



Office of
Inspector
General

Work Plan

FISCAL YEAR
2013



U.S. Department of Health & Human Services
Office of Inspector General

oig.hhs.gov

Introductory Message From the Office of Inspector General

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) *Work Plan for Fiscal Year 2013 (Work Plan)* summarizes new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs and operations during the next fiscal year (FY) and beyond.

The [Work Plan](#) is one of OIG's three core publications. The [Semiannual Report to Congress](#) summarizes OIG's most significant findings, recommendations, investigative outcomes, and outreach activities in 6-month increments. The annual [Compendium of Unimplemented Recommendations](#) (Compendium) describes open recommendations from prior periods that when implemented will save tax dollars and improve programs.

What is our responsibility?

Our organization was created to protect the integrity of HHS programs and operations and the well-being of beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws. Our mission encompasses the more than 300 programs administered by HHS at agencies such as the Centers for Medicare & Medicaid Services (CMS), National Institutes of Health (NIH), Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), and Administration for Children and Families (ACF).

The majority of our resources are directed toward safeguarding the integrity of the Medicare and Medicaid programs and the health and welfare of their beneficiaries. Consistent with our responsibility to oversee all HHS programs, we also focus considerable effort on HHS's other programs and management processes, including key issues such as food and drug safety, child support enforcement, conflict-of-interest and financial disclosure policies governing HHS staff, and the integrity of contracts and grants management processes and transactions. Our core organizational values are:

- **Integrity**—Acting with independence and objectivity.
- **Credibility**—Building on a tradition of excellence and accountability.
- **Impact**—Yielding results that are tangible and relevant.

How and where do we operate?

Our staff of more than 1,700 professionals are deployed throughout the Nation in regional and field offices and in the Washington, DC, headquarters. We conduct audits, evaluations, and investigations; provide guidance to industry; and, when appropriate, impose civil monetary penalties, assessments, and administrative sanctions. We collaborate with HHS and its operating and staff divisions, the Department of Justice (DOJ) and other executive branch agencies, Congress, and States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds. The following are descriptions of our mission-based components.

- The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.
- The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in HHS programs. OEI reports also present practical recommendations for improving program operations.
- The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in almost every State and the District of Columbia, OI actively coordinates with DOJ and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, or CMPs.
- The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

The organizational entities described above are supported by the Immediate Office (IO) of the Inspector General and the Office of Management and Policy (OMP).

How do we plan our work?

Work planning is a dynamic process, and adjustments are made throughout the year to meet priorities and to anticipate and respond to emerging issues with the resources available. We assess relative risks in the programs for which we have oversight authority to identify the areas most in need of attention and, accordingly, to set priorities for the sequence and proportion of resources to be allocated. In evaluating proposals for the *Work Plan*, we consider a number of factors, including:

- mandatory requirements for OIG reviews, as set forth in laws, regulations, or other directives;
- requests made or concerns raised by Congress, HHS management, or the Office of Management and Budget (OMB);
- top management and performance challenges facing HHS;
- work to be performed in collaboration with partner organizations;
- management's actions to implement our recommendations from previous reviews; and
- timeliness.

What do we accomplish?

For FY 2011, we reported expected recoveries of about \$5.2 billion consisting of \$627.8 million in audit receivables and \$4.6 billion in investigative receivables (which includes \$952 million in non-HHS investigative receivables resulting from our work in areas such as the States' share of Medicaid restitution). We also identified about \$19.8 billion in savings estimated for FY 2011 as a result of legislative, regulatory, or administrative actions that were supported by our recommendations. Such savings generally reflect third-party estimates (such as those by the Congressional Budget Office (CBO)) of funds made available for better use through reductions in Federal spending.

We reported FY 2011 exclusions of 2,662 individuals and entities from participation in Federal health care programs; 723 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 382 civil actions, which included false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalty settlements, and administrative recoveries related to provider self-disclosure matters.

What can you learn from our Work Plan?

The OIG *Work Plan* outlines our current focus areas and states the primary objectives of each project. The word "New" after a project title indicates the project did not appear in the previous *Work Plan*. At the end of each project description, we provide the internal identification code for the review (if a number has been assigned), the year in which we expect one or more reports to be issued as a result of the review, and whether the work was in progress at the start of the fiscal year or is planned as a new start. Typically, a review designated as "work in progress" will result in reports issued in FY 2013, but a review designated as "new start," meaning it is slated to begin in FY 2013, could result in an FY 2013 or

FY 2014 report, depending upon the time when the assignments are initiated during the year and the complexity and scope of the examinations.

The body of the *Work Plan* is presented in seven major parts followed by Appendix A, which describes our reviews related to the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), and Appendix B, which describes our oversight of the funding that HHS received under the American Recovery and Reinvestment Act of 2009 (Recovery Act).

