



Department of Health
and Human Services

Office of Inspector General

Semiannual Report

April 1, 1998 - September 30, 1998



June Gibbs Brown
Inspector General

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. 99-499	Superfund Amendments and Reauthorization Act of 1986
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
P.L. 104-156	Single Audit Act Amendments of 1996
P.L. 104-191	Health Insurance Portability and Accountability Act of 1996
P.L. 104-193	Personal Responsibility and Work Opportunity Act of 1996
P.L. 104-208	Federal Financial Management Improvement Act of 1996

Office of Management and Budget Circulars:

A- 21	Cost Principles for Educational Institutions
A- 25	User Charges
A- 50	Audit Follow-up
A- 76	Performance of Commercial Activities
A- 87	Cost Principles for State, Local and Indian Tribal Governments
A-102	Grants and Cooperative Agreements with 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	Management Accountability and Control
A-127	Financial Management Systems
A-129	Policies for Federal Credit Programs and Non-Tax Receivables
A-133	Audits of States, Local Governments and Non-Profit Organizations
A-134	Financial Accounting Principles and Standards

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(1), 274e, 290dd-2, 300w-8, 300x-8, 707, 1320a-7b, 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 False Claims Act and 3801 et seq., the Program Fraud Civil Remedies Act
- Title 42, United States Code, sections 1320a-7, 1320a-7a, 1320b-10, 1320c-5, 1395l, 1395m, 1395u, 1395dd and 1396b



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

A MESSAGE FROM THE SECRETARY

The American people rely on the benefits and services provided under the many programs of the Department of Health and Human Services (HHS). We at HHS are committed to safeguarding those benefits and services into the future. Key to achieving that goal is practicing a policy of zero tolerance for fraud and abuse. And one of our most valuable partners in this effort is the Office of Inspector General (OIG).

The Administration and the Congress have repeatedly recognized the importance of fighting fraud in the health care arena. In 1996, they gave law enforcement a major boost through the establishment of the Fraud and Abuse Control Program, authorized in the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA envisions a fraud-fighting program that coordinates the efforts of a broad array of law enforcement and health care agencies and provides the framework and resources for the struggle to improve the Nation's health care system. Since enactment of HIPAA, the number of health care fraud convictions and exclusions of unsuitable health care providers have increased dramatically. Moreover, we have seen implementation of OIG recommendations for policy and procedural changes which will result in savings of billions of dollars for the taxpayer.

Recognizing that fighting fraud is not just a challenge for law enforcement, we are working to detect and stop fraud before it ever happens. The OIG's preventive and deterrent function, including the development of front-end controls when designing benefit programs, has been crucial to those efforts. The OIG has also successfully enlisted the help of the public and the health care industry itself in identifying fraud and helping us fight it.

The Inspector General and I have the same mission. I am pleased that at HHS we have been able to work so successfully as a team towards our common goal of ensuring excellent service to our customers. Working together, we will continue to make real progress against fraud and abuse and restore public confidence in the ability of Government to ensure and improve the health and well-being of our children, our families, our Nation.

I extend my appreciation to the Inspector General for her efforts on behalf of the Department and the American taxpayer, and I commend her staff for their continued professionalism and dedication.

A handwritten signature in black ink, appearing to read "Donna E. Shalala". The signature is fluid and cursive, with a large initial "D" and "S".

Donna E. Shalala

FOREWORD

This semiannual report highlights the activities and accomplishments of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) for the 6-months ending September 30, 1998. During this period, we continued to build on our solid record of achievement, identifying opportunities for improving quality of care and services and enhancing program efficiency and effectiveness.

The success of our efforts is largely the result of the collaborative working relationship that exists between OIG and the Department. The OIG must work closely and constructively with departmental managers to ensure that HHS programs are administered in a cost-effective manner and structured so as to avoid fraud and abuse. At the same time, OIG must maintain the independence necessary to investigate, audit and critique those programs in the best interest of the American taxpayer. I believe that we have achieved this balance at HHS. We are supported in our dual role by Secretary Shalala, who has always regarded OIG as a valuable resource. In this environment, departmental managers are encouraged to confer with OIG staff in developing policy and procedures, and to act to close loopholes in response to OIG findings of vulnerability in agency programs or operations.

One of the areas of greatest concern within the Department continues to be the integrity of the Medicare program. During this reporting period, we issued our second comprehensive financial statement audit of the Health Care Financing Administration and found that unnecessary or improper benefit payments continued to plague the program. We will continue to work with the Department to ensure that identified weaknesses are corrected. Also, we are monitoring HHS's progress in meeting one of the greatest challenges facing Federal agencies today, that of readying for the year 2000.

In seeking ways to further extend our reach, we have established numerous partnerships with others inside and outside the Department. These initiatives have allowed us to stretch our dollars, drawing upon the expertise of others while sharing our own. In one such effort, OIG and the Office of Child Support Enforcement joined together to design a criminal justice model to combat the problem of criminal nonpayment of child support. Using multiagency task forces, this approach is intended to create a streamlined system of case identification, referral and prosecution which will heighten the impact of law enforcement efforts in the field of child support enforcement.

Moreover, we have broadened the focus of our work beyond the traditional after-the-fact investigations and audits of past conduct, so that we not only detect fraud, waste and abuse, but also work to prevent them. Recognizing that Government alone cannot solve the

problems of fraud, we have sought ways to inform and educate the public, including the provider and beneficiary communities, and enlist their help in avoiding impropriety. During this reporting period, OIG unveiled its comprehensive compliance program guidance for the home health industry. This is the third set of guidelines to be developed by OIG for a provider group doing business with the Federal health care programs, and others are under development.

Another key aspect of our prevention initiatives has been to step up our efforts to exclude offending providers from future participation in Federal health care programs. Such exclusions serve the dual purpose of preventing continued payments to providers deemed untrustworthy and protecting beneficiaries from substandard care. This year, we reported a record 3,021 exclusions of such providers.

In addition, we are pleased that our efforts have once again yielded impressive savings to the Government: over \$11.6 billion for Fiscal Year 1998. We will continue to seek opportunities to enhance the efficiency and effectiveness of HHS programs and to improve the lives of the programs' beneficiaries.

A handwritten signature in black ink, reading "June Gibbs Brown". The signature is written in a cursive style with a large, looping initial "J".

June Gibbs Brown
Inspector General

HIGHLIGHTS

Introduction

During the 6-month period ending September 30, 1998, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) carried out a number of initiatives in furtherance of its mission to protect HHS programs and the health and welfare of the beneficiaries served by them. Highlights of OIG's accomplishments for this period follow.

Statistical Accomplishments

The OIG is pleased to report record savings of \$11.6 billion for fiscal year (FY) 1998, comprised of \$10,964.8 million in implemented recommendations and other actions to put funds to better use, \$146.5 million in disallowances from questioned costs and \$515.9 million in investigative receivables. (See Appendix A and the sections entitled "Resolving Office of Inspector General Recommendations, A. Questioned Costs" and "Investigative Prosecutions and Receivables" in the General Oversight chapters of OIG's FY 1998 semiannual reports for details.)

In addition, for FY 1998, OIG reported 3,021 exclusions of individuals and entities for fraud or abuse of the Federal health care programs and/or their beneficiaries, 261 convictions of individuals or entities that engaged in crimes against departmental programs, and 927 civil actions. (See sections entitled "Fraud and Abuse Administrative Sanctions" in the Health Care Financing Administration chapters and "Investigative Prosecutions and Receivables" in the General Oversight chapters of OIG's FY 1998 semiannual reports.)

Medicare Managed Care

As of February 1998, over 6 million Medicare beneficiaries received their health care services through managed care plans, such as health maintenance organizations (HMOs). During this reporting period, OIG looked at several aspects of managed care:

Beneficiary and Physician Satisfaction

Beneficiaries sampled in an OIG review generally reported good access to HMO services in 1996 and substantial improvement in some problem areas since a 1993 review. Nevertheless, OIG recommended that the Health Care Financing Administration (HCFA) better inform beneficiaries about their rights and HMO procedures and restrictions, and improve its oversight of enrollee access to health care and reasons for disenrollment. In another review, OIG proposed that HCFA address the access problems reported by a sample of particularly vulnerable Medicare beneficiaries. (See page 19)

In a survey of physicians, OIG found that overall satisfaction with HMOs was low. However, despite concerns with the referral process, clinical independence, access to care

and other matters, most physicians believed that their Medicare patients received good care. (See page 18)

Oversight by HCFA

In a report on HCFA's processes for monitoring the performance of managed care plans, OIG proposed revisions to better ensure beneficiaries' access to services. For example, OIG recommended that the processes be more geared to capturing information on the plans' performance in today's evolving managed care market and targeted to specific characteristics of individual plans. (See page 17)

Administrative Costs

Two reviews assessed the administrative costs included in adjusted community rate (ACR) proposals, HMOs' estimates of the funds needed to provide Medicare services to beneficiaries in the upcoming contract year. In a review of the ACR process, OIG found that Medicare could save about \$1 billion a year if administrative costs were determined in accordance with Medicare's longstanding principle of paying only its fair share of needed health care costs. A review focusing on a particular HMO identified over \$700,000 in administrative costs that would be considered inappropriate in other Medicare reimbursement situations. The results of additional reviews underway will be shared with HCFA for its consideration of legislative changes to clearly delineate allowable administrative costs. (See pages 20 and 21)

Institutionalized Beneficiaries

At another HMO, OIG's sample of beneficiaries found that many had been incorrectly classified as institutionalized. Since Medicare pays a higher rate for such beneficiaries, OIG estimated that the HMO received at least \$1.6 million more than allowed over a 2-year period. A breakdown in the transmission of information in the HMO's computer system was the primary cause of the overpayments. (See page 20)

Quality of Care

Some of OIG's most significant work during this reporting period related to the quality of care provided to program beneficiaries.

Elder Abuse in Nursing Homes

With public concern for the safety of the elderly on the rise, OIG continued to concentrate on measures used by nursing homes and other long-term care facilities to prevent abuse and neglect. A recent consolidated report concluded that current State safeguards did not ensure that potentially abusive nursing home staff were systematically identified and excluded from employment. Instead, States used a patchwork of measures, including criminal background checks and screens of nurse aide registries. These safeguards varied in coverage from State to State and were usually limited to Statewide records. The records themselves lacked critical information on some individuals' criminal histories.

To better ensure a safe and secure nursing home environment, OIG recommended stronger safeguards, including the development of a national abuse registry. Also, OIG suggested

that its Healthcare Integrity and Protection Data Bank (HIPDB) be expanded to include the national abuse registry. The HCFA and the Administration on Aging generally agreed with OIG's recommendations, and HCFA planned to further examine the expansion of HIPDB. (See page 50)

Institutional Review Boards

The OIG released four final inspection reports that addressed the role of institutional review boards (IRBs) in protecting human subjects participating in clinical research. Although OIG did not claim that there are widespread abuses of human research subjects, the findings serve as a warning signal of a system in jeopardy. The OIG concluded that IRBs are reviewing too much, too quickly, with too little expertise. They are conducting minimal continuing reviews of approved research, facing conflicts that threaten their independence, and providing little training for clinical investigators and board members. Further, OIG believes that neither IRBs themselves nor the Department devote sufficient attention to evaluating IRB effectiveness. (See page 36)

Distribution of Organs for Transplantation

In updating a 1991 inspection report in response to a congressional request, OIG found that both racial and geographic disparities in waiting times still exist and, in some cases, seem to be growing for those waiting for transplant organs. Black recipients still wait longer than white recipients for kidney transplants and the difference in waiting times has grown. This inspection report reemphasizes that the national organ allocation system should focus on equity among patients, not among transplant centers, and on common medical criteria, not the circumstances of a patient's residence or transplant center affiliation. (See page 37)

Patient Dumping

Referrals to OIG of potential violations of the patient anti-dumping statute have increased dramatically. The statute requires that an emergency medical screening examination and appropriate stabilizing treatment be provided to patients who present at the emergency department of a Medicare participating hospital. The OIG is currently investigating over 150 cases of alleged patient dumping, representing hundreds of instances where individuals were potentially refused medical screening examinations and/or treatments for possible emergency medical conditions. In FY 1998, OIG settled 54 cases with the imposition of \$1.83 million in civil monetary penalties and community outreach obligations. In addition, OIG is preparing for hearings in three other dumping cases, involving two physicians and one hospital. (See page 12)

Child Support Enforcement

Along with the Office of Child Support Enforcement (OCSE) and its other Federal, State and local partners, OIG has developed procedures designed to expedite the detection and prosecution of absent parents who are delinquent in their child support. To date, OIG has investigated 378 child support cases nationwide. These cases have resulted in 75 convictions and court-ordered restitution of over \$6.6 million. Moreover, OIG has conducted audits and inspections involving various aspects of the child support enforcement program.

Child Support Enforcement Task Force

As part of its effort to further increase child support collections, OIG and OCSE initiated a multiagency, multijurisdictional investigative task force which consists of three investigative units from different States. The task force is designed to identify, investigate and prosecute criminal nonsupport cases both on the Federal and State levels through the coordination of law enforcement, criminal justice and child support office resources. It is anticipated that the task force will streamline the process by which the cases best suited for criminal action will be identified and prosecuted. (See page 45)

Satisfaction Survey

An extensive survey of State child support agencies found that most States were satisfied overall with both the central and regional OCSE, especially in the areas of communication, coordination and program support. The survey found that opportunities to improve services remained, but OCSE got high marks for its performance, particularly in recent years. Case studies for programs in Colorado, Massachusetts, Minnesota, New York, South Carolina and Texas were developed by OIG to supplement the first report. The case study report discussed each State's program highlights, working relationships with the Federal OCSE, some cross-analysis on specific issues and suggestions for support. (See page 44)

Availability of Health Insurance: Connecticut

In a separate review, OIG determined that children under the CSE program were receiving Medicaid benefits because private health insurance was unavailable or unaffordable to their noncustodial parents. The report noted that taxpayers, rather than the noncustodial parents, provided medical support to nearly 14,000 of these children through the Medicaid program in Connecticut. The OIG estimated that the State could save about \$11.4 million (Federal and State combined) in annual Medicaid costs if it required noncustodial parents to offset Medicaid premiums paid by the State on behalf of their children. The State agreed to do so, and both HCFA and the Administration for Children and Families endorsed OIG's suggestion. (See page 44)

Departmental Oversight

As part of its oversight responsibilities for departmental activities, OIG assessed progress toward Year 2000 computer system readiness and, through the financial statement audit process, accountability for taxpayer dollars.

Year 2000 System Compliance

As the millennium approaches, OIG is monitoring the Department's progress in renovating its mission-critical computer systems to recognize and process four-digit dates. This effort is part of an initiative by the President's Council on Integrity and Efficiency to monitor preparations throughout the executive branch.

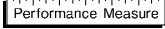
To allow time for dealing with unanticipated problems, the Department set December 31, 1998 as its deadline for system compliance. The OIG's first status report indicated, however, that both Medicare contractor and departmental systems were at risk of missing the deadline. Equally important was the apparent widespread lack of adequate contingency

planning -- a critical need in the event of mission-critical system failures. Additional status reports will be issued until the Year 2000. (See page 54)

Federal Financial Accountability

The OIG's recent audit of the departmentwide consolidated financial statements for FY 1997 noted an improvement in Federal financial accountability; that is, OIG's opinion on the statements advanced from a disclaimer for FY 1996 to a qualification for FY 1997. Because of continuing problems, however, OIG was unable to issue an unqualified (or "clean") opinion. The audit report estimated that improper Medicare fee-for-service payments in FY 1997 amounted to about \$20.3 billion, or about 11 percent of the total \$177.4 billion in fee-for-service payments. Additionally, OIG identified systemic internal control problems which were related to material financial statement amounts or which affected a number of operating divisions. For instance, although required by Federal accounting standards, the Department did not have an acceptable method for estimating incurred but unreported grantee expenses at yearend. The OIG continues to work with the Department in its efforts to achieve full financial discipline. (See pages 2, 40, 50, 54)

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 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.dhhs.gov/progorg/oig>

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**Health Care
Financing
Administration**

Chapter I

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 low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for cash assistance programs. 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 Federal/State Children's Health Insurance Program (CHIP), created under the new title XXI of the Social Security Act, will expand health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage. The CHIP program is a partnership between the Federal and State Governments in which States may choose to expand their Medicaid programs, design new child health insurance programs or create a combination of both.

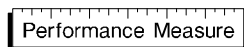
The Office of Inspector General (OIG) has devoted significant resources to investigating and monitoring the Medicare and Medicaid programs. These activities have often led to criminal, civil and/or administrative actions against perpetrators of fraud and abuse. They also have helped ensure the cost-effective 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; 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's documentation of excessive payments led to recent statutory changes in the way and/or the amount Medicare reimburses rural health clinics, skilled nursing facilities, home health agencies, hospices, ambulance services, oxygen suppliers, clinical laboratories, suppliers of certain Medicare-covered drugs and biologicals, teaching hospitals for indirect medical education costs and the States for Medicaid disproportionate share payments. To ensure quality of patient care, OIG has assessed clinical and physiological laboratories; evaluated the medical necessity of medical equipment and of services provided by home health agencies; 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 audits HCFA's financial statements, which account for more than 83 percent of Department of Health and Human Services (HHS) outlays. In addition to issuing an opinion on the statements, OIG has assessed compliance with Medicare laws and regulations and the adequacy of internal controls.

Financial Statement Audit of Health Care Financing Administration for Fiscal Year 1997



In its audit report on HCFA's fiscal year (FY) 1997 financial statements, OIG issued a qualified opinion on the statements, an improvement over the disclaimer issued for FY 1996. This improvement was attributed to a series of actions taken by HCFA following the earlier audit. Most important, HCFA developed a more reliable method for estimating Medicare accounts payable, and OIG was satisfied with the reasonableness of this estimate.

Also, OIG estimated that the dollar value of improper Medicare fee-for-service benefit payments made during FY 1997 totaled about \$20.3 billion nationwide, or about 11 percent of the \$177.4 billion in fee-for-service payments reported by HCFA. While this point estimate was \$3 billion less than last year's point estimate of \$23.2 billion, OIG was unable to conclude that the error rate was statistically different. Once again, OIG noted that the improper payments were caused primarily by provider billings for services that were insufficiently documented, medically unnecessary, incorrectly coded or noncovered. Considering the significance of the error rate, OIG concluded that HCFA's oversight of the Medicare program continued to fall short of providing reasonable assurance of detecting and preventing improper Medicare payments.

The HCFA concurred with OIG's recommendations and is in the process of taking corrective action. The OIG's report appears in HCFA's FY 1997 Financial Report. (CIN: A-17-97-00097)

Fraud and Abuse Control Program

During this reporting period, OIG took additional steps toward implementing the important responsibilities assigned by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Act established a comprehensive program to combat fraud committed against all health plans, both public and private. This legislation required the Departments of Justice (DOJ) and HHS to establish a Fraud and Abuse Control Program, effective January 1, 1997. Under the joint direction of the Attorney General and the Secretary, acting through the HHS Inspector General, the Fraud and Abuse Control Program is to achieve certain statutory goals: coordinating Federal, State and local law enforcement efforts relating to health care fraud; conducting investigations, audits and evaluations relating to health care fraud; facilitating enforcement of the civil, criminal and administrative statutes applicable to health care; providing industry guidance relating to fraudulent health care practices; and establishing a national data bank to report final adverse actions against health care providers.

To fund the coordinated antifraud effort, HIPAA directs that an amount equaling recoveries derived from health care cases -- including civil monetary penalties (CMPs), fines, forfeitures and damages assessed in criminal, civil or administrative health care cases -- be transferred to the Federal Hospital Insurance Trust fund. Monies are appropriated from the trust fund to a newly created expenditure account, called the Health Care Fraud and Abuse Control (HCFAC) account, in amounts that the Secretary and the Attorney General annually certify are necessary to finance antifraud activities. Of the amount so certified and appropriated, a stipulated sum is available only for the purposes of the "activities of the Office of the Inspector General of the Department of Health and Human Services, with respect to medicare and medicaid programs."

