Medicare paid over \$80 million for the therapy. Nursing facilities are required to purchase supplies and equipment at a reasonable cost (prudent buyer theory). If the suppliers' costs are unreasonable or if amounts billed by suppliers are not supported by the services they provide, nursing home claims will adversely affect the Medicare program.

OAS; W-00-98-30022; A-06-97-00086, A-06-98-00031, A-06-97-00053, A-06-97-00061, A-06-97-00062, A-06-97-00063

Medicare Nebulizer Drugs

We will continue reviews to determine the extent to which durable medical equipment suppliers and/or mail order pharmacies have either paid or received referral fees to fill Medicare nebulizer drug prescriptions. These reviews will lead us to revisit pricing and reimbursement methodologies used by HCFA for nebulizer drugs and make appropriate recommendations. Excessive reimbursement rates have created an environment that encourages payment of referral fees.

OAS; W-00-98-30022; A-06-98-various

OTHER MEDICARE SERVICES

Excess Payments for Ambulance Services

This review will examine Medicare Part B carriers' payment systems to determine if excess payments are being made for certain types of ambulance services. We recently completed a review of medical claims for ambulance services by one company and found that the carrier's system did not prevent excess payments for some ambulance transports. We plan to determine if similar situations are occurring at other carriers.

OAS; W-00-99-00021; A-03-99-00000

Comparison of Ambulance Reimbursement Policies

We will identify how different payers (e.g., fee-for-service providers, health maintenance organizations, and preferred provider organizations) reimburse ambulance suppliers for services. We will compare this information with Medicare reimbursement for the same services in similar geographic areas and use all data to project savings for the geographic areas. Our recent studies of Medicare ambulance services have raised concerns that Medicare allowances may be excessive.

OEI; 09-95-00411

Partial Hospitalization Services

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

OAS; W-00-98-30026; A-03-98-00000, A-04-98-02145; A-05-98-00000, A-07-98-01263

Medicare Reimbursement for Outpatient Psychotherapy

We will determine the medical necessity of a national sample of outpatient psychotherapy services paid by Medicare. Medicare reimbursement for the five most commonly reimbursed mental health codes for psychiatrists, clinical psychologists, and clinical social workers showed a 57 percent increase from \$353 million in 1991 to \$556 million in 1993. In 1996, Medicare-allowed charges for just code 90844 (45 to 50 minutes of psychotherapy) were almost \$500 million. This study is a follow-up to a recent OIG report on mental health services in nursing homes, which found a medically unnecessary service rate of 32 to 46 percent.

OEI; 00-00-00000

MEDICARE MANAGED CARE

General and Administrative Costs

This review will determine if the administrative costs allocated for Medicare beneficiaries enrolled in risk-based health maintenance organizations (HMO) are proper. General and administrative costs include costs associated with enrollment, marketing, membership costs, directors' salaries and fees, executive and staff administrative salaries, organizational costs, and other plan administrative costs. Inflated general and administrative costs could increase plan profits, in which case the plans would be required to return the excess to HCFA, lower Medicare enrollees' premiums, offer extra benefits to enrollees, or take a reduction in Medicare payments. A cap on these costs would require legislative action.

OAS; W-00-98-30012, A-01-98-00510, A-02-98-01004, A-03-98-00022, A-05-98-00049, A-06-98-00046, A-09-99-00000

Payments Based on Institutional Status

This series of reviews will determine if HCFA has made proper capitation payments to risk-based HMOs for beneficiaries classified as institutionalized. Risk-based HMOs are paid based on a prospectively determined capitation rate. However, a higher capitation rate is paid for beneficiaries classified as institutionalized. Preliminary findings indicate that HCFA's databases have not been updated for changes in beneficiary status. We will focus on both HCFA and HMO controls regarding beneficiary status.

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

Payments for End Stage Renal Disease Beneficiaries

This review will update past OIG work on the appropriateness of Medicare payments to risk-based HMOs for beneficiaries with end stage renal disease (ESRD). Risk-based HMOs are paid based on a prospectively determined capitation rate. That rate is enhanced for certain high-cost categories of beneficiaries, such as those with ESRD. Previous OIG work identified system problems that resulted in payments to HMOs for

beneficiaries no longer ESRD-eligible. Our current review will evaluate the effectiveness and timing of the system used to report beneficiaries' ESRD status.

OAS; W-00-98-30012; A-14-98-00211

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

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

OAS; W-00-98-30012; A-05-98-00000

Physician Incentive Plans in Managed Care Contracts

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

OEI; 00-00-00000

Duplicate Fee-for-Service Billings

This review will determine whether fiscal intermediaries and carriers improperly reimbursed Medicare providers for services provided to beneficiaries enrolled in risk-based managed care plans during calendar years 1995 through 1997. Medicare payments for beneficiaries enrolled in Medicare risk-based managed care plans are made directly to the managed care plans. The managed care plans are to arrange and pay for all necessary

medical services. The *Part A Fiscal Intermediary Manual* further instructs that Medicare contractors are not to duplicate payments for services the HMO has paid.

OAS; W-00-98-30012; A-07-97-01247

Investment Income Earned by Risk-Based HMOs

This review will determine if risk-based HMOs should be held accountable for investment income earned on Medicare funds. Since HCFA pays risk-based HMOs a predetermined rate for each Medicare beneficiary by the start of every month, the HMOs have an opportunity to earn investment income on Medicare funds until they are used to pay for services rendered during the month. Any investment income earned on Medicare funds is not factored into the HMOs' payment rates; this income also does not have to be used to increase services offered or reduce premiums charged to Medicare beneficiaries. We will estimate the investment income earned on Medicare funds and analyze the flow of this income to determine if HCFA needs to establish criteria on the application of investment income.

OAS; W-00-99-30012; A-02-99-00000

National Marketing Guidelines for Medicare Managed Care Plans

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

OEI; 03-98-00270

Assessing Managed Care Health Plan Data

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

OEI; 00-00-00000

Managed Care Additional Benefits

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

OEI; 00-00-00000

Enrollee Access to Emergency Services

We will determine if existing Federal protections for access to emergency treatment are adequate as the health care delivery system increasingly relies on managed care and gatekeeping mechanisms. The anti-dumping law, which applies to all Medicare-reimbursed hospitals, restricts the way in which a hospital may transfer or deny treatment to a person who comes to the emergency room. In addition, the health maintenance organization sanctions protect Medicare and Medicaid beneficiaries from health maintenance organizations' unreasonable refusal to provide needed care. Violation of either of these protections may result in sanctions, including penalties and program exclusion. We will examine whether the reach of these Federal enforcement authorities

adequately protects patients who need and seek emergency care but are prevented from receiving such care by managed care rules or hospital policies.

OEI; 09-98-00220

Services Provided After Disenrolling

This series of reviews will examine the services paid by Medicare as fee-for-service after beneficiaries disenroll from a risk-based managed care organization as an indicator of whether all needed services were provided. We will focus on HCFA's monitoring of the risk plans' quality assurance programs to ensure compliance with Federal requirements. We will also review the plans' incentive arrangements to ensure that they do not include any specific payment to be made directly or indirectly to a physician or physician group as an inducement to withhold, limit, or reduce services to a specific enrollee. Under the Medicare risk-based program, managed care plans must assume responsibility for providing all Medicare-covered services in return for a predetermined capitated payment and must provide the same services as traditional Medicare fee-for-service. Beneficiaries may not be involuntarily disenrolled from the plan for medical reasons.

OAS; W-00-98-30012; A-07-98-01256

MEDICAID MANAGED CARE

States Use of External Quality Review Organizations

We will assess States' use of contractors to monitor the quality of care delivered by Medicaid managed care programs and identify lessons learned. The Balanced Budget Act of 1997 grants States increased authority to establish Medicaid managed care programs without waivers of Federal law. In addition, HCFA and the States must establish a method to identify entities that are qualified to perform external independent quality reviews and to contract with an independent quality review organization to develop the protocols to be used in conducting these reviews. The HCFA indicated that OIG's work would help identify qualified entities and effective review techniques.

OEI; 01-98-00210

Impact on Mental Health Services

We will provide a preliminary description of the impact of managed care on the delivery of mental health services to the Medicaid population. State Medicaid programs are increasingly adopting managed care approaches. We will gather information on how the managed care approach has affected the services available to adults with serious mental illnesses and children with serious emotional disturbances, the mental health delivery systems, and standards and performance measures.

OEI; 04-97-00340

Fraud and Abuse in Medicaid Managed Care

We will describe and assess the manner in which States detect, review, and refer for investigation Medicaid fraud and abuse cases in State-wide managed care programs. Many States are moving toward managed care to provide cost-effective medical care while enhancing access to quality care and preventing unnecessary medical treatment. Our review will provide information on mechanisms used by Federal and State Governments to detect, refer, and investigate fraud and abuse cases.

OEI; 07-96-00250

MEDICAID - CHILDREN S HEALTH INSURANCE PROGRAM

Best Practices in Medicaid and Children s Health Insurance Program Outreach

We will examine the strategies States use to inform eligible families about the Children's Health Insurance Program. We will also examine whether States with historically low take-up rates have enhanced their outreach and enrollment efforts for the new program. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. States are allowed to use up to 10 percent of their Federal Children's Health Insurance Program allotment for administrative costs, outreach, and services other than the standard benefit package for eligible children. Our

review will include a determination of the best practices used by a sample of States to promote cooperative outreach projects in both Medicaid and the Children's Health Insurance Program.