Because we make continuous adjustments to the Work Plan as appropriate, we do not provide status reports on the progress of the reviews. However, if you have other questions about this publication, please contact our Office of External Affairs at (202) 619-1343.

OIG on the Web: <https://oig.hhs.gov>
Follow us on Twitter: <http://twitter.com/OIGatHHS>

FY 2013 Work Plan Major Parts and Appendixes

Part I:	Medicare Part A and Part B
Part II:	Medicare Part C and Part D
Part III:	Medicaid Reviews
Part IV:	Legal and Investigative Activities Related to Medicare and Medicaid
Part V:	Public Health Reviews
Part VI:	Human Services Reviews
Part VII:	Other HHS-Related Reviews
Appendix A:	Affordable Care Act Reviews
Appendix B:	Recovery Act Reviews

Part I

Medicare Part A and Part B

Hospitals	1
Hospitals—Inpatient Billing for Medicare Beneficiaries (New)	1
Hospitals—Diagnosis Related Group Window (New)	2
Hospitals—Same-Day Readmissions	2
Hospitals—Non-Hospital-Owned Physician Practices Using Provider-Based Status (New)	2
Hospitals—Compliance With Medicare’s Transfer Policy (New)	3
Hospitals—Payments for Discharges to Swing Beds in Other Hospitals (New)	3
Hospitals—Acute-Care Inpatient Transfers to Inpatient Hospice Care	3
Hospitals—Payments for Canceled Surgical Procedures (New)	3
Hospitals—Payments for Mechanical Ventilation (New)	4
Hospitals—Admissions With Conditions Coded Present on Admission	4
Hospitals—Inpatient and Outpatient Payments to Acute Care Hospitals	4
Hospitals—Inpatient Outlier Payments: Trends and Hospital Characteristics	5
Hospitals—Reconciliations of Outlier Payments	5
Hospitals—Quality Improvement Organizations’ Work With Hospitals (New)	5
Hospitals—Duplicate Graduate Medical Education Payments	5
Hospitals—Occupational-Mix Data Used To Calculate Inpatient Hospital Wage Indexes	6
Hospitals—Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices	6
Hospitals—Outpatient Dental Claims	6
Hospitals—Outpatient Observation Services During Outpatient Visits	6
Hospitals—Acquisitions of Ambulatory Surgical Centers: Impact on Medicare Spending (New)	7
Critical Access Hospitals— Variations in Size, Services, and Distance From Other Hospitals	7
Critical Access Hospitals—Payments for Swing-Bed Services (New)	7
Inpatient Rehabilitation Facilities—Transmission of Patient Assessment Instruments	8
Inpatient Rehabilitation Facilities—Appropriateness of Admissions and Level of Therapy	8
Long -Term-Care Hospitals—Payments for Interrupted Stays (New)	8
Nursing Homes	8
Nursing Homes—Adverse Events in Post-Acute Care for Medicare Beneficiaries	9
Nursing Homes—Medicare Requirements for Quality of Care in Skilled Nursing Facilities	9
Nursing Homes—State Agency Verification of Deficiency Corrections (New)	9
Nursing Homes—Oversight of Poorly Performing Facilities	9
Nursing Homes—Use of Atypical Antipsychotic Drugs (New)	10
Nursing Homes—Hospitalizations of Nursing Home Residents	10
Nursing Homes—Questionable Billing Patterns for Part B Services During Nursing Home Stays	10
Nursing Homes—Oversight of the Minimum Data Set Submitted by Long-Term-Care Facilities (New)	10
Hospices	11
Hospices—Marketing Practices and Financial Relationships with Nursing Facilities	11
Hospices—General Inpatient Care	11