As required by the HIPAA legislation, in January 1998, DOJ and HHS issued their annual report of accomplishments achieved in the first year of the HCFAC program. This report details monetary recoveries of \$1.087 billion, of which nearly \$1 billion was restored or transferred to the Medicare Trust Funds. The HIPAA statute also requires that the General Accounting Office (GAO) conduct a biennial review of these recoveries, as well as expenditures and savings under the HCFAC program. In addition, GAO must review expenditures of HCFAC monies on activities not related to Medicare, and any other aspects of the program that GAO considers appropriate. During this semiannual period, GAO issued its first such financial report (GAO-AIMD-98-157). Importantly, their report found that the intricate processes developed by DOJ and HHS to track both expenditures and recoveries were sound. The GAO noted that non-Medicare expenditures were not tracked or reported separately from other authorized inquiries under the program, and that savings realized during FY 1997 were often attributable to activities that commenced in earlier years, but culminated in the year under review. Finally, the report noted that implementation of the Healthcare Integrity and Protection Data Bank was behind schedule, and gave revised implementation dates.

With the added resources and authorities provided by HIPAA, OIG has stepped up its efforts designed to prevent fraud and abuse. A key part of OIG's prevention efforts is the development of compliance program guidance to assist various sectors of the health care industry in establishing measures to combat fraud and abuse. The guidance, developed in conjunction with the provider community, seeks to promote voluntary compliance with applicable statutes, regulations, and program requirements governing Federal health care programs, by identifying steps that health care providers could undertake to improve adherence to Medicare and Medicaid rules. During this reporting period, OIG released compliance program guidance for home health agencies, and revised compliance program guidance for clinical laboratories. The OIG also solicited, by notice in the Federal Register, input and comments on issues that should be addressed in the upcoming guidance for the durable medical equipment industry. These compliance program guidances are discussed further on page 15.

The OIG has pursued other measures designed to promote fraud prevention as a central component of the HCFAC program; among them, issuance of fraud alerts, advisory opinions and other guidance as part of an ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry. In accordance with HIPAA, OIG has enlisted the help of the provider and beneficiary communities to prevent impropriety, by soliciting proposals (via Federal Register notice) for modifying existing safe harbors to the anti-kickback statute, and for developing new safe harbors and fraud alerts. The OIG received 32 timely-filed responses to the 1996 notice and 17 to the 1997 notice. A more detailed description of these proposals is set forth in Appendix G.

The OIG continues to provide direction, technical assistance and advice regarding the development and operation of HIPAA's required final adverse actions data bank, now named the Healthcare Integrity and Protection Data Bank (HIPDB). During this reporting period, the Notice of Proposed Rule Making (NPRM) for the regulations required by HIPAA to implement the new final adverse actions data bank was developed by the Department, signed by the Secretary and forwarded to the Office of Management and Budget (OMB) for review and clearance prior to its publication in the Federal Register for public comment this fall. The Health Resources and Services Administration continues its work in implementing the HIPDB on behalf of OIG. The OIG also continues to chair the Executive Steering Council that participates in oversight of the HIPDB, and acts as liaison to involve other Federal and State law enforcement agencies in both reporting to and querying the HIPDB.

Regulations implementing various provisions of HIPAA are under development. Proposed rules revising OIG's civil money penalty (CMP) authorities were published for public comment in March. Also during this reporting period, a final rule strengthening OIG's authority to exclude individuals and entities from participation in Medicare and State health care programs was approved by the Secretary and is under review in OMB.

The OIG has added additional staff to accomplish the office's responsibilities under the expanded antifraud and abuse program, and to continue to move toward its goal to have an investigative presence in every State. Implementation of HIPAA has been a cooperative effort. The OIG has and will continue to work closely with other components of HHS, chiefly HCFA and the Assistant Secretary for Management and Budget.

Copies of OIG's compliance program guidances, as well as other materials developed by OIG as part of its effort to identify and curb health care fraud, are available on the Internet at <http://www.dhhs.gov/progorg/oig>.

Major Hospital Initiatives

The OIG has launched five national projects involving civil actions at hospitals that were falsely billing the Medicare program. Four of the five grew from OIG hospital audits that identified irregularities in Medicare billing practices.

A. Physicians at Teaching Hospitals

The OIG has undertaken a nationwide initiative to review compliance with the rules governing reimbursement to physicians at teaching hospitals (also known as the PATH initiative). The specific objectives of the PATH audit initiative are to verify compliance with the Medicare rules governing payment for physician services provided by residents and interns, and to ensure that all claims for physician services accurately reflect the level of service provided to the patient.

Medicare pays the costs of training residents and interns through the graduate medical education (GME) program. Medicare also pays an additional amount in recognition of the additional costs associated with training residents and interns (also known as indirect medical education or IME). These payments can total over \$100,000 per resident per year. Medicare paid approximately \$8.1 billion to teaching hospitals in 1996 for the costs of training residents and interns. The Medicare payments described above include payments to teaching physicians for their role in supervising residents and interns.

The fundamental tenet of the PATH initiative is that in order to receive reimbursement from Medicare Part B for a service rendered to a patient, the teaching physician must have personally provided that service or have been present when the intern or resident furnished the care. Physicians claiming reimbursement for services performed by the intern or resident alone are making a duplicate claim--one that has already been paid for under Part A through the GME and IME payments.

The PATH audits also include a review of Part B claims information and medical records to determine if the teaching physician claimed the appropriate reimbursement for the level of service provided. The Medicare billing system's vulnerability to upcoding is a longstanding

concern at OIG. The PATH reviews are designed to detect patterns or practices of upcoding, resulting in unwarranted loss to the Medicare Trust Fund.

In sum, the PATH initiative has been undertaken as a result of OIG's extensive audit and investigative work in this area. To date, four institutions have entered into settlements with the Federal Government to resolve potential False Claims Act liability related to improper claims for Part B physician services submitted in the teaching setting. These settlements have resulted in the Government's recovery of over \$67 million. As a condition of settlement, these institutions have also implemented corporate integrity programs to prevent and detect future improper claims. An audit completed at two other institutions disclosed no major problems with either billings in the teaching setting or upcoding, demonstrating that providers can and do bill the Medicare program correctly.

To determine whether, and to what extent, problems similar to those noted above were present at other teaching institutions throughout the country, the PATH project was expanded into a national initiative, but limited to those institutions that received clear guidance before December 30, 1992 from the Medicare Part B carriers communicating the applicable HCFA reimbursement standards. As an alternative to OIG auditors conducting the audits, these providers are given the opportunity to conduct self-audits by contracting with an independent third party for a review of their Medicare billing practices, with Government oversight, and to report the audit results to OIG.

B. Diagnosis Related Group Payment Window Project

In 1995, OIG and DOJ launched a national project to recover overpayments made to hospitals as a result of claims submitted for nonphysician outpatient services that were already included in the hospitals' inpatient payment under the PPS. Hospitals that submit claims for the outpatient service in addition to the inpatient admission are, in effect, submitting duplicate claims for the outpatient services. In addition, the project seeks to recover for those services rendered to beneficiaries during the inpatient admission that should be included in the diagnosis related group (DRG), but are separately charged. A prevalent pattern of abuse was identified through repeated OIG audits of hospital claims for inpatient services under PPS. Prior to the inception of this project, OIG had issued four reports to HCFA identifying approximately \$115.1 million in Medicare overpayments to hospitals caused by these improper billings.

This national project identified 4,660 hospitals that submitted improper billings for outpatient services. These hospitals receive notification from the local U.S. Attorney's Office concerning OIG's identification of erroneous claims and the facility's potential exposure under the False Claims Act. The hospitals are given the opportunity to enter into a settlement with the Government under which the financial exposure of the institution is substantially less than if litigated under the Act. Compliance measures to prevent and detect erroneous billing are also required under the terms of the settlement. The project is

primarily coordinated by the U.S. Attorney's Office - Middle District of Pennsylvania. As of the end of the reporting period, settlements had been executed with 2,483 hospitals and about \$63.8 million had been recovered.

One of the most important parts of this project is the stipulation in each settlement agreement that each hospital will assure compliance with proper billing for inpatient/outpatient services. It is hoped that the deterrent effect of possible civil actions, along with promised compliance, will remove this source of improper claims.

C. Operation Bad Bundle

The OIG, DOJ and multiple States have joined forces to target false or fraudulent Medicare and Medicaid claims in hospital outpatient laboratories. A project begun in Ohio by OIG, DOJ, the State of Ohio and the Medicare fiscal intermediary proved so successful, United States Attorneys' Offices in other States began their own investigations as part of an expanded effort known as Operation Bad Bundle. This project involves the recovery of multiple damages, when appropriate, for improper and excessive claims submitted for hematology and automated blood chemistry tests by hospital outpatient laboratories. These abuses stem from the improper unbundling and double billing of laboratory tests, and, in certain cases, the billing for certain medically unnecessary tests.

Clinical laboratory services were particularly vulnerable to these abuses because of the multiple number of tests ordered at one time and the capability of automated equipment to run numerous tests from one sample of blood at a low cost. Under Medicare guidelines, the hospitals were required to bill certain groupings of blood tests using a bundled code. The reimbursement for blood chemistry tests bundled into a panel is significantly less than that for each test run separately.

The OIG and DOJ are working together on the national project to provide targeting data to the United States Attorneys' offices interested in pursuing this recovery initiative in their districts. The OIG also collaborated with DOJ to produce a model settlement agreement that includes compliance measures, which has been disseminated to all participating districts throughout the United States.

Thus far, 221 hospitals have entered settlements in Operation Bad Bundle, with settlements totaling more than \$45 million. More hospitals are expected to settle in the near future.

D. Patient Transfers

Another OIG/DOJ nationwide initiative is focused on improper payments to hospitals for patient transfers between two PPS hospitals. Under Medicare reimbursement rules, the hospital transferring a patient is to receive a per diem payment based on the length of stay, and the hospital receiving the transferred patient is to be paid a diagnosis-related payment based on the final discharge code.

Since 1986, however, OIG has found that many transferring hospitals inappropriately claim full diagnosis-related payment rather than the per diem payment. The HCFA has already acted on OIG's first report, which identified \$227 million in recoveries and savings. The OIG's second report, issued in November 1996, and a more recent computer analysis of claims disclosed additional overpayments of approximately \$202 million. Currently, OIG is working with U.S. Attorneys' offices nationwide to address this continuing problem.

E. Bacterial Pneumonia Project

The OIG and DOJ are investigating whether hospitals across the country have routinely assigned the incorrect diagnosis code to hospital admissions for bacterial pneumonia. Medicare pays for inpatient hospital services based on DRGs, which are assigned based on the diagnosis codes identifying the condition(s) treated during the hospital admission. One diagnosis code is to be used for "bacterial pneumonia - other specified bacteria," i.e., where a physician diagnoses the patient with a pneumonia caused by a specific bacteria and there is no other diagnosis code for that particular bacteria. This code should rarely be used since there are specific diagnosis codes for pneumonia caused by almost all known pneumonia-causing types of bacteria. Because cases that should properly be coded as "other specified bacteria" are expected to be complex, such cases are grouped to a higher-paying DRG than most pneumonia cases. The OIG believes that many hospitals have been using the "other specified bacteria" diagnosis code for hospital admissions where the physician has not diagnosed a specific bacteria as the cause of the pneumonia. In such cases, the hospital should use a different diagnosis code for "bacterial pneumonia - unspecified," which generally results in the case being grouped to a DRG which pays several thousand dollars less than the code for "other specified bacteria."

The OIG is currently investigating the coding for bacterial pneumonia at over 100 hospitals. To date, one hospital has settled its liability for such coding by paying over \$644,000 and agreeing to corporate integrity requirements.

Other Hospital Investigations

The following cases are significant examples of other hospital cases resolved during this period, which were not part of the special projects described above:

- A medical center in Texas entered a settlement agreement to pay the Government \$17.2 million for allegedly defrauding Medicare, Medicaid, the Tricare/Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and other Federal health care programs. In addition, the medical center agreed to enter into a 5-year program to ensure compliance with the billing requirements of Medicare, Medicaid and all other Federal health care programs. A qui tam action filed by a former employee alleged that the center submitted false claims by representing that services were

personally provided by faculty physicians employed by the center, but the center did not possess sufficient documentary evidence to show the involvement of these physicians.

- A psychiatric hospital located in Florida agreed to pay \$4.7 million to resolve its civil liability for fraudulent Medicare billings. Investigation showed that over a 6-year period, the hospital routinely admitted elderly patients for inpatient services that were not medically necessary. Many of the patients suffered from organic brain disorders and would not have benefitted from psychiatric treatments. In addition, the hospital provided inadequate patient care and falsified patients' medical records. As part of the settlement, the hospital agreed to enter into a comprehensive corporate integrity program which will be monitored and enforced by OIG for the next 5 years.
- In Georgia, a hospital agreed to pay nearly \$4.3 million to settle a qui tam False Claims Act case. The Government alleged that the hospital's pharmacy improperly billed the Georgia Department of Medical Assistance (GDMA) for dispensing fees relating to prescription medications. The hospital pharmacy routinely billed GDMA for dispensing fees over and above an allowable amount authorized by GDMA. This hospital also agreed to an extensive 5-year corporate integrity agreement.
- A hospital in Georgia agreed to pay more than \$950,000 to settle allegations that it improperly coded services in its chemical dependency unit in 1991 - 1992, before it was acquired by the Nation's largest for-profit hospital corporation. In addition, it was not properly licensed by the State to perform such services. A corporate integrity agreement was negotiated, but since the hospital no longer offers chemical dependency treatment and the corporation did not own or operate the hospital at the time of the misconduct, no provisions specific to a chemical dependency unit were included.

Using Software to Detect Upcoding of Hospital Bills

This inspection report focused on using commercial off-the-shelf software to detect diagnosis related group (DRG) upcoding. The OIG tested the ability of two software products to identify hospitals with a high rate of DRG upcoding. Hospitals identified by the software had an average upcoding rate that was twice as high as the upcoding rate of other hospitals. However, when examining performance at the DRG level, the software was distinctly less successful for all but a small group of DRGs with the very highest rates of upcoding. The testing results led OIG to raise caution about the ability of these products at this time. (OEI-01-97-00010)

Hospital Stays for Medicare Beneficiaries Discharged to Home Health Agencies

Hospital ownership of a home health agency affects hospital length of stay, according to this OIG inspection report. For example, patients who had bowel procedures were discharged 4 days sooner from hospitals that owned a home health agency than from those that did not. A 1-day difference was found for patients with joint replacements and pulmonary disease. No such differences were found for patients with heart failure and shock, vascular procedures and heart procedures. The OIG suggested that HCFA consider hospital ownership as an additional factor when selecting future diagnosis related groups to be covered under the recently enacted "transfer reimbursement provision" of the Balanced Budget Act of 1997 (BBA). (OEI-02-94-00321)

Fraud and Abuse Administrative Sanctions

During this reporting period, OIG imposed 2,117 sanctions, in the form of exclusions or civil actions, on individuals and entities for engaging in fraud or abuse of Federal and State health care programs and/or their beneficiaries. More than half the exclusions were based on conviction of program-related crimes, conviction for the illegal manufacture or distribution of controlled substances, conviction related to patient abuse or neglect, or loss of license to practice health care, as well as other bases.

A. Program Exclusions

Title XI of the Social Security Act provides a wide range of authorities to exclude individuals and entities from participation in Federal health care programs. Exclusion is mandatory for those convicted of program-related crimes, crimes related to patient abuse or neglect, felony convictions for defrauding other health care programs and felony convictions for the illegal manufacture or distribution of controlled substances. Exclusion is discretionary for those who have lost a license or the right to participate in a State health care program for reasons related to professional performance, professional competence or financial integrity, or provided substandard care or unnecessary services, or engaged in various types of prohibited activities.

The BBA was designed to ensure further protection of the integrity of Medicare and other Federal and State health care programs for current and future beneficiaries, and to combat fraudulent and abusive program activities. As a result of the Act, the scope of an OIG exclusion now extends beyond Medicare and the State health care programs to any Federal health care program. The Act also requires a mandatory exclusion of not less than 10 years for individuals who have been convicted on one previous occasion of an offense, and a permanent exclusion if the individual has been convicted on two or more previous occasions of one or more offenses (including program-related crimes, patient abuse or neglect, health care fraud and convictions relating to controlled substances).

During this reporting period, OIG imposed exclusions on 1,624 individuals and entities. The following are examples of some of the exclusions that were imposed:

- A California DME supplier was excluded for 20 years based on a conviction for Medi-Cal theft. He submitted false claims representing products that were either not needed or not delivered, or the amount provided was overstated. He purchased Medi-Cal stickers from recipients, which allowed him to bill for these products. He was sentenced to 4 years and 4 months imprisonment and ordered to make restitution in the amount of \$5.2 million.
- An internist from New York was excluded for 15 years based on his conviction relating to Medicare fraud. The scheme involved authorizing the medical necessity of certain DME equipment when there was no need. The court sentenced him to serve 46 months imprisonment and to make restitution of \$1.2 million to the Medicare program.
- A dentist and owner of a dental clinic in Kentucky was convicted of mail fraud involving false Medicaid claims. The individual was sentenced to 30 months incarceration and ordered to pay \$1 million to the United States, the amount he received in Medicaid reimbursement from the State for dental procedures which he had not performed. He was excluded for 15 years.
- As a result of his conviction, a psychological examiner in Maine was excluded for 10 years. While working as a licensed psychological examiner, the subject billed the Medicaid program for \$131,400 for services that he failed to provide.
- As a result of a conviction involving assault and injury to an elderly resident of a nursing facility, a nurse's aide in Texas was excluded for 15 years. The aide was sentenced to 10 years imprisonment and was convicted as a result of the victim's daughter placing a video camera in the victim's nursing facility room to document the abuse.
- A conviction in New Jersey for a felony involving counterfeit prescriptions, forged doctors' signatures and the resale of controlled substances resulted in the exclusion of two individuals involved in the scheme. They were both excluded for the minimum mandatory period of 5 years.
- A Michigan pharmacist was excluded for a period of 10 years based on his conviction involving mail fraud and Michigan Blue Cross/Blue Shield. The pharmacist billed for prescription drugs which he did not fill. As a result of

the conviction, he was sentenced to 78 to 97 months incarceration. The scheme resulted in financial damages of approximately \$207,549, which he was ordered to repay.

- A nurse in Texas was excluded for 3 years based on a conviction involving obtaining dangerous drugs by forgery. While working as the director of nurses at a nursing home, the individual took discontinued drugs for her own use. She also altered prescriptions that were given her for her own health problems before she presented them to the pharmacist to be filled.
- A physician was excluded indefinitely based on the revocation of his license to practice medicine in New York. The State Board for Professional Medical Conduct had found the subject guilty of willfully harassing, abusing or intimidating a patient either physically or verbally, engaging in conduct in the practice of medicine which evidences moral unfitness to practice medicine and practicing the profession fraudulently.
- An EKG monitoring center in Pennsylvania was excluded for a minimum period of 25 years. This exclusion was based on the company's association with an individual who had been convicted and excluded. The individual was also excluded for 25 years and was the center's president, secretary and treasurer. The scheme involved electronically billing for services and products that were not provided to out-of-state and deceased beneficiaries.

B. Civil Penalties for Patient Dumping

Section 1867 of the Social Security Act (42 U.S.C. 1395dd) provides that when an individual presents to the emergency room for examination or treatment, a hospital which has a Medicare provider agreement is required to provide an appropriate medical screening examination to determine whether that individual has an emergency medical condition. If an individual has such a condition, the hospital must provide, within the capabilities of the staff and facilities available at the hospital, treatment to stabilize the condition, unless a physician certifies that the individual should be transferred because the benefits of medical treatment elsewhere outweigh the risks associated with transfer. If a transfer is ordered, the transferring hospital must arrange for a safe transfer, which includes providing stabilizing treatment to minimize the risks of transfer, making sure the receiving hospital has agreed to accept the transfer and effecting the transfer through qualified personnel and transportation equipment. A hospital is prohibited from delaying provision of examination or treatment for an emergency medical condition to inquire about an individual's method of payment or insurance status. Further, a participating hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who needs those services if the hospital has the capacity to treat the individual.

