Semiannual Report

Office of Inspector General

October 1, 1995 - March 31, 1996

June Gibbs Brown
Inspector General

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

A MESSAGE FROM THE SECRETARY

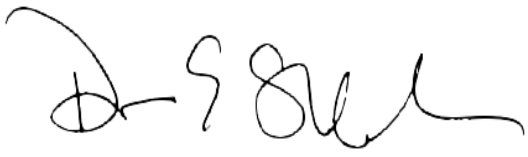
The 6-month period ending March 31, 1996 was a frustrating time in many sectors of the Federal Government. Amid the constraints imposed by the budget impasse and two consequent furloughs, the Department of Health and Human Services (HHS) strove to meet its overriding commitment to provide efficient and effective services to the American people.

I am pleased to note that, despite the difficulties, the Office of Inspector General (OIG) did a remarkable job in executing its oversight responsibilities. The OIG focused its energies on the most critical areas within HHS and worked to promote the highest level of integrity and accountability in the Department's programs and operations.

Among OIG's most significant accomplishments during this period were its successes under Operation Restore Trust. A 2-year partnership of Federal and State agencies announced by the President in May 1995, the project was designed to protect the health care trust funds more effectively through shared intelligence and coordinated enforcement, and to enhance the quality of care for Medicare and Medicaid beneficiaries. This interdisciplinary initiative, targeting fraud, waste and abuse in nursing homes, home health agencies and durable medical equipment suppliers, is underway in the five States which together account for about 40 percent of the Nation's Medicare and Medicaid beneficiaries.

This semiannual report marks the partnership's 1-year anniversary. The OIG's fraud and abuse hotline (1-800-HHS-TIPS), established in June 1995, has received thousands of calls related to the initiative since its inception. Investigations have led to numerous convictions, indictments, civil judgments and exclusions during the project's first year of operation, as well as significant fines, recoveries, settlements and civil monetary penalties. Audits and inspections have identified investigative targets, and made recommendations for recoveries and program and policy changes intended to render the Medicare and Medicaid programs less vulnerable to abuse. In addition, OIG has issued several special fraud alerts to educate the public and the health care industry about fraudulent and abusive health care practices.

The President and I are very pleased with the progress made by OIG and its partners in Operation Restore Trust's first year. We hope to see the knowledge and experience gained from this fruitful undertaking extended to other areas in the future. I commend the efforts of the Inspector General and her staff and applaud their accomplishments in these challenging times.



Donna E. Shalala

FOREWORD

I am pleased to present this semiannual report describing the accomplishments of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) for the 6-month period ending March 31, 1996.

As noted in the Message from the Secretary, this first half of Fiscal Year (FY) 1996 was a challenging time in the Federal Government. The budget deadlock caused many of OIG's critical antifraud and abuse activities to be seriously curtailed. We were forced to suspend several enforcement efforts, audits and inspections, and were unable to launch many planned initiatives. In addition, OIG's statistical results for the 6-month period showed the initial impact of the Social Security Administration's departure and the consequent transfer of approximately one-quarter of OIG's staff to the newly independent agency.

Nevertheless, we enjoyed many notable successes during this semiannual period. These successes followed from our commitment to developing innovative ways of leveraging our limited resources and supplementing those resources through collaboration with other Federal, State and local agencies in areas of mutual interest.

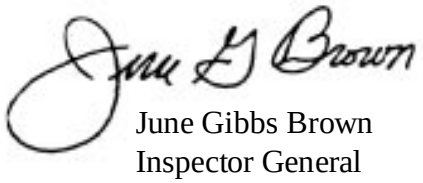
One of our most noteworthy achievements during this semiannual period underscores that commitment. Operation Restore Trust, a multidisciplinary approach to reducing fraud, waste and abuse in specific sectors of the health care industry, is well underway. Despite the project's limited scope, much has already been accomplished. The benefits gained from this experience, both in the reduction of fraud and abuse and the collaboration by numerous agencies in an effort to attack these problems in a comprehensive way, will have an impact for many years to come.

In another cooperative effort, described in Chapter II, OIG formed partnerships with State auditors and evaluators, as well as the Health Care Financing Administration, to identify opportunities for curbing Medicaid costs and to produce savings at both the Federal and State levels.

By targeting our resources to the most crucial issues within HHS and collaborating with others to our common benefit, we have worked to maximize the return to the American taxpayer. In FY 1995, we reported over $10 billion in savings, or $115 for each dollar invested in OIG and an average of $9.7 million per OIG employee. These savings resulted from implementation of OIG recommendations by the Congress or management through legislation, regulations or administrative action, as well as investigative receivables and

audit disallowances. Moreover, as detailed in OIG's Red Book, we have identified billions of dollars in potential savings through recommendations which are being considered for implementation. A summary of our accomplishments during this 6-month period is included in the Highlights section of this semiannual report.

We will continue to seek creative ways of fulfilling our mission to protect the integrity of HHS programs and the health and welfare of the beneficiaries served by those programs. With the support of the Department and the Congress, we are confident of success in meeting the challenges that lay ahead.



June Gibbs Brown
Inspector General

HIGHLIGHTS

Introduction

In these times of fiscal austerity, the Office of Inspector General (OIG) has maximized its impact by targeting its resources to promoting improved service delivery and program effectiveness; addressing systemic problems of fraud, waste and abuse; and devising innovative ways to fulfill its mission. Within its own organization, OIG has reengineered basic work processes and instituted team approaches. The OIG's components have heightened their collaboration, initiating joint audits, evaluations and investigations in the fight against fraud in health care and other areas. On the Department level, OIG has intensified its efforts to develop more effective working relationships with program managers, and assisted them in formulating performance measures for assessing the achievement of program goals.

To further extend its reach, OIG has identified opportunities for mutually beneficial coordination with other Federal, State and local agencies. The results of these cooperative ventures have been impressive and are reflected throughout this semiannual report. The single best example of such a partnership is Operation Restore Trust, discussed in Chapter I.

Operation Restore Trust

A major program integrity project, Operation Restore Trust models an approach for attacking health care fraud through focused intergovernmental teams. New and innovative methods are being utilized in this concerted effort, including the application of advanced computer technology and data gathering techniques; personal contact with beneficiaries in the course of health care provider audits; and collaboration with State long-term care ombudsmen and quality assurance specialists from the State surveyors' offices.

The OIG and its partners have much to be proud of at the project's one year anniversary. Even greater achievements are anticipated for the coming year. At the conclusion of this project, OIG expects that its investment in the detection and pursuit of fraud, waste and abuse in these areas will be returned many times over in recoveries, fines, penalties and savings to the Medicare trust fund.

Within the text of this semiannual report, summaries of audits, evaluations and investigations related to Operation Restore Trust which were finalized during this 6-month period are labeled with the symbol 

for ready identification. The labeled summaries are listed in Appendix G.

Some of OIG's most significant accomplishments under Operation Restore Trust in this 6-month period were:

- A former nursing home owner/operator was sentenced in California to 11 years and 3 months in prison and ordered to pay more than $3.5 million in fines, restitution and assessments for filing fraudulent Medicare reports. (See page 19)

- Five nursing homes paid a total of $2.9 million to settle civil allegations that they entered into a scheme with a billing company to submit claims for medical supplies not covered by Medicare. (See page 14)

- Four of nineteen persons were sentenced for participating in a scheme that cost Medicare more than $13 million which included filing false statements, conspiracy and accepting kickbacks from a New York durable medical equipment (DME) company. (See page 23)

- As part of the project, 21 DME companies and DME owners, as well as skilled nursing facility employees, were excluded from Medicare and State health care program participation for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. (See page 11)

- An OIG inspection that surveyed beneficiary satisfaction with home health services recommended that HCFA improve upon opportunities to explain the home health benefit to Medicare beneficiaries to correct a weakness disclosed by the survey. (See page 16)

- The OIG found that questionable billing practices in Medicare for incontinence supplies were mirrored in the Medicaid program, and noted problems with recoveries of overpayments associated with dually eligible beneficiaries, prompting HCFA to take corrective action. (See page 27)

- In a series of reports on Medicare reimbursement for wound care supplies, OIG found that questionable payments may account for as much as two-thirds of the $98 million in allowances from June 1994 to February 1995. (See page 24)

Other OIG Achievements

The following examples reflect other major OIG accomplishments realized during this semiannual period:

- A Pennsylvania teaching hospital and a physician group at the hospital agreed to pay $30 million to resolve their civil liability because the

physician group billed for a higher level of service than what was in fact provided. (See page 13)

- The owner/chief executive officer, former vice president and former manager of Georgia's largest home health agency were sentenced to serve lengthy prison terms and ordered to pay close to $38 million in fines and restitution for a wide-range of crimes related to Medicare and Medicaid fraud. (See page 19)

- An Ohio hospital paid $1.17 million to settle allegations that it billed Medicare and Medicaid for blood specimen collections when in fact it was performing other nonreimbursable services. (See page 14)

- The owner of six Pennsylvania DME companies was sentenced to 78 months imprisonment, and he and his company assessed $88,400, for soliciting Medicare beneficiaries by telephone to accept items their physicians said were not medically necessary. (See page 25)

- The OIG identified $35.7 million in overpayments made to health maintenance organizations and competitive medical plans for Medicare beneficiaries inappropriately identified as having end stage renal disease. (See page 7)

- In an inspection of unused Medicare provider numbers, OIG found that vulnerabilities still existed in the system because numbers were deactivated after 3 years of nonuse rather than annually, as OIG recommended. (See page 18)

- Partnerships with State auditors are identifying opportunities to curb Medicaid costs. Five States have produced eight reports during this semiannual period uncovering several million dollars in potential recoveries. Audits are underway in another five States and OIG is working with another four States to develop partnership arrangements. (See page 28)

- From 1991 to 1994 emergency assistance expenditures increased by 400 percent to $782 million and they are expected to increase to over $1 billion in 1996. The OIG recommended options to the Administration for Children and Families to curb the growth of this program. (See page 42)

- The OIG identified best practices and opportunities for States to increase specialized transportation services to the elderly and disabled without increasing Federal expenditures. (See page 46)

OIG Work in Performance Measurement

In order to identify work done in the area of performance measurement, OIG has labeled some items throughout this report as "performance measures" with the symbol Performance Measure . Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program which is measured by the number of inoculations provided per dollar of cost. In OIG's opinion, the audits, inspections and investigations identified with the performance measure symbol offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals. These proposals are provided to management for their consideration as they develop their performance measures. (See Appendix F)

Internet Address

This semiannual report and other OIG materials may be accessed on the Internet at the following address:
http://www.sbaonline.sba.gov/ignet/internal/hhs/hhs.html

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Operation Restore Trust

Chapter I

OPERATION RESTORE TRUST

Operation Restore Trust targets fraud, waste and abuse in home health agencies, nursing homes and durable medical equipment suppliers in five States: New York, Florida, Illinois, Texas and California.

This semiannual report marks the 1-year anniversary of Operation Restore Trust. Initiated by the Office of Inspector General (OIG) in March 1995, and publicly announced by the President on May 3, 1995, Operation Restore Trust is an ambitious interdisciplinary project in which Federal and State agencies join to fight fraud, waste and abuse in home health agencies, nursing homes, and the medical equipment and supply industry. The 2-year project is an expansion of the team concept OIG has found fruitful over the years, based on collaboration and sharing of resources among multiple law enforcement agencies. It initially has targeted five States which account for 40 percent of the Nation's Medicare and Medicaid beneficiaries: New York, Florida, Illinois, Texas and California. Funds available under the demonstration authority of Operation Restore Trust support only Operation Restore Trust projects during the 2-year demonstration period.

As the project's coordinator, OIG assembled teams that include investigators from its Office of Investigations and the States' Medicaid Fraud Control Units; auditors and evaluators from both OIG and HCFA; quality assurance specialists from the State surveyors and durable medical equipment regional coordinators; State long-term care ombudsmen through the Administration on Aging; and prosecutors from the Department of Justice and the State Attorneys General. These teams have been conducting financial audits of providers, criminal investigations and referrals to Federal and State prosecutors, civil and administrative sanctions and recovery actions, and surveys and inspections of nursing facilities. The collective experience of these teams also is used to recommend to HCFA and the Congress program adjustments to prevent future fraud and to reduce waste and abuse.

The OIG also enlisted the support and participation of the public and the industries that the initiative targets. A hotline (1-800-HHS-TIPS) was established to receive allegations of fraud and abuse on a confidential basis. To further educate the public and health care providers, OIG will continue its practice of issuing special fraud alerts to identify and describe fraudulent and abusive health care practices. Moreover, a voluntary disclosure

program was initiated on a pilot basis under the auspices of Operation Restore Trust. Through this pilot program, OIG and the Department of Justice established procedures by which home health and nursing home suppliers and providers in the five States may come forward with full disclosure of potential fraud and abuse. By doing so, self-disclosing providers may minimize the cost and disruption of an investigation, negotiate a monetary settlement in lieu of prosecution, and possibly avoid exclusion from Medicare and Medicaid program participation when appropriate. The disclosure program also benefits the Government by exposing schemes that might otherwise go undetected, and expediting the investigation and resolution of program abuses.

All OIG ongoing and new investigations, audits and inspections related to fraud and abuse in the targeted areas of the five States were gathered into the project, that they might benefit from its focused attention, expertise and energies. Since that time, 117 other investigations have been initiated, for a total of 252 cases involving more than 1,340 subjects. Fifty-nine are joint investigations with other law enforcement agencies, including the Federal Bureau of Investigation, the United States Postal Service, the Railroad Retirement Board OIG, the Defense Criminal Investigation Service and State Attorneys General offices.

Since the special hotline was established in June 1995, it has received more than 23,600 calls and letters, of which well over 6,600 were related to Department programs. Of the 780 calls or letters related to Operation Restore Trust during that time, about 560 were related to nursing homes and related medical services, and 220 to home health agencies.

The distribution of all Operation Restore Trust cases among the target States mirrors the beneficiary population of each State. New York, California and Florida have 75 percent of the investigations. The remaining 25 percent are equally divided between Illinois and Texas. Nursing home facilities and related medical services comprise approximately 80 percent of the cases, home health agencies the remaining 20 percent.

During its first year of operation, 32 criminal convictions, 10 civil judgments and 18 indictments were obtained under Operation Restore Trust. Twenty-eight criminal convictions, 9 civil settlements and 18 indictments involved nursing facilities and related medical services cases, and 4 convictions and 1 settlement concerned home health agencies. In addition, OIG has collected a total of more than $37 million in fines, recoveries, settlements and civil monetary penalties during this same period. Thirty-six exclusions of Operation Restore Trust providers from the Medicare and Medicaid programs for convictions of health care fraud have been processed.

Numerous audit and inspection reports related to Operation Restore Trust have already been issued and work continued during this semiannual period. In reviews involving claims by home health agencies, OIG continued to find instances in which Medicare patients were not homebound, or the services were not necessary or not rendered. In these cases, auditors kept

in constant communication with OIG investigators so that they could intervene if warranted. The OIG also continued its audits at hospices and identified additional people who appeared to be ineligible based upon their medical condition at the time they entered the hospices. The OIG is working closely with the Office of General Counsel in adjudicating these cases. Further, OIG completed a pilot review in Florida on evaluating skilled nursing facility care at individual providers. The OIG modified the audit protocol and will use it during its expanded reviews of other nursing facilities.

Within the text of the semiannual report, summaries of audits, evaluations and investigations related to Operation Restore Trust which were finalized during this 6-month period have been labeled with the symbol 

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The project will take 2 years for completion and evaluation. If it continues to prove to be both effective and efficient, other areas may be singled out for similar treatment. Employing these and other initiatives, OIG is working to ensure the integrity and efficiency of the Medicare and Medicaid programs and to protect the beneficiaries of those programs.

Health Care Financing Administration

Chapter II

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare and Medicaid programs. Medicare Part A provides hospital and other institutional insurance for persons age 65 or older and for certain disabled persons, and is financed by the Federal Hospital Insurance Trust Fund. Medicare Part B (Supplementary Medical Insurance) is an optional program which covers most of the costs of medically necessary physician and other services, and is financed by participants and general revenues.

The Medicaid program provides grants to States for medical care for approximately 37 million low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children or Supplemental Security Income. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average.

The Office of Inspector General (OIG) has devoted significant resources to investigating and monitoring the Medicare and Medicaid programs. These activities have often led to criminal, civil and/or administrative actions against perpetrators of fraud and abuse. They also have helped ensure the cost-effective delivery of health care, improved the quality of health care and reduced the potential for fraud, waste and abuse.

Over the years, OIG findings and recommendations have contributed to many significant reforms in the Medicare program. Such reforms include implementation of the prospective payment system (PPS) for inpatient hospital services and a fee schedule for physician services; the Clinical Laboratory Improvement Amendments of 1988; regional consolidation of claims processing for durable medical equipment (DME); establishment of fraud units at Medicare contractors; prohibition on Medicare payment for physician self-referrals; and new payment methodologies for graduate medical education.

The OIG has documented excessive payments for hospital services, indirect medical education, DME and laboratory services, which led to statutory changes to reduce payments in those areas. To ensure quality of patient care, OIG has assessed clinical and physiological laboratories; evaluated the medical necessity of certain services and medical equipment;

analyzed various State licensure and discipline issues; reviewed several aspects of medical necessity and quality of care under PPS, including the risk of early discharge; and evaluated the care rendered by itinerant surgeons and the treatment provided by physicians performing in-office surgery.

The OIG also plays a role in the Department's Federal Managers' Financial Integrity Act process designed to detect and correct systemic weaknesses, and reviews HCFA's financial statements under the Chief Financial Officers Act.

Medicare Risk Health Maintenance Organization Performance Indicators

Performance Measure

The rapidly increasing participation of Medicare and Medicaid beneficiaries in managed care has heightened the need to find valid measures and performance indicators for health maintenance organizations (HMOs). Two measures which have been considered by researchers and policy analysts are HMO disenrollment rates and direct surveys of HMO members. In an analysis of data from a previous OIG survey of 2,882 enrolled and disenrolled beneficiaries in 45 Medicare risk HMOs, OIG determined that HMO disenrollment rates may provide an early alert of possible problems among Medicare risk HMOs.

The OIG recommended that HCFA use systematically developed HMO disenrollment rates and beneficiary survey data to improve its monitoring activities. Specifically, OIG proposed that HCFA: track disenrollment rates over time to detect potential problems among HMOs; use adjusted disenrollment rates along with other available HMO information to target reviews of HMOs; conduct disenrollment surveys that fully capture beneficiaries' reasons for leaving risk HMOs.; survey enrollees systematically and routinely on key questions and on their desire to leave/remain with their HMOs as a complement to disenrollment data; monitor Medicare risk HMOs with high disenrollment rates and reported service access problems, and work with HMOs to respond to the needs of beneficiaries at risk of disenrolling.

The HCFA concurred with OIG's recommendations and noted several projects underway by the Office of Managed Care and other work groups addressing many of them. (OEI-06-91-00734)

Medicare Beneficiary Interest in Health Maintenance Organizations

Performance Measure

This report concerned Medicare beneficiary awareness of and interest in joining HMOs. Although most of the 1,000 beneficiaries who responded to OIG's survey had heard of HMOs, 64 percent said they would like more information about them. The OIG found that HCFA has a potentially receptive population for increasing the use of HMOs: 27 percent of

the respondents expressed an interest in joining an HMO and an additional 34 percent said they did not know if they would be interested in joining. Only 39 percent said they were not interested, mainly because they could not select their own physicians. The HCFA concurred with OIG's recommendation that it continue efforts to educate Medicare beneficiaries on managed care options and HMOs. (OEI-04-93-00142)

Medicare Payments to Health Maintenance Organizations for End Stage Renal Disease Beneficiaries

The OIG found that between October 1990 and February 1995 approximately $35.7 million in overpayments were made to HMOs and competitive medical plans for Medicare beneficiaries inappropriately identified as having end stage renal disease (ESRD). This was due to systems weaknesses at HCFA. The OIG found that when an HMO or competitive medical plan advised HCFA that a beneficiary no longer met the ESRD definition, HCFA's systems did not recognize ESRD termination. This resulted in the HMO or competitive medical plan continuing to receive an enhanced ESRD capitation payment. The enhanced monthly ESRD capitation rate is approximately $3,000 per beneficiary.