Home Health Services.....	11
HHAs—Home Health Face-to-Face Requirement (New)	11
HHAs—Employment of Home Health Aides With Criminal Convictions (New).....	12
HHAs—States’ Survey and Certification: Timeliness, Outcomes, Followup, and Medicare Oversight	12
HHAs—Missing or Incorrect Patient Outcome and Assessment Data	12
HHAs—Medicare Administrative Contractors’ Oversight of Claims	12
HHAs—Home Health Prospective Payment System Requirements.....	13
HHAs—Trends in Revenues and Expenses.....	13
Medical Equipment and Supplies	13
Quality Standards—Accreditation of Medical Equipment Suppliers (New).....	13
Program Integrity—Reliability of Service Code Modifiers on Medical Equipment Claims	14
Program Integrity—Use of Surety Bonds To Recover Medical Equipment Supplier Overpayments.....	14
Lower Limb Prostheses—Supplier Compliance With Payment Requirements (New)	14
Power Mobility Devices—Supplier Compliance With Payment Requirements (New).....	14
Vacuum Erection Systems—Reasonableness of Medicare’s Fee Schedule Amounts Compared to Amounts Paid by Other Payers (New).....	15
Back Orthoses—Reasonableness of Medicare Payments Compared to Supplier Acquisition Costs	15
Parenteral Nutrition—Reasonableness of Medicare Payments Compared to Payments by Other Payers.....	15
Frequently Replaced Supplies—Supplier Compliance With Medical Necessity, Frequency, and Other Requirements	16
Continuous Positive Airway Pressure Supplies—Reasonableness of Medicare’s Replacement of Supplies Compared to That of Other Federal Programs (New).....	16
Diabetes Testing Supplies—Supplier Compliance With Payment Requirements for Blood Glucose Test Strips and Lancets.....	16
Diabetes Testing Supplies —Effectiveness of System Edits To Prevent Inappropriate Payments for Blood-Glucose Test Strips and Lancets to Multiple Suppliers	17
Diabetes Testing Supplies—Potential Questionable Billing for Test Strips in 2011.....	17
Diabetes Testing Supplies—Improper Supplier Billing for Test Strips in Competitive Bidding Areas (New)	17
Diabetes Testing Supplies—Supplier Compliance With Requirements for Non-Mail-Order Claims (New)	17
Competitive Bidding—Mandatory Review	18
Other Providers and Suppliers.....	18
Program Integrity—Onsite Visits for Medicare Provider and Supplier Enrollment and Reenrollment (New) .	18
Program Integrity—Medical Review of Part A and Part B Claims Submitted by Top Error-Prone Providers ...	19
Program Integrity—Improper Use of Commercial Mailboxes (New).....	19
Program Integrity—Payments to Providers Subject to Debt Collection (New).....	19
Program Integrity—High Cumulative Part B Payments	19
Independent Therapists—High Utilization of Outpatient Physical Therapy Services	20
Sleep Testing—Appropriateness of Medicare Payments for Polysomnography.....	20
Sleep Disorder Clinics—High Utilization of Sleep Testing Procedures.....	20
Physician-Owned Distributors— High Utilization of Orthopedic Implant Devices Used in Spinal Fusion Procedures.....	20
Ambulances—Compliance With Medical Necessity and Level-of-Transport Requirements	21
Anesthesia Services —Payments for Personally Performed Services (New)	21
Ophthalmological Services—Questionable Billing (New).....	21

Ambulatory Surgical Centers—Payment System	22
Ambulatory Surgical Centers and Hospital Outpatient Departments—Safety and Quality of Surgery and Procedures.....	22
Partial Hospitalization Programs—Services in Hospital Outpatient Departments and Community Mental Health Centers.....	22
Rural Health Clinics—Compliance With Location Requirements (New).....	22
Electrodiagnostic Testing—Questionable Billing (New).....	23
Part B Imaging Services—Payments for Practice Expenses	23
Diagnostic Radiology—Medical Necessity of High-Cost Tests	23
Laboratory Tests—Billing Characteristics and Questionable Billing in 2010.....	23
Laboratory Tests—Reasonableness of Medicare Payments Compared to Those by State Medicaid and Federal Employees Health Benefit Programs	24
Laboratory Tests—Part B Payments for Glycated Hemoglobin A1C Tests.....	24
Physicians and Other Suppliers—Noncompliance With Assignment Rules and Excessive Billing of Beneficiaries	24
Physicians—Error Rate for Incident-To Services Performed by Nonphysicians	25
Physicians—Place-of-Service Coding Errors	25
Evaluation and Management Services—Potentially Inappropriate Payments in 2010.....	25
Evaluation and Management Services—Use of Modifiers During the Global Surgery Period.....	25
Chiropractors—Part B Payments for Noncovered Services	26
Organ Procurement Organizations—Compliance With Supporting Documentation and Reporting Requirements	26
Claims Processing Errors—Medicare Payments for Part B Claims With G Modifiers (New).....	26
End Stage Renal Disease—Medicare’s Oversight of Dialysis Facilities.....	26
End Stage Renal Disease—Bundled Prospective Payment System for Renal Dialysis Services.....	27
End Stage Renal Disease—Payments for ESRD Drugs Under the Bundled Rate System.....	27
Prescription Drugs	27
Ethics—Conflicts of Interest Involving Prescription Drug Compendia (New)	27
Patient Safety and Quality of Care—Off-Label Use of Medicare Part B Drugs	28
Patient Safety and Quality of Care—Physicians’ Experiences With Drug Shortages (New).....	28
Patient Safety and Quality of Care—Hospitals’ Experiences With Drug Shortages (New)	28
Patient Safety and Quality of Care—Manufacturer Sales of Prescription Drugs in Short Supply (New)	28
Potential Savings From Manufacturer Rebates for Part-B Drugs (New)	29
Comparison of Average Sales Prices to Average Manufacturer Prices	29
Comparison of Average Sales Prices to Widely Available Market Prices	29
Payments for Immunosuppressive Drug Claims With KX Modifiers (New)	29
Payments for Multiuse Vials of the Drug Herceptin	30
Payments for Outpatient Drugs and Administration of the Drugs	30
Payments for Physician-Administered Drugs and Biologicals	30
Payments for Drugs Infused Through Medical Equipment Compared to Provider Acquisition Costs (New)...	30
Payments for Prostate Cancer Drugs Under Current Policy (New).....	31
Part A and Part B Contractors	31
Overview of CMS’s Contracting Landscape (New).....	31
CMS’s Compliance With Contract Documentation Requirements (New).....	31