The OIG is authorized to impose CMPs of up to \$25,000 against hospitals with less than 100 beds and up to \$50,000 against hospitals with 100 beds or more for each instance where the hospital negligently violates any of the requirements of section 1867 of the Act. In addition, OIG may impose a CMP up to \$50,000 against a physician who is responsible for the examination or treatment of an individual in a participating hospital, including a physician on-call, for each negligent violation of any of the requirements of section 1867.

The OIG collected \$1.1 million in CMPs from 32 providers and practitioners during this reporting period. The following are examples of CMP cases resolved by OIG:

- An Oregon hospital agreed to pay \$175,000 to resolve allegations of not providing appropriate medical screening examinations to all patients who came to the emergency room. It was hospital policy to contact a patient's health maintenance organization for payment authorization after triage, but prior to performing a medical screening examination. When "prior authorization" was denied, the patient left the hospital without further evaluation or treatment. The seriousness of the medical conditions upon presentment ranged from not very serious to very serious (such as potential heart attack or stroke).
- A small New York hospital agreed to pay \$15,500 to resolve allegations that it did not assure safe and appropriate transfers to two patients, including the transfer of a pregnant woman in labor.
- A small Georgia hospital agreed to pay \$20,000 to resolve allegations that it failed to provide an appropriate medical screening and stabilizing treatment to a 5-year old who was brought into the emergency room by his mother. This was the second time this hospital paid CMPs for not performing an appropriate medical screening examination to a person presenting with a significant medical problem.
- An on-call doctor from Arkansas agreed to pay \$37,500 to resolve allegations that he failed to come to the hospital to stabilize a pregnant woman in labor or to ensure a safe transfer of the patient. The decision not to treat and to transfer the patient was allegedly due to her status as a Medicaid patient.

C. 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 for the imposition of CMPs

and assessments in lieu of damages. The OIG also assists DOJ in bringing (and settling) cases against wrongdoers under the False Claims Act. Many providers elect to settle their cases prior to litigation. As part of resolving these cases, OIG frequently imposes corporate integrity agreements on entities as a condition for being allowed to remain as a provider in the Medicare program. These integrity programs established by these agreements are designed to prevent a recurrence of the fraudulent activities which gave rise to the case at issue. The Government, with the assistance of OIG, recouped more than \$320.8 million through both CMP and False Claims Act civil settlements related to the Medicare and Medicaid programs during this reporting period. Some examples of these cases include:

- In Illinois, one of the largest Medicare carriers in the country agreed to pay \$140 million to resolve its civil liability. In addition to the civil settlement, the corporation pled guilty to obstructing and conspiring to obstruct a Federal audit, and making false statements to HCFA. As part of the plea, the corporation also agreed to pay \$4 million in criminal fines. An investigation by OIG and several other Federal agencies showed that the corporation falsified reports used to evaluate its performance. The corporation concealed its poor performance and falsely claimed superior performance in processing Medicare claims for the Federal Government. Earlier, two corporation managers pled guilty and five employees were indicted on various criminal charges related to the scheme.
- A Pennsylvania Medicare carrier agreed to pay \$38.5 million to resolve its liability for misconduct in its performance as a carrier. Investigation by OIG and other Federal agencies found that during the years 1988 through 1996, the carrier engaged in the following misconduct: failing to properly process and/or take appropriate action to recover Medicare secondary payer claims; obstructing the carrier performance evaluation program by rigging samples for HCFA audits; failing to recover overpayments; failing to monitor end stage renal disease laboratory claims; and overriding payment safeguards when processing Part B claims. As part of the settlement, the carrier agreed to enter into an extensive corporate integrity program to ensure proper training for its employees and external reviews of its performance under its contract with Medicare.
- In Louisiana, a rehabilitation corporation and a physician stockholder in the corporation agreed to pay the United States the sum of \$4.4 million to settle their civil liability for allegedly billing Medicare for inpatient rehabilitation when the Medicare beneficiaries treated could not benefit from such rehabilitation. These patients were also admitted for inpatient rehabilitation for longer periods of time than were medically necessary.

- In New Jersey, a national provider of parenteral and enteral therapy (PEN therapy) agreed to pay \$4 million to settle its civil liability under the False Claims Act and the CMP law. Between January 1990 and June 1995, this corporation submitted claims to the Medicare program for PEN therapy for patients in Puerto Rico. The Medicare claims and supporting documents falsely stated that the patients suffered from a medical or physical condition that would make them eligible for Medicare coverage of PEN therapy. In fact, the patients did not suffer from those conditions. There were eight-criminal convictions in Puerto Rico relating to this scheme.
- A contract management company entered into a settlement agreement with the United States in the amount of almost \$2.8 million. This company also agreed to pay the States of Arkansas, Louisiana, Maryland, Massachusetts, Michigan, New Jersey, New York, Pennsylvania, West Virginia, New Hampshire and Texas a total of \$381,584. The Government alleged that from 1990 through 1994, the company, which provided physician services management to hospital emergency departments, submitted false claims to Medicare and Medicaid by routinely upcoding to levels III, IV and V, when they should have been reimbursed as levels I and II.

D. Compliance Activities

The existence of an "effective" compliance program can offer an organization certain credit under the Federal Sentencing Guidelines. This and other benefits have served to encourage the private sector to develop methods to prevent and detect violations under the False Claims Act and the CMP law. The OIG has already initiated significant outreach efforts with the private sector to discuss these endeavors.

The OIG continues in its efforts to promote voluntarily developed and implemented compliance programs by providing guidance for the various parts of the health care industry. To this end, OIG has developed and released compliance program guidance for clinical laboratories, hospitals and home health agencies. The OIG is currently working on guidance for other sectors of the industry, including third-party medical billing companies and durable medical equipment suppliers. The seven fundamental elements of an effective compliance program are: implementing written policies, procedures and standards of conduct; designating a compliance officer and compliance committee; conducting effective training and education; developing effective lines of communication; enforcing standards through well-publicized disciplinary guidelines; conducting internal monitoring and auditing; and responding promptly to detected offenses and developing corrective action initiatives.

In addition to developing compliance program guidance, OIG monitors corporate integrity obligations imposed on health care providers as part of global settlements of OIG investigations and audits. Presently, OIG is monitoring over 340 Government-imposed

corporate integrity agreements. These agreements cover the range of providers from small physician offices to large laboratory corporations. The duration of most corporate integrity agreements is 5 years and these agreements require a substantial effort by the provider to ensure that the organization is operating within HCFA rules and regulations and the parameters established by the corporate integrity agreement. Failure to adhere to the corporate integrity agreement could result in exclusion of the provider in addition to other penalties.

Medicare Beneficiary Satisfaction: 1997

Performance Measure

This is the sixth national survey of Medicare beneficiary satisfaction. As in 1995, beneficiaries reported positive experiences with several key aspects of the Medicare program. For example, 89 percent were satisfied with the way Medicare processed claims and 75 percent said they could get information when they needed it. One service improved -- 83 percent of beneficiaries were aware of Medicare's coverage of flu immunizations; in 1995, only 76 percent knew. However, the number of beneficiaries aware that Medicare limits physicians' fees and covers second surgical opinions decreased. There was still a need for improvement in some areas, such as carrier telephone service and beneficiary awareness of their appeal rights. Less than half of the beneficiaries knew that Medicare paid for pneumonia shots and only about a fourth of those who had received home health services knew that States had a "hotline" to report complaints. The OIG recommended that HCFA develop a plan for improving beneficiary understanding in these problem areas. The HCFA concurred with OIG's recommendation. (OEI-04-07-00030)

Medicare Beneficiaries with Additional Medical Insurance in 1997

Performance Measure

As part of its annual survey of Medicare beneficiaries, OIG looked at those beneficiaries who had medical insurance that supplemented Medicare. The OIG surveyed Medicare beneficiaries nationwide and compared their responses to those of a similar 1995 survey. The current survey showed that, in 1997, 86 percent of beneficiaries had medical insurance coverage in addition to Medicare; this was about the same as in 1995. As illustrated on the facing page, in both survey years, most beneficiaries were satisfied with their supplemental insurance policies. (OEI-04-97-00031)

SATISFACTION WITH INSURANCE THAT SUPPLEMENTS MEDICARE

Level of Satisfaction	Percent of Beneficiaries	
	1995	1997
Very Satisfied	53%	53%
Generally Satisfied	35%	35%
Neither Satisfied Nor Dissatisfied	7%	6%
Generally Dissatisfied	3%	4%
Very Dissatisfied	2%	2%

Medicare's Oversight of Managed Care

As of February 1998, 439 managed care plans counted over 6 million Medicare beneficiaries as members, a 90 percent increase since December 1994. Ideally, managed care's capitated payment leads to innovation in providing cost-effective, high quality health care. However, because the economic incentives of operating within a fixed budget may encourage plans to limit access to needed care in the interest of increasing profits, HCFA has a particular responsibility to ensure beneficiaries' access to services. The 10 HCFA regional offices carry out direct oversight of managed care plans with a site visit conducted every 2 years.

In a report on the processes HCFA uses to monitor the performance of managed care plans, OIG proposed some revisions. The OIG recommended that the processes be better geared to capturing information that reflects plans' performance in the constantly evolving managed care market and provide greater flexibility to target reviews on the specific characteristics of individual plans. Further, OIG recommended that HCFA take better advantage of data that are currently available to the agency as a way of monitoring plan performance on an ongoing basis. For example, HCFA should establish a centralized information system that aggregates the results of plan monitoring reports in electronic form; implement a system to track beneficiary inquiries and complaints received regarding managed care; and provide monthly reports to regional offices on enrollment, disenrollment and rapid disenrollment. The HCFA generally concurred with OIG's recommendations and indicated a number of actions it is taking to address the issues raised. (OEI-01-96-00190)

In a related report on staffing, OIG recommended that HCFA develop, coordinate and provide a comprehensive training program for regional office staff with responsibility for oversight of managed care plans; seek out people with experience in managed care, data analysis and clinical expertise as it increases regional office staff in its managed care operations; and develop a pilot program to provide opportunities for staff development and

staff sharing with managed care plans and beneficiary advocacy groups. The HCFA generally concurred with these recommendations as well. (OEI-01-96-00191)

Physician Perspectives of Medicare Health Maintenance Organizations

Performance Measure

The OIG conducted a survey to determine the experiences and perspectives of physicians who work with Medicare health maintenance organizations (HMOs). As illustrated in the following chart, OIG found that overall physician satisfaction with HMOs is low.

[Click Here to see chart](#)

Many physicians reported concerns with Medicare HMOs, specifically regarding the referral process, clinical independence, access to care, the complaints and appeals process, utilization and quality assurance reviews, and marketing practices. Further, OIG found that most physicians rated Medicare enrollees' knowledge of their HMO as low. Despite these misgivings, most believed that their Medicare patients received good care.

The OIG concluded that HCFA should work with physicians to address their concerns about Medicare HMOs and to improve the quality of services provided to Medicare enrollees. The OIG believes that greater physician satisfaction with the Medicare HMO program will enhance both enrollees' and providers' experiences with the program. The HCFA generally concurred with OIG's observations and conclusions. (OEI-02-97-00070)

Beneficiary Perspectives of Medicare Risk Health Maintenance Organizations: 1996

Performance Measure

Medicare beneficiaries may join a risk HMO through the Medicare program. In return for a predetermined monthly amount per enrollee, the HMO must provide all Medicare-covered services that are medically necessary, except hospice care. Once enrolled, beneficiaries are usually required to use HMO physicians and hospitals. As of October 1997, HCFA reported that 307 risk HMO plans served more than 5 million Medicare enrollees.

In a random sample survey of enrollees and disenrollees from 40 Medicare risk HMOs, OIG found that, overall, beneficiaries reported good access to service in 1996. There had been substantial improvement in some of the problem areas noted in an earlier OIG review in 1993. However, some reported problems continued in 1996 and some new ones surfaced. The OIG continues to believe that HCFA needs to improve its oversight of the Medicare risk HMO program in six persistent problem areas: assuring HMOs properly inform beneficiaries about their appeal and grievance rights; improving beneficiaries' understanding of HMO procedures and restrictions for obtaining medical services; preventing inappropriate screening of beneficiaries health status at application; identifying and carefully monitoring service access problems encountered by functionally limited, disabled and chronically ill beneficiaries; systematically collecting and tracking, over time, HMO-specific beneficiary-reported data on access to medical services and reasons for disenrollment; and distinguishing between administrative and nonadministrative disenrollments, if HMO disenrollment rates are to be used as a performance indicator. The 1996 survey data also suggested that HCFA needs to take steps to better inform older women about gynecological services and health. The HCFA concurred with OIG's recommendations. (OEI-06-95-00430)

Beneficiary Perspectives of Medicare Risk Health Maintenance Organizations - 1996: Beneficiaries with Functional Limitations, Comorbidities and Disabilities

Performance Measure

The OIG found that functionally limited, comorbid and disabled beneficiaries experienced more problems in accessing services, particularly specialized services, than healthier beneficiaries in Medicare risk HMOs. Twenty-seven percent of disabled disenrollees said their physicians failed to give them needed Medicare covered services, as did 20 percent of comorbid and 8 percent of functionally limited disenrollees. Thirty-six percent of disabled and 21 percent of comorbid disenrollees said their physicians failed to refer them to needed specialists. The OIG recommended that HCFA address these and other similar problems identified by vulnerable beneficiaries in Medicare risk HMOs. (OEI-06-95-00434)

Payments to a Risk-Based Health Maintenance Organization for Beneficiaries with Institutional Status

Under risk-based contracts, HCFA makes monthly advance payments to HMOs at the per capita rate set for each enrolled beneficiary. A higher capitation rate is paid for risk-based HMO enrollees who are institutionalized.

In a review at one risk-based HMO covering the period October 1, 1994 through September 30, 1996, OIG identified Medicare overpayments totaling \$167,630 for 41 beneficiaries incorrectly classified as institutionalized from a sample of 100. Based on these sample results, OIG estimated that the HMO received Medicare overpayments of at least \$1.6 million for beneficiaries incorrectly classified as institutionalized during the audit period. The majority of the overpayments occurred due to a breakdown in the transmission of information in the HMO's computer systems. The OIG recommended that the HMO continue to strengthen internal control procedures to ensure that errors do not occur in the future, refund the overpayments identified, and review the balance of the institutionalized beneficiary universe to identify and refund additional overpayments. While the HMO agreed with OIG's findings, it also stated that the systems limitations that caused overpayments also caused instances of underreporting. If so, the HMO should work with HCFA to determine if submitting retroactive claims is allowable. (CIN: A-05-97-00014)

Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on Adjusted Community Rate Proposals

Through adjusted community rate (ACR) proposals, HMOs present HCFA with their funding estimates for providing Medicare-covered services to beneficiaries in the upcoming contract year. The estimate, which covers anticipated medical and administrative costs, must be supported by the individual HMO's experiences with utilization and expenses. The ACR proposal is integral to pricing an organization's benefit package, computing savings (if any) from Medicare payments, and determining additional benefits or reduced premiums that could be made available to Medicare beneficiaries. Two recent OIG reviews evaluated aspects of the administrative costs included in ACR proposals.

A. Adjusted Community Rate Proposal Process

This review found that the ACR process enables HMOs to exploit the use of certain utilization factors when computing anticipated administrative costs. About \$1 billion a year could be saved if such costs were determined in accordance with Medicare's longstanding principle of paying only its fair share of needed health care costs. The OIG recommended that HCFA require HMOs to allocate administrative costs using a more realistic method, such as the ratio of Medicare enrollees in the HMO to total HMO enrollment, and introduce legislation to return the resulting savings to the Medicare trust fund. In response to the draft

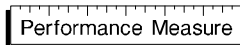
report, HCFA agreed with the first recommendation but not the second. (CIN: A-14-97-00202)

B. Administrative Cost Component at One HMO

Another review assessed the reasonableness of the administrative cost component of the ACR proposal for one risk-based HMO. The OIG identified over \$700,000 in administrative costs that would be considered inappropriate and unallowable in light of the Medicare program's general principle of paying only reasonable costs. Examples of such costs included political and charitable contributions.

The OIG noted that, unlike other areas of the Medicare program, there is currently no statutory or regulatory authority governing allowability of risk-based HMOs' administrative costs. Additional reviews are underway, and preliminary results show similar charges at other contractors. The results of these reviews will be shared with HCFA so that appropriate legislative changes can be considered. (CIN: A-14-97-00205)

Medicare Hospice Beneficiaries: Services and Eligibility



In this review, OIG determined that hospice agencies generally planned for and provided appropriate services. The hospice agencies that treated the sampled beneficiaries had developed formal plans of care for 96 percent of the beneficiaries and 93 percent of beneficiary families. In 99 percent of the patient records examined by the medical reviewer, documentation showed that beneficiaries and their families received services as indicated by the plans of care. Hospice services for both the patients and their families were provided continuously, allowing agency personnel to remain close to the beneficiaries and the families on a regular basis throughout the course of treatment.

However, OIG found that a significant portion of hospice patients in nursing homes were ineligible for the hospice benefit. Twenty-nine percent of sampled hospice beneficiaries in nursing homes were ineligible, while only 2 percent of beneficiaries not residing in nursing homes were ineligible. In prior reviews, OIG had identified relatively high ineligibility rates for hospice patients; a disproportionate share of these ineligible patients resided in nursing homes. This study adds to OIG's concern about the Medicare hospice program in the nursing home setting. The report refers the reader to the recommendations made in OIG's earlier reports. The HCFA stated that it is currently studying the issues involved and working to identify ways to correct the problems noted. (OEI-04-93-00270)

Development of a Prospective Payment System for Skilled Nursing Facilities

As required by the Balanced Budget Act of 1997, HCFA is developing a Medicare PPS for skilled nursing facilities (SNFs), effective for cost reporting periods beginning July 1, 1998.

The OIG's report on the methodology used to develop the system expressed concern that the PPS rates may be inflated because they were not adjusted downward for improper payments made to skilled nursing facilities in the past. Substantial improper payments, such as those for medically unnecessary services, were identified in prior OIG reviews. If such payments are not eliminated from the base period (FY 1995) costs, skilled nursing providers will realize an unwarranted financial windfall. In response to the draft report, HCFA agreed to work with OIG in examining base-year cost data and eliminating inappropriate costs. (CIN: A-14-98-00350)

Medical Necessity of Physical and Occupational Therapy in Skilled Nursing Facilities: California

Many residents of Medicare-certified SNFs receive physical and occupational therapy. In 1996, SNFs submitted claims totaling almost \$7 billion for physical and occupational therapy. Steep increases in outlays for these services have prompted OIG and others to examine this area. The OIG conducted this inspection to determine, through a probe sample, whether there is sufficient evidence of medically unnecessary physical and occupational therapy to warrant a national study.

In a sample of six SNFs in California, OIG and a medical review contractor assessed 80 records. The OIG found that medically unnecessary physical and occupational therapy services at the sampled facilities ranged from less than 4 percent to more than 80 percent. Multiple factors accounted for the high volume of medically unnecessary services; for instance, skilled services were frequently provided when nonskilled services would have been more appropriate. The review raised additional concerns as well. For example, OIG observed instances in which billing was inflated by including time to transport the patient to a therapy area and when patient fatigue required that a therapist halt the session.