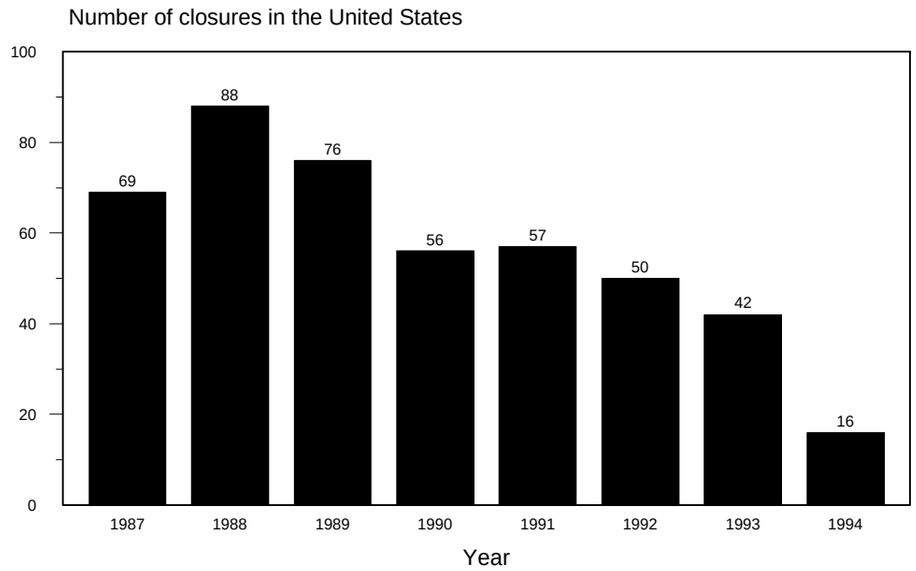
The OIG recommended that HCFA advise all risk-based HMOs and competitive medical plans that ESRD capitation rates are only effective for beneficiaries who currently are diagnosed as having ESRD, recover the $35.7 million in overpayments identified through February 1995 as well as subsequent overpayments that have occurred, and make systemic and procedural changes to prevent future overpayments. The HCFA agreed with OIG's findings and recommendations. (CIN: A-04-94-01090)

Hospital Closure: 1994

The closure of general, acute care hospitals in recent years has generated public and congressional concern. In response, OIG has released annual reports describing the extent, characteristics and impact of hospital closure from 1987 through 1993. This report continues that analysis.

As illustrated in the following chart, 16 hospitals closed in 1994, the lowest number of yearly closings since OIG began these inspections.

HOSPITAL CLOSURE



While 16 hospitals closed in 1994, 13 hospitals opened. Most of the hospitals that closed were small and had low occupancy. The average daily patient load in the year prior to closure was about 5 in rural hospitals and about 39 in urban hospitals. Rural hospitals that closed had an average occupancy rate of 28 percent; urban hospitals that closed had an average occupancy rate of 41 percent. Although residents of a few communities had to travel greater distances for hospital care, most had emergency and inpatient medical care available within 10 miles of a closed hospital. (OEI-04-95-00100)

Medicare Part B Billings at Teaching Hospitals

The OIG reported to HCFA on the status of a nationwide project involving a review of Medicare Part B billings by physician group practices at teaching hospitals. This two-stage project is being conducted jointly by OIG and the Department of Justice (DOJ) and is a good example of the successful use of audit resources in investigative work.

The OIG/DOJ project emanated from an OIG audit of Medicare billings by the Clinical Practices of the University of Pennsylvania (CPUP). The OIG/DOJ review found that, for a significant number of Medicare Part B bills, the medical records had no documentation to show that a CPUP physician was present when residents of the teaching hospital performed a service. Without such documentation, these bills were ineligible for Medicare reimbursement. In addition, a significant number of services were billed at a higher level of care than the level supported by the medical records. While most of the upcoding involved just one level of care, many services were upcoded two levels and some were upcoded three

levels. Generally, the higher the level of care provided, the higher the Medicare reimbursement.

Negotiations between CPUP and OIG/DOJ culminated in a signed agreement under which CPUP will pay over $30 million to the Federal Government as full and final settlement for claims submitted during the years 1989 through 1994. A summary of the settlement is reported on page 13. Because of the success of phase one, OIG and DOJ are expanding the project to physician group practices at other teaching hospitals nationally. (CIN: A-03-94-00016)

Medicare Transaction System

This report summarizes the results through December 1994 of OIG's monitoring of HCFA's Medicare transaction system (MTS) initiative — a major effort on HCFA's part to implement a single, integrated national claims processing system. The system is expected to be phased in at a small number of sites beginning in 1997 with full implementation before the end of 1999. The OIG found that HCFA had taken a number of steps to include a broad range of functions related to Medicare benefits administration within the scope of the new system and also to improve internal and financial management controls over Medicare benefit payments. However, OIG found that HCFA needed to identify and share with its MTS design contractor the full range of possible Medicare program changes so that the contractor could build an adaptable system design. Also, OIG found that HCFA needed to cover certain previously identified weaknesses and limitations in current Medicare claims processing.

In response to OIG's findings, HCFA noted that it had provided its design contractor with program and operations planning scenarios addressing issues that could have a major impact on MTS over its useful life for the contractor's use in evaluating alternative systems design. The HCFA also identified a number of actions already taken to address previously identified weaknesses and limitations in claims processing. (CIN: A-14-93-02543)

Medicare Peer Review Organizations' Role in Identifying and Responding to Poor Performers

Performance Measure

The OIG found that, as the peer review organization (PRO) program becomes increasingly committed to improving the overall practice of medicine, its ability to find and take action on poorly performing physicians and hospitals is questionable. The PROs have very limited leads with which to identify poor performers, and they are unlikely, under their current contracts, to determine if leads are isolated events or part of a pattern of poor care. In addition, PROs rarely follow up on poor care by initiating improvement plans that compel poor performers to address the quality of care problems. Further, as OIG has reported previously, the sanction referral authority continues in its moribund state and PROs continue to make minimal referrals to State medical boards. While some expressed reservations

about their impact on protecting beneficiaries from poor performers, PROs themselves find much that is positive about the current direction of the program.

The OIG recommended that HCFA reconsider the PROs' function to identify and respond effectively to poorly performing physicians and hospitals. Toward that end, this report presented HCFA with two options: proceed toward directing the PROs to focus exclusively on improving the mainstream of care and consider other ways in which to identify and respond to poor performers, or devote further inquiry to determine if and how these two functions can be performed simultaneously by the PROs. The HCFA concurred with the recommendation. (OEI-01-93-00251)

Beneficiary Complaint Process of the Peer Review Organizations

Performance Measure

The PROs aim to improve the overall practice of medicine by analyzing patterns of care and outcomes, and by sharing information with the medical community. The Medicare beneficiary complaint process is a primary vehicle through which the PROs are able to identify and respond to individual instances of poor medical care. The OIG found that complaints to PROs are an important source for identifying quality of care problems. Between 10 and 15 percent of the complaints to all 53 PROs led to confirmed quality of care problems. Half the PROs in OIG's sample identified health systems problems through complaints. However, OIG found that Medicare beneficiaries are often unaware of their opportunity to complain to PROs about the quality of their medical care. Moreover, OIG determined that the complaint process has some flaws that undermine its effectiveness. To remedy these, OIG recommended that HCFA: require the PROs to respond more substantively to complainants; identify cost-effective ways to enhance beneficiary awareness of the PROs and the complaint process; and streamline the complaint process. While HCFA agreed with some of the recommendations, it expressed concerns about preserving the due process rights of providers and the completeness of the PRO reviews. (OEI-01-93-00250)

Medicare Administrative Costs

The HCFA contracts with private insurance companies (fiscal intermediaries [FIs] and carriers) to process and pay Medicare claims. The OIG reviews the allowability of costs claimed for reimbursement by these contractors.

A. Aetna Life Insurance Company

The OIG determined that the Aetna Life Insurance Company charged unallowable administrative costs to Medicare Parts A and B for Fiscal Years (FYs) 1990 through 1994, and recommended a financial adjustment totaling nearly $2.94 million. Aetna concurred with this adjustment except for $512,330 related to facilities and occupancy costs. The HCFA is currently negotiating a settlement. (CIN: A-01-95-00504)

B. Blue Cross and Blue Shield Association

An OIG audit of Blue Cross and Blue Shield Association (BCBSA) for FYs 1990 through 1993 determined that unallowable administrative costs were charged to Medicare Part A. The OIG recommended a financial adjustment totaling over $1.3 million. The BCBSA concurred with portions of the amounts questioned for travel and entertainment and other costs. The HCFA is currently negotiating a settlement. (CIN: A-05-95-00042)

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 786 sanctions, in the form of exclusions or monetary penalties, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. About three-fourths of the exclusions were based on conviction of program-related crimes, conviction of controlled substance manufacture or distribution, conviction related to patient abuse or loss of license to practice health care. Monetary penalties can be assessed under several civil monetary penalty (CMP) authorities which have been delegated to OIG.

The OIG has continued to leverage its resources by forming multidisciplinary teams composed of its own auditors and investigators, as well as outside investigative groups when appropriate, to increase its focus on combating fraud, waste and abuse in departmental programs.

A. Program Exclusions

Title XI of the Social Security Act provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, distribution of a controlled substance, revocation or surrender of a health care license, or failure to repay health education assistance loans (HEALs). Exclusion is mandatory for those convicted of program-related crimes or crimes relating to patient abuse. A significant number of OIG exclusions involve failure to repay HEALs, as discussed in more detail in the chapter on the Public Health Service. During this reporting period, OIG imposed exclusions on 615 individuals and entities in all.

The OIG reviews all factors involved in a case to determine whether an exclusion is appropriate and, if so, the proper length of the exclusion. Factors reviewed include information solicited directly from the provider and information obtained from outside sources such as courts, licensing agencies, or other Federal or State programs. The following exclusions are examples of some imposed during this reporting period:

- To date, 14 of the 23 social workers and HMO representatives involved in an elaborate scheme to defraud the Medicaid program have each been

excluded for 5 years. The remaining individuals are in the process of being excluded. As part of the scheme, they used such tactics as forgery and bribery to obtain confidential information on Maryland medical assistance recipients to enroll them in HMOs without their knowledge.

- A 15-year exclusion was imposed on a West Virginia dentist convicted of receiving over $600,000 in Medicaid reimbursement for services he did not perform. In addition, he was convicted of using a medical device from a foreign country for which approval had not been given by the Food and Drug Administration.

- After being convicted of three counts of indecent assault on patients, a Pennsylvania gynecologist was excluded for 10 years.

- Two Texas nurse's aides were excluded for 5 years after being convicted, in separate instances, of nursing home patient abuse. Another Texas nurse's aide was excluded for 5 years after being convicted of failure to report the abuse or neglect of a nursing home patient.

- A 20-year exclusion was imposed on a Pennsylvania physician convicted of defrauding the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program of over $4.4 million. He had previously been excluded in 1982 as a result of his conviction for fraud against the Medicaid program.

- An Ohio physician was excluded for an indefinite period after his license was revoked for failure to provide care that met minimum standards.

- A physician was excluded from program participation indefinitely after the Indiana Medical Licensing Board revoked his license for engaging in a course of repeated conduct which demonstrated a failure to exercise reasonable care and diligence as is ordinarily exercised by practitioners.

- An individual wishing to work as a certified nursing assistant was barred from receiving Medicaid reimbursement by the Maine Department of Human Services as a result of his conviction for tampering with public records or information. Based on the debarment, he was excluded for 15 years.

- After being convicted of conspiracy to defraud, filing false and fraudulent claims, and paying kickbacks for the referral of Medicare patients, the owner and operator of eight Florida DME companies was excluded for 30

years. In addition, one of his employees was also convicted of conspiracy and has been excluded for 10 years.

The actions taken by OIG to exclude individuals and entities have made it a focal point in the credentialing of health care providers. As a means of safeguarding the provision of health care in the private sector, a number of hospitals and others in the health care industry have established a routine practice of querying OIG to ensure that individuals they are considering hiring have not been excluded from Medicare and State health care program participation. In fact, the National Committee on Quality Assurance (NCQA) has mandated that any HMO seeking accreditation by it must credential all of their health care professionals. The NCQA has included in this credentialing process the requirement that the Department of Health and Human Services' OIG specifically be queried to determine if any of the HMO's health professionals have been excluded from program participation.

As more and more HMOs have sought accreditation and the practice of credentialing has grown in the health care arena, the number of queries to OIG for exclusion information has increased substantially. During this 6-month period, OIG responded to credentialing requests from HMOs, hospitals, medical societies, licensing boards, etc., to certify the exclusion status of over 11,000 individuals.

B. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law allows recoupment of monies lost through illegitimate claims, and it also protects health care providers by affording them due process rights. Many providers elect to settle their cases prior to litigation. The Government, with the assistance of OIG, recouped more than $50.5 million through both CMP and False Claims Act civil settlements related to health care during this reporting period. Some examples of these cases include:

- In Pennsylvania, a component of a university health system agreed to pay the Federal Government $30 million in settlement of charges of defrauding the Medicare program. An audit and investigation revealed that false Medicare bills were submitted for physician services. Many of the claims improperly reported the level of care provided or falsely reported the involvement of attending physicians, in addition to residents, rendering the service. The resulting overpayment was approximately $10 million. The civil settlement also requires that the component institute a compliance program to assure correct billing practices in the future. See page 8 regarding the audit findings.

- A New Jersey corporation agreed to pay $2.1 million to settle the civil aspects of a scheme to defraud Medicare. The corporation used its subsidiaries in Pennsylvania and Massachusetts to bill carriers in each other's areas to obtain the best reimbursement for x-ray and electrocardiographic services. Approximately 6,000 false claims were submitted in violation of point-of-sale regulations. The Pennsylvania subsidiary, its president and its vice president agreed to plead guilty to criminal charges for their involvement in the scheme.

- Five nursing homes in the States of Florida and Washington agreed to pay nearly $2.9 million to resolve their civil liability for complicity in the submission of false claims to the Medicare program as a result of a joint audit and investigation. The nursing homes entered into contracts with a billing agent, under the terms of which the agent reviewed medical records and then billed Medicare for so called "lost charges." These charges were for medical supplies for which the nursing homes had initially not filed claims. The billing agent induced Medicare to pay these claims by putting false diagnoses on the claims forms. In fact, the supplies which were billed were not reimbursable by Medicare. Under the contracts, the nursing homes kept 50 percent of all reimbursement by Medicare. As part of the settlements, the nursing homes were required to enter into compliance plans designed to ensure the accuracy and validity of future billings and cost reports.

- A California hospital paid nearly $1.3 million to resolve its civil liability for allegedly submitting false claims to the Medicare and Medicaid programs. The hospital submitted claims for experimental cardiac devices that had not received final approval by the Food and Drug Administration, in contravention of Medicare rules and policies.

- A medical center in Ohio agreed to pay $1.17 million to settle allegations of Medicare and Medicaid fraud. The hospital submitted duplicate and multiple billings for venipuncture (blood specimen collection) and claims for venipunctures when other, nonreimbursable services were actually provided. The claims were submitted through a computerized billing system designed by consultants who are also under investigation. Estimated damages amounted to $390,000. The hospital has agreed to an independent audit of other billings, back to 1989, and to reporting any improper payments. In addition it will set up a compliance program to educate employees on accurate and valid filing of claims with Government programs.

- A 48-bed psychiatric hospital for children and adolescents in Nebraska and its Tennessee parent corporation agreed to pay close to $554,700 to settle allegations it filed false Medicaid claims as a result of a joint audit and investigation. The hospital inflated the time its psychiatric doctors spent with patients by 35 to 60 minutes. The hospital also allegedly billed for some psychiatric services that were never delivered. Under the settlement, the companies also entered into an agreement to assure proper Medicaid training of employees and to audit all Medicaid billings for the next 5 years.

- A Philadelphia psychiatrist, his wife and their nonprofit corporation agreed to pay $500,000 in settlement for defrauding the Medicare and Medicaid programs of $300,000. In addition, the corporation agreed to enter into a compliance program to ensure that false billings would not recur. From 1991 to 1993, the psychiatrist and his wife filed numerous false Medicare and Medicaid claims by billing for more therapy units than were provided to beneficiaries, billing for unsupervised treatments and billing for therapy which was not provided. When agents conducted a search in January 1994, the psychiatrist attempted to remove records from the corporate office to prevent the Government from seizing them. The records were recovered before he could destroy or alter them. The psychiatrist has agreed to plead guilty to criminal charges of mail fraud and making false statements.

- An Ohio physician agreed to pay $300,000 in civil damages and penalties for defrauding Medicare, Medicaid, CHAMPUS, and the Railroad Retirement Board. The physician billed for laboratory services that were unnecessary or not performed, and double-billed by fragmenting and unbundling services. He was convicted earlier of Medicaid fraud in State court and pled guilty to mail fraud and money laundering in Federal court. In the plea he agreed to cooperate with the Government in exchange for dismissal of charges under pretrial agreements against his corporation and his sister, a corporation employee.

- A Pennsylvania gynecologist/obstetrician agreed to pay $98,000 to settle allegations that he filed false claims with Medicare, the Federal Employees Health Benefits program and a private insurer. Among other fraudulent claims, the physician billed Medicare for Pap smears which were not provided, and for services provided to his parents, which are not reimbursable under Medicare. He also billed routine office visits by pregnant women as emergency visits and billed for hospital services which had already been paid to the hospital.

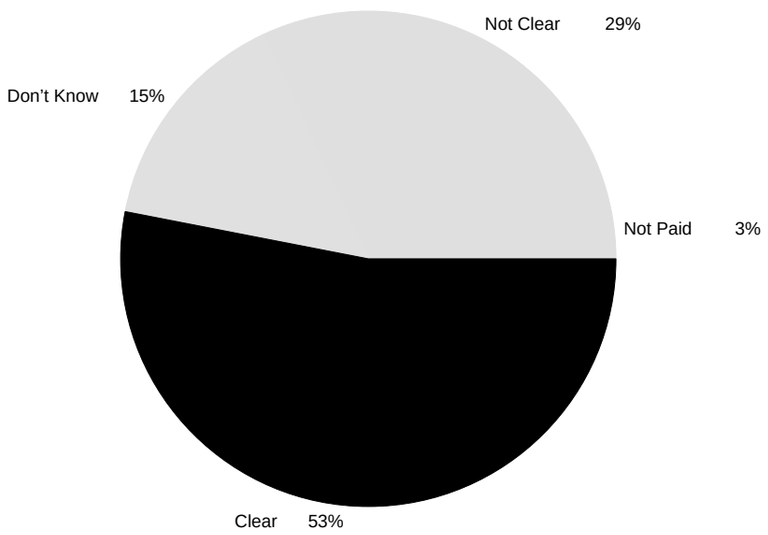
- An Illinois physician agreed to pay $43,700 to resolve civil liabilities under the False Claims Act and the CMP law. Investigation showed that between 1990 and 1993 the physician submitted Medicare claims under his own name for an unlicensed physical therapist. He retained 20 percent of the Medicare reimbursement and the therapist got the remainder. The physician surrendered his license. The therapist negotiated a settlement of $50,000 for his part in the scheme.

Medicare Beneficiary Satisfaction with and Understanding of Home Health Services

Performance Measure

As part of a recurring nationwide Medicare beneficiary satisfaction survey, OIG found that most beneficiaries were satisfied with home health care: 91 percent said home health agency (HHA) personnel did an adequate job, 86 percent said they received the number of home health care visits they thought they needed, and 76 percent reported that a physician or HHA employee had explained how their medical condition should improve as a result of care received from an HHA. However, as illustrated in the following chart, about half the beneficiaries in OIG's survey did not understand what Medicare paid for.

BENEFICIARY UNDERSTANDING OF WHAT MEDICARE PAID FOR HOME HEALTH SERVICES



Home health beneficiaries do not receive an Explanation of Medicare Benefits (EOMB), as do hospital beneficiaries.

The OIG strongly supports HCFA's efforts to improve beneficiary understanding of the home health benefit. The OIG recommended that HCFA improve upon existing opportunities to explain the home health benefit to beneficiaries, including: developing a plan to increase understanding of the home health benefit by physicians and discharge planners, and encouraging them to explain the benefit to patients receiving home health services; and stressing the requirement that HHAs explain the benefit as well as patients' rights to beneficiaries when they start home health services. In addition, HCFA should pursue new methods, such as providing an EOMB to home health beneficiaries and issuing a description of the home health benefit directly to Medicare beneficiaries.

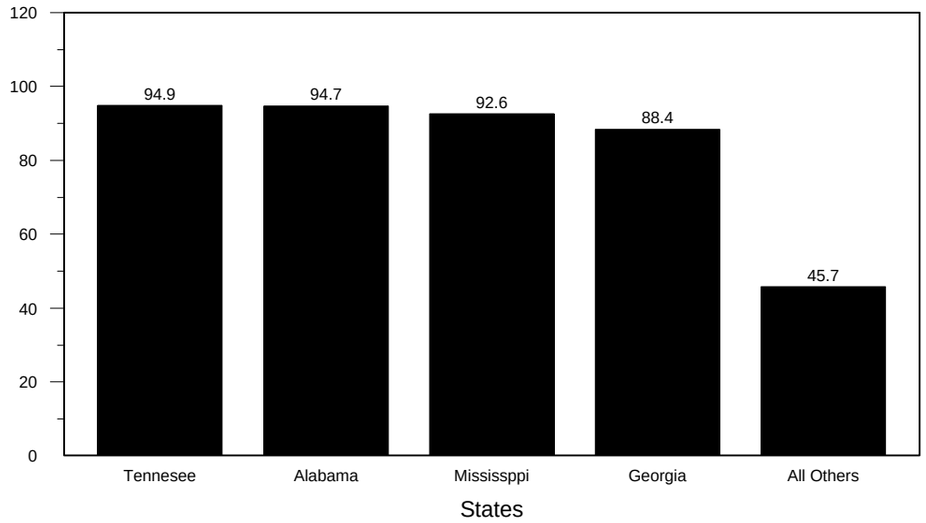
The HCFA concurred with OIG's recommendations, and is currently testing an EOMB for home health services and a pamphlet on the home health benefit that they plan to distribute to home health beneficiaries. (OEI-04-93-00143)

Geographical Variation in Visits Provided by Home Health Agencies

This OIG report, which identifies geographic locations of high-visit HHAs, should prove useful to HCFA, State survey agencies, regional home health intermediaries, and law enforcement agencies in targeting resources for detection and prevention of fraud and abuse.