OEI; 00-00-00000

Special Needs Children

We will examine State strategies for providing insurance and access to appropriate health care for children with special health care needs. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. Approximately 10 million children have some type of chronic conditions, and about 4 million of these children are limited in school or play activities. We will document States' experiences and innovative approaches, including strategic planning activities, benefit packages, and service delivery systems.

OEI; 00-00-00000

Involvement of Federally Funded and Qualified Health Centers

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

OEI; 00-00-00000

States' Application Procedures

We will review selected States' application procedures under the Children's Health Insurance Program. The Balanced Budget Act of 1997 authorized \$24 billion over 5 years for expanded health insurance coverage for children. The law allows States to

expand Medicaid eligibility to new groups of children or to establish a new program to aid children who are ineligible for Medicaid or are uninsured. We will determine effective models for application and enrollment of children.

OEI; 00-00-00000

MEDICAID REIMBURSEMENT

Coordination of Care for Dual Eligibles

We will assess the coordination of care and identify issues related to beneficiaries entitled to both Medicare and Medicaid. Approximately 6 million Medicare beneficiaries have some level of supplemental care coverage under the Medicaid program and are known as “dual eligibles.” We will determine if these beneficiaries' care is monitored appropriately to ensure access to and use of services in both the managed care and fee-for-service settings. We will also look at innovative techniques used to coordinate care for dual eligibles.

OEI; 00-00-00000

Federal Reimbursement for Psychiatric Care

This series of reviews will determine whether one State is properly claiming Federal Medicaid reimbursement for services provided to psychiatric patients in different settings, including those released to acute care facilities or living in community residences, as well as the propriety of ancillary medical services for certain aged patients living in psychiatric hospitals. Previous work in this area disclosed the potential for improper charges. We will initially follow up on our earlier review related to patients temporarily released to acute care facilities.

OAS; W-00-98-30013; A-02-98-00000

Follow-Up on Medicaid Clinical Labs

This follow-up review at a State Medicaid agency will determine whether prior audit recommendations were implemented, i.e., whether (1) recommended edits are in place to

detect and prevent payments for unbundled tests and duplicate tests, (2) Medicaid laboratory fees do not exceed Medicare laboratory fees, and (3) overpayments have been recovered from those providers with the largest total potential overpayments.

OAS; W-00-98-30027; A-05-98-00000

MEDICARE CONTRACTOR OPERATIONS

HCFA Oversight of Medicare Contractors

We will evaluate HCFA's Contractor Performance Evaluation program which HCFA uses to monitor contractor performance. Beginning in 1993, HCFA revised this monitoring program by replacing numerical scoring with narrative reports. An August 1995 OIG report provided a preliminary assessment of the changes. This follow-up study will take a new look at the revised monitoring system now that it has been in place longer.

OEI; 00-00-00000

Comparison of Payment Safeguard Activities

We will compare Medicare and Medicaid payment safeguard activities with those undertaken by other payers to determine best practices and promising approaches that could be adapted for HCFA programs. As national health care expenditures rise and public awareness of health care fraud increases, health care payers will continue to develop payment safeguards to control costs. These techniques may include prepayment screens, targeted medical review protocols, and establishment of special investigative units. A survey and comparison of payment safeguard activities will further the OIG's responsibility under the Health Insurance Portability and Accountability Act to coordinate national health care fraud control activities, in addition to providing recommendations for Medicare and Medicaid fraud control.

OEI; 00-00-00000

Factors in Identifying Potentially Fraudulent Providers

We will evaluate the various methods and approaches contractors use to identify potentially fraudulent providers and assess HCFA oversight in this area. Building on our previous work in evaluating contractor payment safeguard activities, we will focus on proactive techniques, such as payment edits and data analysis, and determine the factors present at the contractor level that contribute to the effectiveness of these techniques. We will make recommendations for HCFA to incorporate successful methods into its new anti-fraud contracting initiatives.

OEI; 00-00-00000

Excessive Numbers of Billings

We will determine the extent of inappropriate or unnecessary services for beneficiaries who receive a large number of medical services in a short time period. Using a computer edit, a Medicare carrier in one State identified numerous beneficiaries whose sheer number of Part B claims over a set period of time was considered "medically impossible." Through a medical review, we will determine whether this type of edit is effective and whether it should be used on a national basis. In addition, we will survey beneficiaries regarding the services they have received.

OEI; 07-97-00080

Mutually Exclusive Medical Procedures

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

OAS; W-00-98-30003; A-01-98-00507

Suspension of Payments to Medicare Providers

We will evaluate contractor suspensions of payments to providers. The Medicare program may suspend payments under certain circumstances, such as to recover overpayments or to prevent program losses from fraud and abuse. We will review suspension actions under recent regulatory changes and determine if suspension of payment is an effective tool for averting overpayments. We will also assess whether contractors consistently adhere to program requirements regarding suspension of payments.

OEI; 00-00-00000

Identifying and Collecting Overpayments

We will assess the effectiveness of contractor activities to identify and collect Medicare overpayments. Providers are often paid more than the appropriate amount for services they bill. Although contractors use a variety of methods to identify, quantify, and recover overpaid trust fund amounts, some types of overpayments may never be identified. Further, once overpayments are identified, contractor efforts and success in recovering them vary widely. We will examine the methods of identifying overpayments with attention to overpayments that may not be captured through these methods. We will also describe the approaches and results of contractor efforts in overpayment collections.

OEI; 00-00-00000

Management Service Organizations

We will determine whether the advent of management service organizations in health care delivery systems has created vulnerabilities for Medicare. These organizations provide various services under contract to hospitals and physician groups, including management of contracts, information systems, credentialing, and financial transactions. The increasing use of these organizations may call for particular payment safeguards, such as enhanced protection of health insurance claim numbers and monitoring of billing patterns and practices for problems related to fraud and abuse. We will examine the

extent of vulnerabilities and assess the effectiveness of Medicare contractors' existing payment safeguard activities.

OEI; 00-00-00000

Contractor Medical Review

We will assess how contractors use medical review to identify potential problem areas. Medicare carriers use this approach to conduct many of their postpayment reviews. Since physicians account for the majority of payments under Medicare Part B, much of the carriers' activity is expected to focus on this group. This study, following up on prior studies on Medicaid fraud control units and carrier fraud units, will assess how carriers perform focused medical reviews, what corrective actions carriers pursue, and what educational interventions and/or referrals for fraud investigation result from these activities.

OEI; 06-98-00160

Medicare Provider Numbers and Unique Physician Identification Numbers

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

OEI; 00-00-00000

Provider Billing Numbers Issued to Resident Physicians

We will assess the extent of improper Medicare billings resulting from a control problem we noted at one carrier relative to issuing provider billing numbers to resident physicians at teaching hospitals. In general, Medicare regulations do not allow residents to bill Medicare for their services. The exception is if the billable services are related to “moonlighting” activities unrelated to the resident’s training program. We noted that one hospital requested and received over 40 billing numbers for its residents over a 6-year period. The residents were not involved in “moonlighting” activities, and the hospital used the numbers to improperly bill Medicare for services provided by the residents. We will determine the extent of this condition at the carrier in this State and at other carriers.

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

Medicare Administrative Appeals

We will identify potential improvements in the appeals process for Medicare providers, particularly those related to Part B claims and claims under the Part A home health benefit. The increasing rate of provider appeals is raising Medicare administrative costs and is contributing to other problems in Medicare claim payments. We will examine the appeals process, particularly from the perspective of the Medicare contractors and the administrative law judges.

OEI; 04-97-00160

Preaward Review of Medicare Integrity Program Contract Proposals

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

OAS; W-00-99-30006; Various CINs

Preaward Review of Medicare Peer Review Organizations

Throughout the fiscal year, we will review approximately 50 cost proposals submitted by the Medicare peer review organizations (PROs) under HCFA's sixth Statement of Work. Our reports to the HCFA contracting officer will contain recommendations on the propriety of the proposed costs. In the past, our reports have assisted the contracting officer in negotiating contract award amounts that were substantially lower than proposed.

*OAS; W-00-98-30006; Various CINs
Expected Issue Date: FYs 1999 and 2000*

Audit of Peer Review Organization Incurred Costs

We will audit the allowability, allocability, and reasonableness of costs incurred by approximately 17 PROs whose contracts under HCFA's fifth Statement of Work will expire at the end of the second fiscal quarter. Our reports will provide HCFA's contracting officer with recommendations on the amount, if any, of the PROs' claimed costs that should be disallowed.

*OAS; W-00-98-30004; Various CINs
Expected Issue Date: FYs 1999 and 2000*

Claim Processing Contractors Administrative Costs

This series of reviews requested by HCFA will address costs claimed by various contractors for processing Medicare claims. Special attention will be given to costs claimed by terminated contractors. In the past, these reviews have been beneficial since HCFA has used the results to deny claims for millions of dollars of unallowable costs. We will coordinate the selection of the contractors with HCFA staff (using results of their completed risk assessment review guide) and determine whether the costs claimed were reasonable and allowable under the terms of the contracts.