The OIG noted that the Balanced Budget Act of 1997, with its implementation of a prospective payment system for Part A beneficiaries and a \$1,500 cap on therapy for Part B beneficiaries, creates an appropriate structure to control the cost of therapy services. However, OIG believes that the cost formulas being used to develop the prospective payment rates and Part B cap could be significantly compromised by the volume of medically unnecessary services. The OIG will conduct a full national study to quantify the extent of medically unnecessary services and to develop baseline data to compare therapy utilization before and after implementation of the Balanced Budget Act. (OEI-09-97-00120)

Home Health Care Visits: Texas

The OIG reviewed costs claimed for visits by a Texas home health care agency to determine whether the visits met Medicare reimbursement guidelines. As a result of the review, overpayments totaling \$4.7 million were identified. Of this amount, \$1.8 million has been

recovered, and an additional \$2.9 million remains in bankruptcy court. (CIN: A-06-95-00092)

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:

- In Florida, four persons pled guilty and were sentenced for conspiring to defraud Medicare of more than \$6 million between 1993 and 1996. Two of those sentenced were owners/operators of six clinics and diagnostic companies, and the other two were clinic employees. They were among twelve persons indicted in a scheme that also involved physicians, patient recruiters and unlicensed physicians' assistants. Medicare was billed for services that were not medically necessary or were not performed, and the proceeds were laundered by the clinic owners and employees. Sentences ranged from 4 years probation to 51 months imprisonment, and restitution ordered totaled more than \$3 million. Two persons were acquitted and several others are to be sentenced shortly. One subject remains a fugitive.
- A psychiatrist, who owned businesses offering psychological services to residents of adult congregate living facilities, and his business manager were sentenced in Florida for submitting false Medicare and Medicaid claims. The psychiatrist's business offered structured recreational/leisure services at no cost to operators, beneficiaries and recipients at the living facilities, then billed the health insurance programs for psychiatric and psychotherapeutic services never provided. The psychiatrist was sentenced to 78 months imprisonment, followed by 3 years probation, and ordered to pay full restitution of \$1.6 million. The manager was sentenced to 4 months home detention and 3 years supervised release. Sentencing is pending on two additional defendants.

Occasionally, criminal fraud involves illegal kickbacks. Many businesses engage in referrals to obtain expertise, services or items which are not part of their own operations or products in order to meet the needs of customers or clients. The medical profession relies heavily upon referrals because of the myriad specialities 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 the receiver may violate the Medicare/Medicaid anti-kickback statute. Violators are subject to criminal penalties, or exclusion from participation in the Medicare and Medicaid programs, or both. The following case is an example of a fraudulent kickback scheme which resulted in a successful prosecution:

- An unlicensed physician from Cuba and owner of a Florida clinic was sentenced for conspiracy to defraud Medicare and for money laundering. He filed more than \$3 million in false Medicare claims for physician services, respiratory equipment and medication, and cardiovascular testing. The owner also received approximately \$85,000 in kickbacks from another DME company's owner. He then laundered the proceeds through various bank accounts. His sentence, 51 months incarceration and restitution of close to \$1.5 million, was an enhanced one because of patient endangerment -- giving medication to patients without physicians examining them.

Medicare Contractors' Excess Pension Assets

Medicare contractors are allowed to allocate a portion of employee pension costs to Medicare for payment. However, Medicare contracts specifically prohibit any profit from Medicare activities. Regulations and the Medicare contracts provide that pension gains that occur when a Medicare segment closes should be credited to the Medicare program.

A. Colorado

A Colorado corporation was a Medicare Parts A and B contractor until its contracts were terminated in 1994 and 1995, respectively. The OIG computed excess Medicare pension assets of \$4.1 million as of January 1, 1996, which the contractor should remit to the Federal Government. Although the contractor disagreed with the findings, HCFA agreed with OIG's analysis and resultant recommendation. (CIN: A-07-97-01234)

B. Connecticut

Two insurance companies formed a joint venture by contributing their medical businesses (including one company's Medicare operations) to the joint venture on January 3, 1995. Consequently, the one company's Medicare segment employees were terminated and the Medicare segment was closed effective December 31, 1994. The company's former Medicare segment employees began working for the joint venture on January 3, 1995, but continued to accrue benefits under the former company's pension plan through January 31, 1996.

The OIG determined that as of January 1996, the company had excess Medicare pension assets of over \$5.6 million which should be remitted to the Federal Government. The company agreed with the recommendation but proposed reducing the amount. However, HCFA agreed with OIG's analysis and recommendation. (CIN: A-07-97-01213)

Home Office Costs

This Operation Restore Trust review, conducted jointly by a Medicare contractor and OIG, examined the home office costs of a major home health care chain to determine if they were reasonable, allowable and allocable under Medicare reimbursement principles. For the

fiscal year ended February 28, 1994, OIG found that Medicare costs were overstated by \$3.4 million due to improperly classified home office costs, costs primarily related to private lines of business, income offsets and clerical errors, undocumented expenses and other unallowable costs. In addition, a limited review of internal controls identified significant weaknesses. The chain's home office agreed that many of the costs questioned had been improperly claimed. (CIN: A-02-95-01019)

Laboratory Fraud

During this reporting period, OIG successfully completed some civil cases related to fraudulent billings to Medicare, Medicaid and other Federal health care programs on the part of independent laboratories and physicians. Convictions and settlements were also obtained for other types of fraudulent or abusive activities involving these health care providers. One of the most reprehensible cases involving fraudulent billings for laboratory tests bears noting.

- A national laboratory based in Massachusetts agreed to pay \$15 million to resolve its civil liability for submitting false Medicare claims. The laboratory also owned and operated several clinical testing laboratories. In 1987, the laboratory and two diagnostic companies entered into a joint venture agreement to operate a clinical laboratory for the purpose of performing laboratory tests for end stage renal disease patients. Over a 9-year period, the laboratory billed Medicare for thousands of tests that were not medically necessary and unbundled blood chemistry tests to receive a higher rate of reimbursement. In addition, the laboratory falsified claims by misrepresenting patients' medical conditions. As a result, the laboratory received approximately \$5.8 million in Medicare overpayments. A civil complaint has been filed against the diagnostic companies.

Independent Physiological Laboratories

Performance Measure

In two reports on independent physiological laboratories (IPLs), OIG looked at the vulnerabilities confronting Medicare and the perspectives of carriers. The OIG found a number of program vulnerabilities associated with these service providers. Based on site visits performed, OIG believes that as many as one out of five IPLs registered with HCFA may not exist. Moreover, the inspection found suspect patient-physician relationships indicating potential misuse of beneficiary health insurance numbers and unique physician identifiers. The OIG also questioned assigning IPL provider numbers to physicians and hospitals that appear not to meet HCFA's definition of operating independently. The Medicare carriers surveyed for this study shared these concerns about IPLs. The OIG recommended that HCFA clearly define the criteria for operating independently from a hospital, rural health clinic or a physician practice; establish a more stringent enrollment and

verification process; and strengthen the monitoring and control processes, or completely reform the payment method for IPLs. (OEI-05-97-00240, OEI-05-97-00241)

Medicare Allowances for Lymphedema Pumps

Medicare allowed charges for the most expensive lymphedema pump increased from \$18.5 million in 1991 to \$106.7 million in 1995 -- almost 500 percent. As a result of actions taken by OIG and HCFA to counteract abuse, these charges dropped to \$8.8 million in 1996 -- a 92 percent decrease -- as illustrated below.

[**Click Here to see chart**](#)

This decrease saved the Medicare program \$76.2 million in 1 year. If HCFA's new documentation requirements and continued OIG surveillance succeed in discouraging unnecessary payments for the expensive model lymphedema pump, the 5-year savings will total \$381 million. (OEI-04-97-00130)

Medicare Part B Allowances for Wound Care Supplies

In a series of earlier reports, OIG had identified suspect billing practices that led to questionable Medicare allowances for wound care supplies. In this inspection report on trends in Medicare Part B allowances for wound care supplies, OIG concluded that concerted efforts by HCFA, DME regional carriers (DMERCs) and OIG contributed to the dramatic decline in allowances for wound care supplies, saving Medicare \$58 million between 1995 and 1996. Five-year savings were estimated at nearly \$300 million. In

addition, changes enacted by the Balanced Budget Act of 1997 may further reduce allowances for claims that exceed DMERC guidelines. The HCFA concurred with OIG's conclusions, as well as the savings estimated. (OEI-03-94-00793)

Ancillary Medical Supplies in Skilled Nursing Facilities: California

The OIG reviewed the costs claimed for ancillary medical supplies by 31 skilled nursing facilities owned by a large corporation in California. The review identified overpayments totaling \$1 million as a result of misclassified costs for FY 1991. The corporation repaid the \$1 million plus an additional \$600,000 to cover estimated overpayments for FYs 1992 through 1995. (CIN: A-09-98-00060)

Medicare Payments for Therapeutic Shoes

In this report, OIG identifies questionable practices relating to therapeutic footwear provided to Medicare beneficiaries with diabetes. The OIG found that Medicare allowed more than \$7 million for therapeutic footwear claims which had missing or inadequate documentation. In most of these cases, suppliers had improperly indicated on the claims that appropriate documentation was contained in their files. Some beneficiaries reported that they seldom or never wore the shoes provided because they fit poorly or were uncomfortable; these shoes represented \$1.1 million in allowances in 1996. In addition, OIG found that Medicare guidelines do not specify standards, training or minimum qualifications for nonphysicians who fit and furnish the footwear. The report also determined that there is potential for enormous growth in the therapeutic footwear benefit which could reach hundreds of millions of dollars a year.

The OIG recommended that HCFA develop a strategy to make coverage requirements more explicit and specific, eliminate the documentation problems encountered and develop a plan to ensure that the therapeutic footwear benefit contains quality assurance safeguards. (OEI-03-97-00300)

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. A few years ago, HCFA published new regulations addressing reimbursement problems that have recurred over the years, especially those created by telemarketing and carrier shopping. Consolidation of claims processing into four regional jurisdictions, as specified in the regulations, may 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 New York physician was sentenced for his part in a scheme involving a DME company and its subsidiaries. The physician signed certificates of medical necessity for expensive medical equipment that was never provided to beneficiaries. Instead, the beneficiaries received only non-DME items. He also billed Medicare for office visits which were not made. He was sentenced to 51 months imprisonment and 3 years probation, and ordered to pay \$1.4 million in restitution. Nineteen persons involved in this scheme have been indicted including doctors, salespersons and managers, for filing false Medicare claims, conspiracy, and paying and accepting kickbacks. Thus far, 17 of the 19 individuals have been sentenced in this case. Sentencing is pending on two additional defendants.
- A California-based company that licenses franchises to nearly three dozen home oxygen suppliers across the country, along with its billing company and two franchises and their owners, agreed to pay \$5 million to resolve allegations of Medicare fraud. A former owner and employee of a Kentucky franchise and an employee of a Pennsylvania franchise accused them of engaging in a scheme to have Medicare pay for oxygen service for beneficiaries who did not qualify for it. In part, they gave false medical information, such as a patient's blood oxygen level, to receive payment. The company also agreed to institute a corporate integrity program.
- In Vermont, a DME supplier agreed to pay \$240,000 to resolve its civil liability for submitting false Medicare claims. The company engaged in a telemarketing scheme whereby Medicare beneficiaries were contacted by telephone and were solicited to accept DME products. The company then billed Medicare for body jackets, flotation mattresses and foam cushions that the beneficiaries never used or that were medically unnecessary. As a result, the company was overpaid approximately \$400,000. The DME company and its three principals agreed to permanent exclusion from Medicare, Medicaid and all other Federal health care programs.

Impact of High-Priced Generic Drugs on Medicare and Medicaid

In this inspection report, OIG examined the impact of high-priced generic drugs on the Medicare and Medicaid programs. The OIG found that the Medicare program and its beneficiaries could have saved \$5 to \$12 million for four drugs if 1997 reimbursement had been based on the average wholesale price of the brand name products or the median of generic drugs with prices less than the brands, rather than on higher-priced generic versions. Also, OIG also found that Florida's Medicaid program could have saved half a million

dollars for just eight drugs in 1996 if higher-priced generic drugs had been reimbursed at brand prices.

For the Medicare program, OIG recommended that HCFA not include higher-priced generic drugs in the median calculation to determine allowances or propose limiting allowances to brand prices when higher-priced generic drugs are involved. For Medicaid, OIG recommended that HCFA limit reimbursement of higher-priced generic drugs to the amount reimbursed for lower-priced brand or appropriately-priced generic drugs. The HCFA agreed with OIG's recommendation for Medicare, but not for Medicaid. It will, however, inform States of the study results so they can take appropriate action. (OEI-03-97-00510)

Medicare Allowances for Albuterol Sulfate

In this inspection, OIG assessed the reasonableness of the current Medicare allowance for albuterol sulfate. The OIG found that Medicare will allow between 56 to 550 percent more than the Department of Veterans Affairs will pay for generic versions of albuterol sulfate in 1998. Moreover, Medicare allowed 20 percent more than the average Medicaid payment for albuterol sulfate in 1997 and up to 333 percent more than acquisition costs available for albuterol sulfate in 1998. The OIG recommended that HCFA immediately reduce Medicare reimbursement for albuterol sulfate by 15 percent, resulting in annual savings of \$30 million. (OEI-03-97-00292)

Transportation Fraud

A common Medicare fraud scheme associated with transportation and ambulance companies is the submission of claims for transportation of patients to a hospital when they are really taken somewhere else for which claims are nonreimbursable. Other schemes include billing singly for patients who were transported as a group and falsely claiming reimbursement for ambulatory patients. The following cases are examples of some of those settled during this reporting period:

- An ambulance company in Louisiana entered into a civil settlement agreeing to pay the Government \$1.9 million for submitting false claims to Medicare and Medicaid for nonemergency transportation of dialysis patients. Over a 4-year period, the company submitted fraudulent claims for transporting renal disease patients to and from dialysis centers whose condition did not qualify for Medicare and Medicaid coverage of nonemergency transportation. The company also entered a corporate integrity agreement.
- After pleading guilty, the president of an ambulance company was sentenced in Georgia for conspiracy in a Medicare fraud scheme. He submitted fraudulent claims for transporting patients to a dialysis center,

when several were actually hospitalized at the time. He also filed claims for oxygen that was never administered and for inflated mileage. The estimated loss to Medicare was more than \$259,000. He was sentenced to 12 months incarceration, followed by 3 years supervised release and ordered to pay \$294,770 in restitution.

- In Illinois, two owners/operators of two separate ambulance companies were sentenced for their part in a Medicaid fraud scheme. Each was sentenced to 12 months and one day incarceration to be followed by 3 years supervised probation, and ordered to pay \$2,000 in restitution. The owners purchased Medicaid information, which identified recipients who had been transported to the hospital by car or by public transportation, from an individual who worked at a local hospital. The owners used the information to create false claims, then billed Medicaid for ambulance services which were never provided. They received more than \$120,000 as a result of the false claims.
- An ambulance company, operating as a subsidiary of an integrated delivery system in Minnesota, agreed to pay \$500,000 to settle civil liability for furnishing medically unnecessary ambulance services from January 1989 through December 1992. It also agreed to a 3-year corporate integrity plan that involves careful presubmission of each ambulance claim, employee training, written compliance procedures, annual audits and annual reporting to OIG.

Federal and State Partnership: Joint Audits of Medicaid

One of OIG's major initiatives has been to work more closely with State auditors in reviewing the Medicaid program. To foster the creation of these joint review efforts and to provide broader coverage of the Medicaid program, the Partnership Plan was developed. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors.

To date, partnerships have been developed with 20 State auditors, 11 State Medicaid agencies and 2 State internal audit groups. Extensive sharing of audit ideas, approaches and objectives has taken place between Federal and State auditors. Completed reports have resulted in recovered and/or identified overpayments and potential program savings of \$140 million in Federal and State government funds.

During this reporting period, a partnership report on outpatient claims for California's Medicaid program was issued. California administers the Selective Provider Contracting Program under which it contracts with hospitals to provide inpatient care at a negotiated rate. The rate covers designated services during the inpatient stay and prohibits the separate

billing on an outpatient claim form of certain services covered by the inpatient rate, including those performed within 24 hours of the inpatient admission or on the discharge date.

The California State auditor (CSA) estimated that the State overpays hospitals about \$1.6 million annually because its automated payment system lacks certain edits necessary for administering the contracting program. Further, CSA noted that the State's plan to implement edits contained problems, such as inaccurate databases, faulty edit definitions and inefficient procedures. There were additional problems related to specific terms of the contracts the State had negotiated with hospitals. The CSA believes that correcting these problems will eliminate overpayments to hospitals. California officials generally agreed with CSA's recommendations in these areas. (CIN: A-09-98-00068)

Medicaid Managed Care and HIV/AIDS

Performance Measure

Factors that affect both Medicaid financing and the treatment of Medicaid patients with HIV/AIDS include the devolution of Medicaid control from Federal to State authority, the continued expansion of managed care, the changing face of HIV/AIDS and new drugs to treat HIV/AIDS. The OIG surveyed all States to examine the extent of managed care coverage of Medicaid beneficiaries with HIV/AIDS and visited six States operating various managed care models to observe how these States address concerns of persons with HIV/AIDS in Medicaid managed care.

The OIG found that those Medicaid managed care organizations that are paid an AIDS-enhanced rate appear to provide all needed medical services and drugs to AIDS patients. Those not paid an enhanced rate report that they cannot afford to continue providing these services and drugs without adequate financial compensation. In the States OIG visited, the Medicaid managed care and Ryan White programs do not coordinate the services they provide to persons with HIV/AIDS. The health of persons with HIV/AIDS is increasingly dependent upon the integration of these services.

The OIG recommended that HCFA, in conjunction with the Health Resources and Services Administration (HRSA), develop and disseminate technical assistance and guidance on strategies that State Medicaid programs can use to establish appropriate managed care contracts for needed medical services, and costs related to these services, for beneficiaries with HIV and AIDS. Further, OIG proposed that HCFA urge States to require Medicaid managed care plans to coordinate with Ryan White programs on the services they provide to Medicaid beneficiaries with HIV/AIDS. The HRSA should continue to encourage Ryan White grantees to work with Medicaid managed care plans. Together these agencies should work to develop strategies of coordination for Medicaid managed care and the Ryan White programs. The HCFA and HRSA concurred with OIG's findings and recommendations. (OEI-05-97-00210)

Routine Prenatal and Postpartum Care for Undocumented Aliens

The Omnibus Budget Reconciliation Act of 1986 amended the Social Security Act to limit Federal payment for undocumented aliens' emergency medical care under the Medicaid program. Emergency medical care includes labor and delivery, but does not include routine prenatal and postpartum care. In October 1994, HCFA issued a policy memorandum requesting its regional offices to advise States that nonemergency services provided to illegal aliens are not eligible for Federal funds.

The OIG conducted a follow-up to an earlier inspection which found that two States had covered and claimed Federal funds for routine postpartum care for undocumented alien women. In the current study, OIG determined that six States have claimed Federal funds for routine prenatal and postpartum care for undocumented alien women; three still do. Moreover, survey respondents in 31 States and territories indicated that they were not aware of HCFA's guidance on this subject. Two HCFA regional offices had not sent guidance to States.

Since misinterpretation or misunderstanding of the law on this matter continues to exist in some States, OIG recommended that HCFA identify and recover funds that Minnesota, Nebraska, Oklahoma, Vermont and West Virginia inappropriately claimed, and assure that States and territories are aware of and implementing policy provisions applicable to claiming Federal funds for routine prenatal and/or postpartum services. Also, OIG suggested that HCFA continue to monitor and support Department of Justice efforts to have the Federal Court in New York vacate its order to continue such benefits. The HCFA agreed with OIG's recommendations and will take appropriate action. (OEI-07-96-00310)

Calculation of Medicaid Drug Rebates and Medicaid Drug Reimbursement

This report points out the disparity between how Medicaid drug rebates are based and calculated, and how the Medicaid program reimburses pharmacies for prescription drug purchases. The OIG believes that the current program of basing rebates on a manufacturer calculated average manufacturers' price (AMP) should be changed to calculating rebates based on average wholesale price (AWP).

Requiring manufacturers to pay Medicaid drug rebates based on AWP would: eliminate inconsistencies in the present methods used by drug manufacturers to calculate AMP; establish a much needed connection between the calculation of Medicaid drug rebates and the calculation of Medicaid's reimbursement for drugs at the pharmacy level; and reduce the burden of administering the Medicaid drug rebate program at the Federal, State and manufacturer levels.