The OIG found that 19 States had a larger concentration of high-visit HHAs than the 34 other States (including the District of Columbia, the Virgin Islands and Puerto Rico). The HHAs in the southeastern region averaged the most visits per beneficiary and HHAs in four of those States averaged twice as many visits per beneficiary as HHAs in all other States, as illustrated below.

AVERAGE NUMBER OF VISITS PER BENEFICIARY



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Further, OIG determined that regardless of their location, HHAs serviced by regional home health intermediaries located in the southeast had the highest number of visits per beneficiary.

In a previous report, OIG recommended that HCFA take action to eliminate inappropriate variation in Medicare reimbursement among HHAs, targeting high-visit HHAS for further review. The information in this report should assist HCFA in implementing that recommendation. The OIG believes that the variation in average number of visits by State and regions raises questions about the uniformity of oversight among State survey agencies, HCFA regional officials and regional home health intermediaries. The OIG plans to continue its analysis of these and related questions under Operation Restore Trust. (OEI-04-93-00262)

Carriers Need to Purge Unused Provider Numbers

In 1991, OIG reported that most Medicare carriers did not systematically update provider files and recommended that HCFA require deactivation of all provider numbers without current billing history. In October 1994, HCFA instructed the carriers to deactivate provider numbers if no claims were submitted over a 3-year period. The deactivation was completed by February 1995.

In a review of Medicare carrier data obtained during May and June 1995, OIG found that the vulnerabilities remain. For physicians who filed only paper rather than electronic claims, OIG determined that 65 percent of the “active” provider numbers in carrier files were not

being used for submitting claims. Because the large number of active but unused numbers raised significant concerns regarding integrity and efficiency, OIG recommended that HCFA require carriers to deactivate all provider numbers without current billing history annually and to update provider records periodically. The HCFA agreed with the finding, but thought that the 3-year deactivation threshold was adequate. Since OIG's data showed that the deactivation completed in February 1995 left many unused provider numbers active in their files, OIG believes that more aggressive corrective action is necessary. (OEI-01-94-00231)

Criminal Fraud

The most common fraud investigated by OIG against health care providers is the filing of false claims or statements in connection with the Medicare and Medicaid programs, as illustrated in the following cases:

- The owner and chief executive officer of Georgia's largest home health agency, who pled guilty to charging Medicare and Medicaid for campaign contributions, ghost employees and personal vacation trips, was sentenced to 33 months incarceration followed by 3 years supervised work release, during which she is to perform 200 hours of community service. She was fined $25 million and ordered to pay $11.5 million in restitution. The company's former vice president was sentenced to 151 months incarceration and 3 years probation, fined $75,000 and ordered to repay $710,100. He was convicted of making false statements about salaries for ghost employees and a related organization, converting workers compensation premiums to his own use, using Medicare funds to support a consulting business, embezzling employee health insurance and benefit plan funds, committing bank fraud and laundering money. In addition, the former agency risk manager was sentenced to 97 months incarceration and 3 years probation, and ordered to repay $710,000 after being convicted of mail fraud and conspiracy to defraud the Medicare and Medicaid programs. The consulting business of which the risk manager had been president was sentenced to 5 years probation, fined $250,000 and ordered to pay restitution of $710,000. This case is an excellent example of a successful joint audit and investigative effort.

- A former nursing home owner and operator was sentenced in California for filing over 7,000 fraudulent Medicare claims. He was sentenced to 11 years and 3 months imprisonment and ordered to pay fines, restitution and special assessments of more than $3.5 million. A joint audit and investigation revealed that the nursing home owner had billed Medicare for nonexistent medical supplies for his nursing home, and filed cost reports with false expenses. He attempted to conceal the scheme by submitting false cost reports to Medicare supported by falsified medical records and fabricated

invoices. Two of his employees and two former Medicare carrier employees who testified against him pled guilty and were sentenced earlier.

- A Virginia chiropractor, his brother and his corporation were sentenced for a scheme to defraud Medicare, Medicaid, the Civilian Health and Medical Program of the Uniformed Services and Blue Cross Blue Shield of Virginia. The chiropractor had been convicted on 44 counts of false claims, mail fraud, obstruction of justice, money laundering and structuring. He used the provider number of a doctor he hired to bill for services by chiropractors in his office. His brother, a stock broker, helped him liquidate his stock portfolio in which the proceeds of the scheme were invested. The two then withdraw funds in less than $10,000 increments from the bank account in which the stock funds were invested. The brother was convicted of structuring, and the corporation on 32 counts of false claims and mail fraud. The chiropractor was sentenced to 51 months of incarceration and 5 years probation, and ordered to pay $100,000 restitution and a $2,200 special assessment. His brother was sentenced to 7 months incarceration, and his corporation was fined $32,000 and given a $6,400 special assessment. The chiropractor's wife/office manager entered an agreement earlier to pay civil and criminal penalties, as did two other chiropractors who used the same physician's number in similar schemes.

- An Illinois physician was sentenced to 24 months in prison and ordered to pay a $25,000 fine and $41,460 in restitution for defrauding Medicare and private insurers. Unable to recruit physicians and sufficient referrals for a multi-million dollar diagnostic clinic he had built, the physician billed for every patient who visited the clinic $4,000 to $6,000 in unnecessary tests. He entered false symptoms in the patients' records to justify the billings. The case involved the difficult issue of proving lack of medical necessity. The sentencing culminated a lengthy investigation and a 5-month trial, the longest in the southern district of Illinois.

- A former co-owner of an Ohio ambulance service company was sentenced to 14 months imprisonment, 2 months home confinement and 3 years supervised release for mail fraud in relation to false Medicare, Medicaid and Railroad Retirement Board claims. He was also ordered to pay $65,895 in restitution, plus a $150 special assessment, and to perform 100 hours community service. He and his former business partner and co-owner of the ambulance service company had been charged with filing Medicare and Medicaid claims through the company for transporting dialysis patients to the hospital when they were really transported to dialysis centers, a noncovered service. They also billed Medicare for oxygen not

administered, to reinforce charges for the emergency trips, and forged physicians' signatures and diagnoses. Identified Medicare and Medicaid losses amounted to about $65,000. The other co-owner was acquitted earlier.

- A former billing clerk for a diagnostic laboratory was sentenced in Florida to 9 months imprisonment and 2 years supervised release, and ordered to pay $50 special assessment for submitting false Medicare claims. The clerk and her husband, who was president of the laboratory, used a fraudulent passport in setting it up and falsified Medicare claims. Investigation showed that the company had submitted 717 claims for 416 beneficiaries, many of whom were already dead, and had been paid $330,000 over a 60-day period. In addition, one of the "referring" physicians had been dead for 2 years. A survey of 150 patients showed that 40 had never received services from the company or had not known the referring physicians. The husband had been arrested after trying to withdraw $200,000 from the corporate account. He was sentenced earlier to 10 months in prison and 3 years probation, ordered to make restitution of $115,800 and fined $100.

- In Pennsylvania, a pharmacist was sentenced to 8 months imprisonment for defrauding Medicaid and Medicare. The pharmacist routinely billed Medicaid for brand name drugs while supplying generic brands. He also was a partner in a DME company, which paid kickbacks to his brother for referrals. The pharmacist was ordered to pay restitution and assessment of $167,200, and the holding company for his pharmacy had to pay a $600 assessment. The company's owner and two employees were sentenced earlier for fabricating test results and forging physician signatures for equipment. The pharmacist's brother is to be sentenced in November.

- The owner of two Pennsylvania HHAs was sentenced to 2 years probation, assessed $50 and ordered to perform 100 hours of community service. She submitted Medicare reimbursement claims for personal expenses, such as placing her husband and nanny on the company's payroll, and for non-Medicare expenses such as hotel stays, meals, flowers and clothing. Because of her financial situation, she will not be prosecuted civilly. However, on the basis of a Medicare carrier review, $300,000 was withheld and will be retained by the Medicare program.

- In Louisiana, an employee of the Medicare carrier was sentenced for embezzling more than $6,470 from the Medicare program. The employee, a claims adjuster, caused four checks to be repaid to an account of a relative. After they were cashed, she deleted them from the payment history record.

She was sentenced to 1 year probation, assessed $50 and ordered to make full restitution.

Kickbacks

Many businesses engage in referrals to meet the needs of customers or clients for expertise, services or items which are not part of their own regular operations or products. The medical profession relies heavily upon referrals because of the myriad specialties and technologies associated with health care. If referrals of Medicare or Medicaid patients are made in exchange for anything of value, however, both the giver and receiver may violate the Federal anti-kickback statute.

Among its provisions, the anti-kickback statute penalizes anyone who knowingly and willfully solicits, receives, offers or pays remuneration in cash or in kind to induce or in return for:

- referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Medicare or Medicaid programs; or

- purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service or item payable under the Medicare or Medicaid programs.

Violators are subject to criminal penalties, or exclusion from participation in the Medicare and Medicaid programs, or both. Almost all of the convictions for paying or accepting kickbacks during this reporting period happened to be related to the DME industry in New York. The following cases are some of the examples of the sentencings for this crime:

- A New York jury returned a guilty verdict against two brothers for conspiracy related to fraudulent Medicare claims. The two visited senior citizen high rises and conducted health fairs where they coaxed beneficiaries into giving them their Medicare numbers. They furnished these numbers, along with forged certificates of medical necessity (CMNs), to two DME companies. The companies then billed for equipment, much of which was never supplied, causing Medicare to pay more than $750,000. The brothers were paid "commissions" depending on the cost of each piece of equipment. The two had formerly worked for two other New York DME companies which were convicted and sentenced earlier as a result of OIG investigations.

- A former salesman for another DME company in New York was sentenced to 4 months imprisonment and 2 years probation and was ordered to pay restitution of $13,500 for Medicare fraud conspiracy. The salesman and his father, a semi-retired podiatrist, participated in a scheme which involved billing Medicare for services not rendered. The salesman recruited patients for his father, and in return the father gave him the Medicare numbers of his patients and signed CMNs. The salesman "sold" the CMNs to his employer. The father, who billed Medicare and private health insurance companies for treatments not done and visits not made, was sentenced earlier to 3 years probation and 4 months home confinement. The owner of the DME company pled guilty and is awaiting sentencing.

- Four sales representatives for yet another New York DME company were sentenced for their part in a conspiracy which resulted in Medicare overpayments of $13 million. The scheme involved at least 19 persons, including company officials and physicians as well as sales representatives. The sales representatives collected names and numbers of beneficiaries, for which they were paid by the company. Physicians signed certificates of medical necessity for the beneficiaries, and were paid kickbacks as well, and the company filed claims for equipment never supplied. Other conspiracy participants await sentencing or trial.

Medicare Payments for Clinical Laboratory Tests

In a prior review, OIG had determined that Medicare, which pays for laboratory tests based on fee schedules, was paying nearly twice as much as physicians for the same tests. Much of the difference was attributable to the way in which Medicare reimbursed groups of tests ordered as a package by physicians. While laboratories offered groups of tests to physicians at greatly reduced prices, Medicare usually paid the fee schedule rates for the individual tests.

Although a follow-up audit showed that Medicare continues to pay clinical laboratories more than physicians pay for the same tests, recent legislation will reduce Medicare fees for clinical laboratory tests to 76 percent of the national average by 1996. Accordingly, OIG recommended that HCFA periodically evaluate the national fee schedule to ensure that it is in line with the prices physicians pay for clinical laboratory services. (CIN: A-09-93-00056)

Payments for Prescription Drugs Used with Nebulizers

In this report, one of a series, OIG concluded that in 1994 Medicare allowed $37 million more than Medicaid would have paid for three commonly prescribed nebulizer drugs used in inhalation therapy. Prescription drugs used with nebulizers are reimbursed under the

Medicare Part B program as necessary for the effective use of the equipment. Many States also pay for prescription drugs, including nebulizer drugs, under the Medicaid program. (OEI-03-94-00390)

Wound Care Supplies

In a review of claims selected for a 1 percent sample of beneficiaries who received wound care supplies between June 1994 and February 1995, OIG found that questionable payments may account for as much as two-thirds of the $98 million in Medicare allowances during this period. Many of the excessive payments were concentrated in 8 States, 48 suppliers and 1 carrier. Less than 40 percent of beneficiaries resided in skilled nursing or nursing facilities, yet these beneficiaries received over 70 percent of wound care benefits.

The OIG also found that, although nursing homes and physicians determine which patients need supplies, some suppliers determine the amount provided. Wound care supplies are frequently provided in standard kit form to beneficiaries, and some suppliers provide inducements to nursing homes and beneficiaries to accept their products. Further, beneficiaries may not be receiving or using all of the wound care supplies reimbursed by Medicare.

In an accompanying report, OIG identified questionable billing practices and supplier and nursing home practices leading to questionable payments in the five States targeted by Operation Restore Trust.

The HCFA and the DME regional carriers have taken corrective actions to address wound care abuses and continue to explore others. A long term solution would require the bundling of services in nursing homes. Previous OIG studies involving payments on behalf of Medicare beneficiaries in nursing homes and the current findings on wound care products provide continued support for HCFA's effort to implement this requirement. (OEI-03-94-00790; OEI-03-94-00791; OEI-03-94-00792)

Fraud Involving Durable Medical Equipment Suppliers

The DME industry has consistently suffered from waves of fraudulent schemes in which Medicare or Medicaid is billed for equipment never delivered, higher-cost equipment than that actually delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State from that billed in order to obtain higher reimbursement. Two years ago, HCFA published new regulations addressing reimbursement problems that have recurred over the years, especially those created by telemarketing and carrier shopping. It is hoped that consolidation of claims processing into four regional jurisdictions, as specified in the regulations, will resolve many of these problems. In the meantime, OIG continues to obtain settlements and convictions of unscrupulous suppliers for other schemes, as shown in the following examples:

- A Maryland DME company agreed to pay $1.5 million to resolve liabilities under the CMP law. Over a year's time the company submitted claims for lymphedema pumps under a code for which the pumps did not meet specifications. As a result, the company was overpaid approximately $690,000. As part of the settlement it was required to enter into a compliance plan to prevent improper billing. The case was the fourth settled in a national project focusing on manufacturers and retailers of lymphedema pumps.

- The owner of six DME companies, his companies and his general manager were sentenced in Pennsylvania for mail fraud and submitting false Medicare claims. The companies contacted Medicare beneficiaries by telephone and solicited them to accept items which their physicians said were not medically necessary. The owner was sentenced to 78 months imprisonment and ordered to pay a special assessment of $10,200. The companies were assessed a total of $78,200, and the general manager was sentenced to 8 months home confinement and 5 years probation. The total estimated loss to the Government was $2.5 million.

- Also in Pennsylvania, a man who owned two companies, along with one of the companies, was sentenced after pleading guilty to mail fraud related to Medicare. The man was sentenced to 6 months home confinement with electronic monitoring, 5 years probation and 250 hours of community service. He was ordered to pay a $5,000 fine, and the company was assessed $200 in court costs. Both of his companies had been billing for DME although they were not DME suppliers. Moreover, they billed the Pennsylvania carrier because it paid a higher reimbursement than the carriers for the beneficiaries' areas. Earlier the man, his wife and son, and the two companies settled a civil case by agreeing to make restitution of $1.5 million. The companies also gave up more than $465,000 held in escrow by the carrier.

- Another owner of a Pennsylvania DME company was also sentenced to 10 months home detention, 5 years probation and 500 hours of community service for Medicare fraud. He was fined $25,000 and ordered to pay a $150 special assessment. His company filed false claims for surgical dressings and for incontinence, ostomy and urostomy supplies. The owner ordered employees to forge doctors' signatures on certificates of medical necessity and beneficiaries' signatures on benefits assignment forms. He also violated point of sale regulations by accepting orders from independent sales representatives. He received a significant downward departure from sentencing guidelines because of his cooperation in investigations of several

companies and his testimony before a congressional subcommittee hearing on Medicare fraud. His company's parent company entered a $3.4 million civil agreement last year.

- Under the terms of a civil agreement, an Illinois DME company and its owner paid the Government $474,730 to settle liabilities for misrepresenting products billed to Medicare. The company billed for female urinary collection devices, which cost $10 each, when it actually supplied diapers costing 30 cents each.

- The former owner of a New Hampshire DME supplier agreed to pay the Government $100,000 for submitting false claims to Medicare. Between 1990 and 1991, he billed Medicare for prosthetic and orthotic devices not provided to customers, either to compensate for copayment charges not collected from beneficiaries or to compensate for equipment not covered by Medicare. As a result, his company was overpaid $11,720. As part of the settlement, he agreed to refrain from performing, participating in or overseeing any billing activities relating to Medicare or any State-funded health care program for 5 years.

- A DME company in Texas was sentenced to 1 year of probation for filing false Medicaid claims for services not rendered. As part of the plea agreement the company was also ordered to pay restitution of $450,000. The DME company supplied wheel chair pads to nursing home patients and then fraudulently billed Medicare under the code for a lumbar sacral support system, also known as a "body jacket." Earlier, the former owner of the DME company pled guilty to mail fraud.

- The manager of a now-bankrupt DME company was sentenced in Hawaii to 6 months in a community correctional institution for Medicare fraud. He had submitted claims for purchase of equipment which patients had actually leased on long-term rentals or which had never been purchased or delivered. He was also placed on 5 years probation and ordered to pay restitution of $12,000.

Vulnerabilities in Medicaid Asset Verification

In a study of States' Medicaid long term care eligibility systems, asset verification processes and fraud referral techniques, OIG found that most States rely only on readily available sources for asset verification. Medicaid eligibility staff allege that they do not have adequate time to effectively ascertain the extent of all potential assets of Medicaid applicants. Thirty States have Medicaid fraud hotlines and 38 States have specific Medicaid long term care fraud penalties for the nonreporting of resources, although in general

prosecution of medical assistance fraud was a low priority for States. The OIG also determined that HCFA has worked in partnership with State Medicaid agencies to improve asset verification, actively monitoring States' activities and progress in identifying assets and sharing best practices of asset verification.

The OIG recommended that States enhance investigative skills and request more detailed applicant information. The HCFA should continue to promote the sharing of technical assistance among States, especially asset verification processes, fraud identification techniques, and other effective practices that have proven to be predictable and reliable indicators for States in identifying undisclosed, concealed or transferred assets. The HCFA concurred with OIG's recommendations. (OEI-07-92-00882)

Medicaid Drug Rebate Program

Performance Measure

Based on a congressional request, OIG conducted a study to determine the changes in best prices available to the Medicaid prescription drug rebate program. Specifically, OIG sought to determine the extent to which best prices have increased over and above the consumer price index-urban (CPI-U) and the monetary impact of indexing best price to the CPI-U on the Medicaid drug rebate program. The OIG found that drug manufacturers have consistently increased best prices in excess of inflation, as measured by the CPI-U, for a large number of the drug products reviewed. The number of drug products with best price increases in excess of the CPI-U rose almost every quarter since the inception of the rebate program. For example, in the first quarter (April through June 1991) 94 of 363 products reviewed had an average price increase of 38.3 percent over the CPI-U. Five quarters later, 225 of 401 drug products reviewed had an average price increase of 59.7 percent over the CPI-U. The OIG calculated that rebates to the States would have been increased by about $123 million in 1993 had the best prices been indexed to the CPI-U based on the quarter ending December 1992. (CIN: A-06-94-00039)

Medicaid Payments for Incontinence Supplies

In an earlier review, OIG found that questionable billing practices may account for almost $100 million or one half of Medicare incontinence allowances in 1993. The OIG also found that suppliers engage in questionable marketing practices to nursing homes and that Medicare beneficiaries may be receiving unnecessary or noncovered supplies. The current review was undertaken to determine if similar practices exist in the Medicaid program.

The OIG found that 7 of the 14 sampled States identified a wide variety of improper claims such as billings for recipients who were not incontinent, for supplies that were never delivered and for excessive quantities of diapers for nursing home patients. Further, OIG determined that States do not generally review the appropriateness or necessity of incontinence services paid by them on crossover (payments for the recipient's premium, deductible and coinsurance made by Medicaid for individuals also entitled to Medicare), and

Medicare does not require carriers to notify Medicaid State agencies of improper payments made on behalf of Medicaid beneficiaries.

The OIG recommended that HCFA alert Medicaid State agencies about this vulnerability and take appropriate steps to ensure that they are notified of improper Medicare payments which contractors discover have been made on behalf of a Medicaid beneficiary. The second recommendation is applicable to all Medicare services provided to Medicaid recipients, not just incontinence supplies. The HCFA concurred with the recommendations and plans to take corrective action. (OEI-03-94-00771)

Medicaid Reimbursement for Clinical Laboratory Services

As part of a nationwide review of the adequacy of State procedures and controls over Medicaid payments for claims involving clinical laboratory services, OIG determined that the States of Alabama, New Hampshire, Iowa and Kansas were reimbursing providers for services that were not properly grouped together (bundled into a panel) or were duplicated for payment purposes. The OIG determined that overpayments were due to the States not having adequate edits in place to prevent the payment of unbundled or duplicated claims for certain laboratory services.