Preaward Reviews of Contractor Cost Proposals.....	32
Administrative Costs Claimed by Medicare Contractors	32
Contractor Pension Cost Requirements.....	32
Contractor Postretirement Benefits and Supplemental Employee Retirement Plan Costs	32
Contractor Error Rate Reduction Plans.....	32
Medicare Administrative Contractors—CMS’s Assessment and Monitoring of Performance (New)	33
Medicare Administrative Contractors—Use and Management of System of Edits (New)	33
Claims Processing Contractors—Failure To Conduct Prepayment Reviews in Response to Edits (New)	33
Recovery Audit Contractors—Identification and Recoupment of Improper and Potentially Fraudulent Payments and CMS’s Oversight and Response	34
Zone Program Integrity Contractors—CMS’s Oversight of Task Order Requirements (New)	34
National Supplier Clearinghouse—Performance and CMS Oversight	34
Contractor Information Systems Security Programs— Annual Report to Congress	34
Contractor Closeout—Disposition of Government Systems and Data	35
Medicare and Medicaid Security of Portable Devices Containing Personal Health Information at Contractors and Hospitals	35
Local Coverage Determinations—Impact on Physician Fee Schedule, Services, and Expenditures	35
Other Part A and Part B Management and Systems Issues	36
Medicare as Secondary Payer—Improper Medicare Payments for Beneficiaries With Other Insurance Coverage	36
Payments for Incarcerated Beneficiaries (New)	36
Payments for Alien Beneficiaries Unlawfully Present in the United States on the Dates of Service (New).....	36
Payments for Services After Beneficiaries’ Death (New).....	37
Undelivered Medicare Summary Notices (New)	37
Medicare Integrity Program—CMS’s Overall Strategy (New)	37
Comprehensive Error Rate Testing Program—Fiscal Year 2012 Error Rate Oversight	37
National Provider Identifier Enumeration and Medicare Provider Enrollment Data.....	38
CMS Disclosure of Personally Identifiable Information	38
CMS Oversight of Currently Not Collectible Debt.....	38
Grant Management —Stabilization Grant in the Greater New Orleans Area (New)	38
First Level of the Medicare Appeals Process	39

Part II

Medicare Part C and Part D

Program Integrity Oversight of Part C and Part D.....	41
Benefit Integrity Activities by CMS Contractors in Medicare Part C and Part D (New).....	41
 Part C – Medicare Advantage	41
Special-Needs Plans—CMS Oversight of Enrollment and Special-Needs Plans.....	42
Provision of Services—Compliance With Medicare Requirements	42
Beneficiary Appeals—Beneficiary Requests for Reconsideration of Denied Services or Payments (New).....	42
MA Organization Bid Proposals—CMS Oversight of Data Quality and Accuracy.....	42
Duplicate Payments—Cost-Based Health Maintenance Organization Plans Paid Under Capitation Agreements and Fee for Service.....	43
Encounter Data—CMS Oversight of Data Integrity (New)	43
Risk Adjustment Data—Sufficiency of Documentation Supporting Diagnoses	43
Risk Adjustment Data—Accuracy of Payment Adjustments.....	43
Risk-Adjusted Payments—Medicare Advantage Organizations That Offer Prescription Drug Plans	43
Cost Reports—Accuracy of Expenditures Claimed by Health Care Prepayment Plans.....	44
Reporting Requirements—CMS Quality Oversight of MA Organization Reporting.....	44
 Part D – Prescription Drug Program	45
Program Integrity—Beneficiary Use of Manufacturer Copayment Coupons (New).....	45
Program Integrity—Voluntary Reporting of Fraud, Waste, and Abuse by Plan Sponsors (New).....	45
Pharmacy Benefit Managers—Part D Sponsors’ Oversight of Pharmacy Benefit Managers’ Administration of Plan Benefits (New)	45
Patient Safety and Quality of Care—Part D Drugs Approved and Registered by FDA	46
Drug Payments—Specialty Tier Formularies and Related Cost Sharing (New).....	46
Drug Payments—Characteristics Associated With Atypically High Billing	46
Drug Payments—Part D Claims Duplicated in Part A and Part B	46
Drug Payments—Questionable Claims for HIV Drugs	47
Drug Payments—Drugs Dispensed Through Retail Pharmacies With Discount Generic Programs	47
Coverage Gap—Quality of Sponsor Data Used in Calculating Coverage-Gap Discounts	47
Coverage Gap—Accuracy of Sponsors’ Tracking of True Out-of-Pocket Costs.....	47
Prescription Drug Event Data—Data Submitted for Incarcerated Individuals	48
Sponsors’ Bid Proposals—Documentation of Administrative Costs	48
Sponsors’ Bid Proposals—Documentation of Investment Income	48
Reconciliation of Payments to Sponsors—Discrepancies Between Negotiated and Actual Rebates	48
Reconciliation of Payments to Sponsors—Reopening Final Payment Determinations.....	49
Risk Sharing and Risk Corridors—Savings Potential of Adjusting Risk Corridors	49
Information Systems—Supporting Systems at Small- and Medium-Size Plans and Plans New to Medicare ..	49