OAS; W-00-98-30004; Various CINs

Unfunded Pensions

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

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

Pension Segmentation/Charges

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

OAS; W-00-98-30005; Various CINs

Pension Termination

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

OAS; W-00-98-30005; A-07-98-02522, A-07-98-00000

GENERAL ADMINISTRATION

Year 2000 Computer Renovation Plans

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

OAS; W-00-98-40007; A-14-98-02561

Expected Issue Date: Periodic Reporting FYs 1999 and 2000

OIG-Excluded Persons

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

OEI; 00-00-00000

Medicare Secondary Payer

This study will determine the extent to which Medicare inappropriately pays when beneficiaries have other insurance which is required to pay primary. By statute, Medicare payments for such beneficiaries are required to be secondary to certain types of private insurance coverage. A 1991 OIG report found that inappropriate Medicare secondary payer payments totaled more than \$637 million in 1988. Since that time, a

number of new initiatives have been implemented to prevent inappropriate payments. This study will help assess the effectiveness of these initiatives.

OEI; 07-98-00180

Employer Insurance Replies

In the past, we reported that Medicare often made overpayments for beneficiaries who had some form of private (often employer-sponsored) health insurance. Our earlier report recommended that HCFA take action against employers that failed to provide private insurance information for these dually eligible beneficiaries. In this follow-up review, we will evaluate the effectiveness of HCFA's corrective actions.

OAS; W-00-98-30003; A-02-98-01036

Physician Referrals to Self-Owned Laboratory Services

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

OEI; 09-97-00250

Medicare Part B Billings by State-Owned Facilities

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

OAS; W-00-98-30030; A-09-98-00072

Organ Transplant Costs

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

OAS; W-00-98-30030; A-04-98-00000

Joint Work with Other Federal and State Agencies

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

OAS; W-00-99-30001; Various CINs

INVESTIGATIONS

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

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

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

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

Medicare Part A

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

Medicare Part B

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

Medicare Part C

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

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

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

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

Medicaid

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

Pneumonia DRG Upcoding Project

This cooperative effort with the Department of Justice focuses on information that hospitals have upcoded the DRG for pneumonia claims from viral to bacterial pneumonia.

By doing this, the hospitals obtained almost \$2,500 extra per claim in reimbursement. The OIG is looking at both civil and criminal implications.

LEGAL COUNSEL

In addition to providing day-to-day internal legal advice and representation to the OIG, the Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of all major health care fraud cases, including the imposition of exclusions and civil monetary penalties and assessments. The Office provides administrative litigation services required by OIG, such as patient dumping cases and administrative exclusion cases. In addition, OCIG issues special fraud alerts and advisory opinions regarding the application of OIG's sanction statutes and is responsible for the development of OIG regulations, including new safe harbor regulations under the anti-kickback statute. Work planned in FY 1999 includes:

Compliance Program Guidance

We will continue to issue compliance program guidance to assist the health care industry in establishing voluntary corporate compliance programs and in developing effective internal controls that promote adherence to applicable Federal statutes, regulations, and the program requirements of Federal health care plans. We plan to issue program guidance documents during the first half of FY 1999 pertaining to independent third party billing companies, coordinated care plans in the Medicare + Choice program, and durable medical equipment companies. The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse, and waste in Federal health care plans, while at the same time furthering the health care industry's fundamental mission to provide quality care to patients.

Expected Completion Date: Ongoing

Corporate Integrity Agreements

We will continue to monitor providers' compliance with the terms of over 250 corporate integrity agreements into which they have entered in conjunction with the settlement of fraud and abuse allegations. Included in this monitoring process will be the establishment of a tracking system to determine the amount of money returned to the

Medicare Trust Fund as a result of a provider's having established certain mechanisms, including auditing and reporting, required by the OIG under these corporate integrity agreements.

Expected Completion Date: Ongoing

Advisory Opinions and Fraud Alerts

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

Expected Completion Date: Ongoing

Anti-Kickback Safe Harbors

We will evaluate comments from the public in response to OIG's solicitation of comments on the existing and additional proposals for safe harbor exemptions from the anti-kickback statute and, where appropriate, develop proposed regulations for additional safe harbors.

Patient Anti-Dumping Statute Enforcement

We expect to increase the number of patient anti-dumping cases analyzed, negotiated, and litigated, with the resolution of approximately 50 such cases in FY 1999. In addition, we plan on continuing our efforts to enhance awareness of the statute's requirements and increase the referral of possible violations through an outreach program aimed at State survey agencies, State peer review organizations, and hospital personnel. In addition, we anticipate publishing guidance regarding identified problem areas under the statute, such as with respect to a hospital's obligations to provide emergency care to managed care enrollees.

Expected Completion Date: Ongoing

Program Exclusions

In coordination with the Office of Investigations, we anticipate increasing the number of program exclusions imposed by the OIG. In addition, we will review public comments and anticipate finalizing regulations which will implement the requirements of the Balanced Budget Act of 1997 with respect to program exclusions.

Expected Completion Date: Ongoing

Civil Monetary Penalties

We will be finalizing regulations which will implement new and revised civil monetary penalty (CMP) authorities delegated to the OIG, which were included in the Health Insurance Portability and Accountability Act of 1996. We will also be promulgating regulations for implementing the CMP authorities applicable to Medicare + Choice organizations, codified at section 1857 of the Social Security Act. In addition, we will be continuing our CMP enforcement activities and specifically focusing on cases involving improper conduct by managed care organizations.

Expected Completion Date: Ongoing

Department of Health and Human Services

Office of Inspector General



Public Health Service Agencies

Table of Contents

CENTERS FOR DISEASE CONTROL AND PREVENTION

Control and Oversight of Grantee Operations	1
Collaboration Between Public Health Agencies and Managed Care Organizations	1

FOOD AND DRUG ADMINISTRATION

Food Safety Inspections	2
Biennial Inspection Requirement	2
FDA Warning Letters	2
Arkansas Regional Laboratory Costs	3
Drug Adverse Event Reporting System	3
Blood Safety Consent Decrees	3
Sanctions of Clinical Investigators	4

HEALTH RESOURCES AND SERVICES ADMINISTRATION

State Licensure Boards and Discipline of Physicians	4
Managed Care Organizations' Reporting to the National Practitioner Data Bank	4
Training Programs in the Maternal and Child Health Bureau	5
Ryan White Comprehensive AIDS Resources Act	5
New York's Use of CARE Act Funding	6
Referral of Hospital Deaths to Organ Procurement Organizations	6
Grantee Satisfaction with HRSA Technical Assistance and Monitoring	6

Primary Care Effectiveness Reviews and Community Health Centers	7
HRSA's Management of the National Health Service Corps	
Scholarship and Loan Repayment Program	7
Cash Management Practices at Institutions Participating in the Health	
Professions and Nursing Student Loan Programs	8
Hemophilia Treatment Centers' Purchase of Drugs at Discount Prices	8

INDIAN HEALTH SERVICE

Impact of Self-Governance on IHS Services	8
Use of Self-Governance Funds by the Cherokee Nation of Oklahoma	9
Tribal Self-Governance Compact Award Process	9
Medicare Pricing for Contract Health Services Program: Outpatient Services ..	9

NATIONAL INSTITUTES OF HEALTH

Superfund Financial Activities for Fiscal Year 1998	10
Compliance with Federal Depository Library Program	10
Reporting Under the Bayh-Dole Act	10

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

ADMINISTRATION

State Systems Development Program	11
Substance Abuse Treatment Needs of Welfare Recipients	11

PHS AGENCIES-WIDE ACTIVITIES

Year 2000 Computer Renovation Plans	12
Disclosure Statements Filed by Colleges and Universities	12
Recipient Capability Audits	13
Reimbursable Audits	13
Indirect Cost Audits	13
Follow-Up on Nonfederal Audits	13

INVESTIGATIONS

Referrals by Office of Research Integrity	14
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CENTERS FOR DISEASE CONTROL AND PREVENTION

Control and Oversight of Grantee Operations

We will determine whether CDC's internal and management controls are adequate to ensure that grantees accomplish program objectives effectively and efficiently. The CDC awards more than \$1.2 billion annually—more than half of its total budget authority—in grants to State, local, and territorial health departments; colleges and universities; nonprofit organizations; and other entities. Activities funded through these grants are essential to the accomplishment of CDC's mission in childhood immunization, disease prevention, AIDS education, and other programs. Building upon findings previously identified in nonfederal audits and in OIG audits (including those of CDC's financial statements), we will assess preaward and postaward policies, procedures, and practices related to the control and oversight of grantee operations.

OAS; W-00-99-50003; A-04-99-00000

Collaboration Between Public Health Agencies and Managed Care Organizations

We will provide an overview of the existing collaboration between managed care organizations and State and local government public health agencies. Funded through several Federal public health programs (including CDC), State and local agencies are responsible for providing population-based public health services and medical care to the uninsured, in addition to conducting surveillance and data collection to maintain the Nation's public health infrastructure. Before the growth of Medicaid managed care, they were also a major supplier of medical care to Medicaid clients. Now, Medicaid clients in most States receive care through managed care arrangements, and public health agencies no longer receive Medicaid reimbursement. Previously, many of the agencies had used this revenue to defray the cost of providing infrastructure and population-based services, as well as the cost of providing uncompensated care. As a result of this change, many public health agencies have begun to work collaboratively with managed care organizations to ensure that population-based services continue to be provided.

OEI; 01-98-00170

FOOD AND DRUG ADMINISTRATION

Food Safety Inspections

We will assess the progress made by the Food and Drug Administration in implementing the recommendations made in the 1991 OIG report on low-risk inspections and food safety. A number of recent outbreaks have brought national attention to the dangers of food-borne diseases. Several of these outbreaks have involved products used by food firms historically considered low-risk by the FDA. Concurrently, through the President's Food Safety Initiative, the Administration and the Department are focusing on food safety issues.