The OIG recommended that HCFA develop and submit a legislative proposal to the Congress that would require drug manufacturers participating in the Medicaid outpatient prescription drug program to pay Medicaid drug rebates based on AWP. While HCFA does not believe that such legislation is feasible at this time, it is planning a comprehensive study of AWP. (CIN: A-06-97-00052)

Medicaid Fraud

At present, 47 States have Medicaid fraud control units (MFCUs). Three States, Nebraska, North Dakota and Idaho, have received waivers from establishing MFCUs as required by the Omnibus Budget Reconciliation Act of 1993. The District of Columbia MFCU was decertified in 1983; the District of Columbia has neither applied for Federal assistance to be recertified as a MFCU, nor received a waiver. The MFCUs conduct investigations and prosecute providers charged with defrauding the Medicaid program or persons charged with patient abuse and neglect.

During FY 1997, OIG provided oversight and administered approximately \$82 million in funds granted by HCFA to the MFCUs to facilitate their mission.

Although most Medicaid fraud cases are investigated by the MFCUs, OIG occasionally works with them and/or other law enforcement agencies on such cases.

Following is an example of a settlement that was reached in a significant case of misconduct in the use of Medicaid funds:

- The OIG, the U.S. Attorney's Office in southern Illinois and the State Medicaid agency obtained a global settlement in a qui tam case for \$5.3 million. A pharmacy which serves nursing homes failed to properly credit the State Medicaid program for unused medications that were returned from the nursing homes. When the pharmacy was purchased in 1992 by a pharmacy company, the company failed to identify the fraudulent conduct before or after the purchase. The pharmacy and the company agreed to pay \$2 million in restitution, \$2 million to a crime victim fund and the remainder to Federal and State agencies involved. The settlement included a corporate integrity agreement.

**Public Health Service
Operating Divisions**

Chapter II

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 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.

The Office of Inspector General (OIG) has concentrated on a variety of public health programs and issues such as biomedical research funding, substance abuse, Indian health services, drug approval processes and community health center programs. The OIG has 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, as well as audits of the financial statements and operations of the PHS operating divisions. 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.

Institutional Review Boards

Performance Measure

Institutional review boards (IRBs) play a vital role in protecting human subjects who participate in research funded by HHS or carried out on products regulated by FDA. In a broad-based inquiry, OIG concluded that the system of protections provided by IRBs in a rapidly changing research environment is in jeopardy. The OIG determined that IRBs are reviewing too much, too quickly, with too little expertise; conducting minimal oversight of approved research; facing conflicts that threaten their independence; and providing little training for clinical investigators and board members. Moreover, neither the IRBs nor the Department devotes much attention to evaluating IRBs' effectiveness.

While OIG does not claim that there are widespread abuses of human research subjects, the system does have some significant vulnerabilities. The OIG's recommendations were directed jointly to FDA and NIH (through the Office for Protection from Research Risks). The OIG urged FDA and NIH to grant more flexibility to IRBs while holding them more accountable for results; strengthen continuing protections for human subjects; establish requirements for educating investigators and IRB members about human subject protections; help insulate IRBs from conflicts that can compromise their mission; and address the seriousness of the workload pressures facing many IRBs. In addition, OIG proposed that FDA and NIH reexamine and reengineer their practices in overseeing IRBs. (OEI-01-97-00190; OEI-01-97-00191; OEI-01-97-00192; OEI-01-97-00193)

Food and Drug Administration's Citizen Petition Process

Performance Measure

The FDA regulations permit any person to submit a citizen petition to FDA requesting the Commissioner to issue, amend or revoke a regulation or order, or take or refrain from taking any other form of administrative action.

The OIG determined that FDA does not have an effective process for handling such petitions in a timely manner, as evidenced by a backlog of approximately 250 petitions that had not been fully answered, some dating to the 1970s and early 1980s. The FDA regulations require tentative or final responses to citizen petitions within 180 days. Because this has not been a high priority among FDA's responsibilities, the agency has provided limited resources to the process and there has been little central oversight of the process across FDA program areas. In the early 1990s, FDA developed options to improve the process and, since the start of OIG's review, closed out slightly more petitions than it received. The OIG made specific recommendations to reduce the backlog, many of which were agreed to by FDA. (CIN: A-15-97-50002)

Annual Reporting Process for Investigational New Drugs

The FDA is responsible for overseeing biological products that sponsors develop under investigational new drug applications (INDs). As of September 30, 1997, FDA was overseeing 2,748 active INDs, which allow drug sponsors to conduct research on the safety and effectiveness of promising new drugs. Federal regulations require drug sponsors to submit annual reports to FDA for all active INDs.

The OIG determined that FDA's process for obtaining IND annual reports does not ensure that the reports are consistently received on time or at all. From March 1996 to July 1997, FDA significantly reduced the number of outstanding reports from 454 (21 percent) to 267 (13 percent). However, OIG made several recommendations to improve the process so as to further reduce the number of annual reports awaiting review, ensure that a new backlog does not develop and improve efficiency in obtaining reports not yet submitted. The FDA generally concurred with OIG's proposals. (CIN: A-15-96-50001)

Cancer Information Service

Performance Measure

These reports discuss the Cancer Information Service's (CIS's) toll-free telephone service. The OIG found that this telephone service provides the public and national cancer organizations with an invaluable resource for information about cancer. However, the service routinely experiences high busy signal and abandonment rates. These are due, in part, to the telephone technology now being used by CIS and data gathering requirements that adversely affect contractors' call efficiency. Further, the information specialists who answer the telephones could be more efficient if their resources were more readily accessible and user-friendly. The OIG also identified issues related to the current regional configuration, the lack of customer service standards and benchmarks, and the need for CIS or its contractors to collect and maintain local community service information.

The OIG recommended upgrading technology; establishing performance standards; reducing data gathering requirements; improving, modernizing and computerizing reference materials; reevaluating the regional structure; discontinuing efforts to collect and disseminate information on community services; and encouraging contractors to enhance staff training. The National Cancer Institute generally concurred with OIG's recommendations and has already taken some action on these proposals. (OEI-09-97-00360; OEI-09-97-000361)

Racial and Geographic Disparity in the Distribution of Organs for Transplantation

Performance Measure

At the request of the Congress, OIG updated its 1991 inspection report entitled "The Distribution of Organs for Transplantation: Expectations and Practices." This follow-up looked at racial and geographic disparities in waiting times for cadaver kidneys and livers. The findings of this report indicated that both racial and geographic disparities in waiting

times still exist and, in some cases, seem to be growing. Black recipients still wait longer than white recipients for kidney transplants and the difference in waiting times has grown. The OIG reemphasized the thrust of the 1991 report: that the national organ allocation system should focus on equity among patients, not among transplant centers; and on common medical criteria, not the circumstances of a patient's residence or transplant center affiliation. (OEI-01-98-00360)

Health Centers' Access to the National Practitioner Data Bank

Performance Measure

A number of health centers funded by HRSA do not have access to the National Practitioner Data Bank. The inability of health centers to query the Data Bank places patients at risk for possible substandard care and the Federal Government at risk since many health centers are covered under the Federal Tort Claims Act. The OIG recommended that HRSA take appropriate action to allow all health centers to query the Data Bank. The HRSA agreed with this recommendation and indicated that it will advise community health centers to have an appropriate system for querying the Data Bank. (OEI-12-98-00190)

Use of the 340B Drug Pricing Program

Performance Measure

The section 340B drug pricing program of the PHS Act was intended to provide an effective means of lowering drug prices for covered entities. Although the program provides access to drugs at discounted prices, covered entity participation is voluntary. The HRSA's database indicated that approximately 66 percent of eligible grantees did not participate and therefore did not purchase covered outpatient drugs at the best prices.

Recognizing the potential savings available, HRSA drafted a Federal Register notice requesting comments on a proposed condition of grant award that would require participation in the 340B program for all eligible entities. The OIG believes that this requirement could result in savings to be used for additional patient services. (CIN: A-01-98-01500)

Exclusions for Health Education Assistance Loan Defaults

Through the Health Education Assistance Loan (HEAL) program, HRSA guarantees commercial loans to students seeking an education in a health-related field of study. The students are allowed to defer repayment of these loans until after they have graduated. The Department's Program Support Center (PSC) takes all steps that it can to ensure repayment. However, some loan recipients ignore their indebtedness.

After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Once the individual has been declared in default, 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 period, 119 individuals were excluded as a result of PSC referral of their cases to OIG.

Individuals who have been excluded as a result of their default may enter into settlement agreements and have the exclusion 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. Some of the health professionals, upon being notified of their exclusion, immediately repay their HEAL debt.

At the conclusion of this reporting period, 970 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 over \$60.6 million. The following are examples of some of these settlements:

- A dentist and a physician in New York signed settlement agreements to repay their HEAL debts after being excluded for defaulting on their obligations. One agreed to repay over \$117,500, and the other agreed to repay almost \$250,000.
- After being notified that she was excluded as a result of her failure to repay her HEAL, a California psychologist entered into a settlement agreement to repay over \$111,000.
- A settlement agreement was signed by a Hawaii osteopath who agreed to repay her debt of over \$171,000.
- A Pennsylvania pharmacist entered into a settlement agreement to repay a HEAL debt of over \$139,000.
- Shortly after being notified of his exclusion for defaulting on his HEAL, a Mississippi dentist entered into a settlement agreement to repay over \$128,000.

Substance Abuse and Mental Health Services Administration's Treatment Improvement Protocols

Performance Measure

Treatment Improvement Protocols (TIPs) are consensus-based "best practice" guidelines developed for SAMHSA for use in the treatment of individuals with alcohol and other drug problems. Since 1993, 23 TIPs have been developed and issued. To determine the extent of dissemination and practitioners' awareness and use of TIPs, OIG surveyed a broad range of

provider types regarding five specific TIPs. The sample included SAMHSA-funded grantee service providers, the "target audience" for whom TIPs are developed.

The OIG concluded that SAMHSA should take a more proactive approach to advertising the availability of all past and future TIPs. Less than half the SAMHSA-funded grantees that responded were aware of TIPs. However, 84 percent of the survey respondents that were aware of any of the five TIPs were using them in their practices. In expanding efforts to advertise TIPs, OIG proposed that SAMHSA look beyond its "target audience." Specifically, it should consider including community mental health centers (CMHCs); 81 percent of CMHCs that were unaware of any of the 5 TIPs showed an interest in using them in their practices. The SAMHSA generally agreed with OIG's findings and recommendations. The SAMHSA is in the second year of a 4-year, \$3.2 million TIPS Field Evaluation Study to assist in expanding and improving its dissemination activities. (OEI-07-96-00130)

Fiscal Year 1997 Financial Statement Audits

Performance Measure

As required by the Government Management Reform Act of 1994, OIG audited, through contracts with independent accounting firms, the financial statements of the major PHS agencies. This work was undertaken as part of OIG's audit of the consolidated HHS-wide financial statements discussed on page 54.

A. Food and Drug Administration

The accounting firm qualified its opinion on FDA's FY 1997 financial statements, primarily because it was unable to conclude on the reasonableness of estimated unreported grantee expenses or to determine if an adjustment to grant advances was necessary or reasonable. Additionally, records did not adequately support the amounts shown for property and equipment, accumulated depreciation and related depreciation expenses. The FDA did not concur with the firms's findings. (CIN: A-17-97-00003)

B. National Institutes of Health

The accounting firm qualified its opinion on NIH's FY 1997 financial statements, primarily because it was unable to conclude on the reasonableness of estimated unreported grantee expenses and because NIH could not provide supporting documentation for the value of its fixed assets. The NIH concurred with the accounting firm's recommendations and is in the process of taking corrective action. (CIN: A-17-97-00008)

C. Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry

The accounting firm issued a qualified opinion on the consolidated FY 1997 financial statements of CDC and ATSDR, primarily because it was unable to conclude on the reasonableness of estimated unreported grantee expenses. Also, the accounts payable and

deferred revenue yearend balances pertaining to reimbursable agreements were not determinable in this first-year audit. Agency officials agreed with the accounting firm's recommendations and are taking corrective action. (CIN: A-17-97-00007)

D. Health Resources and Services Administration

The accounting firm qualified its opinion on HRSA's financial statements, primarily because of its inability to conclude on the reasonableness of estimated unreported grantee expenses and questions as to the composition of net position balances. The HRSA concurred and is taking corrective action. (CIN: A-17-97-00005)

E. Substance Abuse and Mental Health Services Administration

A qualified opinion was also issued on SAMHSA's financial statements, essentially for the same reasons as noted above for HRSA. The SAMHSA agreed with the accounting firm's recommendations and is taking corrective action. (CIN: A-17-97-00006)

F. Indian Health Service

The accounting firm qualified its opinion on the IHS financial statements due to questions about the composition of net position balances and because an adequate loss was not established for certain claims and lawsuits that were subsequently settled or near settlement after yearend. The IHS agreed and is taking corrective action. (CIN: A-17-97-00004)

**Administration
for Children
and Families,
and Administration
on Aging**

Chapter III

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: Temporary Assistance for Needy Families (TANF), Child Support Enforcement (CSE), Foster Care, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant program.

The Personal Responsibility and Work Opportunity Act of 1996 eliminated the Aid to Families with Dependent Children, Emergency Assistance and Job Opportunities and Basic Skills Training programs as of FY 1997 and created the TANF block grant, which was designed to reduce dependency on welfare programs. The block grant eliminated individual entitlement to assistance, established time limits on benefits and set strong work participation requirements. However, the Act gave States and tribal governments greater flexibility to establish and operate programs structured to their needs. While the Federal role in TANF has changed, OIG will continue to ensure program integrity, identify opportunities for program improvement, and provide Federal and State management with useful information regarding the goal of moving individuals and families from welfare dependency to self-sufficiency.

In addition, OIG reviews the Department's programs that serve children, and has issued a number of reports in this area. The OIG reports have focused on ways to increase the efficient use of the program dollar, more effective program implementation, and how to better coordinate program implementation among the Federal, 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.

State Child Support Satisfaction Survey

Performance Measure

A. Survey Results

According to this OIG survey, most States were satisfied overall with both the central and regional Office of Child Support Enforcement (OCSE), although they rated some regional offices higher than others. States rated OCSE high in the areas of communication, coordination, recent contacts and program support. They also believed that the Federal offices worked with them as partners. States offered suggestions for improving their relationship with OCSE, including improving the timeliness of communications to States and strengthening the role of regional offices. They would also like OCSE to provide more systems and practical support and training, continue to improve the audit process and improve the timeliness of the Annual Report to Congress. The OIG concluded that States gave OCSE high marks for its performance, particularly in recent years. But opportunities to improve remain, and the office should consider the suggestions cited by States to further improve its performance. (OEI-02-97-00310)

B. Case Studies

Case studies for programs in Colorado, Massachusetts, Minnesota, New York, South Carolina and Texas were developed by OIG to supplement a related report on States' satisfaction with the services provided to them by the Federal OCSE. The report discusses each State's program highlights, working relationships with the Federal OCSE and suggestions for support. The OIG also conducted a cross-case analysis on four issues of common concern to respondents in all six States: Federal and State roles, interstate cases, State innovative practices and the future of the program. (OEI-02-97-00311)

Availability of Health Insurance for Children under the Child Support Enforcement Program: Connecticut

Performance Measure

Despite recent initiatives, significant numbers of children under the State's CSE (IV-D) program still do not receive medical support from their noncustodial parents. The OIG conducted a review to determine whether children under the CSE program are receiving Medicaid benefits because private health insurance is unavailable or unaffordable to noncustodial parents.

The OIG found that Connecticut has an opportunity to increase the number of noncustodial parents providing medical support for their children and reduce Medicaid costs. These goals could be achieved by either requiring the parents to pay for all or part of the Medicaid premiums or establishing a new comprehensive health insurance plan for children with premiums paid by the parents. The OIG determined that taxpayers, rather than noncustodial

parents, provided medical support to nearly 14,000 title IV-D children through the Medicaid program in Connecticut between April 1996 and March 1997. While these parents were required by court order to provide health coverage to their children, they were unable to meet their obligation because either their employers did not offer health insurance or available health insurance was not reasonably priced. Using premium information from the State's current Medicaid managed care program, OIG determined that the State could save an estimated \$11.4 million (Federal and State combined) in annual Medicaid costs if it required noncustodial parents to offset Medicaid premiums paid by the State on behalf of their children.

Both ACF and the Health Care Financing Administration agreed with OIG's recommendations, and the State agreed to require noncustodial parents to pay all or part of the insurance premiums for their dependent children enrolled in Medicaid. The OIG suggested that ACF make this report available to other States to apprise them of the alternatives for increasing the number of noncustodial parents providing medical support for their children and reducing Medicaid costs. (CIN: A-01-97-02506)

Automated Data Processing Expenditure Reporting: Missouri

This review of Missouri's automated child support system disclosed a clerical error in reporting automated data processing expenditures. Because of this error, the State inadvertently reported \$2 million (Federal share \$1.8 million) more than the amount supported by accounting records. The OIG recommended that the State correct this error and add a review step to ensure the accuracy of figures. As a result, the State made adjusting entries and indicated that it had established quality control reviews. (CIN: A-07-98-01034)

Child Support Enforcement

The United States Attorney General has placed enforcement of the Child Support Recovery Act of 1992 as a top Department of Justice (DOJ) priority. The Act made it a Federal misdemeanor crime for a parent in one State to refuse to pay past due support for a child in another State, when the support has been owed for more than 1 year or exceeds \$5,000. Any subsequent offense is a felony violation. A recent amendment to this Act has created two other felony provisions for the most egregious first time violations.

The OIG has made the investigation of these matters a high priority. The OIG and OCSE are the sponsors of a multiagency, multijurisdictional investigative task force headquartered in Columbus, Ohio, whose mission is to identify, investigate and prosecute the most egregious violators of the Federal and State child support laws in the States of Illinois, Michigan and Ohio. The task force is comprised of personnel from the OIG Office of Investigations, U.S. Marshals Service, U.S. Attorneys Offices, the Department of Justice, State and local child support offices, State and local law enforcement, State and local

prosecutors, representatives from the judiciary (both State and Federal), and representatives from the corrections and probation offices at both the Federal and State levels.

The task force is structured to identify, investigate and prosecute criminal nonsupport cases both on the Federal and State levels through the coordination of law enforcement, criminal justice and child support office resources. There are three investigative units -- one each in Illinois, Michigan and Ohio -- which conduct the actual investigations. The units work with the State child support offices to identify the cases that the States then refer to the task force. The units also work with prosecutors at State and Federal levels to ensure that the cases worked are those that will be prosecuted in a volume consistent with the resources of those offices.

Central to the task force is a screening unit in Columbus, Ohio which is manned by analysts and auditors from both OIG and OCSE. This unit receives the child support cases from the States, conducts preinvestigative analyses of these cases through the use of information databases and then forwards the cases to the investigative task force units where they are assigned and investigated. This will streamline the process by which the cases best suited for criminal prosecution are identified, investigated and brought to fruition. As the task forces bring in more law enforcement partners on the State level, the number of cases adjudicated will rise dramatically. At this point, the task force units have actively investigated over 250 cases at the Federal and State levels with another 40 cases being evaluated at the screening unit. Currently, 25 Federal arrests have been executed and 5 individuals already sentenced. The total arrearage amount related to the Federal convictions is \$147,000. There have been 162 arrests on the State level.

The Federal arrests, convictions and sentencings during this reporting period include the following:

- A computer consultant was sentenced in Michigan to 30 months probation for failure to pay legal child support obligations. He was ordered to pay \$1,200 a month in support until the balance of \$32,900 in arrearages is paid. The consultant earned approximately \$70,000 a year.
- In Ohio, a man was sentenced after pleading guilty to refusing to pay child support. He was sentenced to pay full restitution of \$19,000 and placed on probation for 5 years.
- Another man pled guilty and was sentenced in Ohio for failing to pay past due child support. He agreed to pay the total amount of \$19,580 for all outstanding child support arrearages and \$1,225 for his child's medical bills. A fine of \$50 was also imposed and probation was waived.