Part III

Medicaid Reviews

Medicaid Prescription Drug Reviews	51
Patient Safety and Quality of Care—Claims for and Use of Atypical Antipsychotic Drugs Prescribed to Children in Medicaid (New)	51
Drug Pricing—Calculation of Average Manufacturer Prices	51
Drug Pricing—State Maximum Allowable Cost Programs	52
Drug Pricing—Manufacturer Compliance With AMP Reporting Requirements	52
Drug Pricing—Drugs Purchased Under Retail Discount Generic Programs	52
Manufacturer Rebates—States Collection of Rebates on Physician-Administered Drugs (New)	53
Manufacturer Rebates—States’ Collection of Supplemental Rebates (New)	53
Manufacturer Rebates—Impact of the Deficit Reduction Act of 2005 on Rebates for Authorized Generic Drugs	53
Manufacturer Rebates—Zero-Dollar Unit Rebate Amounts	54
Manufacturer Rebates—New Formulations of Existing Drugs	54
Manufacturer Rebates—States’ Efforts and Experiences With Resolving Rebate Disputes	54
Manufacturer Rebates—Federal Share of Rebates	54
Home, Community, and Personal Care Services.....	55
Home Health Services—Duplicate Payments by Medicare and Medicaid (New)	55
Home Health Services—Screenings of Health Care Workers	55
Home Health Services—Provider Compliance and Beneficiary Eligibility	55
Home Health Services—Homebound Requirements	56
Medicaid Waivers—Quality of Care Provided Through Waiver Programs	56
Medicaid Waivers—Supported Employment Services (New)	56
Medicaid Waivers—Adult Day Health Care Services (New)	56
Medicaid Waivers—Unallowable Room and Board Costs (New)	57
School-Based Services—Students With Special Needs	57
Community Residence Rehabilitation Services	57
Continuing Day Treatment Mental Health Services	57
Personal Care Services—Compliance With Payment Requirements	58
Other Medicaid Services, Equipment and Supplies.....	58
Nursing Facility Services—Communicable Disease Care (New)	58
Dental Services for Children—Inappropriate Billing (New)	59
Dental Services for Children—Billing Patterns in Five States (New)	59
Hospice Services—Compliance With Reimbursement Requirements	59
Family Planning Services—Claims for Enhanced Federal Funding	59
Transportation Services—Compliance With Federal and State Requirements	60
Health-Care-Acquired Conditions—Prohibition on Federal Reimbursements	60
Medical Equipment and Supplies—Potential Savings From the Competitive Bidding Program (New)	60
Medical Equipment and Supplies—Opportunities To Reduce Medicaid Payment Rates for Selected Items (New)	60