Based on its audits, OIG estimated the following recoveries for Calendar Years (CYs) 1993 and 1994: Alabama, $1.1 million (Federal share $813,000); New Hampshire, $160,000 (Federal share $80,000); Iowa, $171,000 (Federal share $107,000); and Kansas, $344,000 (Federal share $202,000). The OIG recommended that the States install edits to detect and prevent payments for unbundled services and billings which contain duplicative tests, recover overpayments for clinical laboratory services identified in the review, and make adjustments for the Federal share of the amounts recovered by the State in its quarterly report of expenditures to HCFA. The OIG estimates that, if the States implement its recommendations, approximately $935,000 ($615,000 Federal share) could be saved annually. New Hampshire and Iowa concurred with the recommendations. Alabama agreed with the programmatic recommendation but disagreed that the amounts identified should be recovered as overpayments. Kansas did not concur with the recommendations. (CIN: A-04-95-01108; CIN: A-01-95-00005; CIN: A-07-95-01139; CIN: A-07-95-01147)

Federal and State Partnership: Joint Audits of Medicaid

The OIG has formed partnerships with State auditors and other interested State groups, as well as HCFA staff, to identify opportunities for curbing Medicaid costs and to produce savings at both the Federal and State levels. These partnerships which provide broader coverage of the Medicaid program with limited resources have produced a number of reports during this semiannual period.

A. Partnerships with State Auditors

Under these partnership arrangements, OIG works jointly with State auditors providing technical assistance and focusing State attention on issues that will result in program improvements and reduce the cost of providing needed services to Medicaid recipients. These partnerships are producing results: five States have produced eight reports to date and audits are underway in another five States. In addition, OIG is working with another four States to develop partnership arrangements.

1. Louisiana

The Louisiana legislative auditor has issued two reports under the partnership plan. The first report was on Louisiana's Medicaid prescription drug rebate program. Louisiana found that an adequate control structure was not established to record, process, summarize and report financial data of the drug rebate program. Louisiana also found that a hearing mechanism had not been established for drug manufacturers to resolve disputes and the rebates posted to accounts receivable records were not reconciled to amounts in the State's financial system. Recommendations were made for the State agency to establish an adequate control structure, develop a hearing process to resolve drug manufacturers' disputes and initiate a timely reconciliation process. The State agency concurred with the findings and implemented corrective actions. (No CIN assigned)

The second Louisiana report was a joint audit on Medicaid payments for laboratory services for the 2-year period ending December 1994. Louisiana estimated that the State Medicaid agency may have overpaid providers by about $1 million (Federal share over $792,000) for tests that should have been grouped together and billed as one test. Louisiana also noted that over $324,000 (Federal share nearly $239,000) could be saved if the State agency required two individual automated chemistry test to be bundled and paid as a single test. The State agency generally concurred with the recommendations. (CIN: A-06-95-00031)

2. North Carolina

The North Carolina State auditor issued two joint audit reports through partnering with OIG. The first report was on the State's drug rebate program. This review did not disclose any major problems with the internal controls over rebate funds collected or in the remitting of the Federal share of rebates. However, the report indicated that the State agency needs to strengthen its accountability and internal controls over reporting Medicaid rebate funds and resolving drug rebate disputes. Through implementation of these recommendations, over $12.2 million in drug rebates could be collected. (No CIN assigned)

The second North Carolina report was on Medicaid payments for selected clinical laboratory services. Similar to the Louisiana review, North Carolina found that the State agency did not have adequate edits in place to prevent payment of unbundled or duplicated claims for certain laboratory services. The auditors estimated that the State overpaid providers by nearly $1.3 million (Federal share) for certain tests for CYs 1993 and 1994.

Recommendations called for appropriate recovery, and for the State agency to install edits to detect and prevent payments for unbundled services and billings which contain duplicate tests. State officials generally concurred with the recommendations. (CIN: A-04-95-01113)

3. Texas

The Texas State auditor issued two reports to date as part of the partnership plan efforts. In a review of the Medicaid drug rebate program, Texas identified over $4 million in revenue and cost savings opportunities which would result from timely mailing of invoices, timely resolution of disputes and timely deposit of rebate checks received. (No CIN assigned)

The second Texas report involved three Medicaid issues: hospital transfers, laboratory services and nonphysician services. Texas found that the State could save approximately $1.9 million annually for these three distinct payment issues. These savings could be realized by correcting ineffective postpayment and prepayment automated controls, refining other controls and broadening payment policy to reflect the Medicare reimbursement policies for hospitals. (CIN: A-06-95-00078)

4. Massachusetts

The Massachusetts State auditor issued a report on an audit of Medicaid payments for laboratory services for the period January 1, 1992 through December 31, 1993. As in Louisiana and North Carolina, Massachusetts found that the State agency did not have adequate controls to preclude payments of unbundled or duplicated claims for certain laboratory services.

Massachusetts estimated a potential overpayment of $3.4 million (Federal share $1.7 million) for the period covered by the audit. Recommendations called for installation of appropriate edits and recovery of overpayments. (CIN: A-01-96-00001)

5. Ohio

The Ohio State auditor issued a joint report on selected clinical laboratory services for CYs 1993 and 1994. Ohio determined that the State agency was reimbursing providers for services that were not properly grouped together or that were duplicated for payment purposes. Based on its review, Ohio estimated that the State agency overpaid providers by $5.2 million in CYs 1993 and 1994. Appropriate corrective action was recommended. (CIN: A-05-96-00019)

B. Partnering with the National State Auditors Association

The OIG also worked with the National State Auditors Association (NSAA) on a nationwide review of the Medicaid prescription drug program in eight States: Delaware, Iowa, Maryland, Michigan, Missouri, Ohio, Texas and Utah. The OIG provided training during the initial planning of the reviews to NSAA and technical assistance to the individual States

during the course of the fieldwork. The reviews included the drug rebate program, ulcer treatment usage, and the use of generic drugs and mail order pharmacies. Numerous problems were noted with respect to drug rebates and potential cost savings were identified regarding ulcer treatment drugs, generic drugs and mail order pharmacies. Each State auditor issued separate reports to its respective State and NSAA issued a roll-up report during 1995.

Medicaid Inpatient Alcoholism Claims: New York State

In two prior reports, OIG had recommended that New York State (NYS) refund $3.9 million in improper payments identified during two audit periods; cease claiming Federal financial participation for such services at free-standing inpatient alcoholism facilities; develop edits or controls to prevent future improper claims; and identify and return unallowable amounts claimed subsequent to the audit cut-off date of October 31, 1990.

In a follow-up review, OIG found that HCFA had properly closed the first recommendation, sustaining and recovering the $3.9 million, and properly cleared but did not close the second and third recommendations because it was still working with NYS on a State plan amendment. However, OIG determined that HCFA improperly closed the fourth recommendation after receiving a voluntary refund of nearly $655,000 from NYS for periods after October 31, 1990.

The OIG recommended that HCFA: recover an additional $5.7 million not returned by NYS through its voluntary refund computations; strengthen its resolution procedures to ensure that proper testing is done to validate the reasonableness of future refund amounts computed by NYS; and make appropriate provisions to obtain the necessary expertise to resolve recommendations involving computer programming and systems issues. The HCFA concurred with OIG's recommendations. (CIN: A-02-94-01026)

State Medicaid Fraud Control Units

In FY 1995, payments by both the Federal and State Governments to Medicaid health care providers were approximately $155 billion. The Medicaid fraud control units (MFCUs) are responsible for investigating fraud in more than 98 percent of all Medicaid health care provider payments. Forty-seven States now have units and are receiving funds and technical assistance from OIG. Three States have received waivers from establishing MFCUs as required by the Omnibus Budget Reconciliation Act of 1993. The MFCUs conduct investigations, and bring to prosecution persons charged with defrauding the Medicaid program or with patient abuse and neglect.

During FY 1995, OIG administered approximately $110 million in appropriated grants to the MFCUs. The MFCUs reported 308 convictions and $19.76 million in fines, restitutions and overpayments collected for the period July 1, 1995 through December 31, 1995.

Public Health Service Operating Divisions

Chapter III

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Overview of Program Area and Office of Inspector General Activities

The activities conducted and supported by the Public Health Service (PHS) operating divisions represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. These currently independent operating divisions within the Department include: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed drugs, biological products and medical devices; Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support the development, distribution and management of health care personnel, other health resources and services; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Health Care Policy and Research (AHCPR), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), to assist States in refining and expanding treatment and prevention services.

In the past 5 years, the Office of Inspector General (OIG) has significantly increased its oversight of public health programs and activities. The OIG has concentrated on a variety of issues such as biomedical research funding, substance abuse, Indian health services, drug approval processes and community health center programs. The OIG has also looked at the regulation of drugs, foods and devices, and explored the potential for improving these activities through user fees. The OIG has conducted audits of colleges and universities which annually receive substantial research funding from the Department. The OIG continues to examine policies and procedures throughout the agencies to determine whether proper controls are in place to guard against fraud, waste and abuse. These activities include preaward and recipient capability audits. This oversight work has provided valuable

recommendations to program managers for strengthening the integrity of agency policies and procedures.

Reimbursable Patient Care Costs at the National Institutes of Health's Clinical Center

Performance Measure

At the request of the former NIH Director, OIG conducted a review addressing the potential for charging for standard care provided to research patients at NIH's Clinical Center. The OIG found that standard medical care is provided at no charge to research patients at NIH when patients are admitted to controlled studies at the Clinical Center and to others when they are treated for medical conditions unrelated to the research. The OIG believes that, because of the nature of the medical procedures reviewed, if these patients were not at NIH participating in research, they would be receiving the same or similar care at community hospitals or in doctors' offices, and that this care would be billed to medical insurers.

The OIG recommended that NIH modify its accounting and information systems to collect the full cost of treating patients at NIH; segregate research costs from nonresearch care costs by patient; collect insurance and financial information from patients; seek authority to charge for nonresearch care provided under controlled studies and to other patients participating in research protocols; and develop a plan for using the authority to charge that includes meeting with representatives of major insurers to discuss potential reimbursement procedures.

The Assistant Secretary for Health forwarded the OIG report to a work group which reviewed departmental activities under "Reinventing Government II," which included operations of the Clinical Center. The work group has completed its review and agreed that the Department should seek the right to retain donations and income for Clinical Center services. However, they suggested that charging arrangements should avoid the complexity and cost of fee-for-service systems and recommended several innovative methods for charging, such as the use of flat fees and capitation contracts. (CIN: A-15-92-00011)

National Institutes of Health's Use of Heart Surgery Contracts with Private Hospitals

Performance Measure

In an audit of how the National Heart, Lung, and Blood Institute used contract surgery to support its research mission, OIG found that from 1990 through July 1994 the Institute expended about $9 million on surgeries for 346 patients. About $5.1 million was spent on surgery for 221 patients as an incentive to have them volunteer for research. However, the Institute had no formal patient recruitment policies and some of these patients were not involved in research at the time they received surgery. The remaining $3.9 million was spent on providing surgery to 125 former surgical patients who also were not participating in current research projects. Finally, OIG found that 39 of the 346 patients were foreign

nationals and that NIH had no policy regarding their admission to the program of free surgery.

Primary recommendations called for NIH to conduct a formal study of the Institute's recruitment practices and develop a formal patient recruitment strategy based on the results of the study, and to eliminate the provision of routine surgery to patients not on research protocols. The NIH generally agreed with all but one of OIG's recommendations. The NIH wanted to continue to treat former surgery patients who were not currently on research protocols for humanitarian reasons and to provide clinical training opportunities for its staff. The NIH stated that it will consult with a bioethics group before making a final decision on this issue. (CIN: A-15-94-00022)

Audits of the National Institutes of Health's Trust Funds, the Cooperative Research and Development Agreements, and Royalties for Fiscal Year 1994

Performance Measure

A certified public accounting firm, under contract to OIG, audited the consolidated statements of financial position for NIH administered funds. The funds audited were trust funds, cooperative research and development agreements, and royalties. The auditors were unable to express an opinion on consolidated statements of each of the three funds because NIH was unable to provide support for material account balances. The auditors also reported several significant deficiencies in the design and operation of the internal control structure. The auditors recommended that a fund manager be selected to oversee the maintenance and preparation of financial statements, drafting of an accounting policies and procedures document, preparation of client assistance supporting schedules, and timely and accurate recording of the funds' transactions. The NIH concurred. (CIN: A-17-95-00044)

Attempted Bribery of Food and Drug Administration Inspector

A New York food importer was sentenced to two concurrent 10-month jail terms, 3 years probation and 200 hours of community service for trying to bribe a Food and Drug Administration inspector. After the importer realized the inspector's tests for lead in imported foodstuffs were positive, he offered the inspector $1,000 and airline tickets to Mecca for his family of four if he would overlook the violations. The importer was fined $25,000 and assessed $100. His sentencing had been delayed after OIG became aware that the U.S. Customs Service was investigating him for customs violations and bribery. The OIG assisted Customs in its investigation and the execution of warrants at his warehouse.

Ryan White Comprehensive AIDS Resource Emergency Act: Boston Metropolitan Area for Fiscal Year 1994

The OIG conducted a study to determine whether the Boston Eligible Metropolitan Area (EMA) and its Ryan White Comprehensive AIDS Resource Act (CARE Act) service

providers ensure that all CARE Act clients are individuals with the human immunodeficiency virus (HIV) disease and their families.

The OIG found that two of the three service providers visited did not have proper documentation for 102 of the 113 CARE Act case files reviewed. The third provider had documentation for all clients reviewed. The OIG recommended that the Boston EMA: provide guidance to CARE Act service providers as to what constitutes adequate documentation that CARE Act clients are individuals with HIV disease or their families; visit both deficient providers to ensure that documentation of HIV disease is obtained for the 102 clients identified and that systems are implemented to obtain documentation for further clients; finalize the site visit monitoring program; and fulfill its obligation to make at least one site visit annually to every CARE Act service provider. Further, OIG recommended that HRSA follow up to ensure that the recommendations are implemented. The City of Boston generally concurred with the recommendations and indicated that corrective action has been or will be taken. (CIN: A-01-95-01504)

Exclusions for Health Education Assistance Loan Defaults

Through the Health Education Assistance Loan (HEAL) program, HRSA provides money to students seeking an education in a health-related field of study. Repayment of these loans is deferred until they have graduated and begun to earn some money. Although the Department's Program Support Center (PSC) makes every effort to secure repayment, some loan recipients ignore their indebtedness.

The Social Security Act permits and, in some instances, mandates exclusion from Medicare and State health care programs for nonpayment of these loans. During this 6-month semiannual period, 164 individuals were excluded as a result of PSC referral of their cases to OIG.

Individuals who default may enter into settlement agreements whereby the exclusion is stayed while they pay specified amounts each month to satisfy their debt. If they default on these settlement agreements, they are then excluded until their entire debt is repaid and they have no right to appeal these exclusions. Some of these health professionals, upon being notified of their exclusion, immediately repay their HEAL debt.

At the conclusion of this reporting period, 483 individuals had taken advantage of the opportunity and entered into settlement agreements or completely repaid their HEALs. The amount of money being repaid, through settlement agreements or through complete repayment, totals almost $30 million. The following are examples of some of these settlements:

- The exclusion of an Ohio osteopath was stayed after he entered into a settlement agreement to repay his outstanding debt of almost $123,000.

- After entering into a settlement agreement to repay over $102,000, an Illinois physician's exclusion was stayed.

- After repaying his entire past due debt of over $90,000, an Ohio chiropractor was reinstated to program participation.

Guidelines Sponsored by the Agency for Health Care Policy and Research

Performance Measure

As a result of AHCPR's interest in gaining a better understanding of the extent to which, and the manner in which, health care organizations have been using its guidelines, OIG surveyed 380 key health care organizations.

Twenty percent of the survey respondents reported that they have used one or more of the six AHCPR guidelines about which OIG inquired, and an additional 12 percent reported that they plan to do so. Ninety-six percent of respondents using the guidelines reported that their efforts to do so focused on clinicians, and 36 percent reported that they directed guideline-implementation efforts towards patients. At this point in the implementation process, only eight percent of respondents that used the guidelines reported that they measured the effects of their guideline use. Sixty-three percent of respondents who used the guidelines reported encountering obstacles in doing so. Clinician resistance was the second most frequently cited obstacle; some physicians were concerned about what they perceived to be "cookbook" medicine, and some nurses were concerned about the possibility of increased administrative and patient care workloads.

The OIG recommended that AHCPR: determine more effective ways to promote familiarity with and use of guidelines; make increased technical support available to guideline users; and develop and implement systematic mechanisms for obtaining objective feedback about guideline use, including the sponsoring of regular surveys of health care organizations. (OEI-01-94-00250; OEI-01-94-00251)

Superfund Financial Activities

The Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended, requires the Inspector General of each Federal organization with Superfund responsibilities to conduct audits of payments, obligations, reimbursements and other uses of the Superfund monies.

A. Agency for Toxic Substances and Disease Registry

The ATSDR obligated $66.7 million and disbursed $58.2 million in Superfund resources during Fiscal Year (FY) 1994. The OIG found that ATSDR generally administered the fund according to Superfund legislation. However, OIG again recommended that CDC and ATSDR establish procedures to ensure that all Superfund grantees submit audit reports. The OIG also recommended that CDC and ATSDR improve accounting for administrative costs incurred by CDC on ATSDR's behalf. The ATSDR and CDC agreed with the recommendations. (CIN: A-04-95-04550)

B. National Institute of Environmental Health Sciences

In FY 1994, the National Institute of Environmental Health Sciences (NIEHS) obligated $53 million and disbursed $57 million in Superfund resources obligated during and prior to FY 1994. The OIG found that NIEHS generally administered the fund according to Superfund legislation. The NIEHS agreed with an OIG recommendation to improve accounting for intramural billings. (CIN: A-04-95-04551)

Fraud and Abuse of Grant and Contract Funds

The following cases concluded during this period dealt with fraud and abuse of PHS operating division grant funds:

- Two Connecticut research companies and their owners were debarred for 5 years from receiving Government contracts after being convicted of overbilling NIH and the Air Force for $155,000 and $130,000, respectively. As a result of an investigation by agents from OIG and the Department of Defense, the individuals and their companies have been convicted for submitting false applications for NIH research funding as small businesses, as well as false financial documents and expense reports for research in support of the Strategic Defense Initiative. Each has been sentenced to 6 months in jail and ordered to pay restitution and fines totaling $52,250.

- A former administrative assistant employed by a contractor with the Indian Health Service was sentenced for embezzlement and altering checks. She signed checks for payroll advances totaling more than $45,270, which she had various people countersign, to satisfy her gambling habit. When she was discovered and the agency began deductions from her payroll, she altered checks issued as payment for services. She was sentenced to 5 years probation, 6 months of which are to be home confinement with electronic monitoring and for which she must pay the monitoring and related costs. She was ordered to pay restitution of $24,570. The agency for which she worked is funded by grants and contracts through IHS. Its primary purpose

is making available low-cost health care to Native Americans residing outside the reservation.

- A former director of the St. Croix Tribal Health Department in Wisconsin entered into an 18-month deferred prosecution program, during which she agreed to repay the Government $12,000 she embezzled or face prosecution. Most of her thefts are beyond the State statute of limitations, and all of them are beyond the Federal statute. She had been accused of claiming travel expenses for trips she did not take, using department funds for gambling trips to Las Vegas and using a department van as her personal vehicle. This case is the last in a series of investigations involving the St. Croix Tribal Health Department which began in 1990 with an OIG investigation of the department bookkeeper. The bookkeeper served 1 year in Federal prison for embezzling almost $63,000. The department is supported by IHS funds.

- The executive director of a Wisconsin drug and alcohol rehabilitation agency was sentenced after pleading guilty in State court to fraud and intent to defraud. She embezzled more than $38,000 from the agency through various schemes, including kickbacks, false billings, fraudulent cost reports and insurance fraud. She was sentenced to 2 years probation and ordered to make restitution of $10,000.

- A Florida nonprofit alcohol and drug treatment provider and its holding company paid $500,000 to settle allegations they submitted false information to obtain Federal funds for a drug abuse program. In applying for funds under a program designed to reduce treatment waiting periods, the provider certified that at least 356 persons waited at least a month for treatment at its facilities. Investigation showed that no more than 40 persons actually were waiting for drug treatment and that the provider falsified more than 316 names on the waiting list. Under the settlement, the provider agreed to liquidate its major assets and give the proceeds to the Government.

Administration for Children and Families, and Administration on Aging

Chapter IV

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. The major programs include: Aid to Families with Dependent Children (AFDC), Emergency Assistance, Child Support Enforcement (CSE), Foster Care, Job Opportunities and Basic Skills (JOBS) Training, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant program.

The Family Support Act of 1988 was the last comprehensive restructuring of the welfare system to reduce long term dependency on welfare programs. The Office of Inspector General (OIG) reviews the cost-effectiveness of the various social services and assistance programs, including determining whether authorized services are rendered to eligible recipients at the lowest cost. Welfare reform currently under consideration in the Congress may make changes in program requirements and funding provisions. Regardless of whether welfare continues as an entitlement or is administered under a block grant arrangement, OIG will seek to identify opportunities for program improvement.