OEI; 00-00-00000

Biennial Inspection Requirement

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

OAS; W-00-99-50004; A-15-99-00000

FDA Warning Letters

We will evaluate FDA's process and effects of issuing warning letters for violations identified during inspections of drug and device manufacturing practices. The FDA issues warning letters to notify regulated entities about violations of a given regulation or policy under the agency's authority. The warning letter represents the first-line and most readily available of FDA's regulatory actions that may be taken against a regulated company not in compliance.

OEI; 09-97-00380

Arkansas Regional Laboratory Costs

As part of its plans to regionalize its laboratory structure, FDA is currently constructing a new, multidisciplinary regulatory laboratory facility in Arkansas for use by the Office of Regulatory Affairs. Our review will examine the reasons for cost increases of almost 40 percent for the Arkansas Regional Laboratory facility project. The cost to complete the laboratory is now estimated to be \$37.9 million. This assignment is being undertaken as part of a congressional request.

OAS; W-00-98-50004; A-15-98-50002

Drug Adverse Event Reporting System

We will assess FDA's system for obtaining, analyzing, and responding to adverse drug event reports. The FDA conducts postmarket surveillance on drugs to obtain information on rare, latent, or long-term effects not identified during premarket testing. Because the receipt of these reports is critical to FDA's ability to monitor the safety and effectiveness of marketed drugs, FDA is developing the Adverse Event Reporting System to compile and analyze more than 250,000 individual reports received each year. Results of our assessment will be periodically provided as the new reporting system is being developed.

OAS; W-00-98-50004; A-15-98-50001

Blood Safety Consent Decrees

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

OAS; W-00-99-50004; A-03-99-00000

Sanctions of Clinical Investigators

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

OEI; 00-00-00000

HEALTH RESOURCES AND SERVICES ADMINISTRATION

State Licensure Boards and Discipline of Physicians

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

OEI; 00-00-00000

Managed Care Organizations' Reporting to the National Practitioner Data Bank

We will evaluate reporting to the National Practitioner Data Bank by managed care organizations. A managed care organization gives physicians authority to treat its

patients through a contractual relationship that makes the physician eligible for a panel. When such an organization decides to terminate or restrict the physician's membership on the panel, this adverse action, if taken because of competency or substandard care problems, must be reported to the data bank. Specifically, any professional review action that adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days must be reported. Because of the national increase in the number of managed care organizations and the low level of reporting to the data bank, HRSA requested this review.

OEI; 00-00-00000

Training Programs in the Maternal and Child Health Bureau

We will evaluate training programs funded as “Special Projects of Regional and National Significance” under the Maternal and Child Health Program. The statute provides that approximately 15 percent of funds appropriated for the Maternal and Child Health Block Grant be set aside for these special projects. Funding for training has generally been a major portion of the set-aside. According to HRSA budget data, \$37 million of the \$100 million set-aside in FY 1995 was used to fund training grants or projects. The training program has never been evaluated. We will address several issues, including how grants are awarded, what is being done to establish outcome data, the extent training is being targeted to meet demand, and the impact the grants have had on improving Maternal and Child Health services.

OEI; 04-98-00090

Ryan White Comprehensive AIDS Resources Act

We will review the progress made by HRSA and grantees in implementing past OIG recommendations. According to the Department’s FY 1998 budget, HHS is requesting over \$1 billion to fund the Ryan White Program for the next fiscal year, a 42 percent increase from FY 1994. In 1995, OIG issued a series of reports on Ryan White which included recommendations that the program place more emphasis on outcome evaluations at both the local and systems levels. The size of the program has increased significantly since these reports, making a follow-up study timely.

OEI; 00-00-00000

New York's Use of CARE Act Funding

We will assess New York State's administration and use of Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds relative to the State's reimbursement pools for uninsured costs. The State administers three programs for HIV uninsured care: AIDS Drug Assistance (ADAP), ADAP Plus (Primary Care Services), and HIV Homecare Services. The CARE Act represents the largest authorization of Federal funds specifically designed to provide health and social services for people infected with HIV/AIDS. As part of this review, we will determine whether the State has systems and procedures in place to ensure applicants' eligibility for enrollment in the uninsured program (i.e., medical and income criteria) and the appropriateness and accuracy of payments made to providers. In addition, we will review the reasonableness, allocability, and allowability of the administrative costs claimed by the State for operating the programs.

OAS; W-00-99-50005; A-02-99-00000

Referral of Hospital Deaths to Organ Procurement Organizations

We will assess the implementation and impact on organ procurement organizations of State laws requiring hospitals to refer all deaths for consideration as organ donations. More than 55,000 Americans are waiting for life-saving organ transplants, yet only about 20,000 received transplants last year. Eight States have enacted laws requiring referrals as a way to address the shortage. Data from one State show that such a law has led to a 40 percent increase in donors. The Health Care Financing Administration has proposed such an approach in its draft Medicare "conditions of participation" for hospitals.

OEI; 00-00-00000

Grantee Satisfaction with HRSA Technical Assistance and Monitoring

We will survey community health centers to obtain feedback on technical assistance and monitoring activities provided by HRSA. These centers serve a population that includes Medicaid, Medicare, and the uninsured. Total HRSA funding to these centers amounts

to about \$700 million annually. This study was requested by the Bureau of Primary Health Care.

OEI; 00-00-00000

Primary Care Effectiveness Reviews and Community Health Centers

We will evaluate HRSA's oversight of community health centers. The HRSA uses the Primary Care Effectiveness Review, a multipart protocol, to monitor centers. The review covers a community health center's finances, administration, governance, and clinical or quality of care issues. We will focus on the use of the protocol in conducting quality of care reviews.

OEI; 00-00-00000

HRSA's Management of the National Health Service Corps Scholarship and Loan Repayment Program

We will review the National Health Service Corps' process for awarding scholarships and repaying educational loans. Under Section 338 of the Public Health Service Act, the Corps awards scholarships and loan repayments to health profession students and to fully trained health professionals who contractually agree to provide primary health services in health profession shortage areas. Expenditures for these activities amounted to over \$590 million for the 5-year period ending in fiscal year 1997, and receivables totaled \$124 million as of June 30, 1997. We will assess the effectiveness of the Corps' monitoring of recipients to ensure timely fulfillment of their contract obligations or timely recognition and collection of receivables in the event the recipients breach their contract obligations.

OAS; W-00-98-50005; A-15-98-00037

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

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

OAS; W-00-98-50005; Various CINs

Hemophilia Treatment Centers' Purchase of Drugs at Discount Prices

At HRSA's request, we will examine hemophilia treatment centers' efforts to purchase an anti-hemophilic factor drug at 340B discounted prices. Section 340B of the Public Health Service Act provides that drug manufacturers that sell to eligible PHS entities must not charge more for covered drugs than the average manufacturers' price decreased by a rebate percentage. Hemophilia treatment centers are funded by HRSA and qualify for discount pricing under the law as eligible PHS entities; one of the drugs covered under Section 340B is the anti-hemophilic factor drug. Our review will also determine why some centers are not participating in the 340B program.

OAS; W-00-98-50005; A-01-98-01505

INDIAN HEALTH SERVICE

Impact of Self-Governance on IHS Services

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

that needed health care services are provided with compacting funds and (2) the impact on nearby IHS facilities should compacting tribes be unable to adequately or fully meet the health care needs of their members.

OAS; W-00-99-50006; A-06-99-00000

Use of Self-Governance Funds by the Cherokee Nation of Oklahoma

In response to a congressional request, we will review the use of Federal health care funds awarded to the Cherokee Nation of Oklahoma through the Indian Self-Determination and Education Assistance Act of 1975, as amended. This act allows tribes to operate their own health care programs with funds provided by IHS through self-governance compacts and annual funding agreements. Specifically, we will assess whether Federal funds have been spent in accordance with applicable laws, regulations, and policies.

OAS; W-00-98-50006; A-06-98-00060

Tribal Self-Governance Compact Award Process

We will examine the process used by IHS to award compacts to tribes under the Tribal Self-Governance Demonstration Project. With nearly 20 percent of the IHS budget provided to Indian tribes through the compact mechanism—39 compacts totaling \$410 million in FY 1998 and slated to increase—the agency needs to ensure that it has implemented the demonstration project as the Congress intended and has effectively used the authorities available to it. Our review will focus on project compliance with key tenets of the legislative mandate and the use of project management and evaluation tools in support of agency oversight responsibilities.

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

Medicare Pricing for Contract Health Services Program: Outpatient Services

We will analyze the potential cost savings to the IHS Contract Health Services Program if legislation is enacted that requires outpatient health service providers to accept rates similar to Medicare's. This program pays outpatient providers \$44 million annually to

care for eligible beneficiaries living outside IHS' direct care boundaries or for those requiring specialty care. These health services are currently purchased using negotiated contracts, which generally do not reflect competitive rates.

OAS; W-00-97-50006; A-15-97-50001

NATIONAL INSTITUTES OF HEALTH

Superfund Financial Activities for Fiscal Year 1998

As required by Superfund legislation, we will conduct this annual financial audit of the National Institute of Environmental Health Sciences' payments, obligations, reimbursements, and other uses of the Superfund. The Institute's Superfund activities, carried out by its own staff and through cooperative agreements, include training people engaged in hazardous waste activities and studying the effects of exposure to specific chemicals. During FY 1997, agency obligations and disbursements of Superfund resources amounted to \$54 million and \$60.4 million, respectively.