Medical Equipment and Supplies—Opportunities To Reduce Medicaid Payment Rates for Blood-Glucose Test Strips (New).....	61
Medical Equipment and Supplies—States’ Efforts To Control Costs for Disposable Incontinence Supplies (New).....	61
State Management of Medicaid	61
State Use of Provider Taxes To Generate Federal Funding	61
State-Operated Facilities—Reasonableness of Payment Rates	62
State Upper-Payment-Limit-Related Supplemental Payments to Private Hospitals	62
State Use of Incorrect FMAP for Federal Share Adjustments (New)	62
State Allocation of Medicaid Administrative Costs.....	62
State Quarterly Expenditure Reporting on Form CMS-64—CMS Oversight	63
State Medicaid Monetary Drawdowns—Reconciliation With Form CMS-64	63
State Reporting of Medicaid Collections on Form CMS-64	63
State Actions To Address Vulnerabilities Identified During CMS Reviews	63
State Buy-In of Medicare Coverage—Eligibility Controls.....	64
State Medicaid Payments for Medicare Deductibles and Coinsurance (New)	64
State Cost Allocations That Deviate From Acceptable Practices (New)	64
State Recovery Audit Contractor Performance and Results (New).....	64
State Enrollment and Monitoring of Medical Equipment Suppliers (New)	65
State Determinations of Hospital Provider Eligibility and Program Participation (New)	65
State Compliance With Estate Recovery Provisions of the Social Security Act (New)	65
State Compliance With the Money Follows the Person Demonstration Program (New)	65
State Terminations of Providers Terminated by Medicare or by Other States	66
State Payments to Federally Excluded Providers and Suppliers	66
State Compliance With Federal Certified Public Expenditures Regulations	66
State Procedures for Identifying and Collecting Third-Party Liability Payments	66
State Collection and Verification of Provider Ownership Information	66
Children’s Health Insurance Program for Medicaid-Eligible Individuals.....	67
State Claims for Federal Reimbursement Under the Children’s Health Insurance Program for Medicaid-Eligible Individuals	67
State Compliance With Eligibility and Enrollment Notification and Review Requirements for the Children’s Health Insurance Program.....	67
Medicaid Data Systems, Controls, and Claims Processing.....	67
Early Review of the Transformed Medicaid Statistical Information System Pilot Project (New)	68
Claims With Inactive or Invalid Provider Identifier Numbers	68
Beneficiaries With Multiple Medicaid Identification Numbers	68
Use of the Public Assistance Reporting Information System To Reduce Instances of Payments by More Than One State	68
Management Information Systems Business Associate Agreements	69
Security Controls Over State Web-Based Applications.....	69
Security Controls at the Mainframe Data Centers That Process States’ Claims Data	69

Medicaid Managed Care	70
Beneficiary Access to Medicaid Managed Care (New)	70
Beneficiary Grievances and Appeals Process (New).....	70
State Oversight of Provider Credentialing by Managed Care Entities	70
Managed Care Entities’ Marketing Practices.....	70
Completeness and Accuracy of Managed Care Encounter Data	71
Program Integrity—Excluded Individuals Employed by Managed Care Networks	71
Program Integrity—Medicaid Managed Care Organizations’ Identification of Fraud and Abuse (New)	72
Program Integrity—Managed Care Organizations’ Use of Prepayment Review To Detect and Deter Fraud and Abuse.....	72
Medical Loss Ratio—Medicaid Managed Care Plans’ Refunds to States	72
 Other Medicaid-Related Reviews	72
Medicaid Overpayments—Credit Balances in Medicaid Patient Accounts	73
Payment Error Rate Measurement Program—Error Rate Accuracy and Health Information Security.....	73
Nursing Home Minimum Data Set—Accuracy and CMS Oversight	73
Reviews of State Medicaid Fraud Control Units	74

Part IV

Legal and Investigative Activities Related to Medicare and Medicaid

Legal Activities	75
Exclusions From Program Participation	75
Civil Monetary Penalties	75
False Claims Act Cases and Corporate Integrity Agreements	76
Providers' Compliance With Corporate Integrity Agreements	76
Review of Entities That Do Not Enter Into Corporate Integrity Agreements	76
Advisory Opinions and Other Industry Guidance	76
Provider Compliance Training	77
Provider Self-Disclosure	77
Investigative Activities	77
Medicare Strike Force Teams and Other Collaboration	78