The following cases are examples of child support cases successfully prosecuted outside the task force area:

- In Iowa, a woman pled guilty and was sentenced for failing to pay child support for her 10-year-old child who resides in Minnesota with her father. The woman's arrearage amounted to \$16,990 which she failed to pay even though she was employed and aware of her obligation. She was sentenced to 5 years probation and ordered to pay restitution of \$16,050 over the course of the probation period. This is OIG's first successful investigation and prosecution of a woman in the context of child support enforcement.
- A truck driver was sentenced in Iowa to 5 years probation and ordered to pay full restitution for failure to pay child support. His arrearages totaled approximately \$23,178. He made only sporadic payments for his four children since 1990. He frequently moved to avoid support payments, and was finally arrested in Ohio.
- A man was sentenced in Florida for failing to pay nearly \$145,000 for past child support for his two sons. Since he stopped payments in 1993, the man lived in New York, Texas, Georgia, Louisiana and Pennsylvania. When he was found in Pennsylvania, he had remarried and was living in a \$600,000 house bought under his new wife's name. While he lived in high-priced homes and drove Rolls Royce, Porsche, BMW, Mercedes and Infiniti automobiles, his two sons had to get financial aid to attend college. The man was sentenced to 3 years probation and fined \$5,000. As part of his sentence, the man agreed to pay total restitution for arrearages and approximately \$190,000 for his sons' school tuition and legal fees.
- In Virginia, a former Immigration and Naturalization Service agent was sentenced for refusing to pay child support for his two children. He was sentenced to 5 years probation and was ordered to pay \$16,440 in restitution for arrearages. Although he was ordered to pay \$440 per month at the time of his divorce, he only made 2 payments. He frequently moved from State to State to avoid support payments.
- In California, a man was sentenced to 5 years of supervised probation and 250 hours of community service for failure to pay child support. The individual must make full restitution of \$48,324 and pay the mandatory court ordered special assessment. This was the first child support case to come to trial in the Central District of California.

To date, OIG has investigated 378 child support cases nationwide. During this period, these cases resulted in 25 convictions and court-ordered restitution of over \$1 million. Prosecutions in this area are unique in that sentences ordered by a judge take into account the need for the defendant to continue to be able to pay. Therefore, alternative sentencing options -- such as work release, home detention and probation where nonpayment is a violation -- are ordered.

In addition to its work in enforcing the Child Support Recovery Act, OIG has supported and assisted OCSE in implementing its law enforcement initiative, the goal of which is to get local and State law enforcement more involved in investigating criminal nonsupport matters. The initiative aims to demonstrate to local law enforcement that there is a strong connection between the lack of child support and juvenile crime. A highlight of this effort was three symposia at which over 200 chiefs of police and sheriffs were given an overview of the child support program and shown how their resources could be an invaluable tool in this arena. The OIG attended and made presentations at each of the conferences. One of the by-products of the symposia was the idea for the child support multiagency task force described above.

Identifying and Reporting Cases of Statutory Rape

This review examined whether cases of suspected statutory rape in Connecticut were being identified, reported and targeted for intervening services. It also assessed the related implications, including social costs. While the State has taken steps toward addressing the problem of statutory rape, the effectiveness of these steps could be improved. Many of the teenaged girls and boys in OIG's sample were pursued by adults over the age of 21, and over half these adults had histories of reported domestic violence and/or abuse of their children. The OIG recommended that the State identify ways to pursue criminal action against alleged perpetrators and ensure that appropriate services are provided to victims and others, as needed. However, the State should consult with ACF to prevent any possible negative consequence in the area of voluntary paternity acknowledgment. The State indicated it would continue to work to resolve the problems and develop an acceptable protocol. (CIN: A-01-97-02504)

Contract Administration for Head Start Grantee Reviews

The ACF contracts with a corporation to arrange and coordinate reviews of Head Start grantees throughout the country. This OIG review was undertaken to determine the validity of an anonymous allegation of improprieties in contract administration. While the allegation was not substantiated, the review disclosed other weaknesses in contract administration. Specifically, ACF did not adequately maintain and account for official contract files or ensure compliance with contract terms and conditions. The OIG recommended that ACF improve accountability over contract files, closely monitor and enforce compliance with contract terms, and require the contractor to take advantage of opportunities to minimize

travel costs. The ACF generally concurred with the recommendations and has initiated corrective actions. (CIN: A-12-97-00002)

Emergency Assistance Program Costs: Pennsylvania

The OIG reviewed \$46.8 million in costs claimed by Pennsylvania for title IV-A Emergency Assistance services provided to children in the Philadelphia juvenile justice system for the 6 months ended June 30, 1996. According to ACF policy, effective January 1, 1996, Federal funding was not available for juvenile justice services provided to alleged, charged or adjudicated delinquents. However, the State did not follow this policy and, as a result, inappropriately claimed about \$13 million. The OIG recommended that the State refund this amount to the Federal Government and ensure that all adjustments or supplemental claims were properly identified and reported to ACF. The OIG also recommended that Pennsylvania conduct similar reviews in other counties and refund to the Federal Government all costs inappropriately claimed. The State generally agreed with the findings, but has not agreed to make any refunds. Also, the State has appealed ACF's prohibition on claiming delinquent-related costs and the matter is in litigation. (CIN: A-03-98-00590)

Payments under the Refugee Resettlement Program: Florida

During this reporting period, OIG reviewed both cash and medical assistance payments to refugees in Florida to determine whether payments were made within the allowable eligibility period.

A. Cash Assistance Payments

The OIG estimated that Florida made refugee cash assistance (RCA) payments of nearly \$1.9 million to refugees who were not eligible for such assistance for the period July 1991 to February 1997. Federal regulations limit the period for which refugees are eligible for cash assistance under the Refugee Resettlement Program. The OIG recommended that the State make a financial adjustment of \$1.9 million; implement an edit in its computer system to identify and automatically terminate recipients from the program when their eligibility expires; and determine the amount of RCA payments made to ineligible recipients subsequent to the period covered by OIG's review and make the appropriate financial adjustment.

In response to the draft report, the State agreed with the recommendation to refund RCA overpayments, but disagreed with the procedural recommendations. (CIN: A-04-96-00104)

B. Medical Assistance Payments

The Federal Government reimburses States for medical assistance to refugees for 8 months following their entry into the United States. The OIG made this review to determine if Florida had controls in place to prevent medical assistance payments after a refugee's period of eligibility had expired. The review disclosed that Florida's computerized payment system

did not have such controls. Instead, the State relied on its district offices to terminate medical benefits, and these terminations were not always timely. For the period October 1991 through February 1997, OIG estimated that almost \$410,000 was paid for ineligible refugees. The State agreed to make a financial adjustment for this amount and to change its computerized system to prevent payments beyond the eligibility period. (CIN: A-04-98-00119)

Financial Statement Audit of the Administration for Children and Families

Performance Measure

As part of its departmentwide financial statement audit, OIG contracted for an audit of ACF's FY 1997 financial statements. The independent accounting firm qualified its opinion on the statements for several reasons. For instance, a \$500 million adjustment was made to bring the general ledger balance for Treasury funds into agreement with Treasury records. However, the Program Support Center (PSC), which maintains the accounting records for ACF, did not have adequate documentation to support this adjustment.

The firm also noted that grant expenses could be overstated by as much as \$454 million and that documentation was not adequate to determine the reasonableness of estimated unreported grantee expenses or to support nongrant advance liabilities and nongrant assets. The ACF and PSC concurred with OIG's recommendations, and corrective action is underway. (CIN: A-17-97-00002)

Business Process Reengineering Pilot

Performance Measure

The OIG and the Assistant Secretary for Management and Budget (ASMB) conducted a joint review of ACF's business process reengineering pilot, an alternative process for managing grants. The objectives were to evaluate the effectiveness of the pilot and to determine whether ACF should be permitted continued use of deviations from established departmental policy. The review showed that the pilot failed to achieve its goals and did not significantly contribute to overcoming grant management deficiencies cited in a 1994 ASMB report. In one critical area, audit resolution, requirements were not followed, and audits remained open for inordinate periods beyond the 6-month due dates. As of April 1998, 337 Head Start open audits with \$27.4 million in questionable costs needed resolution. The ACF concurred with OIG's recommendation to discontinue the pilot and to implement a corrective action plan addressing grant management deficiencies. (CIN: A-12-97-00006)

Safeguards Against Elder Abuse

Performance Measure

During this reporting period, OIG completed two reviews on current safeguards for preventing elder abuse and neglect in nursing homes and other long-term-care facilities.

A. Safeguarding Long-Term-Care Residents

This report, which consolidated information gathered during reviews of two States and surveys of State and nursing home officials, described the various measures used to identify persons posing a possible threat of elder abuse. While 33 States required criminal background checks, the checks were usually limited to Statewide records and generally covered nurse aides seeking employment but not other prospective employees or current staff. The OIG also found some shortcomings in State nurse aide registries, which are required to record findings of abuse, neglect and misappropriation of property involving the elderly. Convictions for crimes committed outside nursing facilities were not systematically reported to the registries, and Maryland's registry did not include all findings of abuse and convictions.

The OIG recommended, among other things, that HCFA consider establishing Federal requirements and criteria for criminal background checks, assisting in the development of a national abuse registry and expanding current State registries to include all workers who have abused or neglected residents in facilities receiving Federal reimbursement. The OIG also suggested that legislation be enacted to allow the inclusion of the national abuse registry in an expanded version of the current Healthcare Integrity and Protection Data Bank (HIPDB), which OIG developed pursuant to the Health Insurance Portability and Accountability Act of 1996. The HCFA and AoA generally agreed with the recommendations in the draft report. The HCFA indicated, however, that it planned to further examine whether an expanded HIPDB is the appropriate vehicle for a national registry. (CIN: A-12-97-00003)

B. Elder Abuse Safeguards in Illinois

The Illinois nurse aide registry properly recorded almost all substantiated cases of elder abuse, but the State did not fully investigate some alleged abuse cases reported by long-term care facilities. While 13 of 88 alleged abusers in OIG's sample were terminated from employment or disciplined, the State did not determine whether these abuses were substantiated and did not record the incidents in the registry. The OIG also noted that Illinois required background checks on current as well as prospective employees and recorded the results in the registry. The results of background checks that did not find criminal histories, however, were not recorded in a timely manner. The OIG made various recommendations to strengthen safeguards against elder abuse, and State officials generally agreed. (CIN: A-05-97-00010)

Health Care Antifraud Volunteer Project Performance Measures

Performance Measure

The Congress authorized the Health Care Antifraud, Waste and Abuse Community Volunteer Demonstration Program in 1997 to help curb losses to the Medicare program. Two million dollars was transferred to AoA from the Health Care Financing Administration's research

and demonstration budget to support different approaches to recruit and train retired professionals as local, volunteer resources and educators on detecting and reporting Medicare fraud. The Congress directed AoA to consult with OIG to develop outcome measures to test the effectiveness of these different approaches. In May 1997, AoA awarded funds to implement these projects to 12 organizations: two area agencies on aging, six State units on aging and four private aging organizations.

The OIG reviewed the funded grant applications to identify commonly proposed performance measures and activities and developed a set of draft performance measures. These measures were revised based on grantees' experiences and their assessments of the appropriateness and feasibility of collecting data. The OIG and AoA will now develop a reporting format, which OIG will pretest by asking grantees to supply performance data. Subsequently, OIG will issue further reports which track implementation and report on outcomes. (OEI-02-97-00520)

General Oversight

Chapter IV

GENERAL OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities.

The Program Support Center (PSC), a separate 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 (ASMB) 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 activities at the departmental level. A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133, which designates HHS as cognizant agency to audit the majority of the Federal funds awarded to major research schools, State and local government cost allocation plans, and separate indirect cost plans of State agencies and local governments. Also, 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. In addition, OIG is responsible for auditing the Department's financial statements beginning with the FY 1996 statements.

The OIG's 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.

Year 2000 System Compliance

This report, the first in a series, discusses the Department's progress in making its identified mission-critical application systems Year 2000 compliant. The report focuses principally on OIG's work at Medicare contractors as of the end of April 1998.

The Department established an accelerated compliance date of December 31, 1998 to allow adequate time for dealing with unanticipated problems that may hamper compliance by December 31, 1999. The OIG's initial review indicated that Medicare Parts A and B contractors, particularly Part B contractors, were at risk of not meeting the Department's accelerated compliance date, thereby reducing the amount of time available to resolve problems. The OIG also identified several other issues that needed to be addressed immediately. Many of these issues related to Medicare Part A and/or Part B, while others, such as problems with contingency plans, certification and payroll, had departmentwide impact. Since these issues are so closely linked, particularly the Medicare contractor issues, failure to adequately address one could have a corresponding negative impact on the others. The OIG made specific recommendations to deal with these issues and will continue to monitor and report on the Department's progress in these areas. (CIN: A-17-98-00003)

Financial Statement Audit of the Department for Fiscal Year 1997

Performance Measure

As required by the Government Management Reform Act of 1994, OIG audited the departmentwide consolidated financial statements for FY 1997. This audit encompassed individual audits of eight operating agencies' financial statements, which are summarized in previous chapters, along with reviews of departmental service organizations, which are discussed below.

The audit report, which appears in the Department's Accountability Report for FY 1997, indicates a qualified opinion on the FY 1997 statements, an improvement over the disclaimer of opinion for FY 1996. However, due to continuing documentation problems, OIG was unable to determine whether several balances and estimates were fairly presented. Medicare contractors, for instance, did not maintain adequate documentation to support \$2.5 billion in accounts receivable. In addition, the report noted five material internal control weaknesses -- those problems that are systemic across a number of operating divisions, as well as significant dollar issues affecting only one division:

- HCFA's oversight of the Medicare program continues to fall short of providing reasonable assurance of detecting and preventing improper fee-for-service payments.
- Significant improvements are still needed in HCFA's methodology for estimating Medicare accounts payable.

- The HHS and its operating divisions do not have a fully functioning, integrated financial reporting system capable of producing complete and reliable financial statements in a timely manner.
- Although significant progress has been made in resolving grant accounting issues, additional effort is needed to ensure that Payment Management System advance balances reconcile with operating divisions' records.
- Improvements are needed in electronic data processing controls at the HCFA central office, HCFA contractors and the HHS payroll system.

The Department agreed with some of OIG's recommendations to strengthen internal controls. (CIN: A-17-98-00001)

Reviews of Departmental Service Organizations

To support its departmentwide FY 1997 financial statement audits, OIG contracted for reviews of four HHS service organizations which provide common accounting and administrative services to the individual operating agencies. During this reporting period, two of these reviews were completed by an independent public accountant, as discussed below.

A. Departmentwide Payroll System

The accounting firm noted a number of major problems with the payroll system. For instance, a system control feature that limits pay corrections to 25 percent of base pay had been turned off, so that employees with passwords could make corrections to their pay and that of others that would result in a pay increase of 100 percent or more. The system also accepted duplicate corrections and did not flag unusual transactions or trends. In OIG's view, this constitutes a material internal control weakness. (CIN: A-17-97-00010)

B. Division of Financial Operations

In assessing accounting operations at the Division of Financial Operations (DFO), the accounting firm noted several problems with the financial systems. For example, DFO did not have a system that produced timely financial statements or the reports necessary for financial statement audits. Instead of an integrated financial system, DFO relied on two accounting systems, an offline database program and numerous manual adjustments; these conditions were a contributing factor in OIG's finding of a material weakness in financial reporting at the Department level. Moreover, the firm found that DFO did not always comply with the requirements of the Federal Financial Management Improvement Act. The Program Support Center concurred with most of OIG's recommendations and is in the process of taking corrective action. (CIN: A-17-97-00009)

Nonfederal Audits

The OMB Circular A-133 establishes the audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, 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 second half of FY 1998, OIG's National External Audit Review Center (located in Kansas City) reviewed over 1,000 reports that covered over \$151.3 billion in audited costs. Federal dollars covered by these audits totaled \$35.5 billion, about \$20.6 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 has developed 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 program 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 obtained:

- 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 actively assists 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. In addition, formal training was provided to certified public accountant societies and State auditor staff on issues related to Circular A-133.
- The OIG is also very much involved with OMB and the American Institute of Certified Public Accountants in developing authoritative guidance for nonfederal auditors.

B. Quality Control

To rely on the work of 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 1,021 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	896
Reports issued with major changes	12
Reports with significant inadequacies	<u>113</u>
Total audit reports processed	1,021

The 1,021 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling \$2 million as well as 1,961 recommendations for improving management operations. In addition, these audit reports provided information for 42 special memoranda which identified concerns for increased monitoring by departmental management.

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. These costs are separate from the amount ordered or returned as a result of OIG investigations (see page 62).

**TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS**

	<u>Number</u>	<u>Dollar Value</u>	
		<u>Questioned</u>	<u>Unsupported</u>
A. For which no management decision had been made by the commencement of the reporting period ¹	420	\$364,375,000	\$49,710,000
B. Which were issued during the reporting period	<u>84</u>	<u>\$71,043,000</u>	<u>\$14,064,000</u>
Subtotals (A + B)	504	\$435,418,000	\$63,774,000
Less:			
C. For which a management decision was made during the reporting period ² :	158	\$87,687,000	\$2,036,000
(i) dollar value of disallowed costs ³		\$68,824,000	\$410,000
(ii) dollar value of costs not disallowed		\$18,863,000	\$1,626,000
D. For which no management decision had been made by the end of the reporting period	346	\$347,731,000	\$61,738,000
E. For which no management decision was made within 6 months of issuance ⁴	260	\$270,925,000	\$47,783,000

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**

	<u>Number</u>	<u>Dollar Value</u>
A. For which no management decision had been made by the commencement of the reporting period ¹	36	\$34,381,000
B. Which were issued during the reporting period	<u>7</u>	<u>\$1,229,882,000</u>
Subtotals (A + B)	43	\$1,264,263,000
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	5	\$14,367,000
(b) based on proposed legislative action		
Subtotals (a+b)	5	\$14,367,000
(ii) dollar value of recommendations that were not agreed to by management	<u>4</u>	<u>\$5,378,000</u>
Subtotals (i + ii)	9	\$19,745,000
D. For which no management decision had been made by the end of the reporting period ³	34	\$1,244,518,000

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. 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. Regulatory Development Functions

The OIG is responsible for developing a variety of sanction regulations addressing civil monetary penalty (CMP) and program exclusion authorities administered by the Inspector General, as well as advisory opinion and safe harbor regulations related to the anti-kickback statute.

Among the regulatory initiatives promulgated during the reporting period were:

■ OIG Final Rule: Issuance of Advisory Opinions by OIG

The OIG issued final regulations addressing its advisory opinion process, in accordance with section 205 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This final rule addressed the various public comments received as a result of OIG's interim final rule published in February 1997, and serves to revise, refine and clarify various aspects of the advisory opinion process consistent with public comments and OIG's own experience in the issuance of advisory opinions. As a result, OIG has accommodated these concerns by revising the rule to provide greater flexibility for requesters in the submission of advisory opinion requests.

■ OIG Proposed Rulemaking: Revised CMPs Resulting From Public Law 104-191

The OIG issued proposed rulemaking addressing revised OIG CMP authorities, in conjunction with new and revised provisions set forth in HIPAA. The proposed rule is designed to codify, among other provisions, new CMPs for excluded individuals retaining ownership or control interest in an entity; upcoding and claims for medically unnecessary services; offering inducements to beneficiaries; and false certification of eligibility for home health services.

■ Additional Regulatory Activities

The OIG continued its development and promulgation of final regulations addressing new HIPAA exclusion authorities, and the issuance of proposed regulations addressing both the

health care fraud and abuse data bank collection program for reporting final actions and expanded and revised exclusion and CMP authorities resulting from Public Law 105-33, the Balanced Budget Act of 1997. All three rules are expected to be published in the Federal Register shortly.

The OIG also continued to develop interim final regulations addressing the shared risk exception to the anti-kickback statute, in accordance with section 216 of HIPAA, and the final regulations for promulgating new and revised safe harbors to the anti-kickback statute.