In addition, OIG reviews the Department's programs that serve children, and has issued several reports in this area. The OIG reports have focused on health and safety issues, ways to increase the efficient use of the program dollar, more effective program implementation, and how to better coordinate program implementation between the Federal and State and local governments.

The Administration on Aging (AoA), which reports directly to the Secretary, awards grants to States for establishment of comprehensive community-based systems that assist the elderly in maintaining their independence and in remaining in their homes as long as possible. The assistance is targeted to the socially and economically disadvantaged, especially the low-income minority elderly, and includes supportive services, nutrition services, education and training, low-cost transportation and housing, and health services.

The OIG has reported opportunities for program improvements to target the neediest for services; expand available financial resources; upgrade data collection and reporting; and enhance program oversight.

Emergency Assistance Program

The Emergency Assistance (EA) program is an optional supplement to the AFDC program. Each State may decide whether to implement the EA program. The purpose of the program is to provide temporary financial assistance and supportive services to eligible families experiencing an emergency.

A. Rising Costs

Performance Measure

From 1991 to 1994, EA expenditures claimed by the States increased by about 400 percent, rising from $153 million to $782 million. The EA expenditures are expected to reach over $1 billion in 1996. The OIG found that States, in order to maximize Federal revenue, amended their respective EA programs to obtain funding for services traditionally State funded, such as juvenile justice, tuition, foster care and child welfare. One State in OIG's review claimed EA for hospital care services; under this State's EA program, hospital care is reimbursed at total charges, whereas in other Federal health care programs similar hospital care is reimbursed at amounts less than total charges.

The OIG recommended that ACF support legislation that would either cap the Federal share of EA expenditures or include the programs as part of a block grant; revise or rescind its current policies allowing the shifting of costs to the EA program especially where such costs have been borne traditionally by the States (in this regard, the eligibility period should be limited); and issue policy guidelines requiring States to reimburse hospital care at amounts less than total charges.

The ACF agreed to support capping EA expenditures and stated that it fully intends to take action to address inappropriate State practices. Further, ACF notified States that payments for juvenile justice services will be eliminated beginning in 1996 -- resulting in annual savings of over $240 million for three of the States reviewed. However, ACF disagreed with OIG's recommendation to revise or rescind EA policies regarding foster care and child welfare costs. (CIN: A-01-95-02503)

B. Eligibility Determinations

The regulations require that each decision regarding eligibility or ineligibility be supported by facts in the applicant's or recipient's case record. In its review of EA eligibility determination policies and procedures and limited tests of their application, OIG found that four of six States were not verifying all eligibility information. The policies and procedures of three States did not require either gathering and/or verifying eligibility information, and those in the fourth State were not followed in 56 percent of the cases tested. Consequently,

ACF could not be assured that all recipients were eligible for EA and that EA claims and resulting expenditures were appropriate.

The OIG recommended that ACF notify the States involved to ensure that eligibility determinations are made in accordance with Federal regulations. The ACF agreed to discuss these concerns with the States having problems and to conduct reviews to determine the appropriate verification methods for EA. However, ACF stated that the method and process of verifying information are left entirely to the States. (CIN: A-01-95-02507)

C. Kansas Emergency Assistance Program

In a review of the Kansas EA program, OIG sought to determine whether the State complied with Federal requirements. The EA costs increased from $800,000 in 1991 to $18 million in 1994. The OIG found practices which were not in compliance with Federal requirements and contributed to the escalating costs. Further, OIG identified over $630,000 (Federal share) in unallowable costs resulting from the State's failure to prepare EA applications or other evidence of eligibility determinations, and erroneous charges for costs related to income maintenance staff and vendor payments.

The OIG recommended that the State implement controls to ensure costs charged to EA comply with Federal regulation, and to make financial adjustments for costs improperly claimed. The State disagreed with the recommendations except for approximately $17,000 related to income maintenance and vendor payments. (CIN: A-07-95-01009)

Job Opportunities and Basic Skills Program Literacy Training Contract: Mississippi

The State contracted with the University of Mississippi to operate its Learn, Earn and Prosper (LEAP) program designed to help JOBS participants increase their literacy, earn a High School Equivalency Diploma (GED) and prepare for employment. The OIG conducted a limited review to determine if LEAP established and met performance goals and whether costs claimed were allowable.

The OIG found that the contract scope did not include criteria to measure outcomes and hold the University accountable under the contract. Between February 1993 and December 1994, LEAP served about 4,300 JOBS participants at a cost of $15.3 million. The University calculated the average daily attendance at 53 percent. Of the 720 LEAP participants who sat for the GED exam, 377 obtained a diploma. The OIG's review of expenditures found that more than $747,000 (nearly $666,000 Federal share) in contract expenditures did not meet Federal requirements and over $1 million of the expenditures warranted further review.

The OIG proposed that the State include performance indicators and measures in future contracts, refund unallowable costs and undertake a review to determine if there are

additional unallowable costs. The State agreed with the recommendation to evaluate the LEAP contract to determine what changes are needed, including performance indicators and measures in future HHS funded contracts. However, the State disagreed with the facts and conclusions leading to the other recommendations. (CIN: A-04-94-00078)

Fraud in the Aid to Families with Dependent Children Program

Two Venezuelan nationals were sentenced in California for fraud involving AFDC funds. A woman was sentenced to 9 years in State prison, and her son was sentenced to 8. They were part of a ring of South American gypsies who used fraudulently obtained Puerto Rican birth certificates to establish 135 identities in 27 AFDC cases. Over an 8-year period, they received more than $880,490. Two other persons in the case are fugitives and have been listed with Interpol.

Systematic Alien Verification for Entitlements

The Immigration Reform and Control Act of 1986 established the Systematic Alien Verification for Entitlements (SAVE) program to assist eligibility workers in preventing illegal aliens from receiving federally subsidized cash and medical benefits. However, the law permits States to request a waiver if they can demonstrate that either SAVE is not cost-effective for them or their alternative verification system is as effective.

A. Cost-Effectiveness

At ACF's request, OIG reviewed a sample of case files matched between Immigration and Naturalization Service (INS) and States' records to determine if SAVE is cost-effective in verifying the immigration status of aliens applying for AFDC and Medicaid. Based on the data found and the results of its review, OIG could not complete a cost benefit analysis and believes that until INS and States address weaknesses in the systems, such an analysis will not be possible. The OIG found, however, that the SAVE program does have value in identifying ineligible aliens. The OIG outlined a number of areas ACF and the Health Care Financing Administration (HCFA) should be attentive to in reviewing upcoming waiver requests. (OEI-07-91-01230)

B. System Processes

In a companion report, OIG identified deficiencies in the SAVE program and related State processes. The OIG recommended that ACF and HCFA remind States of the SAVE requirements and suggest minimal documentation to be included in the State case files; work with INS to enhance the SAVE program to make it more timely and user friendly; and coordinate with States and INS to identify the most efficient and effective way to designate matching points between their respective data base systems. (OEI-07-91-01231)

Fees Retained by Child Placing Agencies in Texas

For certain foster care placements, the State of Texas contracts with private child placement agencies to recruit qualified foster homes and place children. In this report, OIG noted that the child placing agencies reviewed had improperly retained an average of 38 percent of the foster care maintenance payments. The retained funds were used for such services as cost of operations, case management, therapy, counseling, respite care, psychiatrists, training, transportation, day care assistance, medical needs not covered by Medicaid, recreation and other administrative costs — all of which are covered under other programs.

Based on the nine child placing agencies reviewed, OIG estimated that at least $2.7 million ($1.7 million Federal share) was retained for unallowable services. In addition, OIG found instances where the State made duplicate payments and payments for services not provided or not billed. The OIG recommended that the State refund payments retained by the child placing agencies and other identified overpayments. Also, OIG proposed that the State correct procedural weaknesses in the title IV-E Foster Care program. The State did not agree with the findings and recommendations related to making financial adjustments for the retained maintenance payments. However, ACF agreed with OIG's findings. (CIN: A-06-95-00035)

Retroactive Title IV-E Foster Care Claims: Missouri

At ACF's request, OIG reviewed resubmitted retroactive foster care claims paid to the State of Missouri. The OIG determined that claims totaling nearly $955,000 (Federal share) for the first quarter of the retroactive claim period were filed beyond the 2-year time limitation. An additional $137,000 (Federal share) was unallowable because, in computing the allocation rates used to claim foster care administrative costs, the State included counts of children whose age exceeded the title IV-E criteria. While the State did not agree with the timeliness finding, they did agree that ineligible children should not be included in computations to determine allocation rates.

The OIG also believes that the State may not have completely met the 2-year filing requirement for the remaining three-quarters of the first year of retroactive claims, and has set aside for resolution by ACF the allowability of the related $3.2 million (Federal share). (CIN: A-07-95-01010)

Recovery of Federal Payments in Canceled Checks

The OIG found that the District of Columbia did not have adequate procedures for crediting to the Federal Government its share of canceled checks originally charged to the AFDC and Title IV-E programs. Further, OIG determined that while the District had credited to the Federal Government its share of canceled Medicaid checks, the credits were often made long after the 180 day time frame established by Federal regulations had expired.

The District agreed that the Federal share of canceled checks had not been properly credited and made an adjustment for over $500,000, covering the recommended repayment and additional AFDC escheatments from periods subsequent to OIG's review. Other procedural recommendations were also generally followed. (CIN: A-03-95-00451)

Head Start Fraud

In Tennessee, the former executive director of a Head Start program was sentenced to 16 months imprisonment and 3 years probation for program fraud. She and her husband set up a clinic, which her husband operated, with licensed occupational and speech therapists who were paid $100 a month. The therapists supposedly supervised assistants, who were high school students paid minimum wages, to do work for which Head Start was billed $60 an hour. The Head Start program director had rigged the bids so that the related-party clinic could get the Head Start therapy contract. She was ordered to pay $29,300 in restitution, $28,400 for the cost of incarceration and $7,000 for probation costs after release from prison. Her husband was granted a pretrial diversion.

Coordination of Specialized Transportation Services

Performance Measure

The OIG reviewed specialized transportation services in Ohio and Illinois to identify best practices and opportunities for the States to increase such services for the elderly, disabled and others without a corresponding increase in Federal expenditures. Although OIG found that best practices exist in the two States, only a few communities in each of them have developed comprehensive coordinated transportation systems. The communities having such systems are able to provide more services in a more economical manner. The AoA agreed that there are opportunities to increase transportation services nationwide.

The OIG recommended that AoA actively promote transportation consortiums and provide the assistance needed by State agencies and local transit providers to foster improvements in coordinated transit systems. In addition, AoA should continue its work with other HHS agencies and Federal Departments to encourage further development of coordinated systems. The AoA concurred with OIG's recommendations and will work with the Joint Department of Transportation/HHS Coordinating Council on Human Services Transportation to develop a strategic plan for improving coordinated transportation services. (CIN: A-05-95-00023)

General Oversight

Chapter V

GENERAL OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities. The Program Support Center, a newly created operating division within the Department of Health and Human Services (HHS), provides overall direction for departmental administrative activities as well as common services such as human resources, financial management, administrative operations and information technology. The Office of the Assistant Secretary for Management and Budget is responsible for the development of the HHS budget and its execution, as well as the related activities of establishing and monitoring departmental policy for debt collection, cash management, and payment of HHS grants and contracts. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

The OIG has oversight responsibility for these staff division activities at the departmental level. A related major responsibility flows from the Office of Management and Budget's (OMB's) designation of HHS as cognizant agency to audit the majority of the Federal funds awarded to the major research schools, 104 State and local government cost allocation plans, and separate indirect cost plans of about 1,000 State agencies and local governments. In addition, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations.

The OIG's Fiscal Year (FY) 1996 work in departmental administrative activities and Governmentwide oversight focuses principally on financial statement audits, financial management and managers' accountability for resources entrusted, standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance.

Nonfederal Audits

The OMB Circulars A-128 and A-133 establish the audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal

awards. Under the two circulars, these entities are required to have an annual organizationwide audit which includes all Federal money they receive.

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the first half of FY 1996, OIG's National External Audit Review Center (located in Kansas City) reviewed over 2,100 reports that covered over $470 billion in audited costs. Federal dollars covered by these audits totaled $104 billion, about $41 billion of which was HHS money.

The OIG's oversight of the nonfederal audit activity not only provides Department managers with assurances about the management of Federal programs, but also identifies any significant areas of internal control weakness, noncompliance and questioned costs that require formal resolution by Federal officials.

The OIG is developing a strategy to interrelate the work performed by nonfederal auditors under the Single Audit Act with that required for financial statement audits. Reliance on nonfederal audits wherever possible, such as use of single audits for coverage of Medicaid expenditures, has the potential to maximize benefit from the audit effort expended by the public and private sectors.

A. Office of Inspector General's Proactive Role

The OIG has taken the following steps in the nonfederal area to ensure adequate coverage of the Department's programs and provide for greater utilization of the data provided:

- Through evaluation of reported data, OIG is able to provide basic audit coverage and analyze reports to identify entities for high-risk monitoring and trends that could indicate problems within HHS' programs. These problems are brought to the attention of departmental management to improve program administration. In addition, OIG profiles nonfederal audit findings of a particular program or activity over a period of time to identify systemic problems.

- To ensure audit quality, OIG maintains a quality control program (discussed below) and has taken steps to ensure that adequate guidance is available to the nonfederal auditor. The OIG has been heavily involved in assisting the National Association of State Auditors, Controllers and Treasurers in performing peer reviews of State auditors.

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number (800-732-0679) and through training. During the past 6 months, 484

individuals were provided with technical assistance through OIG's toll free number. In addition, formal training was provided to certified public accountant societies and State auditor staff on issues related to Circulars A-128 and A-133.

- The OIG also has been heavily involved with OMB and the American Institute of Certified Public Accountants in developing authoritative guidance.

B. Quality Control

In order to rely on the work of the nonfederal auditors, OIG maintains a quality control review process which assesses the quality of the nonfederal reports received and the audit work that supports selected reports.

Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 2,111 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,706
Reports issued with major changes	14
Reports with significant inadequacies	391
Total audit reports processed	2,111

The 2,111 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling $5.2 million as well as 3,668 recommendations for improving management operations. In addition, these audit reports provided information for 76 special memoranda which identified concerns for increased monitoring by departmental management. The reports were also used to develop four areas for follow-up by OIG auditors.

Resolving Office of Inspector General Recommendations

The tables and schedules below summarize actions taken on OIG recommendations to recover funds or to put them to better use.

A. Questioned Costs

The following chart summarizes the Department's responses to OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs which are challenged because of a violation of law, regulation, grant, etc. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and the Inspector General Act Amendments of 1988.

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

	Number	Dollar Value (in thousands)	
		Questioned	Unsupported
A. For which no management decision had been made by the commencement of the reporting period[1]	357	$204,729	$12,531
B. Which were issued during the reporting period	154	$161,123	$16,268
Subtotals (A + B)	511	$365,852	$28,799
Less:			
C. For which a management decision was made during the reporting period[2]:	210	$115,827	$887
(i) dollar value of disallowed costs		$110,129	$649
(ii) dollar value of costs not disallowed		$5,698	$238
D. For which no management decision had been made by the end of the reporting period	301	$250,025	$27,912
E. For which no management decision was made within 6 months of issuance[3]	139	$85,262	$11,674

See Appendix D for footnotes.

B. Funds Put to Better Use

The following chart summarizes reports which include recommendations that funds be put to better use through cost avoidances, budget savings, etc.

TABLE II
OFFICE OF INSPECTOR GENERAL REPORTS
WITH RECOMMENDATIONS THAT FUNDS BE PUT
TO BETTER USE

	Number	Dollar Value (in thousands)
A. For which no management decision had been made by the commencement of the reporting period[1]	39	$5,031,989
B. Which were issued during the reporting period	12	$489,940
Subtotals (A + B)	51	$5,521,929
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management		
(a) based on proposed management action[2]	25	$354,350
(b) based on proposed legislative action	0	$0
Subtotals (a+b)	25	$354,350
(ii) dollar value of recommendations that were not agreed to by management	1	$65,577
Subtotals (i + ii)	26	$419,927
D. For which no management decision had been made by the end of the reporting period[3]	25	$5,102,002

See Appendix D for footnotes.

Legislative and Regulatory Review and Regulatory Development

A. Review Functions

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. During this reporting period, OIG reviewed 33 of the Department's regulations under development and 100 departmental legislative proposals.

In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigations and other activities highlighted in this and previous semiannual reports. Recommendations made by OIG for legislative and regulatory change can be found throughout this semiannual report.

B. Legislative and Regulatory Development Functions

The OIG is responsible for developing a variety of legislative proposals and sanction regulations for civil money penalty (CMP) and program exclusion authorities that are administered by the Inspector General.

During this reporting period, OIG published three final regulations related to the safe harbor provisions under the anti-kickback statute, the expansion and revision of the CMP authorities, and OIG's peer review organization (PRO) sanctioning authorities. Among those regulatory initiatives promulgated during this period were:

- final OIG regulations addressing revisions to the CMP provisions for the misuse of certain departmental and program names, symbols and emblems (November 27, 1995, 60 FR 58239);

- a comprehensive rewrite of 42 CFR part 1004, governing the imposition and adjudication of sanctions against practitioners or other persons resulting from recommendations by a State PRO (December 12, 1995, 60 FR 63634);

- OIG final regulations setting forth and revising the standards and guidelines for safe harbor provisions for protecting certain health plans, such as health maintenance and preferred provider organizations, that offer incentives to enrollees or that enter into negotiated price reduction agreements with health care providers (January 25, 1996, 61 FR 2122).

All three final rules met with OIG goals set forth in accordance with the President's National Performance Review initiative to revise or eliminate burdensome or unnecessary

regulations. The OIG is continuing work on regulatory initiatives involving CMP authorities, and safe harbors under the antikickback statute.

In addition, during this period, OIG published a separate Federal Register notice (November 2, 1995, 60 FR 55721) setting forth the OIG Medicare Advisory Bulletin on eligibility and other information on current hospice benefits that was developed in conjunction with Operation Restore Trust.

C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process. For example, OIG testified at three hearings during this 6-month period, principally on health care fraud and abuse issues. On several occasions, the testimony concerned OIG recommendations which, if implemented, could produce billions of dollars in annual savings to the Government. These recommendations are contained in the OIG Cost Savers Handbook, also known as the Red Book. The hearing process offers OIG the opportunity to meet its statutory obligation of keeping the Congress informed of its work with regard to the effective and efficient operation of Department programs. The OIG continues to track all relevant congressional hearings and pending legislation relative to a wide range of issues.

Training Contract Practices: New York

In a joint review of training contract costs claimed by New York State (NYS), OIG and the Department of Justice concluded that several components of the State University of New York knowingly and willfully schemed to overbill the Federal Government for the training of social service workers. The review, which covered a 10-year period, was conducted in response to allegations made by a former NYS Department of Social Services employee under the qui tam provisions of the False Claims Act. The training contract costs reviewed were claimed under programs administered by the Administration for Children and Families, the Health Care Financing Administration, the Department of Agriculture and the Social Security Administration.

The State's December 1994 settlement agreement with the Federal Government included a cash refund of nearly $27 million. In addition to the cash refund, the State agreed to: exclude from its current expenditure report any costs similar to those described in the review; amend its procedures to preclude recurrence of such claims; and not claim any Federal reimbursement for costs incurred in the settlement of these matters. (CIN: A-02-93-02006)

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 72 successful criminal actions. Also during this period, 227 cases were presented for prosecution to the

Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 79 individuals and entities.

The number of convictions in this period declined because of the departure of the Social Security Administration. In keeping with its commitment to Operation Restore Trust, OIG has concentrated on the five States where most of the Department's health care dollars are spent.

In addition to terms of imprisonment and probation imposed in the judicial processes, more than $108.2 million was ordered or returned as a result of OIG investigations during this semiannual period.

Appendices

APPENDIX A

Implemented Office of Inspector General Recommendations to Put Funds to Better Use October 1995 through March 1996

The following schedule is a quantification of actions taken in response to OIG recommendations to prevent unnecessary obligations for expenditures of agency funds or to improve agency systems and operations. The amounts shown represent funds or resources that will be used more efficiently as a result of documented measures taken by the Congress or by management to implement OIG recommendations, including: actual reductions in unnecessary budget outlays; deobligations of funds; reductions in costs incurred or preaward grant reductions from agency programs or operations; and reduction and/or withdrawal of the Federal portion of interest subsidy costs on loans or loan guarantees, or insurance or bonds.

Legislative savings are annualized amounts based on Congressional Budget Office estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures for the year in which the change is effected. Total savings from these sources amount to $1,959.3 million for this period.