Part V

Public Health Reviews

Public Health Agencies.....	81
Agency for Healthcare Research and Quality	82
AHRQ—Early Implementation of Patient Safety Organizations.....	82
Centers for Disease Control and Prevention	82
CDC—Oversight of Security of the Strategic National Stockpile for Pharmaceuticals (New)	82
CDC—Award Process for the President’s Emergency Plan for AIDS Relief Cooperative Agreements (New) ...	82
CDC—Oversight of HIV/AIDS Prevention and Research Grants (New).....	83
CDC—Grantees’ Use of Funds (New)	83
CDC—Oversight of High-Risk Grantees.....	83
Food and Drug Administration	83
FDA—Oversight of Wholesale Prescription Drug Distributors (New)	83
FDA—Complaint Investigation Process	84
FDA—Oversight of Investigational New Drug Applications	84
FDA—Implementation of the Risk Evaluation and Mitigation Strategies Program.....	84
FDA—510(k) Process for Device Approval.....	84
Health Resources and Services Administration	85
HRSA—Health Center Adoption of Routine Testing for Human Immunodeficiency Virus Testing	85
HRSA—Community Health Centers’ Compliance With Grant Requirements of the Affordable Care Act	85
HRSA—Monitoring of Recipients’ Fulfillment of National Health Services Corps Obligations	85
Indian Health Service.....	86
IHS—Contract Health Services Program’s Compliance With Appropriations Laws (New)	86
IHS—Medicaid Reimbursements.....	86
National Institutes of Health	86
NIH—Extramural Construction Grants at NIH Grantees (New)	86
NIH—Equipment Claims by Grantees (New)	87
NIH—Human Subjects Protection Practices of National Cancer Institute Extramural Grantees Collecting Biospecimens (New)	87
NIH—Superfund Financial Activities for Fiscal Year 2011.....	87
NIH—Colleges’ and Universities’ Compliance With Cost Principles	87
NIH—Extra Service Compensation Payments Made by Educational Institutions	87
NIH—Use of Data and Safety Monitoring Boards in Clinical Trials	88
NIH—Oversight of Grants Management Policy Implementation	88
NIH—Inappropriate Salary Draws From Multiple Universities	88
NIH—Cost Sharing Claimed by Universities.....	89
NIH—Awardee Eligibility for Small Business Innovation Research Awards	89

Substance Abuse and Mental Health Services Administration.....	89
SAMHSA—Performance Goals for the Substance Abuse Treatment Block Grant Program	89
SAMHSA—Grantees’ Use of Funds From the Prevention and Public Health Fund.....	90
Other Public-Health-Related Reviews	90
Select Agent Shipments To and From Foreign Countries (New)	90
Protections of Human Research Subjects (New)	90
Federal Response Capabilities for Public Health and Medical Services Emergency Support	91
Pandemic Influenza Response Planning	91
Oversight of Laboratory-Developed Tests (New).....	91
Public Health Legal Activities	91
Public Health Investigations.....	92
Violations of Select Agent Requirements	92

Part VI

Human Services Reviews

Human Services Agencies	93
Administration for Community Living.....	93
AoA—Senior Medicare Patrol Projects Performance Data	93
AoA—State Long-Term-Care Ombudsman Programs’ Efforts To Identify, Investigate, and Resolve Elder Abuse Cases.....	94
Administration for Children and Families	94
Child Care and Development Fund—Monitoring of Licensing and Health and Safety Requirements for Childcare Providers.....	94
Child Care Development Fund—Licensing, Health, and Safety Standards at Federally Funded Facilities (New)	94
Child Care Development Fund—Direct Services (New)	95
Child Care Development Fund—Targeted Funds (New)	95
Adoption Assistance Subsidies	95
Head Start—Reviews at Selected Grantees (New)	95
Foster Care—State Oversight and Coordination of Health Services for Children in Foster Care (New)	96
Foster Care and Adoption Assistance Training Costs and Administrative Costs	96
Foster Care—Per Diem Rates	96
Foster Care—Group Home and Foster Family Agency Rate Classification	96
TANF—Oversight of Work Participation and Verification Requirements.....	97
Refugee Resettlement—Services for Recently Arrived Refugees	97
Community Action Agencies—Pension Costs Claimed on HHS-Funded Programs.....	97
Low-Income Home Energy Assistance Program (New).....	97
Low-Income Home Energy Assistance Program—Duplicate Payments	97
Child Support Enforcement—State and Local Protection of Child-Support Information (New).....	98
Child Support Enforcement—Increasing Collections.....	98
Child Support Enforcement—Investigations Under the Child-Support Enforcement Task Force Model.....	98

Part VII

Other HHS-Related Reviews

Financial Statement Audits.....	99
Audits of Fiscal Years 2012 and 2013 Financial Statements	99
Fiscal Year 2013 Statement on Standards for Attestation Engagements No. 16.....	100
Fiscal Years 2012 and 2013 Financial-Related Reviews	100
Financial Accounting Reviews.....	101
Certification of Predictive Analytics (New).....	101
HHS Contract Management Review (New).....	102
Compliance With Improper Payment Elimination and Recovery Act	102
The President’s Emergency Plan for AIDS Relief Funds	102
Annual Accounting of Drug-Control Funds.....	102
Reasonableness of Prime Contractor Fees	103
Non-Federal Audits.....	103
Reimbursable Audits	103
Requested Audit Services.....	104
Automated Information Systems.....	104
Information System Security Audits	104
Federal Information Security Management Act of 2002	104
Information Technology Systems’ General Controls.....	104
Fraud Vulnerabilities Presented by Electronic Health Records.....	105
Other HHS-Related Issues.....	105
HHS Programs’ Vulnerabilities to Grant Fraud (New).....	105
HHS Compliance with the Reducing Over-Classification Act (New)	105
Review of Calendar Year 2011 Purchase Card Purchases (New)	105
Use of HHS Grant Funds for Lobbying Activities (New)	106
State Protections for People in Residential Settings Who Have Disabilities	106