OAS; W-00-99-50025; A-04-99-00000

Compliance with Federal Depository Library Program

We will review NIH's commercial printing program to determine whether copies of publications are being provided to the Government Printing Office for distribution to depository libraries and foreign governments, where applicable. The Depository Library Program generally requires Government publications to be made available to depository libraries (usually located in existing public or academic libraries) through the Superintendent of Documents. The Congressional Joint Commission on Printing has expressed interest in this issue.

OAS; W-00-97-50025; A-15-98-80001

Reporting Under the Bayh-Dole Act

Through two reviews, we will evaluate NIH's procedures for ensuring that grantees disclose new inventions developed with NIH grant funds. Our first review will follow up on weaknesses identified several years ago with procedures for monitoring

compliance with reporting requirements of the Bayh-Dole Act at the Scripps Research Institute. We will also examine the accuracy and completeness of invention reporting by several other major research institutions, and we will assess NIH's system for ensuring that grantees make timely election regarding title of inventions, acknowledge NIH support in their patent applications, and provide NIH with a nonexclusive paid-up license to use the invention and obtain it without a royalty fee. Our second review will look at NIH's procedures for ensuring that recipients of Small Business Innovation Research program grants comply with Bayh-Dole Act invention reporting requirements regarding commercialization activities.

OAS; W-00-98-50025; A-15-98-00030, A-15-98-00039

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

State Systems Development Program

At SAMHSA's request, we will determine the impact of the agency's technical assistance to States under the State Systems Development Program. This program, which is administered by SAMHSA's Center for Substance Abuse Treatment, evaluates State treatment programs through "technical reviews" conducted by a private company under contract with the Center. Results are reported to the States. Technical assistance plans are developed as a result of these reports, and technical assistance is subsequently provided to States. States are reviewed every 3 years.

OEI; 00-00-00000

Substance Abuse Treatment Needs of Welfare Recipients

We will examine the strategies States use to address the substance abuse treatment needs of welfare recipients. States' assessments of the employability of these recipients may indicate the need for appropriate substance abuse treatment. While welfare reform legislation provided additional funding for treatment programs, this funding is unlikely to meet the increased demand expected as recipients are referred to treatment programs to

ultimately become employable. We will attempt to find promising approaches for service delivery that respond to treatment needs within resource constraints.

OEI; 00-00-00000

PHS AGENCIES-WIDE ACTIVITIES

Year 2000 Computer Renovation Plans

We will evaluate the efforts of the PHS operating divisions, as well as those of the Program Support Center, to meet Year 2000 computer renovation and validation goals. The Federal Government's Year 2000 project strategy regarding computer systems places emphasis on ensuring that agencies' mission-critical systems are Year 2000 compliant well before December 31, 1999, to avoid widespread system failures. As of May 1998, the Department reported to OMB that the PHS agencies had 127 mission-critical systems and that the Program Support Center had 8. This review is part of our Departmentwide Year 2000 compliance review.

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

Expected Issue Date: Periodic Reporting FYs 1999 and 2000

Disclosure Statements Filed by Colleges and Universities

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

OAS; W-00-98-50007; Various CINs

Recipient Capability Audits

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

OAS; W-00-99-50013; Various CINs

Reimbursable Audits

We will conduct a series of audits in response to OMB Circular A-21, which assigns audit cognizance for approximately 95 percent of the Nation's nearly 3,000 colleges and universities to the Inspector General of HHS. Audit cognizance requires that we perform audits at these schools, including those requested by other Federal agencies. Our audits may include activities related to the review of disclosure statements filed by universities in conjunction with the cost accounting standards recently incorporated in Circular A-21.

OAS; W-00-99-50012; Various CINs

Indirect Cost Audits

We will provide assistance, as requested, to the Department's Division of Cost Allocation on specific indirect cost issues at selected institutions. In previous years, we have reviewed such issues as library allocations, medical liability insurance, internal service funds, fringe benefit rates, and space allocation. These assist audits have helped to substantially reduce indirect cost rates at the institutions reviewed.

OAS; W-00-99-50010; Various CINs

Follow-Up on Nonfederal Audits

These reviews will determine whether auditees have implemented the recommendations in prior nonfederal audit reports to correct reported findings. The OIG's National

External Audit Review group has identified certain prior audits by nonfederal auditors as having circumstances that need further investigation.

OAS; W-00-99-50019; Various CINs

INVESTIGATIONS

Referrals by Office of Research Integrity

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

Department of Health and Human Services

Office of Inspector General



Administration for Children and Families Projects

Table of Contents

WELFARE REFORM

Measurement and Reliability of Outcome Data	1
State Assessments of Welfare Recipients' Skills	1
Education and Training	1
Maintenance of Effort	2
Administrative Cost Adjustments	2
Surplus Welfare Funds	2
Two-Parent Participation Rate	3
Implementation of Recipient Sanction Policies	3
Privatization and Welfare Reform	3
Welfare Recipient Perspectives	4
State Fraud and Abuse Activities	4

CHILD CARE

Quality of Care	4
Technical Assistance Contracts for Quality Child Care	5
Enforcement of State Child Care Health and Safety Standards	5
Use of Tribal Child Care Funds - An Early Alert	5
Head Start and Child Care Collaboration	6

CHILD PROTECTIVE SERVICES

Service Effectiveness	6
Emergency Shelters	6

Interstate Compact on the Placement of Children	7
Coordination of Child Welfare Efforts	7

CHILD SUPPORT

Collection Methods	8
Improving Interstate Case Collections	8
Earnings of Noncustodial Parents	9
Paternity Establishment	9
Welfare Recipient Cooperation	9
Review and Adjustment of Child Support Orders	10
Welfare and Child Support Agency Coordination	10
Employer Compliance with New Hire Directories	10
Medical Insurance Coverage: Detection and Coordination with Medicaid	11
Child Support Annual Report: A Customer Survey	11

INVESTIGATIONS

Child Support Enforcement Task Force Model	11
--	----

FOSTER CARE

Child Abuse in Foster Care Settings	12
State Oversight of Foster Care Residential Facilities	12
Foster Family Operations	13
Foster Care Group Homes	13
Independent Living Program	13
Foster Care Rates	13
Reimbursement for Residential Foster Care	14
Level of Care: Therapeutic Foster Care Per Diem Rates	14
Cost Shifting of Juvenile Justice Costs	15
Foster Care Claims Filed by States	15
Barriers to Freeing Children for Adoption: Follow-up Study	15
Adoption and Foster Care Analysis and Reporting System	16

HEAD START

Health and Safety Standards	16
Family and Community Partnerships	16
Technical Assistance to States	17

OTHER ISSUES

Year 2000 Computer Renovation Plans 17
Abuse of Disabled Children 17
State Developmental Disabilities Councils 18
Management and Performance of OCS Discretionary Grants 18
Emergency Assistance Retroactive Claims 18
Statewide Automated Child Welfare Information Systems 19

WELFARE REFORM

Measurement and Reliability of Outcome Data

We will examine how States plan to measure the outcomes experienced by recipients under the Temporary Assistance for Needy Families (TANF) block grant, in concert with other provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The TANF program transformed welfare into a system that requires work in exchange for time-limited assistance. The program is intended to end dependence on Government benefits by promoting job preparation, work, and marriage. We will test the accuracy of reported data and discern the data States need to collect to measure outcomes. We will also discuss the potential ease and/or difficulty of collecting this data.

OAS; W-00-99-20016; A-02-99-00000

OEI; 05-98-00130 (Expected Issue Date: FY 2000)

State Assessments of Welfare Recipients Skills

We will examine States' compliance with the requirement of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to assess the skills, prior work experience, and employability of each TANF recipient. We will also describe the assessment tools States use to screen and appropriately refer recipients for job search, job training, and other support services. Early indications show some States may not complete these assessments in a timely manner.

OEI; 00-00-00000

Education and Training

We will determine whether States have used Federal funds provided by the Job Opportunities and Basic Skills program to supplant State funds for training and education. Our review of Wisconsin's education and training programs, which was coordinated with the U.S. Department of Agriculture's (USDA) OIG, found that the State's accounting methodology resulted in State and local funds' being replaced by Federal funds. Nearly \$6 million in ineligible Federal funds was identified. Both USDA and HHS regulations provide that Federal funds to operate a training and education

component not be used to supplant State funds for existing educational services and activities. We plan work in another State and propose a national review in coordination with USDA auditors.

OAS; W-00-98-20016; A-05-98-00010

Maintenance of Effort

We will examine how States have implemented the maintenance of effort provision under the TANF program. States are required to expend at least 80 percent (75 percent if they meet participation requirements) of their historical spending level under AFDC and related programs. Some uncertainty may exist about which expenditures of State funds count toward the maintenance of effort requirement.

OAS; W-00-99-20016; A-06-99-00000, A-07-99-00000

Administrative Cost Adjustments

The OIG, in partnership with USDA and nonfederal auditors, will provide audit assistance to the Assistant Secretary for Management and Budget in its effort to assess administrative costs in public assistance programs. The TANF block grant to each State inadvertently included common administrative costs attributable to AFDC, Medicaid, and Food Stamps. The Agriculture Research, Extension, and Education Reform Act of 1998 requires the Secretary to determine the amount of administrative costs attributable to each of these programs in the TANF base year. The purpose is to determine the reductions in payment needed to preclude double charging that may now result as States start allocating administrative costs to the Food Stamps and Medicaid programs.