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Personal Care Services: Reinstate personal care services as a State optional service. (CIN: A-02-93-01022)	Section 13601 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 repeals the mandate for coverage of personal care services and allows the States to cover personal care services furnished outside the home, effective October 1, 1994.	$980
Reimbursement for Outpatient Facility Services: The Health Care Financing Administration (HCFA) should limit hospital outpatient department (OPD) facility fees to the applicable ambulatory surgical center (ASC) rate or reduce payments for OPD services to bring them in line with ASC payments. (OAI-85-IX-00046; CIN: A-14-89-00221)	Section 13522 of OBRA 1993 extended the 5.8 percent reduction in payment for OPDs through 1998.	437
Medicare Home Health Care Services: The HCFA should revise Medicare regulations to require that the treating physician establish the plan of care and specifically prescribe the type and frequency of home health services needed.(CIN: A-04-94-02087)	Effective February 1995, Medicare regulations require that a beneficiary be under the care of a physician who establishes the plan of care and that the physician's orders for services in the plan of care specify the medical treatments to be furnished, the discipline to furnish the services and their frequency.	199.2
Medicare Secondary Payer Period for End Stage Renal Disease Beneficiaries: Extend the Medicare secondary payer (MSP) provision to the period of time that end stage renal disease (ESRD) beneficiaries have employer group health insurance. (CIN: A-10-86-62016)	Section 13561(c) of OBRA 1993 maintained the provision to extend the MSP period for ESRD beneficiaries from 12 to 18 months through Fiscal Year 1998.	84

OIG Recommendation	Status	Savings in Millions
Modifications to Medicaid Drug Rebate Program: Establish State-specific cost reduction targets based on the comparison of individual State drug prices with national and international drug price data; set specific drug price limits for brand name drugs similar to those in place for multi-source drugs; or negotiate directly with manufacturers for prescription drug discounts and rebates. The HCFA should support legislation to retain the current procedures for computing additional rebates. (CIN: A-06-93-00070; OEI-12-90-00800)	Section 13602 of OBRA 1993 permitted States to operate prescription drug formularies meeting certain requirements; removed current law prohibition on the imposition of prior authorization controls with respect to new drugs during the first 6 months following Food and Drug Administration approval; and repealed the weighted average manufacturer price inflation formula for calculating the additional rebate under current law.	$64
Payment Rates for the Drug Epogen: The HCFA should reduce the reimbursement rate not to exceed $10.10 per 1,000 units administered. (CIN: A-01-92-00506)	Section 13566 of OBRA 1993 reduced the reimbursement rate for Epogen to $10 per thousand units.	56
Medicare Payments for Unnecessary and Poor Quality Endoscopies: The HCFA should reduce the incidence of payments for unnecessary and poor quality gastrointestinal endoscopies. (OEI-09-88-01006)	The OIG accepted the PROs' Fourth Scope of Work as an acceptable corrective action plan for HCFA to address OIG's recommendation and reduce payments for unnecessary and poor quality endoscopies.	54.8
Medicaid Estate Recoveries: The HCFA should make stronger programmatic initiatives on estate recoveries and encourage statutory changes to enhance asset control and recovery activities, such as making liens (or some other form of encumbrance) a condition of eligibility. States should be required to recover Medicaid personal needs allowance funds from a deceased individual's estate to offset the cost of care. (OAI-09-86-00078; CIN: A-01-93-00002)	Section 13612 of OBRA 1993 required States to recover the costs of nursing facility and other long-term care services furnished to Medicaid beneficiaries from the estates of such beneficiaries, and establish hardship procedures for waiver of recovery in cases where undue hardship would result.	52
Intraocular Lenses in Ambulatory Surgical Centers and Hospitals: Reduce payments for intraocular lenses (IOLs) to current acquisition costs. (OEI-05-92-01030)	Section 13533 of OBRA 1993 reduced payments for IOLs in ASCs to $150.	18
Short/Doyle Medicaid Payment Rates: The State of California should ensure that Short/Doyle payments are limited in accordance with the State's Medicaid plan and Federal requirements. (CIN: A-09-91-00076; CIN: A-09-92-00094)	The HCFA approved a California State plan amendment that modified and clarified the States's reimbursement policy for Short/Doyle Medicaid mental health services.	5.7

OIG Recommendation	Status	Savings in Millions
Ambulatory Surgical Services Performed in Hospital Outpatient Departments:		
Implement a computer system edit to ensure that the payment amount for ambulatory surgical services is not accumulated subsequent to the original claim, educate providers regarding the proper submission of claims and instruct the fiscal intermediaries to utilize data from OIG's computer application to determine if adjustments to providers' cost reports are required. (CIN: A-01-93-00502)	The HCFA implemented the computer edit in July 1995 and revised the Hospital Manual to clarify billing requirements for outpatient ambulatory surgical services. The Medicare Intermediary Manual was revised to require installation of the edit.	$2.2
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Foster Care Retroactive Claims:		
The State of Indiana should reduce Title IV-E retroactive maintenance claims submitted for the quarters ending December 31, 1991 through December 31, 1993. (CIN: A-05-95-00029)	The OIG provided audit assistance to the Administration for Children and Families (ACF) in a review of Indiana's Title IV-E Foster Care retroactive claims submitted by the Indiana Family and Social Services Administration. This joint ACF/OIG review of the methodology used for identifying retroactive claims and the validation of the retroactive claims data base resulted in the State agreeing to reduce the Federal financial participation by $6.4 million.	6.4

APPENDIX B

Unimplemented Office of Inspector General Recommendations to Put Funds to Better Use

This schedule represents potential annual savings or one-time recoveries which could be realized if Office of Inspector General (OIG) recommendations were enacted by the Congress and the Administration through legislative or regulatory action, or policy determinations by management. (In many cases, these recommendations are beyond the direct authority of the departmental operating division.) It should be noted, however, that the Congress normally develops savings over a budget cycle which results in far greater dollar impact statements. Savings are based on preliminary OIG estimates and reflect economic assumptions which are subject to change. The magnitude of the savings may also increase or decrease as some of the proposals could have interactive effects if enacted together.

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Modify Formula for Costs Charged to the Medicaid Program: The Health Care Financing Administration (HCFA) should consult with the Congress on modification of the Federal Medical Assistance Percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per-capita income relationships. (CIN: A-06-89-00041)	No legislative proposal was included in the President's Fiscal Year (FY) 1996 budget.	$4,100
Indirect Medical Education: Reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether any adjustment factor is warranted for all teaching hospitals. (CIN: A-07-88-00111)	The HCFA agrees that the IME factor should be reduced and such proposals have been included in past Presidents' budgets. In its March 1995 report to the Congress, the Prospective Payment Assessment Commission (PROPAC) recommended that, for FY 1996, the IME factor be reduced from 7.7 percent to 6.7 percent. The PROPAC stated that ultimately the IME factor should be 4.5 percent.	2,130
Medicare Coverage of State and Local Government Employees: Require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1988. If this proposal is not enacted, seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (CIN: A-09-88-00072)	Although the President's FY 1995 budget contained a proposal to include under Medicare all State and local government employees hired before April 1, 1988, no legislative proposal was included in the President's FY 1996 budget.	1,559

OIG Recommendation	Status	Savings in Millions
Clinical Laboratory Tests: Require laboratories to identify and bill profiles (groups of related tests) at reduced rates whenever they are ordered, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CIN: A-09-89-00031; CIN: A-09-39-00056)	Although the President's FY 1995 budget included a proposal to reinstitute coinsurance for clinical laboratory services, no legislative proposal was included in the President's FY 1996 budget. The Omnibus Budget Reconciliation Act 1993, however, will reduce Medicare fees for clinical laboratory tests to 76 percent of the national average in 1996. The HCFA is profiling physicians' ordering and referring patterns as part of focused medical review efforts.	$1,130
Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)	The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.	1,100
Reduce Hospital Capital Costs: Seek legislative authority to continue mandated reductions in capital payments beyond FY 1995. The HCFA should determine the extent of the capital reductions that are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070; CIN: A-14-93-00380)	The HCFA is seeking public comment on reducing prospective capital rates.	820
Medicaid Payments to Institutions for Mentally Retarded: The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)	The HCFA nonconcurred with OIG's recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA and OIG negotiated an agreement for HCFA to send the report to all State Medicaid directors. This action has been taken.	683

OIG Recommendation	Status	Savings in Millions
Medicare Secondary Payer - End Stage Renal Disease Time Limit: Extend the Medicare secondary payer (MSP) provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016)	The President's FY 1996 budget contains a proposal to extend the MSP provision for individuals with ESRD to 24 months. Notwithstanding this proposal, OIG continues to advocate that Medicare should always be a secondary payer for ESRD beneficiaries.	$503
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt policy. The OIG presented an analysis of four options for HCFA to consider including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system (PPS) hospitals which are profitable, and the inclusion of a bad debt factor in the diagnosis related group (DRG) rates. (CIN: A-14-90-00339)	This proposal was not included in the President's FY 1996 budget.	487.7
Terminate Medicare Disproportionate Share Adjustments: Terminate disproportionate share adjustment payments without redistribution of the funds to PPS hospitals. Payments under PPS adequately compensate hospitals for services provided to Medicare patients, including low-income patients. (CIN: A-04-87-00111)	Although the President's FY 1995 budget contained a proposal to phase down Medicare disproportionate share payments, no legislative proposal was included in the President's FY 1996 budget.	430
Flexible Benefit Plans: The value of flexible benefit plans, as defined by section 125 of the Internal Revenue Code, should be included in the hospital insurance portion of the Federal Insurance Contributions Act taxable wage base. (CIN: A-05-93-00066)	While HCFA agreed with the report findings related to revenue to the Hospital Insurance Trust Fund, a legislative proposal was not included in the President's FY 1996 budget.	420
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality. (CIN: A-05-89-00055; CIN: A-05-92-00006)	The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. As a final measure, HCFA may submit a legislative proposal to remove these stays from the usual DRG payment methodology. No proposal was included in the President's FY 1996 budget.	210

OIG Recommendation	Status	Savings in Millions
Graduate Medical Education: Revise the regulations to remove from a hospital's allowable graduate medical education (GME) base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020)	The HCFA is studying various options for legislative changes and believes a total restructuring of the GME payment system may be necessary. No legislative proposal was included in the President's FY 1996 budget.	$157.3
Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 chemistry tests identified by the OIG audit. (CIN: A-01-93-00521)	The HCFA agreed with 8 of the 10 tests recommended for addition to the list. In November 1995, HCFA updated its carrier manual adding three of the tests recommended in the OIG report. A legislative proposal to add 11 tests (including those identified in OIG's review) was included in the President's December 7, 1995 Medicare savings package.	130
Eliminate Inappropriate Payments for Total Parenteral Nutrition: The HCFA should: instruct carriers to adhere to a strict interpretation of the coverage guidelines for concentrated, purified nutrients; require the carriers to intensify review of certificates of medical necessity, discuss therapeutic options with physicians and monitor the use of nutrients over time; and review research into the clinical appropriateness of and payment methodologies for intradialytic parenteral nutrition (IPN). (OEI-12-92-00460; CIN: A-04-93-02073)	While HCFA generally agreed with OIG's recommendations, a subsequent review revealed that new claims were being paid for IPN contrary to Medicare coverage guidelines and the carriers' own guidelines which do not provide coverage for supplemental nutrition.	96.8
Reduce Medicare Payments for Hospital Outpatient Department Services: Establish a legislative initiative to reduce the current payments for services in outpatient departments to bring them more in line with ambulatory service center (ASC) approval payments. Pay outpatient departments the ASC-approved rate or adjust hospital payments by a uniform percentage. (CIN: A-14-89-00221; OEI-09-88-01003)	In March 1995, HCFA sent a report to the Congress on developing a PPS for outpatient departments. In addition, although the President's FY 1995 budget contained a proposal to eliminate a formula-driven overpayment in hospital outpatient departments, no legislative proposal was included in the President's FY 1996 budget.	90

OIG Recommendation	Status	Savings in Millions
Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The fiscal intermediaries should recover improper payments made to hospitals for nonphysician outpatient services (such as diagnostic tests and laboratory tests) rendered within 72 hours of the day of an inpatient admission, and refund the beneficiaries' coinsurance and deductible related to these payments. The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)	The HCFA agreed to recover the improper billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and OIG. The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's FY 1996 budget.	$83.5
Generic Drugs: The HCFA should identify and alert States to methods which would encourage the use of lower priced generic drug products in the Medicaid program. The HCFA should also take a more active role to encourage States to use generic drugs; provide stronger incentives for States to adopt policies that encourage use of generic drugs; monitor the States' efforts to encourage the use of lower priced drugs; and formally assess those activities. (CIN: A-06-93-00008)	The HCFA has provided a copy of the OIG report to States and encouraged them to use lower priced generic products. On February 2, 1996, States were requested to provide a description of any policies adopted by States that encourage use of equivalent generic drugs. This information will be included in the 1995 State Drug Utilization Review Annual Report due to regional offices by June 30, 1996.	49
Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)	The HCFA considered a proposal recommending that the 190-day lifetime limit for psychiatric hospitals be extended to general hospitals; however, such a proposal was not included as part of the President's FY 1996 budget.	47.6
Nonemergency Advanced Life Support Ambulance Services: The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513)	The HCFA prepared a draft regulation in late 1995 that would shift the policy focus away from the type of vehicle used and towards the medical condition of the beneficiary.	47
Medicaid Payments for Employer Group Health Insurance: The HCFA should continue to strongly support States implementing Section 1906 of the Social Security Act, and should propose legislation that allows States to pay employer group health plan (EGHP) deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules. (OEI-04-91-01050)	The HCFA concurred with the first recommendation and has been working in partnership with regional offices and States to promote full implementation. The HCFA deferred comment on the second recommendation.	32

OIG Recommendation	Status	Savings in Millions
Medicaid Cost Sharing: The HCFA should promote the development of effective cost sharing programs by: allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services; and allowing for higher beneficiary cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800)	The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. It plans to solicit information from States implementing cost sharing and distribute it to States that do not impose it. Several States have submitted waiver applications to HCFA to develop demonstration projects which include experimental cost sharing provisions.	$19.8
Monitored Anesthesia: The HCFA should study the appropriateness of paying the same amount for monitored anesthesia care and general anesthesia in view of the fact that other insurers are more restrictive than Medicare. (OEI-02-89-00050)	The HCFA does not concur with this recommendation.	18
Establish Mandatory Prepayment Edit Screens for Medicare and Medicaid: The HCFA should move swiftly with the process of establishing mandatory prepayment edit screens for the Medicare and Medicaid programs. (CIN: A-03-91-00019)	The HCFA has designated the National Technical Information Service (NTIS), Department of Commerce, as the sole distributor of the Correct Coding Initiative edits. The NTIS made the edits available in hard copy and diskette form as of December 31, 1995. Updates to the edits will be made quarterly by NTIS.	12.9
Medicare Claims for Railroad Retirement Beneficiaries: Discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)	While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.	9.1
Medicare Payments for Orthotic Body Jackets: The HCFA should require the durable medical equipment regional carriers (DMERCs) to closely monitor claims for body jackets, including: analysis of payment trends, provision of an early warning of abusive practices and monitoring of suppliers who have engaged in abusive practices. (OEI-04-92-01080)	The HCFA concurred and has instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices. The statistical analysis DMERC produces quarterly reports and monthly ad hoc reports which assist the DMERCs in identifying potential abusive practices, and monitors those suppliers that appear to engage in abusive practices.	7

OIG Recommendation	Status	Savings in Millions
Limit Reimbursement for Hospital Beds: The HCFA should develop a new approach for reimbursing suppliers for hospital beds used by Medicare beneficiaries at home. A new reimbursement methodology should reflect a hospital bed's useful life and the number of times a bed can customarily be rented over that period. (CIN: A-06-91-00080)	The HCFA awarded a demonstration project on this subject in 1996. The project is expected to run in at least 3 sites for 2 cycles of 2 years each beginning in January 1997.	$6.2
Medicare's Reimbursement for Hospital Emergency Room X-Rays: The HCFA should pay for reinterpretations of x-rays only when attending physicians specifically request a second physician's interpretation in order to render appropriate medical care before the patient is discharged. (OEI-02-89-01490)	The HCFA will revise the hospital emergency room x-ray interpretation policy guidelines in the Medicare Carriers Manual 2020G. The manual revision is currently under development.	4
Third Party Liability Settlements and Awards: The HCFA should develop legislative proposals to close the loopholes in the Omnibus Budget Reconciliation Act of 1993 that allow Medicaid beneficiaries who receive settlements and awards from third parties as a result of accidents to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. The HCFA should also develop guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties. (CIN: A-09-93-00033)	The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g. health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements.	3
Hospital General and Administrative and Fringe Benefit Costs: Revise the Provider Reimbursement Manual (PRM) to provide explicit guidelines on the allowability of certain general administrative and fringe benefit costs. (CIN: A-03-92-00017)	The HCFA has published changes to the PRM to clarify the allowability of several of the cost categories identified in OIG's report. The HCFA has not yet clarified the remaining cost categories noted in OIG's report.	2.1 [1]
PUBLIC HEALTH SERVICE OPERATING DIVISIONS		
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)	In the absence of specific authorizing legislation, the Food and Drug Administration is precluded by statute from imposing user fees to cover additional functions.	44.4

[1] *Medicare savings only. The bulk of costs were passed to other health care consumers.*

OIG Recommendation	Status	Savings in Millions
Limit Graduate Student Compensation: The Assistant Secretary for Management and Budget (ASMB) should work with the Office of Management and Budget (OMB) to revise Circular A-21 to stipulate a reasonableness standard for graduate student compensation charged to federally sponsored research based on assigned responsibilities and not to exceed compensation paid to other individuals of similar experience for similar work. (CIN: A-01-94-04002)	The ASMB endorsed the OIG recommendation, concluding that a prudent person would not provide greater compensation to individuals who are less qualified by education and practical experience than others performing similar work.	$5.7
Recharge Center Costs: Universities should: improve their oversight of recharge centers; develop and implement policies and procedures for the operation of recharge centers that are consistent with OMB Circular A-21; establish and maintain adequate accounting and recordkeeping procedures for recharge centers; and analyze and adjust billing rates to eliminate deficit and surplus funds. (CIN: A-09-92-04020)	The ASMB concurred with the recommendations and has recommended to OMB that Circular A-21 be revised to provide more definitive guidance on the financial operations of recharge centers.	3.2
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Reducing Federal Financial Participation: The Administration for Children and Families should consult with the Congress on modifications to the Federal medical assistance percentages formula which would result in distributions of Federal funds that would more closely reflect per-capita income relationships. (CIN: A-06-90-00056)	This proposal was not included in the President's FY 1996 budget.	1,100
Reduce Incentive Payments and Base Them on States' Performance: Base incentive payments on the States' demonstrated ability to meet Federal child support enforcement (CSE) requirements and performance objectives. Also, consider OIG recommended options to reduce financial incentives realized by States that would result in a more equitable cost sharing with the Federal Government. These options are: limiting incentives to a break-even point where a State's share of Aid to Families with Dependent Children collections, plus incentive, equal the State's share of CSE costs; eliminating incentives to poor performing States; and reducing the Federal share of administrative costs. (CIN: A-09-91-00147; CIN: A-09-91-00034)	This proposal was not included in the President's FY 1996 budget.	277

OIG Recommendation	Status	Savings in Millions
Limit Federal Participation in States' Costs for Administering the Foster Care Program: Limit Federal participation in foster care administrative costs through one of the following actions: limit future increases in administrative costs to no more than 10 percent per year; fund administrative activities via a single block grant with future increases based on the consumer price index; limit administrative costs to a percentage of maintenance payments; or restrict, through legislation, the filing period for retroactive claims, namely require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. (CIN: A-07-90-00274; OEI-05-91-01080)	This proposal was not included in the President's FY 1996 budget.	$247
GENERAL OVERSIGHT		
Disallow Interest Charges on Unfunded Liabilities of Government Pension Plans: The OMB should revise Circular A-87 limiting Federal sharing of actuarially determined pension costs, including amortization of unfunded liabilities, to situations where the State and local governmental unit are funding such costs through an actuarially sound plan. Interest costs caused by late funding should not be allowed. (CIN: A-09-87-00031)	Because of the sensitivity and financial impact of the proposed changes on the State and local governmental entities, OMB has expended considerable effort working with State and local interest groups prior to issuance as a draft proposed rule change. The OIG continues to recommend that OMB clarify the rule relating to pensions by finalizing revisions to Circular A-87.	1,300
Pension Reserves: Recover the Federal Government's proportionate share of pension reserve funds used by California to pay current period employer pension costs. (CIN: A-09-92-00116)	The Department's Division of Cost Allocation concurred with OIG's finding; resolution with the State is in progress. The State did not agree that the Federal Government should receive a proportionate share of the reserves saying that the use of the funds was mandated by State law specifically restricting the use to State funding sources only.	111
Internal Service Funds: California should refund the Federal share of accumulated surpluses in its internal service fund that provides goods and services to State agencies on a cost reimbursable basis, and adjust billing rates to eliminate future surpluses or deficits. (CIN: A-09-93-00039)	The Department's Division of Cost Allocation generally agreed with OIG's findings. However, California did not concur.	12.2

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

This schedule represents Office of Inspector General (OIG) findings and recommendations which, if implemented, would result in substantial benefits. The benefits relate primarily to effectiveness rather than cost-efficiency. More detailed information may be found in OIG's Program and Management Improvement Recommendations (the Orange Book).