Appendix A

Affordable Care Act Reviews

New Programs and Initiatives	107
Pre-Existing Condition Insurance Plans, § 1101	107
Controls Over Pre-Existing Condition Insurance Plans and Collaborative Administration	108
Early Retiree Reinsurance Program, § 1102	108
CCIIO's Internal Control Structure for the Early Retiree Reinsurance Program	109
CCIIO's Certification Procedures for Employment-Based Plans and Plan Sponsor's Use of Federal Funds ..	109
CCIIO's System Security Controls Over Protected Health Information	109
CCIIO's Reimbursements to Plans	109
Employment-Based Plans' Costs for Items and Services Reimbursed.....	109
Employment-Based Plan Sponsors' Use of Early Retiree Reinsurance Program Funds	110
Health Insurance Web Portal, § 1103	110
Oversight of Private Health Insurance Submissions to the HealthCare.gov Plan Finder.....	110
Affordable Insurance Exchanges, §§ 1311, 1321, and 1413.....	110
CCIIO Oversight of Health Insurance Exchange Establishment Grants (New)	111
States' Readiness To Comply With Exchange and Medicaid Eligibility and Enrollment Requirements.....	111
Consumer Operated and Oriented Plan Program, § 1322.....	111
Assessment of the CO-OP Program Award Process (New).....	112
Affordable Care Act: Early Implementation of the Consumer Operated and Oriented Plan (CO-OP)	
Loan and Grant Program (New).....	112
Existing Programs.....	113
Medicare	113
Hospitals—Same-Day Readmissions	113
HHAs—Home Health Face-to-Face Requirement (New).....	113
Power Mobility Devices—Supplier Compliance With Payment Requirements (New)	113
Program Integrity—Onsite Visits for Medicare Provider and Supplier Enrollment and Reenrollment (New)	
.....	113
State Health Insurance Assistance Programs' Provision of Medicare Fraud Information (New)	114
Recovery Audit Contractors—Identification and Recoupment of Improper and Potentially Fraudulent	
Payments and CMS's Oversight and Response	114
Part C: Special-Needs Plans—CMS Oversight of Enrollment and Special-Needs Plans	114
Part D: Coverage Gap—Quality of Sponsor Data Used in Calculating Coverage-Gap Discounts.....	114
Medicaid	114
Manufacturer Rebates—Federal Share of Rebates.....	114
Manufacturer Rebates—New Formulations of Existing Drugs.....	115

Health-Care-Acquired Conditions—Prohibition on Federal Reimbursements	115
State Terminations of Providers Terminated by Medicare or by Other States	115
Completeness and Accuracy of Managed Care Encounter Data	115
State Enrollment and Monitoring of Medicaid Medical Equipment Suppliers (New)	115
Public Health.....	116
HRSA—Community Health Centers’ Compliance With Grant Requirements of the Affordable Care Act.....	116
HRSA—Monitoring of Recipients’ Fulfillment of National Health Services Corps Obligations.....	116
SAMHSA—Grantees’ Use of Funds From the Prevention and Public Health Fund	116

Appendix B

Recovery Act Reviews

Medicare and Medicaid	117
Medicare Part A and Part B	117
Medicare—Incentive Payments for Electronic Health Records	117
Medicaid Administration	117
Medicaid—Incentive Payments for Electronic Health Records	117
Medicare and Medicaid Information Systems and Data Security	118
Health Information Technology System Enhancements	118
Contractor System Enhancements	118
OCR Oversight of the HIPAA Privacy Rule	118
OCR Oversight of the HITECH Breach Notification Rule	119
Public Health Programs	119
Health Resources and Services Administration	119
HRSA—Limited-Scope Audits of Grantees’ Capacities	119
HRSA—Recovery Act Funding for Community Health Centers Infrastructure Development	119
HRSA—Community Health Centers Receiving Health Information Technology Funding	120
HRSA—Health Information Technology Grants	120
National Institutes of Health	120
NIH—Internal Controls for Extramural Construction and Shared Instrumentation	120
NIH—College and University Indirect Costs Claimed as Direct Costs	121
Human Services Programs	121
Administration for Children and Families	121
ACF—Grantees’ Use of Funds	121
ACF—Grant System	121
ACF—Health Information Technology Grants	122
Other HHS-Related Issues	122
Office of the National Coordinator	122
ONC—State Compliance With Grant Requirements	122
Cross-Cutting Investigative Activities	122
Integrity of Recovery Act Expenditures	122

<http://oig.hhs.gov>