OAS; W-00-99-20016; A-12-99-00000

Surplus Welfare Funds

We will determine whether States have inappropriately funded other programs with surplus TANF funds. As a result of a decline in welfare caseloads, many States are incurring a surplus of these funds. Federal regulations allow transfers of up to 30 percent of surplus funds to the Child Care and Development Block Grant or the Social Services

Block Grant programs. As part of our review, we will determine the extent that TANF funds have been used to subsidize any unauthorized activities.

*OAS; W-00-99-20016; Various CINs
Expected Issue Date: FY 2000*

Two-Parent Participation Rate

We will describe barriers States face, and report innovative practices found helpful, in meeting the TANF two-parent participation rate requirement. States must have 90 percent of their two-parent families participating in work by 1999. Those that do not meet this requirement face a reduction in welfare grants.

OEI; 00-00-00000

Implementation of Recipient Sanction Policies

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

OEI; 09-98-00290

Privatization and Welfare Reform

We will examine current State efforts to privatize aspects of welfare programs under the Personal Responsibility and Work Opportunity Reconciliation Act. States have the flexibility to contract the administration of child support enforcement, TANF, and other assistance programs to private nonprofit and for-profit organizations. Cost savings, the ability to begin new services quickly without additional employees, and the flexibility to meet seasonal service peaks in service demand are major reasons for privatizing. No

comprehensive studies have indicated the extent of privatization or described the successes and barriers encountered in contracting for welfare services.

OEI; 00-00-00000

Welfare Recipient Perspectives

We will describe welfare recipients' experiences with and perceptions of the TANF program. At the heart of the program is the expectation that States be held accountable for moving families from welfare to self-sufficiency through work. Since the success of welfare reform will rely, among other things, on recipients' understanding of their role, we will identify early indications of their changing role.

OEI; 00-00-00000

State Fraud and Abuse Activities

We will describe States' fraud and abuse prevention and detection activities under the TANF program. Under this program, States are required to certify that they have established standards and procedures to ensure against fraud and abuse. We will describe State activities relating to preventing pre-eligibility and post-eligibility fraud.

OEI; 00-00-00000

CHILD CARE

Quality of Care

We will review one State's monitoring of the quality of child care services, including checks of providers' criminal backgrounds and child abuse or neglect records. In addition, we will determine whether the State has overpaid providers who care for more children than its regulations permit. Our review will include an evaluation of State site visits to verify reported complaints.

OAS; W-00-99-20018; A-05-99-00000

Technical Assistance Contracts for Quality Child Care

We will examine the States' experiences with, and perceptions of, the technical assistance they receive for administering the Child Care Development Fund and improving the quality of child care. The Administration for Children and Families (ACF) contracts with a private entity to provide technical assistance to State agencies. As States struggle to serve increasing numbers of children in child care as a result of welfare reform, the technical assistance provided through this contract will be critical to assist States in building and maintaining quality child care.

OEI; 07-97-00420

Enforcement of State Child Care Health and Safety Standards

We will examine States' enforcement of child care health and safety standards and identify effective strategies for improved monitoring of child care providers. Child care providers serving children funded by the Federal block grant must meet health and safety requirements set by States and tribes. These requirements address the prevention and control of infectious diseases (including immunizations), building and physical premises safety, and minimum health and safety training. Past OIG studies have found that State efforts may not be sufficient to ensure that health and safety standards are met. Federal funding of child care and the number of children in federally subsidized child care continue to grow and are key components of moving welfare families to self-sufficiency.

OEI; 00-00-00000

Use of Tribal Child Care Funds - An Early Alert

We will examine the challenges tribal child care agencies face in ensuring effective use of increased child care funds. With the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, additional child care funds are available to tribes through the Child Care Development Fund Tribal Mandatory Fund, beyond the congressionally appropriated discretionary funds. This doubles child care funds available to tribes to \$60 million a year.

OEI; 05-98-00010

Head Start and Child Care Collaboration

We will examine how Head Start and child care programs have collaborated to expand Head Start services to full-day, full-year, and alternative-hour programs. With over 50 percent of Head Start children receiving welfare benefits, the movement of their parents into the work force raises concerns about the hours of program operation and the ability of Head Start to meet parents' child care needs. Head Start has provided about \$200 million to support collaboration with child care programs.

OEI; 00-00-00000

CHILD PROTECTIVE SERVICES

Service Effectiveness

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

State investigations are intended to identify the risk factors (stressors) that led or significantly contributed to the child abuse or neglect. Remedial services and/or treatments are usually provided with the objective of eliminating or reducing to an acceptable level the risk of harm to children in the household.

OAS; W-00-99-20018; A-03-99-00000

Emergency Shelters

We will describe the use of emergency shelters in the child welfare system. Emergency shelter care is the door through which many children enter the child welfare system. Shelters also house runaway youths and juvenile delinquents. Our study will look at the

types of services provided, lengths of stay, co-mingling of children, etc. There has never been a national study of these facilities.

OEI; 00-00-00000

Interstate Compact on the Placement of Children

We will examine whether States have met their obligations under ACF's Interstate Compact on the Placement of Children. This compact was created in response to the lack of protective and supportive services provided to children sent into out-of-State placement. When a child is placed in another State, the receiving State must provide required services for the protection of children. The ACF has received complaints that certain States are not meeting their responsibilities under the compact, such as ensuring a safe living environment and conducting periodic site visits for "out-of-State placement" children.

OEI; 02-95-00041

Coordination of Child Welfare Efforts

We will examine the coordination between ACF's child protection programs and child delinquency programs administered by the Office of Juvenile Justice and Delinquency Prevention in the Department of Justice. These programs often cover the same populations and are both adjudicated through the juvenile court system. The juvenile court has played an increasingly significant role in determining dependency case outcomes since the Federal Adoption Assistance and Child Welfare Act of 1980 required greater judicial oversight of the child protective service agency's performance. Program officials are receptive to exploring improved coordination and helping States and local communities build a continuum of services aimed at prevention and early intervention.

OEI; 00-00-00000

CHILD SUPPORT

Collection Methods

We will examine whether States have effectively used available methods to enforce collection of child support payments. Wage withholding is the method most often used by States. However, it is not effective for the self-employed or for accessing nonwage income, such as royalties, commissions, interest, and dividends. States may be missing an opportunity to collect child support arrearages by not garnishing income sources other than wages. We will also assess State procedures for timely withholding of wages when the wage earner changes jobs. Data from a State audit indicated that about 30 percent of wage earners with a garnishment order changed jobs and had continuing income but were no longer paying the mandated child support. Wage withholding through the new employer had not been accomplished in a timely manner.

Liens are another collection method. States are required to have in effect and use procedures for imposing a lien against real and personal property of an absent parent who is delinquent in child support payments. We will examine both intrastate and interstate cases.

OAS; W-00-99-20005; A-01-99-00000

Improving Interstate Case Collections

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

OEI; 00-00-00000

Earnings of Noncustodial Parents

We will examine the earnings of a sample of noncustodial parents, review child support agency actions to collect sums owed, and determine increased collection opportunities for child support cases. Nationally, child support collections are low; only about 30 percent of custodial families receive regular child support. Little empirical data exists showing the actual earnings or earnings potential of noncustodial parents. The Office of Child Support Enforcement and the Assistant Secretary for Planning and Evaluation requested that the OIG examine this issue.

OEI; 00-00-00000

Paternity Establishment

We will identify State methods for establishing paternity and describe how these determinations are used within the child support enforcement system. In recent years, both Federal and State child support enforcement agencies have invested considerable resources in creating in-hospital voluntary paternity acknowledgment programs. Less is known about efforts to establish paternity outside the hospital setting and to ensure that paternity information, regardless of its source, is accessible for use in creating and enforcing child support awards.

OEI; 06-98-00050

Welfare Recipient Cooperation

We will review the processes States use to determine recipient cooperation in establishing child support orders, including provisions that release recipients from cooperation obligations. In an effort to maximize child support collections, welfare recipients must provide information to help identify and locate absent parents. Custodial parents receiving public assistance are required to cooperate with authorities in locating absent parents for payment of child support. Cooperation includes providing the name of the father and any other information that was known, or could be reasonably obtained, by the mother. Under welfare reform, IV-D agencies are mandated to make the cooperation determination.

OEI; 06-98-00040

Review and Adjustment of Child Support Orders

We will describe the States' methods of reviewing and adjusting child support orders. Under welfare reform, State IV-D agencies now have options for review and adjustment of orders using any one of the following methods: (1) periodically reviewing cases, (2) using automated systems to identify cases needing updates, or (3) adjusting for the cost of living. Earlier OIG studies demonstrated that many child support orders were established when the noncustodial parents were young and/or earned little money. Once established, these orders were seldom, more often never, reviewed and adjusted. If child support orders for TANF parents are not modified regularly, custodial parents leaving the program may have a more difficult time attaining orders.

OEI; 05-98-00100

Welfare and Child Support Agency Coordination

We will examine the extent that welfare offices make timely case referrals to child support agencies and establish child support for welfare recipients. Welfare offices are required to refer welfare cases to child support agencies for enforcement. With the advent of time-limited welfare and work participation requirements, it is essential that child support be established for as many welfare cases as possible. Regular child support payments can have a positive impact on moving a welfare family into work.