OIG Recommendation	Status
HEALTH CARE FINANCING ADMINISTRATION	
Medicare Carrier Assessment of New Technologies: The HCFA should foster greater consistency among carriers in their coverage and pricing decisions, by providing carriers with selective access to comparative information on new technologies, reviewing carrier performance and working with the Public Health Service (PHS) operating divisions to disseminate information on new health care technologies. (OEI-01-88-00010)	The HCFA indicated that it recognized the problems with the carrier assessment of new technologies and had taken steps to correct the problems. The OIG plans to conduct a follow-up study to determine if effective actions have been completed.
Carrier Maintenance of Provider Numbers: The HCFA should establish adequate safeguards for detection of abusive providers. (OEI-06-89-00870)	The HCFA is taking steps to address the problems identified in the report, which OIG will monitor. The HCFA agreed to issue a modification to the Medicare Carrier Manual which will clearly state that carriers have a responsibility to ensure the integrity of provider numbers and that only those practitioners and providers with legal authority to practice are given and may retain provider numbers. The HCFA is also implementing changes to the contractor evaluation process, durable medical equipment claims processing and supplier requirements, and provider number system.
Improve the Health Care Financing Administration's Federal Managers' Financial Integrity Act Program: The HCFA should enhance the testing used to evaluate the contractors' claims processing internal controls. (CIN: A-14-93-03026)	The HCFA agreed and has established a work group comprised of OIG and HCFA staff members to address Medicare contractors' controls. The work group is developing an internal control review protocol to review contractors' controls.
Implement Proper Accountability over Billing and Collection of Medicaid Drug Rebates: The HCFA should ensure that States implement accounting and internal control systems in accordance with applicable Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current and complete disclosure of drug rebate transactions and provide HCFA with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (CIN: A-06-92-00029)	The HCFA concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The HCFA hopes to have final regulations during Fiscal Year (FY) 1996.

OIG Recommendation	Status
Physical Therapy in Physicians' Offices: The HCFA should take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. Some options are: conduct focused medical review; provide physician education activities; apply existing physical therapy coverage guidelines for other settings to physicians' offices. (OEI-02-90-00590)	The HCFA concurred with options one and two, and have distributed copies of the report to the carriers to determine if the issues identified are problems in their service areas. The HCFA is also forming a work group that represents physicians who provide physical therapy services in their offices to focus on the clinical appropriateness of services provided, including monitoring of these services.
Use of Nursing Homes and Medigap Guides: The HCFA should work with the Social Security Administration (SSA) and the Assistant Secretary for Public Affairs to develop a more effective strategy to make the booklets available to all beneficiaries. (OEI-04-92-00481)	The HCFA concurred with OIG's recommendation. It is also considering other OIG suggestions, such as distributing information through physicians' offices, hospital personnel and post offices to continue to improve its communication with beneficiaries.
Medicare Trust Funds' Accounts Receivable Balances: The HCFA needs to improve its internal controls and the controls of its fiscal intermediaries and carriers related to the recording and reporting of accounts receivables. Additionally, HCFA needs to properly estimate the allowance for uncollectible receivables and determine the amounts to be written off as uncollectible. In a review conducted in accordance with the Chief Financial Officers Act, OIG continued to find weaknesses in contractors' controls. (CIN: A-01-92-00516; CIN: A-14-93-03027)	The HCFA concurred with the intent of most of the recommendations and is taking corrective actions. However, HCFA has still been unable to resolve all the critical problems. The HCFA and OIG will continue to work together to develop corrective action plans to resolve these deficiencies. The HCFA has established a work group to review Medicare contractor operations and systems, analyze contractor controls and identify internal control weaknesses. The work group has contracted with a Medicare contractor and a certified public accounting firm to develop an approach to evaluate internal controls at Medicare contractors. The HCFA has also requested a clarification of the reporting of Medicaid financial information from the Federal Accounting Standards Advisory Board.
Medicare Trust Funds' Accounts Payable Balances: The HCFA should improve its internal controls and the controls of its fiscal intermediaries and carriers related to the recording and reporting of accounts payable. The HCFA should also perform Federal Managers' Financial Integrity Act (FMFIA) sections 2 and 4 reviews on all carrier accounts payable internal controls and financial management systems. (CIN: A-04-92-02054; CIN: A-05-92-00106)	The HCFA concurred with the recommendations. Regarding recommendations to perform FMFIA section 2 and 4 reviews at contractors, a work group is developing an internal control review protocol to review contractors' controls.
Improve Financial Management Systems to Enhance Financial Reporting: The HCFA should develop and implement financial management systems and related accounting and administrative internal controls to ensure that all Medicare liabilities are reported to the HCFA general ledger at fiscal year end. (CIN: A-14-92-03015)	The HCFA agreed that reasonable data should be included in the reporting of Medicare liabilities. However, HCFA asserts that the process for developing a reasonable estimate of a liability for provider reports would be too cumbersome. The HCFA is currently developing the Medicare Transaction System that will include an integrated accounting subsystem to estimate the amount of appealed cost reports.

OIG Recommendation	Status
Clarify the Allowability of General and Administrative Costs at Medicare Hospitals: The HCFA should revise the Provider Review Manual (PRM) to further clarify the allowability of specific types of general and administrative and fringe benefit costs. (CIN: A-03-92-00017)	The HCFA has published changes to the PRM to clarify the allowability of several of the cost categories identified in OIG's report. The HCFA has not yet clarified the remaining cost categories noted in OIG's report.
Consider Recommended Safeguards over Medicaid Managed Care Programs: The HCFA should consider safeguards available to reduce the risk of insolvency, and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)	The HCFA generally concurred with OIG's recommendations, but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.
Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program: The HCFA should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The HCFA should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)	The HCFA did not concur stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP but did not provide specific written methodology for computing AMP.
Use of Emergency Rooms by Medicaid Beneficiaries: The HCFA should encourage States to develop initiatives to review and reduce nonemergency use of emergency rooms by Medicaid beneficiaries, and assist them through data analysis instructions, expedited review of waiver applications for managed care and dissemination of effective emergency room control practices. (OEI-06-90-00180)	The HCFA indicated that it was concerned that it may not have sufficient resources to encourage States to develop initiatives to review and reduce nonemergency use of emergency rooms or disseminate annual reports on effective practices, but it will assist States by expediting the review of State applications for waivers to implement their efforts to control emergency rooms.
Avoid Future Medicare Secondary Payer Overpayments: To identify Medicare secondary payer (MSP) situations, HCFA should continue to implement its corrective action plan to eliminate the designation of MSP as a high risk area, and seek legislation which would require employers to report other health insurance coverage on the W-2 and tax statement. (CIN: A-09-89-00100; OEI-07-90-00760; OEI-07-90-00763)	The HCFA is continuing implementation of the corrective action plan. The HCFA did not agree with the recommendation on use of the W-2, indicating that it preferred to evaluate the outcome of recent legislation which mandated a data exchange between the Internal Revenue Service, SSA and HCFA.
Recover Past Medicare Secondary Payer Overpayments: The HCFA should ensure that there is adequate funding available to contractors to pursue collection of MSP overpayments, and instruct contractors to recover the MSP overpayment backlog and notify insurance companies of improper payments within recovery regulation time frames. (CIN: A-09-91-00103; CIN: A-04-92-02037)	The HCFA is in the process of establishing funding needs for recoveries and agreed to make recovery of backlog cases a top priority.

OIG Recommendation	Status
Review Social Security Administration Procedures that Impact Medicare Trust Funds: The HCFA should review SSA's wage certification procedures to ensure that the transfer of Medicare Hospital Insurance trust funds is consistent and performed in accordance with the Social Security Act. (CIN: A-14-92-03013)	The SSA is pursuing a legislative solution to this problem.
Sanction Referral Authority of Peer Review Organizations: The HCFA should adopt one or more of the following options for changing the peer review organization (PRO) authority: repeal or modify the "unwilling or unable" requirement; substantially increase the monetary penalty; maintain the authority as it now exists, but mandate referrals to State medical boards when PROs confirm serious quality of care problems. (OEI-01-92-00250)	The HCFA opposed the first option, supported the second and concurred with the third. It plans to develop a Memorandum of Agreement which will provide the necessary mechanism for PROs to exchange information about those physicians found to have serious quality of care problems with the States.
Payments for Total Parenteral Nutrition: The HCFA should review research concerning the use of intradialytic parenteral nutrition (IDPN). If IDPN is considered reasonable and necessary for the treatment of a subset of end stage renal disease patients, it should be paid on a per-capita basis, with discounts negotiated by each facility or the networks, or by using some other method that takes into account the efficiencies associated with facility administration of the nutrients. (OEI-12-92-00460; CIN: A-04-93-02073)	The HCFA agreed that there has been inappropriate coverage of IDPN in the past and has proposed changes in the policy to ensure appropriate coverage. While HCFA generally agreed with OIG's inspection report recommendations, a subsequent audit revealed that new claims were being paid for IDPN. This audit report, Medicare Part B Payments for Intradialytic Parenteral Nutrition, found that payment for IDPN continued after release of the inspection report.
Physician Office Surgery: The PROs should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)	The HCFA continues to work with the PROs to refine a methodology for review of quality of care for ambulatory services. The implementation plan is to expand the review of ambulatory services to additional States, first on a pilot basis, then on an implementation basis in other States.
Patient Advance Directives - Early Implementation Experience: The HCFA should develop and issue specific regulatory guidelines clarifying acceptable documentation methods to assist providers in meeting the requirements of the Federal statute. The statute requires providers to inform individuals of any rights they have under State law regarding self-determination. (OEI-06-91-01130)	The HCFA did not concur with the recommendation, but is willing to provide assistance to States by issuing interpretive guidelines for survey and certification containing examples of what would constitute acceptable documentation of whether a patient has an advance directive.

OIG Recommendation	Status
PUBLIC HEALTH SERVICE OPERATING DIVISIONS	
Fully Implement Internal Controls in the Food and Drug Administration's Medical Device 510(k) Review Process: The Food and Drug Administration (FDA) should modify its exception report for use on a quarterly basis to detect possible manipulation of the 510(k) process; periodically sample reviewer workload to ensure compliance with the "first-in, first-reviewed" policy; require reviewers to document responses to all items on the review checklist; conduct bioresearch monitoring inspections on devices likely to result in 510(k) submissions; complete postmarket testing of the four devices it selected for review and increase the number sampled for future tests; include in its quality control reviews an independent scientific evaluation of reviewers' 510(k) decisions; and periodically monitor employee compliance with procedures for employee/industry contacts. (CIN: A-03-92-00605)	The FDA has made significant progress in rectifying deficiencies in this program area, and that it will continue to monitor FDA's efforts until all corrective actions are implemented.
Federal Involvement in Patents: The National Institutes of Health (NIH) should develop procedures to obtain information on patents issued to NIH grantees and determine if these patents were developed with Federal funds. (CIN: A-15-93-00029)	The PHS generally concurred with OIG's recommendations. The NIH has completed its review of patents issued to one grantee and found additional patents that were made with NIH support. The NIH has implemented a pilot project to assess the accuracy of reporting compliance for selected research institutions and has contacted the U.S. Patent Office to develop procedures which will lead to better monitoring of all federally supported patents.
Ensure that All Superfund Grantees Are Audited: The PHS should direct its Superfund agencies to establish procedures to ensure that all Superfund grantees submit audit reports and that grantees that are unwilling to have a proper audit conducted are sanctioned. (CIN: A-04-93-04506; CIN: A-04-93-04518)	The PHS directed the Superfund grant offices to take steps to ensure that all Superfund grantees provide the required audit reports.
Improve Financial Reporting and Monitoring of Research Funds at Universities: The Department should require grantees to submit a revised budget for the use of unspent grant funds when a substantial carryover of funds occurs from one budget period to another. Additionally, the Department should expedite the pilot project for obtaining detailed expenditure data from universities. (CIN: A-06-91-00073)	The Assistant Secretary for Management and Budget and PHS concurred with OIG's recommendations. In April 1992, the Office of Management and Budget (OMB) gave the Department approval to conduct a pilot project with selected universities to obtain detailed expenditure data by electronic transfer. This project is still under development. In addition, PHS added language to its grant policy statement that defines "significant rebudgeting."

OIG Recommendation	Status
Improve Accountability Over National Institutes of Health's Management and Service and Supply Funds' Activities: The NIH should improve accountability over personal property and inventory by performing monthly reconciliations and perform adequate follow-up procedures on discrepancies noted by physical counts. The NIH should also develop policies and procedures for retaining supporting accounting documentation. (CIN: A-15-93-00008)	A Board of Survey was initiated and presented a series of recommendations to improve property management.
Improve Controls Over Advisory Committee Conflict of Interest: The NIH should: review advisory committee members' financial disclosure forms to identify perceived or actual conflicts of interest; require ongoing reviews to identify changes in financial interest that could result in conflicts of interest; revise required financial disclosures to include involvement in nonfederal grants and contracts; and provide guidance to determine when a waiver should be sought to obtain essential services of a committee member. (CIN: A-15-93-00020)	The NIH concurred with OIG's recommendations and has taken actions which, when fully implemented, will significantly strengthen internal controls.
Implement a Charging System for Centers for Disease Control and Prevention Data Processing Costs: The PHS should require the Centers for Disease Control and Prevention (CDC) to implement a system for charging data processing costs to its component centers consistent with the provisions of the Federal Information Processing Standards Publication 96. (CIN: A-04-92-03503)	The PHS did not concur with OIG's recommendations. However, it agreed to analyze its charging systems and correct any major inequities. The CDC reported that it analyzed its computer charges and found them not to be based on actual utilization. However, it stated that the charges included other costs incurred and that it will analyze these costs to ascertain whether there are any actual inequities.
Improve Monitoring of Community Health Center Grantee Financial Controls: The PHS should strengthen its monitoring procedures to improve community health centers' accountability over grant funds. (CIN: A-07-92-00518)	The PHS concurred with OIG's recommendations and indicated that onsite peer reviews began in FY 1994 to strengthen monitoring of community health centers.
ADMINISTRATION FOR CHILDREN AND FAMILIES AND ADMINISTRATION ON AGING	
Undistributed Child Support Payments: The Administration for Children and Families (ACF) should remind States to: monitor and expedite the distribution of collected child support payments; place undistributed payments in interest bearing accounts; and report escheated payments and interest as State income. (CIN: A-09-93-00030)	The ACF agreed to participate in a joint effort with OIG to determine the extent of these problems, but disagreed with the need to remind States of ACF's policies and procedures for undistributed collections. The ACF expected considerable alleviation of the undistributed collections as States complete their automated systems. The ACF is in the process of reviewing 12 selected States' undistributed collections balances in order to address the wide disparity in the level of balances reported by the States, as well as problems cited in the OIG report. When all 12 reviews are complete, a national report will be issued to outline problems encountered and suggested solutions for the handling and reporting of undistributed collections.

OIG Recommendation	Status
Strengthen Head Start Grantees' Financial Management Systems: The ACF should intensify efforts to assure that Head Start grantees have adequate systems of internal controls; maintain proper accounting records; have systems for assuring program requirements are met; and obtain acceptable independent audits and submit reports in accordance with Federal requirements. The ACF should also take appropriate action when grantees do not meet these requirements. (CIN: A-17-93-00001)	The ACF generally agreed with OIG's recommendations.
Measure Head Start Grantees' Performance: The ACF should establish and implement performance measures and procedures for determining Head Start grantees' compliance with program requirements, and as a basis for establishing uniform ratings and identifying management practices that create high-risk conditions. (CIN: A-04-90-00009)	The ACF agreed with the importance of strengthening performance measurement criteria but disagreed with OIG's conclusions relative to high-risk conditions. The ACF is now completing a major initiative to develop Head Start performance measures designed to assess the quality and effectiveness of the program nationally through stating outcomes for children and families and through program indicators.
Ensure that Head Start Program Attendance Goals and Matching Requirements are Met: The ACF should establish and implement procedures to ensure that center-based Head Start grantees attain the expected attendance goal of 85 percent of funded enrollment. The ACF should also seek a legislative change to require that funding levels be based on current conditions (not historic funding levels) and require current information to support requests for waivers of nonfederal matching requirements. (CIN: A-04-90-00010)	The ACF noted that it is obtaining information from its grantees to improve internal reporting procedures. As far as average daily attendance, ACF states that an average daily attendance of 85 percent is a service goal, not a program requirement of Head Start grantees. The ACF is also reviewing Head Start procedures to grant waivers.
Health and Safety Standards at Child Care Facilities: The ACF should work with States to improve the health and safety practices of child care facilities. In addition to actions ACF is already taking, OIG recommended that ACF provide State agencies with identified best practices including: parental involvement, provider self-appraisals and private/public partnerships. (CIN: A-04-94-00071; CIN: A-07-93-00718; CIN: A-12-92-00044)	The ACF generally concurred with OIG's findings and recommendations, and is taking actions to enhance the health and safety standards of child care facilities.
Improve the Federal Foster Care Program: The OIG provided options for ACF to consider in its efforts to improve its partnership with State and local governments in administering the Federal Foster Care program. The options included streamlining the process; determining whether legislative change is needed; and determining if certain program requirements could be changed to facilitate compliance. (CIN: A-12-93-00022)	The ACF concurred on the issues raised in OIG's report. The ACF has convened two teams whose task is to redesign the titles IV-B and IV-E child welfare reviews. The objectives of the teams are consistent with issues and options described in OIG's report.

OIG Recommendation	Status
Improve Oversight of Audits of Office of Community Service Grantees: The ACF should track Office of Community Services grantees' implementation of recommendations made as a result of single audits, and follow-up with grantees to ensure actions taken were effective. (CIN: A-12-92-00043)	The ACF agreed and will take steps to implement the recommendations within the limitation of current staffing resources.
Colocating Intergenerational Programs: The Administration on Aging (AoA) and ACF should examine whether demonstrated successes in colocating programs and facilities in the private and public sector can be more broadly applied to departmental programs on a voluntary basis. (CIN: A-05-94-00009)	The AoA and ACF generally agreed with OIG's recommendations.
Improving Administration on Aging's Nutrition Program for the Elderly: The AoA and the Department of Agriculture (USDA) should remove barriers to increase States' use of commodities by fostering better communications and working relationships with State distribution agencies which handle USDA commodities; assuring a better variety of commodities; and improving dependability, quality and packaging of commodities. (CIN: A-01-93-02510)	The AoA and USDA generally agreed to address these issues through joint efforts.
GENERAL OVERSIGHT	
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify the Department of Health and Human Services' (HHS') disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to PHS, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040)	The OS and OASH have consolidated into one unit. The OASH had taken the lead in this area and has met with headquarters operating division emergency preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved.
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The OASH should issue guidelines to improve disaster planning. The plans of each operating and staff division should spell out lines of communication with each other, and should specify headquarters and regional lines of communication with the Federal Emergency Management Agency. (OEI-09-90-01040)	The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department. The OASH and OS have consolidated.

OIG Recommendation	Status
Ensure that New York Allocates Training Costs to Federal Programs for Actual Number of Attendees: The Department should be more aggressive when approving State plans to ensure that the State (among other actions): allocates future training contracts to programs based on the actual number of participants; maintains documentation which clearly details which programs benefit from future training and, where applicable, allocates training costs to all benefitting programs; and discontinues using third party contributions provided by private contractors to meet its share of training costs. (CIN: A-02-91-02002)	The Department's Division of Cost Allocation (charged with approval of State cost allocation plans) expressed agreement with the findings and recommendations.
Reform the Systems for Determining State and Local Government Administrative/Indirect Costs: The OIG identified a number of options, some of which require legislative action, to facilitate the allocation of administrative/indirect costs to Federal grants and contracts. These include: establishing a block grant to pay administrative/indirect costs, negotiating nonadjustable rates for a predetermined number of years, and assigning the responsibility for negotiating rates for all entities within a State to one Federal agency. (CIN: A-12-92-00014)	The National Performance Review Report included OIG's recommendations. The OMB is working on the development of guidelines to assist States in the charging of administrative/indirect costs to Federal programs.
Revise Hospital Cost Principles for Federally Sponsored Research Activities: The Department should act to modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with OMB Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (CIN: A-01-92-01528)	The Department intends to begin work on revising hospital cost principles when the revisions of the Governmentwide cost principles for universities and State and local governments (OMB Circulars A-21 and A-87, respectively) are finalized by OMB.
Guidelines to Reimburse Educational Institutions and Nonprofit Organizations: The Department should work with OMB to revise applicable cost principles to reflect the change in accounting for post retirement benefit costs arising from implementation of Financial Accounting Standards Board Opinion 106. It should also advise negotiators for the Department's Division of Cost Allocation to pay special attention to such costs when reviewing fringe benefit rates for schools and nonprofit organizations. (CIN: A-01-93-04000)	The OMB has revised Circular A-87 to limit post retirement benefit costs to the amount funded, and agreed that similar provisions should be incorporated in future modifications of circulars applicable to educational institutions and nonprofit organizations (OMB Circulars A-21 and A-122, respectively). In the interim, the Department has issued instructions to negotiators.
Implement Random Moment Sampling Systems and Other Time Studies: The Department, in conjunction with OMB, should issue definitive, authoritative guidelines for States adopting random moment time studies. (CIN: A-07-93-00645)	The Department agreed with OIG's conclusion and is working with OMB in the development of guidelines related to the determination of administrative costs, including standards for the use of random moment time studies.

APPENDIX D

Notes to Tables I and II

Table I

[1] The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of $14.5 million.