Further, during this period, OIG developed and published three Federal Register notices setting forth the OIG special fraud alert concerning fraud and abuse practices involving nursing home arrangements with hospices, the OIG compliance program guidance for home health agencies and the OIG compliance program guidance for clinical laboratories.

C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process. For example, OIG testified at 11 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 significant annual savings to the Government. These recommendations are contained in the OIG Cost Saver 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.

Governmental Accounting

Each year, State and local government entities receive over \$200 billion for administration of Federal grants and associated activities. As part of its Governmentwide cognizance responsibilities, as defined in OMB Circular A-87, OIG assesses whether charges to Federal programs are in accordance with the appropriate Statewide cost allocation plans and identifies cost containment areas and/or areas where costs are being inappropriately charged. During this reporting period, OIG conducted two reviews of State funds.

A. Tennessee Consolidated Retirement System

The OIG found that the Tennessee consolidated retirement system fund contained over \$538 million (\$49 million Federal share) in excess funds as of June 30, 1997. The excess balance occurred because actual results from the fund's operations significantly deviated from actuarial estimates. Specifically, returns on investments exceeded expectations, and salary increases for participants were less than expected. The OIG recommended that the State consider adjusting future pension contribution rates charged to Federal programs to reduce

the excess fund balance. In response to the draft report, the State agreed and said that it was in the process of reducing contribution rates. (CIN: A-04-98-00118)

B. Virginia Internal Service Funds

At the Department's request, OIG reviewed the Commonwealth of Virginia's internal service fund balances for State FYs 1993 through 1997 to determine the Federal share of profits earned by the funds and transfers made from the funds. The review found that the Commonwealth overrecovered \$15.3 million in Federal funds during the 5-year period. The OIG recommended that the Department require Virginia to refund that amount to the Federal Government, and the Department concurred. (CIN: A-03-98-00457)

Employee Fraud and Misconduct

The OIG has oversight responsibility for the investigation of allegations of Department employee wrongdoing where it affects internal programs. Most of the persons employed full time by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities. The following actions came to OIG's attention as a result of a joint investigation with the Food and Drug Administrations' (FDA's) Office of Internal Affairs.

- A former FDA employee was sentenced in Washington, D.C. for theft of Government property. He was sentenced to 5 years probation and ordered to pay \$11,350 in restitution. He made long-distance calls for which FDA was billed more than \$36,500. During an earlier interview, the employee admitted that he made calls to both a phone sex line and to numerous women around the country whom he met through the sex line. The employee was terminated from his job after being convicted of the charge.
- In Maryland, another former FDA employee was also sentenced for theft of Government property. She used a Government charge card to obtain funds for personal gain. She charged \$9,640 on the card to operate a residential facility for mentally retarded adults from her residence. She was sentenced to 5 years probation and ordered to pay restitution of \$7,160.

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 132 successful criminal actions. Also during this period, 788 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 159 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, nearly \$392.3 million was ordered or returned as a result of OIG investigations during this

semiannual period. Civil settlements from investigations resulting from audit findings are included in this figure.

Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act (PFCRA), passed in October 1986, established administrative penalties for anyone who makes a false claim or written false statements to a Federal agency. It was modeled after the civil monetary penalty law for the Medicare and Medicaid programs, which OIG is responsible for enforcing. Under PFCRA, any person who makes a claim or statement to the Department, knowing, or having reason to know, that it is false, fictitious or fraudulent, may be held liable in an administrative proceeding for a penalty of up to \$5,000 per claim or statement. In addition, that person may be subject to an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims or statements, and for reporting at the end of each fiscal year investigations completed under PFCRA and referred for administrative action.

During FY 1998, no settlements were made under PFCRA. While all cases are routinely analyzed for potential action under PFCRA, the availability of OIG's CMP authorities in health care matters often renders PFCRA unnecessary. Also, PFCRA cannot comfortably be applied to many of the grants and contracts issued and administered by HHS, since these grants often exceed the financial limits of PFCRA.

Appendices

APPENDIX A

Savings Achieved Through Policy and Procedural Changes Resulting from Office of Inspector General Audits, Investigations and Inspections April 1998 through September 1998

The following schedule highlights savings resulting from Office of Inspector General (OIG) efforts to prevent unnecessary obligations for expenditures of agency funds or to improve agency systems and operations. These achievements depend greatly on the contributions of others, such as OIG's partners within the Department and elsewhere. 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 in response to OIG audits, investigations and inspections, 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 (CBO) estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected or for multiple years, if applicable. Total savings from these sources amount to \$7,187 million for this period.

Note that implementation of certain legislative changes may be delayed as a result of Year 2000 readiness priorities (i.e., prospective payment system for hospital outpatient services and consolidated billing for skilled nursing facilities). Nonetheless, it is expected that these savings will be realized when the Year 2000 moratorium is lifted. Accordingly, OIG has not reduced the CBO estimates.

OIG Recommendation	Implementing Action	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Hospital Outpatient Policy: Extend congressionally mandated reductions in hospital costs. Hospitals should limit 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. (CIN: A-14-89-00221; CIN: A-09-91-00070; OAI-85-09-0046; OEI-09-88-01003)	Section 13521 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 mandated a reduction of 10 percent for outpatient capital costs. Sections 4521-4523 of the Balanced Budget Act (BBA) of 1997 eliminated formula-driven overpayments in fiscal year (FY) 1998, extended reductions in payments for costs of hospital outpatient services, and established a prospective payment system (PPS) for hospital outpatient services for FY 1999.	\$1,444
Capital-Related Costs of Hospital Services: Extend congressionally mandated reductions in hospital costs. The Health Care Financing Administration (HCFA) should seek legislative authority to continue mandated reductions in capital payments; excess capacity was not considered in the capital cost policy. (CIN: A-09-91-00070; CIN: A-07-95-01127)	Section 13501(a)(3) of OBRA 1993 mandated a reduction of 7.4 percent for inpatient capital costs. Section 4402 of the BBA of 1997 provided for rebasing of capital payment rates for an additional reduction in the rates.	1,335

OIG Recommendation	Implementing Action	Savings in Millions
<p>Medicare Laboratory Reimbursements: In July 1989, OIG recommended that HCFA take advantage of economies of scale present in the laboratory industry by considering competitive bidding or making reductions to the fee schedule amounts. In January 1990, OIG recommended that HCFA seek legislation to allow across the board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices which laboratories charge physicians in a competitive marketplace. In a January 1996 follow-up, OIG found that Medicare continued to pay more to clinical laboratories than physicians for the same tests. Although OBRA 1993 reduced the fee schedule to 76 percent of the average in 1996, OIG recommended that HCFA periodically evaluate the national fee schedule to ensure that it is in line with the prices physicians pay for the same clinical laboratory services. (OAI-02-89-01910; CIN: A-09-89-00031; CIN: A-09-93-00056)</p>	<p>Section 13551 of OBRA 1993 reduced the national cap to 76 percent of the median of all fee schedules, and froze the annual update for 1994 and 1995. Section 4553 of the BBA provided for reducing fee schedule payments by lowering the cap to 74 percent of median for payment amounts, with no inflation update for 1998 through 2002.</p>	<p>\$1,184</p>
<p>Reforming Medicaid Disproportionate Share Payments: Disproportionate share payments to hospitals should be related to costs incurred in treating Medicaid and indigent patients to correct the inequities and abuses in current payment methodologies. (CIN: A-06-90-00073; CIN: A-04-92-01025)</p>	<p>Section 13621 of OBRA 1993 prohibited designation of a hospital as a disproportionate share hospital (DSH) for purposes of Medicaid reimbursement unless the hospital had a Medicaid inpatient utilization rate of at least one percent. It also limited DSH payment adjustments to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients less payments received from Medicaid (other than DSH payment adjustments) and uninsured patients. Section 4721 of the BBA reformed disproportionate share payments under State Medicaid programs by placing limitations on Federal financial participation.</p>	<p>910</p>
<p>Medicare Secondary Payer - Initial Enrollment Questionnaire: The HCFA should take steps to collect primary insurance information in a more timely and accurate manner, requiring beneficiaries to disclose other health insurance information, and should revise all Medicare claims forms to require spousal information before claims can be paid. (CIN: A-09-89-00100; OEI-07-90-00760)</p>	<p>Since 1995, all Medicare beneficiaries are being asked to complete the Initial Enrollment Questionnaire and list any other health insurance they have. The HCFA has reported that two-thirds of all new beneficiaries are voluntarily completing the questionnaire and this has helped HCFA document 110,000 cases each year in which new beneficiaries have other coverage.</p>	<p>425</p>

OIG Recommendation	Implementing Action	Savings in Millions
<p>Medicare Indirect Medical Education: The HCFA should base the indirect medical education adjustment factor on the level supported by HCFA's empirical data. (CIN: A-07-88-00111)</p>	<p>Section 4621 of the BBA reduced the indirect teaching adjustment factor from 7.7 percent in FY 1997 to 7.0 percent in FY 1998; 6.5 percent in FY 1999; 6.0 percent in FY 2000; 5.5 percent in FY 2001 and thereafter.</p>	\$380
<p>Medicare Secondary Payer Extensions: Establish a centralized database of information about private insurance coverage of Medicare beneficiaries. Extend the Medicare secondary payer (MSP) provision to include end stage renal disease (ESRD) beneficiaries as long as the individual has employer based coverage available. (OEI-07-90-00760; OEI-03-90-00763; CIN: A-10-86-62016; CIN: A-09-89-00100; CIN: A-09-91-00103; CIN: A-14-94-00391; CIN: A-14-94-00392)</p>	<p>The database capacity was achieved through the authorization of a data exchange between the Social Security Administration (SSA) and HCFA and between the Internal Revenue Service (IRS) and HCFA. Section 13561(a) of OBRA 1993 extended the MSP data match through 1998. Section 4631 of the BBA permanently authorized the SSA and IRS data match programs. Section 4631 of the BBA also permanently extended current MSP policies for beneficiaries who are disabled and have ESRD. For ESRD beneficiaries, the statute also increased the time period Medicare is secondary payer from 18 to 30 months.</p>	345
<p>Medicaid Transfer of Assets: Strengthen the transfer of asset rules so that people cannot give away property to qualify for Medicaid. Assets and income from special needs trusts should be counted for Medicaid qualifying purposes and be subject to third party liability recovery. (OAI-09-86-00078; CIN: A-09-93-00072)</p>	<p>Section 13611 of OBRA 1993 provided for a delay in Medicaid eligibility for institutionalized individuals or their spouses who dispose of assets for less than fair market value on or after a specified look-back date; set forth rules under which funds and other assets of an individual placed in trust by or on behalf of an individual or the spouse are treated, for purposes of Medicaid eligibility, as resources available to the individual, and under which payments from the trust are to be considered assets disposed of by the individual; and specified that, for purposes of applying the transfer of asset prohibitions, the look-back period with respect to trusts is 60 months.</p>	225
<p>Medicare Payments for Oxygen: The HCFA should reduce Medicare payments for oxygen concentrators and ensure that beneficiaries receive necessary care and support in connection with their oxygen therapy. (OEI-03-91-00711, OEI-03-91-001710)</p>	<p>Section 4552(a) of the BBA reduced Medicare reimbursement for oxygen 25 percent until 1999 and by 30 percent for each subsequent year; section 4552(c) mandated that the Secretary develop service standards for oxygen provided in the home.</p>	200

OIG Recommendation	Implementing Action	Savings in Millions
<p>Medicare Secondary Payer - Blue Cross and Blue Shield Association: The HCFA should negotiate a reasonable settlement to recover the sums improperly paid by HCFA contractors for which Medicare should have been the secondary payer. (CIN: A-02-93-01006)</p>	<p>The Blue Cross and Blue Shield Association agreed to a global settlement with the Department of Justice and HCFA to settle disputes over MSP claims. In addition to the \$115 million the Blue Cross Association immediately refunded HCFA, as part of the settlement, the Association implemented a 3-year data exchange agreement with HCFA that is expected to result in savings of \$100 million in Fiscal Year 1998 for a 3-year total savings of \$920 million.</p>	\$100
<p>Medicare Part A Payments for Skilled Nursing Facilities: Services should be bundled into Medicare and Medicaid's payments to nursing homes; Part B payments for services normally included in the extended care benefit should continue to be examined for appropriateness; and a legislative recommendation should be developed to prohibit entities other than the skilled nursing facility (SNF) from seeking coverage on behalf of persons in Part A covered SNF stays for enteral nutrition, incontinence care, and surgical dressings, and limit Medicare coverage of these services to Part A. In 1997 congressional testimony, OIG supported establishing a PPS and consolidated billing. (OEI-03-94-00790; OEI-06-92-00863; OEI-06-92-00864; CIN: A-17-95-00096; CIN: A-14-98-00350)</p>	<p>Section 4432 of the BBA phased in a PPS for SNF care. Covered services include Part A SNF benefits and all services for which payment may be made under Part B (except physician and certain other professional services) during the period when the beneficiary is provided covered SNF care.</p>	90
<p>Medicare Payments for Prescription Drugs: The HCFA should reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. (OEI-03-95-00420; OEI-03-94-00390; OEI-03-97-00290)</p>	<p>Section 4556 of the BBA reduced Medicare payments for drugs, which are paid based on the average wholesale price, by five percent.</p>	80
<p>Graduate Medical Education Payments: The HCFA should reevaluate Medicare's policy of paying graduate medical education (GME) costs for all physician specialties and should consider submitting legislation to reduce Medicare's investment in GME to arrive at a more representative and accurate sharing of GME costs. (CIN: A-06-92-00020)</p>	<p>Sections 4623 and 4626 of the BBA provided for limits in the number of residents and offered payments for voluntary reductions in the number of residents to limit Medicare's share of GME costs.</p>	70
<p>Ambulance Services for Medicare End Stage Renal Disease Beneficiaries: The HCFA should ensure fairer payment for services rendered, and ensure that claims meet Medicare coverage guidelines. (OEI-03-90-02130; OEI-03-90-02131)</p>	<p>A set of proposed national codes for use by carriers was developed in January 1994, and a program memorandum was finalized and distributed a year later for January 1995 implementation.</p>	55.4

OIG Recommendation	Implementing Action	Savings in Millions
<p>Fraud and Abuse Provisions of the Balanced Budget Act: Require durable medical equipment (DME) suppliers and home health agencies (HHAs) to provide Social Security numbers (SSNs) and employer identification numbers (OEI-04-96-00240; OEI-09-96-00110); refuse to enter into a provider agreement with any HHA whose owners or principals have prior criminal records or are the relatives of the owner of a provider who had defrauded the Medicare program (OEI-09-96-00110); allow HCFA to apply "inherent reasonableness" provisions when assessing the appropriateness of Medicare payments (OEI-03-94-00392); authorize competitive bidding as a means of providing Medicare services (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230); and require DME suppliers and HHAs to post surety bonds as a condition of participation (OEI-04-96-00240; OEI-09-96-00110). Also, clarify which general and administrative and fringe benefits costs at hospitals and HHAs are related to patient care; specifically, distinguish between employee benefits and/or perquisites to entertainment and patient care, and specify that cost of entertainment, goods or services for personal use, alcohol, all fines and penalties and associated interest, dues, and membership costs associated with civic and community organizations are unallowable. (CIN: A-03-92-00017; CIN: A-04-93-02067)</p>	<p>Subtitle D of the BBA contained a number of provisions that corresponded to and were supported by OIG work: for example, the BBA authorized the Secretary to collect SSNs and employer identification numbers from entities under Medicare, Medicaid and title V; authorized the Secretary to refuse to enter into contracts with physicians or suppliers that have been convicted of felonies; authorized the exclusion of entities owned or controlled by the family or household members of excluded individuals; authorized HCFA to make inherent reasonableness adjustments up to 15 percent to all Part B services except physician services; authorized up to 5 demonstration projects to be completed by December 31, 2002 (one must be oxygen and oxygen equipment), which can have multiple sites, to allow competitive bidding; and prohibited "reasonable cost" payments for items such as entertainment, gifts and donations, education expenses and personal use of automobiles. The BBA also required DME suppliers, HHAs and others to post a surety bond of a minimum of \$50,000.*</p>	\$40
<p>Medicare Payments to Hospitals for Bad Debt: The HCFA should seek legislative authority to modify the bad debt payment policy. (CIN: A-14-90-00039)</p>	<p>Section 4451 of the BBA reduced bad debt payment to providers to 75 percent during FY 1998, 60 percent during FY 1999 and 55 percent in later years.</p>	40

*This latter provision will be implemented upon completion of a congressionally mandated review by the General Accounting Office.

OIG Recommendation	Implementing Action	Savings in Millions
<p>Rural Health Clinics: The oversight and functioning of the current cost reimbursement system should be improved by implementing caps on provider-based rural health clinics (RHCs) and allowing States to do so, or finding other ways to make reimbursement between provider-based and independent RHCs more equitable. In addition, the certification process should be modified to increase State involvement and ensure more strategic placement of RHCs. Recertification should be required of RHCs within a specific time limit (for example 5 years), applying new criteria to document the need and impact on access. (OEI-05-94-00040)</p>	<p>Section 4205 of the BBA extended the per-visit payment limits to provider-based clinics and stipulated that the shortage area requirements designation be reviewed triennially.</p>	<p>\$30</p>
<p>Medicare Disproportionate Share: The disproportionate share adjustment should be reduced, if not eliminated, without redistribution of the funds to PPS hospitals. (CIN: A-04-87-01004)</p>	<p>Section 4403 of the BBA provided for reducing DSH payments by 1 percent in FY 1998, 2 percent in FY 1999, 3 percent in FY 2000, 4 percent in FY 2001, 5 percent in FY 2002 and 0 percent thereafter.</p>	<p>30</p>
<p>Hospital Sales: The HCFA should eliminate the requirement that Medicare make adjustments for gains and losses when hospitals undergo changes of ownership. (OEI-03-96-00170)</p>	<p>Section 4404 of the BBA eliminated the requirement that Medicare make adjustments by setting the Medicare capital asset sales price equal to the net book value.</p>	<p>30</p>
<p>Hospice Certification: The HCFA should restructure hospice benefit policies to curb inappropriate growth in the program, particularly with regard to the fourth benefit period. (OEI-05-95-00250; CIN: A-05-96-00023)</p>	<p>Sections 4441-4449 of the BBA of 1997 contained provisions to control hospice payments and practices, such as replacing the current unlimited fourth benefit period with an unlimited number of 60 day benefit periods (each requiring recertification).</p>	<p>10</p>
<p>Medicare Payments for Home Blood Glucose Monitors: The HCFA should ensure that Medicare payments for monitors are net of any available rebates. (CIN: A-09-92-00034)</p>	<p>The HCFA issued final regulations on the fee schedule for home blood glucose monitors. These regulations refer to the OIG report for support of fee schedule changes.</p>	<p>5</p>
<p>Recoupment of Home Health Overpayment: The HCFA should recover an estimated \$9.8 million Medicare overpayment made to a large home health firm as identified in an OIG audit of claims filed. (CIN: A-06-95-000092 - internal memorandum, no report issued)</p>	<p>On appeal, \$4.7 million of the estimated \$9.8 million was upheld. Of the \$4.7 million, \$1.8 million was recouped by the local Medicare contractor. The other \$2.9 million remains in bankruptcy court.</p>	<p>1.8</p>

Other	Implementing Action	Savings in Millions
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HEALTH CARE FINANCING ADMINISTRATION

Incontinence Supplies:

Information from OIG inspections indicated that suppliers engaged in questionable marketing practices and that beneficiaries were receiving unnecessary or noncovered incontinence supplies. A joint OIG/HCFA effort to address this problem resulted in the initiation of an OIG review of this area and a national investigation examining potentially fraudulent practices by specific suppliers. In addition to issuing reports, OIG dramatized the problem in speeches and congressional testimony. The OIG issued fraud alerts on this topic in December 1994 and August 1995. As a result of OIG investigations, approximately \$50.2 million was recovered through seizures and restitutions from abusive providers, further highlighting the intensity of the OIG/HCFA initiative. In these ways, OIG supported ongoing activity in HCFA and the durable medical equipment regional carriers (DMERCs) to control Medicare outlays for these supplies and equipment. (OEI-03-94-00770; OEI-03-94-00772; OEI-03-94-00773)

The DMERCs issued single national coverage guidelines in October 1995 and educated providers about proper billing. Since the initiative began in 1994, Medicare payments dropped by \$110 million a year, of which \$104 million in 1996 was directly attributable to the problems discussed in the OIG reports.