OEI; 00-00-00000

Employer Compliance with New Hire Directories

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

OAS; W-00-99-20005; A-01-99-00000, A-04-99-00000
Expected Issue Date: FY 2000

Medical Insurance Coverage: Detection and Coordination with Medicaid

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

OEI; 07-97-00500

Child Support Annual Report: A Customer Survey

We will provide the Office of Child Support Enforcement the results of a user survey of the Office's Annual Report to the Congress. The Congress requires the Office to submit an annual report no later than 3 months after the end of each fiscal year, describing the program activities over the prior year. The report is largely based on States' reports of their child support activities. Past studies have raised questions about the accuracy, usefulness, and comparability of this State data. The Office of Child Support Enforcement intends to use the results of our survey in improving the content and format of the report. Of particular interest is user feedback on the new initiatives that will be discussed in the report.

OEI; 02-98-00070

INVESTIGATIONS

Child Support Enforcement Task Force Model

The OIG's Office of Investigations and the Office of Child Support Enforcement developed a task force model that is currently being piloted in Chicago. It calls for the Office of Investigations, U.S. Marshals, U.S. Attorney Offices in seven districts, local

law enforcement, local prosecutors, State child support agencies, and other interested parties to join forces in creating a coordinated effort to identify, investigate, and prosecute criminal nonsupport cases in three States -- Illinois, Ohio, and Michigan.

The task force will investigate intrastate as well as interstate cases, making the involvement of local law enforcement and prosecutors critical. It is hoped that the task force model can then be exported to other areas of the country.

FOSTER CARE

Child Abuse in Foster Care Settings

We will determine the extent to which children in foster care are at risk of child abuse. We will review child abuse reports in several States to assess the incidents that occurred in foster care settings and what remedial actions were taken to reduce the risk to the children. We will also review the screening process, such as criminal background checks, used to determine the suitability of foster care providers.

OAS; W-00-99-20008; A-09-99-00000

State Oversight of Foster Care Residential Facilities

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

OEI; 07-98-00250

Foster Family Operations

This review in one State will examine the use of Federal and State funds for providing foster care services through foster family agencies and the reliability of financial information reported by the agencies for use in rate setting. This State's county welfare offices contract with foster family agencies to provide services for a portion of the State's foster care caseload, such as recruiting and training foster parents, certifying that foster homes meet acceptable standards, and performing other services on behalf of foster children. The use of the agencies has been increasing without State audit of the agencies' financial operations.

OAS; W-00-98-20008; A-09-98-00071

Foster Care Group Homes

At ACF's request, we will assess selected aspects of one State's use of foster care group homes. We will examine the appropriateness of child placement in the homes, licensing procedures, and selected business practices related to the operations of the homes. Our work will be expanded as appropriate.

OAS; W-00-99-20008; A-09-99-00000

Independent Living Program

We plan to review the objectives, performance, and program results of one State's Independent Living Program. To determine if children have successfully transitioned from foster care to independent adult living, we will, as feasible, examine State records to ascertain the outcomes of foster care youth who have and have not participated in the Independent Living Program. We will also review ACF's information sharing among States' Independent Living Programs.

OAS; W-00-99-20008; A-09-99-00000

Foster Care Rates

We will determine if the Title IV-E rates charged by contracted foster care providers are reasonable and supported. These rates should include only those costs that are

reasonable for the maintenance of the foster child, such as costs of food, shelter, and clothing. The State agency contracts with child placement agencies and other providers to care for children in facilities (institutions and group homes) and to place children with foster parents. Payments to these providers are based on a monthly/daily rate per child which is negotiated based on providers' cost reports. The amount determined to be Title IV-E eligible is claimed for Federal reimbursement. We will determine if the State agency adequately reviews the payment rates and if they are based on actual costs.

OAS; W-00-99-20008; A-05-99-00000, A-09-99-00000
Expected Issue Date: FY 2000

Reimbursement for Residential Foster Care

We will examine how residential foster care funds are used and what expenditures reimbursement rates include. Although the American Public Welfare Association conducts an annual rate survey, the survey is limited to family foster care. We will provide information for further work on the relationship between foster care and Medicaid reimbursement; for example, there have been concerns that both programs may be paying for mental health services in residential facilities.

OEI; 00-00-00000

Level of Care: Therapeutic Foster Care Per Diem Rates

We will determine whether Title IV-E has been charged higher therapeutic foster care rates even though the children no longer need that level of care. Children who are considered to be emotionally disturbed and who cannot be placed and properly cared for in regular foster care homes are placed in therapeutic foster care homes. Because the children require intensive monitoring and counseling, their per diem rates are considerably higher than rates for regular foster care. In one State, our survey work disclosed that after 2 to 6 months in therapeutic care, many children no longer needed intense monitoring and counseling. However, children placed in therapeutic foster care homes remained for an average of 2 years and were billed at the higher therapeutic per diem rates. We will evaluate the criteria used to determine whether therapeutic care is needed and whether the need for continued services at that level is adequately supported.

OAS; W-00-99-20008; A-05-99-00000

Cost Shifting of Juvenile Justice Costs

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

*OAS; W-00-99-20008; Various CINs
Expected Issue Date: FY 2000*

Foster Care Claims Filed by States

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

OAS; W-00-98-20008; A-04-98-00123

Barriers to Freeing Children for Adoption: Follow-up Study

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

OEI; 00-00-00000

Adoption and Foster Care Analysis and Reporting System

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

OAS; W-00-99-20008; A-03-99-00000
OEI; 00-00-00000

HEAD START

Health and Safety Standards

We will assess compliance with health and safety standards by grantees of Early Head Start, Head Start, and TANF child care programs. Our review will examine practices for ensuring that child care facilities provide safe and healthy environments for children in the programs. We will also determine if background checks on employees have been performed. Previous OIG reviews showed that, in addition to improvements needed at the State level, greater Federal oversight was needed to improve the health and safety conditions of the Nation's child care programs.

OAS; W-00-99-20009; Various CINs
Expected Issue Date: FY 2000

Family and Community Partnerships

We will review grantee implementation of the Family and Community Partnership performance measure. A May 1993 OIG report, "Evaluating Head Start Expansion Through Performance Indicators," found that grantees frequently did not identify or address families' social service needs. Our December 1993 "Final Report of the Advisory Committee on Head Start Quality and Expansion" noted the Head Start social

services component (now called Family and Community Partnerships) needed improvement. We will review the progress that Head Start grantees have made in meeting the “social service” needs of Head Start parents and children.

OEI; 00-00-00000

Technical Assistance to States

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

OEI; 00-00-00000

OTHER ISSUES

Year 2000 Computer Renovation Plans

We will evaluate ACF's efforts to meet Year 2000 computer renovation and validation goals. The Federal Government's Year 2000 strategy regarding computer systems places emphasis on ensuring that agencies' mission-critical systems are Year 2000 compliant well before December 31, 1999, to avoid widespread system failures. As of May 1998, the Department reported to OMB that ACF had 55 mission-critical systems. This review is part of our Departmentwide Year 2000 compliance review.

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

Expected Issue Date: Periodic Reporting FYs 1999 and 2000

Abuse of Disabled Children

This review will identify opportunities to improve States’ practices for preventing abuse to disabled children in institutions such as nursing homes. Currently, about 6,000

disabled children reside in nursing facilities, where children have been reported as being severely neglected and not receiving needed care.

OAS; W-00-99-20018; A-09-99-00000

State Developmental Disabilities Councils

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

OEI; 07-98-00260

Management and Performance of OCS Discretionary Grants

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

OAS; W-00-98-20019; A-09-98-00065, A-04-98-00000

Emergency Assistance Retroactive Claims

We will examine the amount and nature of retroactive claims by States, as well as FY 1996 claims for juvenile justice costs. A number of consultants have entered into contingency fee contracts with States to maximize Federal financial participation under the emergency assistance program. This effort may be shifting considerable costs to

emergency assistance from other Federal and State programs. Preliminary work in one State indicates that many claims, particularly those for kinship care, contain unallowable and unsupported costs.

OAS; W-00-98-20017; Various CINs

Statewide Automated Child Welfare Information Systems

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

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

OAS; W-00-99-20017; A-06-99-00000, A-07-99-00000

Department of Health and Human Services

Office of Inspector General



Administration on Aging Projects

Table of Contents

Health Care Fraud and Abuse Control Programs	1
State Ombudsman Processes and Data	1
Reporting of Abuse and Neglect Cases	1
Involuntary Transfers of the Elderly - Psychiatric Facilities	2

Health Care Fraud and Abuse Control Programs

We will conduct a limited number of inspections to assist AoA in implementing its health care fraud and abuse program. The AoA funds grantees in 12 States to recruit and train retired professionals as both volunteer resources and educators to Medicare beneficiaries in detecting and reporting Medicare fraud. In addition, AoA funds 18 State Units on Aging to train aging network staff and long-term-care ombudsmen to recognize and report fraud and abuse. The OIG has assisted AoA in developing performance measures for the programs. We will continue that assistance by collecting and analyzing performance measure data and by evaluating the impact of the programs.

OEI; 02-97-00520

State Ombudsman Processes and Data

In selected States, we will examine trends in data reported through the National Ombudsman Reporting System and the extent to which the data indicates problems with quality of care in nursing homes. We will also examine State Ombudsman processes and operations. Through the AoA Long-Term-Care Ombudsman Program, paid and volunteer ombudsmen identify, investigate, and resolve problems related to the health, safety, rights, and welfare of residents of nursing homes and other long-term-care facilities. Since 1995, the ombudsman programs have submitted data through the national reporting system that describes complainants, complaints, and complaint verification and disposition. This review was requested by the Congress and is one in a series of reviews examining the quality of care in nursing homes.