[2] During the period, revisions to previously reported management decisions included:

CIN: A-03-91-00553	Foster Care Allegheny County: The Departmental Appeals board issued a decision which reduced the audit disallowance by $1,486,159.
CIN: A-02-94-30824	Puerto Rico Office of Human Development - Head Start: The grantee provided documentation to support previously disallowed costs of $407,992.
CIN: A-03-93-22784	District of Columbia Department of Human Resources: DHS provided documentation to support previously disallowed costs of $54,008.

Not detailed are revisions to previously disallowed management decisions totaling $1,037,690.

[3] Audits on which a management decision had not been made within 6 months of issuance of the report:

A. Due to administrative delays, many of which were beyond management's control, resolution of the following audits was not completed within 6 months of issuance; however, based upon discussions with management officials responsible for those audits, resolution of these outstanding recommendations is expected before the end of the next semiannual reporting period:

CIN: A-03-91-00552	Independent Living Program - National, March 1993, $6,529,545 (Related recommendation of $10,161,742 outstanding on Table II)
CIN: A-07-92-00578	BC/BS of Texas Inc. - Unfunded Pension Costs, October 1992, $6,244,637
CIN: A-03-89-00046	Maryland BC/BS Administrative Costs Part B FYs 1985 - 1988, September 1991, $5,996,278
CIN: A-03-90-02003	Blue Cross of Western PA Administrative Costs FYs 1986 - 1989, August 1993, $3,355,560
CIN: A-07-93-00633	Pension Segmentation - AETNA Life Insurance Co., October 1993, $3,011,376
CIN: A-05-93-00013	Michigan BC/BS - Contract Medicare Audit, April 1993, $3,010,916
CIN: A-07-92-00585	Pension Segmentation BC/BS of California, January 1994, $2,973,504
CIN: A-03-93-03308	GSX Services, Inc. CACS 263-86-0098, February 1994, $2,806,577
CIN: A-07-92-00579	BC/BS of Michigan Inc - Unfunded Pension Costs, October 1992, $2,535,698
CIN: A-05-92-00026	Associated Insurance Co. - Medicare Administration, February 1992, $2,530,409
CIN: A-02-91-01006	Blue Shield of Western NY Medicare Administrative CTS Porter, September 1991, $2,379,239
CIN: A-03-90-02003	Blue Cross of Western PA Administrative Costs FYs 1986 - 1989, August 1993, $2,218,528
CIN: A-02-93-02001	Manpower Demonstration Res Corp, October 1994, $2,024,444

CIN: A-02-95-33649 Puerto Rico Department of Anti-Addiction Services, April 1995, $1,606,955

CIN: A-03-92-19733 State of Maryland, August 1992, $1,505,462

CIN: A-03-90-00051 Maryland BC/BS Administrative Cost - Part A FYs 1985 - 1988, August 1991, $1,438,414

CIN: A-09-93-00083 Child Support Intercept Programs - California, August 1995, $1,429,837 (Related recommendation of $2,900,000 outstanding on Table II)

CIN: A-05-93-00057 MI BC/BS of MI - Contract Audit, July 1993, $1,409,954

CIN: A-10-91-00011 WPS - Keystone Computer Acquisition, October 1992, $1,346,681

CIN: A-07-93-00700 BC/BS of Mass - Unfunded Pension Cost Audit, May 1994, $1,290,740

CIN: A-07-94-00762 Health Care Service Corp - Unfunded Pension Costs, July 1994, $1,233,337

CIN: A-07-93-00665 Travelers Insurance Co - Unfunded Pension Cost Audit, October 1993, $1,218,963

CIN: A-03-93-03313 Biocon, Inc. CCS 263-86-0098, February 1994, $1,061,376

CIN: A-07-94-00763 Health Care Serv Corp - Pension Segmentation, August 1994, $1,055,458

CIN: A-07-93-00699 BC/BS of Mass - Pension Segmentation Audit, April 1994, $658,471

CIN: A-09-94-01010 Closeout Audit - Contract No. 01-ES-75196 (STRATAGENE), March 1994, $983,208

CIN: A-05-92-00060 Contractor Audit - BCBS - Administrative Cost, February 1993, $879,609

CIN: A-07-95-01149 BC/BS Texas Charging of Pension Costs, July 1995, $874,111

CIN: A-07-93-00701 BC/BS of Mass - Pension Costs Charged Audit, July 1994, $839,740

CIN: A-03-94-03304 Biocon, Inc. CACS No. 1-CP-95644, February 1994, $747,865

CIN: A-05-91-00136 Community Mutual Insurance Co. Administrative Costs, August 1992, $720,668

CIN: A-03-95-33212 State of Pennsylvania, April 1995, $704,872

CIN: A-03-93-00353 D.C. Dept of Human Resources - Block Grants Drugs, April 1995, $657,048

CIN: A-10-95-00001 KCMBS Administrative Cost Audit, January 1995, $620,138

CIN: A-02-95-37125 Columbia University System, May 1995, $594,676

CIN: A-04-94-01078 Monitoring Administrative Cost - Audit Medicare Part B BC/BS, July 1994, $594,092

CIN: A-04-93-01069 Monitoring Administrative Cost - Audit Medicare Part A BC/BS, July 1994, $590,844

CIN: A-07-93-00679 AETNA - Unfunded Pension Cost Audit, May 1994, $590,207

CIN: A-02-91-03508 Audit of New Jersey Child Care and Supportive Services, June 1993, $506,710

CIN: A-03-92-16229 State of Pennsylvania, March 1992, $496,876

CIN: A-09-94-00058 Transamerica Occidental Medicare Administrative Cost, March 1995, $491,479

CIN: A-06-92-00017 IHS Creek Contract Closeout Report, May 1992, $468,217

CIN: A-06-92-00102	JOBS: Federal Financial Participation, October 1993, $438,996 (Related recommendation of $14,999 outstanding on Table II)
CIN: A-06-93-00042	BCBS Texas Administrative Costs - Medicare Parts A & B, January 1993, $434,134
CIN: A-03-95-00451	Escheated Warrants - District of Columbia, August 1995, $420,607
CIN: A-06-95-37434	State of Texas, August 1995, $379,759
CIN: A-05-92-00126	Wisconsin Westcap Head Start ACF/RO Request, March 1993, $347,576
CIN: A-05-93-25697	West Central Wisconsin Community Action Agency, Inc., August 1993, $324,759
CIN: A-09-94-31078	State of Arizona, June 1994, $267,021
CIN: A-03-92-20033	State of Delaware, August 1992, $247,609
CIN: A-07-93-00710	BC/BS of Connecticut-Unfunded Pension Cost Audit, March 1994, $237,392
CIN: A-03-95-37464	Johns Hopkins University Applied Physics Laboratory, May 1995, $215,470
CIN: A-09-95-34788	State of Arizona, August 1995, $209,462
CIN: A-05-93-26106	Economic Opportunity Committee of St. Clair County, August 1993, $188,691
CIN: A-05-94-29229	West Central Wisconsin Community Action Agency Inc., March 1994, $167,977
CIN: A-03-94-26611	State of Delaware, December 1993, $163,100
CIN: A-01-94-00521	Audit of Non PPS A/G and Capital Cost NE Rehab, January 1995, $160,170
CIN: A-09-92-06850	Santa Ysabel Band of Mission Indians, September 1992, $151,081
CIN: A-04-94-00081	Escheated Warrants - Florida, April 1995, $143,291
CIN: A-02-93-01003	Empire BCBS Administrative Cost Medicare Part A, July 1994, $119,293
CIN: A-07-93-00709	BC/BS of Connecticut - Pension Segmentation Audit, April 1994, $119,472
CIN: A-05-92-00048	WI Physicians Services, Pension - Medicare vs. Erisa, October 1992, $130,577
CIN: A-09-92-00093	Blue Cross Arizona Administrative Costs, August 1992, $129,518
CIN: A-05-91-00064	Nationwide Administrative Costs Contract Audit, October 1991, $211,422
CIN: A-04-93-20785	State of Florida, June 1993, $103,486
CIN: A-05-94-31408	Tri State Community Action Commission Inc., July 1994, $98,110
CIN: A-06-95-34421	State of Oklahoma, April 1995, $91,974
CIN: A-05-95-36487	Economic Opportunity Committee of St. Clair County, March 1995, $90,505
CIN: A-03-94-27083	Pennsylvania State University, March 1994, $86,479
CIN: A-04-93-00059	Refugee Social Services and Targeted Assistance - Florida, September 1994, $84,676
CIN: A-05-95-33723	Economic Opportunity Committee of St. Clair County, January 1995, $74,746
CIN: A-02-93-02518	Biederman, Kelly & Shafer Contract No. 26389C0354, February 1994, $72,883
CIN: A-09-93-00091	Walter McDonal - Indirect Cost Rate Audit, June 1994, $68,663
CIN: A-03-91-02002	Delaware Blue Cross Administrative Costs, October 1991, $66,858

CIN: A-02-95-33649 Puerto Rico Dept. of Anti-Addiction Services, April 1995, $65,277

CIN: A-05-95-37615 Illinois Dept. of Children & Family Services, July 1995, $64,000

CIN: A-09-95-33441 State of California, April 1995, $63,666

CIN: A-03-91-16232 Unisys Inc., September 1991, $61,754

CIN: A-06-94-27816 South Plains Health Provider Organization, Inc., March 1994, $60,900

CIN: A-06-92-19887 Central Tribes of the Shawnee Area, Inc., July 1992, $57,944

CIN: A-04-95-32641 State of Florida, April 1995, $56,984

CIN: A-10-95-34220 Grant County Community Action Council, November 1994, $55,004

CIN: A-03-93-03306 Survey Research Assoc. CACS No 1-ES-45067, December 1993, $48,779

CIN: A-04-95-38272 State of Florida, August 1995, $45,398

CIN: A-01-95-36087 State of Maine, June 1995, $45,057

CIN: A-09-94-01022 Intelligenetics #No 1-GM-72110, October 1994, $44,590

CIN: A-01-93-20875 State of Maine, May 1993, $40,540

CIN: A-03-95-03315 Health Systems Research Inc., April 1995, $37,161

CIN: A-03-95-33937 KOBA Institute Inc., August 1995, $32,575

CIN: A-01-94-27881 State of Maine, June 1994, $32,460

CIN: A-03-95-35319 Porter/Novelli, February 1995, $31,332

CIN: A-03-93-24682 Medlantic Research Institute, June 1993, $31,038

CIN: A-09-93-00106 Review of RSS and TAP Grants - CDSS, February 1996, $31,001

CIN: A-05-95-36811 Independent School District No.709-Duluth Minn, April 1995, $30,000

CIN: A-03-95-03313 Quality Resource Systems Inc-#240-89-0044, March 1995, $28,387

CIN: A-09-94-27868 Inyo Mono Advocates for Community Action, November 1993, $22,875

CIN: A-06-92-20334 Pueblo of Jemez, September 1992, $20,156

CIN: A-02-93-24129 Council of Jewish Federations Inc, May 1993, $19,152

CIN: A-03-93-22091 Pennsylvania State University, September 1993, $19,878

CIN: A-01-95-36338 State of New Hampshire, June 1995, $18,600

CIN: A-05-93-21928 Wright State University, July 1993, $18,308

CIN: A-01-95-37861 South County Community Action Inc., July 1995, $15,137

CIN: A-05-95-34584 Wood County Head Start Inc., December 1994, $14,896

CIN: A-02-95-38374 Puerto Rico Office of Human Development - Head Start, August 1995, $46,021

CIN: A-05-95-36498 Hoosier Valley Economic Opportunity Corp., April 1995, $13,116

CIN: A-10-92-20781 Tulalip Tribes of Washington, September 1992, $14,525

CIN: A-05-94-30273 Central Illinois Economic Development Corp., May 1994, $12,518

CIN: A-05-95-37806 Lake-Geagua United Head Start Inc., July 1995, $12,357

CIN: A-03-93-21579 State of West Virginia, April 1993, $11,380

CIN: A-09-92-06864 San Juan Southern Paiute Tribe, September 1992, $10,433

CIN: A-05-95-36138 Community Action Agency of Columbian County Inc., March 1995, $9,976

CIN: A-05-94-31542 Council for Economic Opportunities in Greater Cleveland, June 1994, $9,374

CIN: A-09-95-33652 Hawaii Dept. of Health, December 1994, $7,613

CIN: A-10-93-22136 Confederated Tribes of the Grand Ronde Community, December 1992, $7,384

CIN: A-03-95-32768 Pennsylvania State Univ., October 1994, $7,310

CIN: A-04-94-00079 Head Start - Financial Management Practices of TCRC Child Care, October 1994, $7,241

CIN: A-08-94-32795 Northern Cheyenne Tribe, September 1994, $6,548

CIN: A-09-95-33283 Commonwealth of the Northern Mariana Islands, November 1994, $5,171

CIN: A-06-91-00034 Audit of Collection & Credit Activities at TDHS, January 1992, $5,081

CIN: A-04-95-38272 State of Florida, August 1995, $5,000

CIN: A-04-95-38180 Family Health Centers Inc. South Carolina, August 1995, $4,781

CIN: A-01-94-28754 New England Deaconess Hospital Corp., April 1994, $4,447

CIN: A-07-95-38195 East Central Kansas Economic Opportunity Corp., August 1995, $4,233

CIN: A-01-95-37193 Champlain Valley Office of Economic Opportunity Inc., June 1995, $4,077

CIN: A-01-95-32620 State of Connecticut, January 1995, $4,070

CIN: A-07-95-01123 Review of CPA Administrative Cost-BCBS of Kansas City, May 1995, $4,045

CIN: A-02-01-03508 Second Street Youth Center Foundation Inc, July 1993, $3,989

CIN: A-10-93-26035 State of Washington, September 1993, $3,198

CIN: A-07-94-25955 State of Kansas,December 1993, $2,783

CIN: A-03-95-34716 West Virginia Medical Institute Inc., March 1995, $2,688

CIN: A-05-95-35315 Lake County Economic Opportunity Council, January 1995, $2,650

CIN: A-01-95-36087 State of Maine, June 1995, $2,451

CIN: A-03-94-30398 Medlantic Research Institute, June 1994, $2,306

B. Reports in litigation:

CIN: A-09-91-00155 Blackburn Care Home, November 1991, $1,777,944 (Related recommendation of $662,370 outstanding on Table II)

CIN: A-04-95-02096 Review of FY 1992 Unsupported G&A Costs - ABC, July 1995, $857,684

CIN: A-03-92-00033 Blue Cross of West Virginia Termination, November 1995, $25,200

CIN: A-03-91-02004 W VA BC Administrative Cost FY 1985/1990 and Termination Cost, November 1992

C. Reports that have subsequently been resolved:

CIN: A-09-95-37515 Northern Arizona Council of Governments, August 1995, $36,594

CIN: A-07-95-38136 State of Missouri, August 1995, $10,289

CIN: A-10-95-37226 Clallam-Jefferson Community Action Council, June 1995, $11,434

Table II

[1] The opening balance was adjusted to reflect a downward adjustment of $319.9 million.

[2] Included in the sustained management decisions of funds put to better use is $55,485 attributable to audits performed by the Defense Contract Audit Agency.

[3] Management decisions have not been made within 6 months of issuance on 8 reports.

A. Discussions with management are ongoing and it is expected that the following reports will be resolved during the next semiannual reporting period:

CIN: A-04-93-00062 Refugee Social Services/Target Assist Monitoring/Rollup, May 1995, $9,091,909

CIN: A-01-95-36338 State of New Hampshire, June 1995, $1,373,062

CIN: A-02-95-34946 City of Caguas Puerto Rico, March 1995, $64,206

CIN: A-06-91-00089 Audit of CN B Accounts to Determine Status of IHS Cash On-hand, April 1992, $445,890

CIN: A-06-95-00056 Payment Rate Audit of Glendale Surgicenter, April 1995, $19,111

CIN: A-05-95-34659 Northwest Michigan Human Services Agency, Inc., January 1995, $12,441

CIN: A-05-95-34584 Northwestern Illinois Community Action Agency, December 1994, $4,449

B. One report has subsequently been resolved:

CIN: A-09-94-27864 Solano County Economic Opportunity Council Inc., March 1994, $12,178

APPENDIX E

Reporting Requirements of the Inspector General Act of 1978, as Amended

The specific reporting requirements of the Inspector General Act of 1978, as amended, are listed below with reference to the page in the semiannual report on which each of them is addressed. Where there is no data to report under a particular requirement, this is indicated as "none." A complete listing of Office of Inspector General audit and inspection reports is being furnished to the Congress under separate cover. Copies are available upon request.

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	52
Section 5(a)(1)	Significant problems, abuses and deficiencies	throughout
Section 5(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	throughout
Section 5(a)(3)	Prior significant recommendations on which corrective action has not been completed	appendices B and C
Section 5(a)(4)	Matters referred to prosecutive authorities	53
Section 5(a)(5)	Summary of instances where information was refused	none
Section 5(a)(6)	List of audit reports	under separate cover
Section 5(a)(7)	Summary of significant reports	throughout
Section 5(a)(8)	Statistical table I - reports with questioned costs	50
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	51
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none

APPENDIX F

Performance Measure

Performance Measures

In order to identify work done in the area of performance measurement, OIG has labeled some items throughout the semiannual report as "performance measures" with the symbol Performance Measure. Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program which is measured by the number of inoculations provided per dollar of cost. In OIG's opinion, the following audits, inspections and investigations finalized during this semiannual period offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals.

APPENDIX G

Audits, Inspections and Investigations Related to Operation Restore Trust

The following audits, inspections and investigations finalized during this semiannual period relate to Operation Restore Trust, discussed in Chapter I. These report and case summaries are labeled with the symbol in the text. A multidisciplinary Federal and State approach to preventing and detecting fraud in home health agencies, nursing homes and durable medical equipment suppliers, Operation Restore Trust has targeted the five States with the greatest proportion of Medicare and Medicaid beneficiaries: New York, Florida, Illinois, Texas and California.

ACRONYMS

ACF	Administration for Children and Families
AFDC	Aid to Families with Dependent Children
AHCPR	Agency for Health Care Policy and Research
AoA	Administration on Aging
ASC	ambulatory surgical center
ASMB	Assistant Secretary for Management and Budget
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control and Prevention
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMP	civil monetary penalty
CSE	child support enforcement
CY	Calendar Year
DME	durable medical equipment
DOJ	Department of Justice
DRG	diagnosis-related group
EA	Emergency Assistance
EGHP	employer group health policy
EOMB	explanation of Medicare benefits
ESRD	end stage renal disease
FDA	Food and Drug Administration
FI	fiscal intermediary
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GME	graduate medical education
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHA	home health agency
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IME	indirect medical education
JOBS	Job Opportunity and Basic Skills
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
MTS	Medicare transaction system
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
OPD	outpatient department
PHS	Public Health Service
PPS	prospective payment system
PRM	provider review manual
PSC	Program Support Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SAVE	Systematic Alien Verification for Entitlements

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

The Inspector General Act of 1978 (Public Law 95-452), as amended, sets forth specific requirements for semiannual reports to be made to the Secretary for transmittal to the Congress. A selection of other statutory and administrative reporting and enforcement responsibilities and authorities are listed below:

AUDIT AND MANAGEMENT REVIEW RESPONSIBILITIES AND OFFICE OF MANAGEMENT AND BUDGET CIRCULARS

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 98-502	Single Audit Act of 1984
P.L. 99-499	Superfund Amendments and Reauthorization Act of 1986
P.L. 100-504	Inspector General Act Amendments of 1988
P.L. 101-576	Chief Financial Officers Act of 1990
P.L. 102-486	Energy Policy Act of 1992
P.L. 103-62	Government Performance and Results Act of 1993
P.L. 103-355	Federal Acquisition Streamlining Act of 1994
P.L. 103-356	Government Management Reform Act of 1994

Office of Management and Budget Circulars:

A- 21	Cost Principles for Educational Institutions
A- 25	User Charges
A- 50	Audit Follow-up
A- 70	Policies and Guidelines for Federal Credit Programs
A- 73	Audit of Federal Operations and Programs
A- 76	Performance of Commercial Activities
A- 87	Cost Principles for State and Local Governments
A-102	Uniform Administrative Requirements for Assistance to State and Local Governments
A-110	Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations
A-122	Cost Principles for Nonprofit Organizations
A-123	Internal Controls
A-127	Financial Management Systems
A-128	Audits of State and Local Governments
A-129	Managing Federal Credit Programs
A-133	Audits of Institutions of Higher Education and Other Nonprofit Institutions

General Accounting Office "Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

Title 5,	United States Code, section 552a(i)
Title 18,	United States Code, sections on crime and criminal procedures as they pertain to OIG's oversight of departmental programs and employee misconduct
Title 42,	United States Code, sections 263a(l), 274e, 290dd-2, 300w-8, 300x-8, 707, 1320a-7b and 1320b-10, the Social Security and Public Health Service Acts

Civil and administrative investigative authorities include civil monetary penalty and exclusion authorities such as those at:

Title 31,	United States Code, section 3729 et seq., the Civil False Claims Act and 3801 et seq., the Program Fraud Civil Remedies Act
Title 42,	United States Code, sections 1320a-7, 1320a-7a, 1320c-5, 1395l, 1395m, 1395u, 1395dd and 1396b

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

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