OEI; 02-98-00350

Reporting of Abuse and Neglect Cases

We will examine selected States' procedures and practices for outreach and reporting of elder abuse and neglect cases to either the State Ombudsman and/or the State Department of Health for conducting investigations. Indications are that elder abuse is underreported.

OAS; W-00-99-20001

Involuntary Transfers of the Elderly - Psychiatric Facilities

This study will determine if Medicare and Medicaid funds are inappropriately spent for inpatient psychiatric care when the elderly are involuntarily committed to psychiatric facilities. Current regulations create a financial incentive by allowing the temporary transfer of residents from retirement or nursing homes to for-profit psychiatric facilities. Federal funds pay for the inpatient treatment while concurrently paying the nursing/retirement home to reserve the resident's bed. These psychiatric services may be neither therapeutic nor cost effective.

OAS; W-00-99-20001; A-04-99-00000

Department of Health and Human Services

Office of Inspector General



Departmentwide Projects

Table of Contents

FINANCIAL STATEMENT AUDITS

Audits of FY 1998 Financial Statements	1
Health Care Financing Administration	1
Administration for Children and Families	1
Health Resources and Services Administration	1
Indian Health Service	1
National Institutes of Health	1
Centers for Disease Control and Prevention	1
Food and Drug Administration	1
Substance Abuse and Mental Health Services Administration	2
Program Support Center	2
Consolidated HHS Financial Statements	2
Related Activity to Support FY 1998 Financial Statement Audits--Reviews of HHS Service Organizations	2
NIH Computer Center	2
Program Support Center--Major Administrative Support Services:	2
Payment Management System	2
Accounting Operations--Division of Financial Operations	2
Payroll Operations	2
Audits of FY 1999 Financial Statements	2
Health Care Financing Administration	2
Administration for Children and Families	3

Health Resources and Services Administration	3
Indian Health Service	3
National Institutes of Health	3
Centers for Disease Control and Prevention	3
Food and Drug Administration	3
Substance Abuse and Mental Health Services Administration	3
Program Support Center	3
Consolidated HHS Financial Statements	3
Related Activity to Support FY 1999 Financial Statement Audits--Reviews of HHS Service Organizations	4
NIH Computer Center	4
Program Support Center--Major Administrative Support Services:	4
Payment Management System	4
Accounting Operations--Division of Financial Operations	4
Payroll Operations	4

PROGRAM INTEGRITY AND EFFICIENCY

Year 2000 Computer Renovation Plans	4
Program Support Center Customer Satisfaction	5
State Operations	5
Preaward and Postaward Contract Audits	6
Nonfederal Audits	6

FINANCIAL STATEMENT AUDITS

The Government Management Reform Act of 1994 seeks to ensure that Federal managers have at their disposal the financial information and flexibility necessary to make sound policy decisions and manage scarce resources. This act broadened the Chief Financial Officers (CFO) Act of 1990 by requiring annual audited financial statements--commencing with FY 1996--for *all* accounts and associated activities of selected Federal agencies (including HHS and its operating divisions). The audited FY 1998 consolidated HHS financial statements are due to OMB by March 1, 1999.

Audits of FY 1998 Financial Statements

The following audits of FY 1998 financial statements will be completed and reports issued during FY 1999:

Health Care Financing Administration

OAS; W-00-98-40008; A-17-98-00098

Administration for Children and Families

OAS; W-00-98-40010; A-17-98-00002

Health Resources and Services Administration

OAS; W-00-98-40013; A-17-98-00005

Indian Health Service

OAS; W-00-98-40013; A-17-98-00004

National Institutes of Health

OAS; W-00-98-40013; A-17-98-00008

Centers for Disease Control and Prevention

OAS; W-00-98-40013; A-17-98-00007

Food and Drug Administration

OAS; W-00-98-40013; A-17-98-00014

Substance Abuse and Mental Health Services Administration

OAS; W-00-98-40013; A-17-98-00006

Program Support Center

OAS; W-00-98-40013; A-17-98-00012

Consolidated HHS Financial Statements

OAS; W-00-98-40009; A-17-98-00001

**Related Activity to Support FY 1998 Financial Statement Audits--
Reviews of HHS Service Organizations**

NIH Computer Center

OAS; W-00-98-40012

Program Support Center--Major Administrative Support Services:

Payment Management System

OAS; W-00-98-40012; A-17-98-00011

Accounting Operations--Division of Financial Operations

OAS; W-00-98-40012; A-17-98-00009

Payroll Operations

OAS; W-00-98-40012; A-17-98-00010

Audits of FY 1999 Financial Statements

Work is expected to begin in FY 1999 on the following audits of FY 1999 financial statements:

Health Care Financing Administration

OAS; W-00-99-40008

Expected Issue Date: FY 2000

Administration for Children and Families

OAS; W-00-99-40010

Expected Issue Date: FY 2000

Health Resources and Services Administration

OAS; W-00-99-40013

Expected Issue Date: FY 2000

Indian Health Service

OAS; W-00-99-40013

Expected Issue Date: FY 2000

National Institutes of Health

OAS; W-00-99-40013

Expected Issue Date: FY 2000

Centers for Disease Control and Prevention

OAS; W-00-99-40013

Expected Issue Date: FY 2000

Food and Drug Administration

OAS; W-00-99-40013

Expected Issue Date: FY 2000

Substance Abuse and Mental Health Services Administration

OAS; W-00-99-40013

Expected Issue Date: FY 2000

Program Support Center

OAS; W-00-99-40003

Expected Issue Date: FY 2000

Consolidated HHS Financial Statements

OAS; W-00-99-40009

Expected Issue Date: FY 2000

Related Activity to Support FY 1999 Financial Statement Audits-- Reviews of HHS Service Organizations

NIH Computer Center

OAS; W-00-99-40012

Expected Issue Date: FY 2000

Program Support Center--Major Administrative Support Services:

Payment Management System

OAS; W-00-99-40012

Expected Issue Date: FY 2000

Accounting Operations--Division of Financial Operations

OAS; W-00-99-40012

Expected Issue Date: FY 2000

Payroll Operations

OAS; W-00-99-40012

Expected Issue Date: FY 2000

PROGRAM INTEGRITY AND EFFICIENCY

Year 2000 Computer Renovation Plans

We will determine the adequacy of the Department's planning, management, and assessment of the Year 2000 system compliance problem and assess the risk that mission-critical, internal information systems may not operate effectively and efficiently by January 1, 2000. The Year 2000 remediation efforts, likely the largest computer system conversion effort ever undertaken, is necessary to ensure that computerized systems can distinguish the Year 2000 from 1900, 2001 from 1901, etc., and that they can correctly handle leap year calculations involving the Year 2000 and beyond. To avoid widespread system failures, the Federal Government's Year 2000 strategy places emphasis on ensuring that agencies' mission-critical systems are Year 2000 compliant well before December 31, 1999. As of May 1998, the Department reported to OMB that it had 289

mission-critical systems. It also reported that over the next 2 years, renovation and validation work remained to be done on at least 66 percent of these systems.

Our review is part of an initiative of the President's Council on Integrity and Efficiency to monitor Year 2000 preparations throughout the executive branch. Our compliance work at the individual operating agencies is noted, where applicable, in the preceding chapters.

OAS; W-00-98-40007; A-17-98-00003

Expected Issue Date: Periodic Reporting FYs 1999 and 2000

Program Support Center Customer Satisfaction

We will assess the level of customer satisfaction with the Program Support Center's payroll services and intersecting personnel issues related to payroll functions. The Program Support Center, formed in 1995, operates an automated payroll service for all of the Department's 60,000 employees. Envisioned as a "business enterprise," its mission is to provide the Department and other Federal agencies with administrative support services on a cost-effective, competitive, fee-for-service basis. We plan to assess the Center's performance in delivering payroll services to its clients.

OEI; 09-98-00140

State Operations

We will review selected aspects of State operations, including pensions, self-insurance funds, internal service funds, and escheated warrants. We will:

- Examine the impact of certain pension changes and the effect on Federal programs. Previous reviews have disclosed significant problems with the pension plan costs charged to Federal programs.
- Determine the reasonableness of fund balances in State self-insurance funds.
- Examine surplus balances in internal service funds.

- Determine whether procedures have been implemented to address the problem of escheated warrants (uncashed checks) charged to HHS programs. Previous audit work in Puerto Rico identified significant overcharges to the Department.

OAS; W-00-99-40006

Preaward and Postaward Contract Audits

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

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

OAS; W-00-99-50009 & -50011; Various CINs

Nonfederal Audits

We will continue to review the quality of audits prepared by nonfederal auditors in accordance with OMB Circular A-133. Under this circular, State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards are required to have an annual organizationwide audit of all Federal money they receive. We provide up-front technical assistance to nonfederal auditors to facilitate a clear understanding of the Federal audit requirements and promote effective audit work. In addition, we identify, analyze, and record electronically the audit findings reported by nonfederal auditors for use by Department managers.

Our reviews provide Department managers with assurance about the management of Federal programs and identify significant areas of internal control weaknesses, noncompliance with laws and regulations, and questioned costs that require formal resolution by Federal officials.