\$108

VARIOUS OPERATING DIVISIONS

Results of Investigations:

In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the Operating Division.

The Operating Division takes action based on the results of the OIG investigation to suspend or terminate payments to the offending individual or entity.

48.8

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)	The HCFA did not agree with the recommendation, and no legislative proposal was included in the President's current budget.	\$4,100
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, 1986. 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 HCFA included a proposal to mandate Medicare coverage for all State and local government employees in the FY 1990 budget submission, no legislative proposal was included in the President's current budget. Also, HCFA did not agree with the recommendation to make Medicare the secondary payer.	1,559
Clinical Laboratory Tests:		
Develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, 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-09-93-00056)	The HCFA agreed with the first recommendation but not the second. The Balanced Budget Act of 1997 reduces Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002.	1,130*

*This savings estimate would result from the copayment; the savings estimate for panels has yet to be determined.

OIG Recommendation	Status	Savings in Millions
<p>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)</p>	<p>The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.</p>	\$1,100
<p>Reduce Hospital Capital Costs: Determine the extent that capital reductions 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)</p>	<p>The HCFA did not agree with the recommendation. Although the Balanced Budget Act of 1997 reduces capital payments, it does not include the effect of excess bed capacity and other elements included in the base year historical costs.</p>	820
<p>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)</p>	<p>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. However, pursuant to section 4711 of the Balanced Budget Act of 1997, the Secretary shall conduct a study on the effect on access to, and the quality of services provided to beneficiaries of the rate-setting methods used by States.</p>	683
<p>Flexible Benefit Plans: The value of flexible benefit plans should be included in the definition of wages for the hospital insurance portion of the Federal Insurance Contributions Act. (CIN: A-05-93-00066)</p>	<p>While HCFA agreed with the recommendation and has submitted a legislative proposal to subject flexible benefit plans to the Hospital Insurance tax, the proposal was not included in the President's budget.</p>	291
<p>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)</p>	<p>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. No proposal was included in the President's current budget.</p>	210

OIG Recommendation	Status	Savings in Millions
<p>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)</p>	<p>The HCFA did not concur with the recommendations. Although the Balanced Budget Act of 1997 contains provisions to slow the growth in Medicare spending on GME, OIG believes that its recommendations should be implemented and that further savings can be achieved.</p>	\$157.3
<p>Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 tests identified by the OIG audit. (CIN: A-01-93-00521)</p>	<p>The HCFA agreed with 8 of the 10 tests recommended for addition to the list and added 6 of these tests to its carrier manual. The HCFA will periodically review applicable tests and related equipment. Also, although a legislative proposal to add further tests was included in the President's FY 1997 budget, the Congress decided (through the Balanced Budget Act of 1997) to achieve savings through other means, including freezing laboratory payments through 2002 and reducing the national payment cap to 74 percent of the median of all fee schedules.</p>	130
<p>Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing and begin to plan now for the policy changes that will become necessary to achieve an almost completely paperless environment for processing Medicare claims. (CIN: A-05-94-00039; OEI-01-94-00230)</p>	<p>The HCFA concurred with OIG's recommendations and has developed a corrective action plan.</p>	126
<p>Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (CIN: A-06-94-00039)</p>	<p>The OIG is continuing to monitor the Medicaid drug rebate program. Audits will focus on enhancing the collection of rebates and providing potential savings to the rebate program.</p>	123
<p>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; 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)</p>	<p>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.</p>	122

OIG Recommendation	Status	Savings in Millions
<p>Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The HCFA should propose legislation to expand the diagnosis related group (DRG) payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)</p>	<p>The HCFA agreed to recover the improper Medicare 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 current budget.</p>	\$83.5
<p>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)</p>	<p>The HCFA considered a proposal recommending that the Medicare 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 current budget.</p>	47.6
<p>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)</p>	<p>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.</p>	32
<p>Reduce End Stage Renal Disease Payment Rates: The HCFA should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)</p>	<p>The HCFA agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing these rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatment. A March 1996 study by ProPAC recommended an increase to the current rates, but HCFA did not believe an across-the-board increase was warranted and intended to monitor facilities' costs and other factors to determine if a rate increase would be appropriate. Toward this end, the Balanced Budget Act of 1997 requires the Secretary to audit the cost reports of each renal dialysis provider at least once every 3 years. The HCFA said it plans to begin these audits in FY 1999.</p>	22*

*This savings estimate represents program savings of \$22 million for each dollar reduction in the composite rate.

OIG Recommendation	Status	Savings in Millions
<p>Collect Overpayments from Health Maintenance Organizations for Misclassified End Stage Renal Disease Beneficiaries:</p> <p>The HCFA should issue clear guidelines for the recovery of overpayments from health maintenance organizations (HMOs) and recover all overpayments occurring at least since 1992 that were made to HMOs on behalf of misclassified end-stage renal disease (ESRD) beneficiaries. (CIN: A-14-96-00203)</p>	<p>The HCFA agreed to clarify its policies for collecting overpayments from HMOs. However, it collected overpayments retroactively only to March 1995 for the majority of misclassified beneficiaries and retroactively to October 1993 for the remaining beneficiaries who were misclassified as having ESRD before enrollment in the HMO. Due to this limited recovery schedule, HCFA has not collected \$20.5 million in overpayments which occurred since 1992. The HCFA disagreed with the OIG recommendation to collect the overpayments retroactively to 1992.</p>	\$20.5
<p>Preclude Improper Medicaid Reimbursement for Clinical Laboratory Services:</p> <p>State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings that contain duplicate tests, recover overpayments and make adjustments for the Federal share of the amounts recovered. (CIN: A-01-95-00005; CIN: A-05-95-00035; CIN: A-01-96-00001; CIN: A-06-95-00078; CIN: A-06-95-00031; CIN: A-04-95-01108; CIN: A-04-95-01109; CIN: A-07-95-01139; CIN: A-07-95-01147; CIN: A-04-95-01113; CIN: A-07-95-01138; CIN: A-09-95-00072; CIN: A-05-96-00019; CIN: A-10-95-00002; CIN: A-01-95-00006; CIN: A-02-95-01009; CIN: A-03-96-00200; CIN: A-03-96-00202; CIN: A-03-96-00203; CIN: A-05-95-00062; CIN: A-06-96-00002; CIN: A-06-95-00100)</p>	<p>The HCFA wrote to all State Medicaid directors on January 15, 1997, alerting them to the OIG review, encouraging them to use Medicare's bundling policies and urging them to install appropriate payment edits in their claim processing systems.</p>	14
<p>Nonemergency Advanced Life Support Ambulance Services:</p> <p>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; CIN: A-01-94-00528)</p>	<p>This policy change was included in proposed regulations published by HCFA in June 1997. It will be finalized as part of a negotiated rulemaking process for development of an ambulance fee schedule (as mandated by the Balanced Budget Act of 1997).</p>	12.8

OIG Recommendation	Status	Savings in Millions
<p>High-Priced Generic Drugs: The HCFA should not include higher priced generic drugs in the median calculations to determine Medicare allowances or propose limiting Medicare allowances to brand prices when higher-priced generic drugs are involved. Currently, Medicare determines reimbursement for multiple-source drugs at 95 percent of the median average wholesale price (AWP) for all generic versions of the drug. (OEI-03-97-00510)</p>	<p>In a program memorandum, HCFA instructed contractors to recalculate the median AWP including the brand-name product if the original median AWP was greater than the brand-name AWP. In addition, HCFA has issued a proposed rule that would reimburse multiple-source drugs at the lower of the median prices of the generic AWP or the lowest brand-name AWP.</p>	\$12
<p>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)</p>	<p>The HCFA concurred and has instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices. However, payments continue at high levels. The OIG is planning to continue its work on this issue and is conducting a follow-up study to determine if any progress has been made in disallowing noncovered body jackets.</p>	10.4
<p>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)</p>	<p>While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.</p>	9.1
<p>Medicare Orthotics: Develop guidelines that better define orthotic devices; develop policies for orthotic codes; develop screens for billing many orthotic devices on the same day or within a short time frame; pay special attention to billing for orthotics in nursing facilities; work with the American Orthotic and Prosthetic Association to develop a table of devices that should not be used together, and consider stricter standards to determine who is allowed to bill for orthotics. (OEI-02-95-00380)</p>	<p>The HCFA concurred with the recommendations. The HCFA continues to work with the DMERCs, the American Orthotic and Prosthetic Association to implement the recommendations.</p>	7.9
<p>Limit Reimbursement for Hospital Beds: The HCFA should develop a new approach for reimbursing suppliers of hospital beds used by Medicare beneficiaries at home. The 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)</p>	<p>The HCFA awarded a demonstration project on this subject in 1996. The project is expected to run in at least three sites for two cycles of 2 years each which began in January 1997. The Balanced Budget Act of 1997 requires the Secretary to conduct a competition among individuals and entities supplying Part B items and services. Even though only oxygen and oxygen equipment were specifically mentioned in the statute for one of the five demonstration projects, HCFA is planning to include hospital beds in at least one of the sites.</p>	6.2

OIG Recommendation	Status	Savings in Millions
<p>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)</p>	<p>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. In June 1996, HCFA issued guidelines which set forth advice on ways in which States can better recover Medicaid expenditures from established third-party settlements, especially for the disabled population.</p>	\$3
<p>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 different adjustment factors are warranted for different types of teaching hospitals. (CIN: A-07-88-00111)</p>	<p>The HCFA agreed with the recommendation, and the Balanced Budget Act of 1997 reduces the IME adjustment factor from the current 7.7 percent in Fiscal Year (FY) 1997 to 5.5 percent in 2001 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.</p>	to be determined
<p>Medicare Secondary Payer - End Stage Renal Disease Time Limit: Extend the Medicare secondary payer (MSP) provisions to include ESRD beneficiaries without a time limitation. (CIN: A-10-86-62016)</p>	<p>The HCFA was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. The HCFA favored indefinitely extending the MSP provision for all other services and included this proposal in an earlier budget submission. Although the Balanced Budget Act of 1997 extends MSP policies for individuals with ESRD to 30 months, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.</p>	to be determined

OIG Recommendation	Status	Savings in Millions
<p>Home Health Agencies: The HCFA should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (CIN: A-04-95-01103; CIN: A-04-95-01104; OEI-04-93-00262; OEI-04-93-00260; OEI-12-94-00180; OEI-02-94-00170; CIN: A-04-94-02087; CIN: A-04-94-02078; CIN: A-04-96-02121; OEI-09-96-00110)</p>	<p>Although the Congress and the Administration included provisions to restructure home health benefits in the Balanced Budget Act of 1997, HCFA still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. While agreeing in principle, HCFA said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification.</p>	to be determined
<p>Modify Payment Policy for Medicare Bad Debts: 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 hospitals that are profitable, and the inclusion of a bad debt factor in the DRG rates. The HCFA should seek legislative authority to further modify bad debt policies. (CIN: A-14-90-00339)</p>	<p>The HCFA agreed with the recommendation to include a bad debt factor in the DRG rates. The Balanced Budget Act of 1997 provides for some reduction of bad debt payments to providers, but additional legislative changes are needed to implement the modifications that OIG recommended. The OIG has been informed by HCFA that it submitted a legislative proposal to extend the application of the reduction to all providers, to remove the moratorium on changes to the Medicare bad debt policy and to phase out payments for bad debts for all providers in 5 years.</p>	to be determined
PUBLIC HEALTH SERVICE OPERATING DIVISIONS		
<p>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)</p>	<p>In the absence of specific authorizing legislation, the Food and Drug Administration is precluded by statute from imposing user fees to cover additional functions.</p>	\$44.3
<p>Remove High-Priced Generic Drugs from Medicare Drug Payment Methodology: The HCFA should not include higher-priced generic drugs in the median calculations to determine Medicare allowances, or propose limiting Medicare allowances to brand prices when higher-priced generic drugs are involved.</p>	<p>In a program memorandum, HCFA instructed contractors to recalculate the median average wholesale price (AWP) including the brand-name product if the original median AWP was greater than the brand-name AWP. In addition, HCFA has issued a proposed rule that would reimburse multiple-source drugs at the lower of the median price of the generic AWP or the lowest brand-name AWP.</p>	12

OIG Recommendation	Status	Savings in Millions
<p>Medical Malpractice Coverage: The Health Resources and Services Administration (HRSA) should consider seeking a legislative proposal to limit to \$1 million malpractice settlements or judgments involving community and migrant health centers. (CIN: A-04-95-05018)</p>	<p>After conferring with the Department of Justice, the Department of Health and Human Services has decided not to seek a legislative change at this time.</p>	\$10
<p>Recharge Center Costs: The Assistant Secretary for Management and Budget should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (CIN: A-09-96-04003)</p>	<p>The Deputy Assistant Secretary for Grants and Acquisition Management concurred with the recommendations. In addition, the Council on Government Relations generally agreed and stated that the proposed criteria should be included in the Compliance Supplement to OMB Circular A-133, which provides guidance to independent auditors in conducting compliance audits of educational institutions.</p>	1
ADMINISTRATION FOR CHILDREN AND FAMILIES		
<p>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 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)</p>	<p>This proposal was not included in the President's current budget. The Administration for Children and Families generally agreed with the recommendation, but recently noted that claims for administrative costs have leveled off in the past several years.</p>	247
GENERAL OVERSIGHT		
<p>Simplify Administrative/Indirect Cost Allocation Systems: The OMB should simplify the process for charging administrative/indirect costs to Federal programs through reform of the cost allocation plans. Options for reform include use of block grant awards, a flat percentage rate for administrative/indirect costs, and negotiation of a nonadjustable rate for a predetermined number of years. (CIN: A-12-92-00014)</p>	<p>Some of OIG's recommendations are cited in the National Performance Review report that calls for reform of the cost allocation process. The OMB's revision of Circular A-87 addressed those recommendations. However, further reform is needed to address the bulk of administrative/indirect costs charged to the Federal Government.</p>	660

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	
<p>Improve the Health Care Financing Administration's Implementation of the Federal Managers' Financial Integrity Act Program:</p> <p>The Health Care Financing Administration (HCFA) should reevaluate its review of the Common Working File to ensure that all functional responsibilities of the system are included in Federal Managers' Financial Integrity Act reviews. (CIN: A-14-93-03026)</p>	<p>The HCFA still does not agree with the need to expand financial management reviews to other systems, such as the Common Working File.</p>
<p>Implement Proper Accountability over Billing and Collection of Medicaid Drug Rebates:</p> <p>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)</p>	<p>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 issued interim regulations in Fiscal Year (FY) 1996.</p>
<p>Ensure that the Medicare Accounts Receivable Balance Is Fairly Presented:</p> <p>The HCFA should require contractors to implement or improve internal controls and systems to provide sufficient documentation to support reported accounts receivable. Because of insufficient documentation, OIG again was not able to satisfy itself as to the fair presentation of the Medicare accounts receivable balance (\$2.5 billion in FY 1997). (CIN: A-17-95-00096; CIN: A-17-97-00097)</p>	<p>The HCFA has established a Medicare accounts receivable team to visit several contractors to explore ways in which to strengthen controls and improve contractor reporting.</p>
<p>Consider Recommended Safeguards over Medicaid Managed Care Programs:</p> <p>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)</p>	<p>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.</p>

OIG Recommendation	Status
<p>Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program:</p> <p>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)</p>	<p>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.</p>
<p>Physician Office Surgery:</p> <p>The peer review organizations (PROs) should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)</p>	<p>The HCFA is preparing policy guidance and manual instructions to explicitly state that PROs have the responsibility to review all care in physicians' offices.</p>
<p>Properly Account for Medicare Secondary Payer Overpayments:</p> <p>Although agreement was reached to relieve Blue Cross and Blue Shield plans of past due Medicare secondary payer (MSP) overpayments, HCFA should continue to implement financial management systems to ensure that all overpayments (receivables) are accurately recorded. (CIN: A-09-89-00100)</p>	<p>The HCFA is currently pursuing the recommended administrative action through improved information systems to guard against making improper Medicare payments to the Blue Cross and Blue Shield plans. Also, the President's FY 1999 budget includes a legislative proposal to clarify MSP requirements.</p>
<p>Investigate Patient Dumping Complaints:</p> <p>The HCFA should improve its processes for investigating and resolving complaints involving potential violations of the Examination and Treatment for Emergency Medical Conditions and Workmen in Labor Act, commonly referred to as patient dumping. (CIN: A-06-93-00087)</p>	<p>The HCFA concurred with OIG's recommendations.</p>
<p>Medicare Beneficiary Satisfaction with Durable Medical Equipment Regional Carrier Services:</p> <p>The HCFA should evaluate ways to increase beneficiary satisfaction with the one durable medical equipment regional carrier with a low rating, and review effective ways to educate beneficiaries on what constitutes fraud and abuse. (OEI-02-96-00200)</p>	<p>The HCFA concurred. The HCFA conducts annual evaluations to identify ways to improve performance. The HCFA is also working to develop new outreach techniques to increase beneficiaries' knowledge on detecting fraud and abuse.</p>
<p>Pressure Reducing Support Services:</p> <p>The HCFA should establish the requirement for periodic review and renewal of the medical necessity for beneficiaries' use of group 2 support surface equipment. (OEI-02-95-00370)</p>	<p>The HCFA did not concur.</p>
<p>Excessive Medicare Payments for Prescription Drugs:</p> <p>The HCFA should examine its Medicare drug reimbursement methodologies. (OEI-03-97-00290)</p>	<p>The Balanced Budget Act of 1997 reduced Medicare payments by limiting them to 95 percent of the average wholesale price. Additional corrective action is warranted and called for in the President's 1999 budget and legislative program.</p>

OIG Recommendation**Status**

Monitor the Validity of Medicare Fee-for-Service Payments Made under Title XVIII of the Social Security Act:

Stronger oversight by HCFA is needed to provide reasonable assurance of detecting and preventing improper Medicare payments and to preserve the solvency of the Medicare Trust Funds. To ensure provider compliance with Medicare reimbursement rules and regulations, HCFA should develop a national error rate to objectively measure improper payments and performance in reducing such payments. (CIN: A-17-95-00096; CIN: A-17-97-00097)

The HCFA generally concurred and is increasing the level of claims review and the number of contractor medical directors, improving the use of technology and data, and developing and implementing a substantive testing program.

Medicaid Accounts Receivable and Accounts Payable:

The HCFA should send its annual State survey well in advance of the due date and include clear and complete instructions. Also, procedures should be implemented to address survey problems, and trend data should be developed. (CIN: A-17-95-00096; CIN: A-17-97-00097)

The HCFA sent the FY 1998 survey to the States well in advance of the due date.

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Require AIDS Drug Assistance Programs to Participate in the 340B Drug Pricing Program:

To ensure that eligible entities are accessing lower priced drugs, which enables them to provide additional services, the Health Resources and Services Administration (HRSA) should require State AIDS drug assistance programs to participate in the 340B drug pricing program. (CIN: A-01-97-01501)

The HRSA has drafted a Federal Register notice requesting comments on a proposed condition of grant award that would require participation in the 340B Program for all eligible entities.

Strengthen Policies and Procedures for Medical Personnel Credentialing and Privileging at the Indian Health Service and the Health Resources and Services Administration:

To strengthen requirements and provide more specific guidance on credentialing and privileging to community-based programs receiving Federal funding, the Indian Health Service (IHS) should advocate quality and risk management programs, and the PHS agencies should search the OIG's Medicare/Medicaid exclusion list. (CIN: A-15-94-00006)

The IHS is continuing to advocate the use of credentialing and privileging procedures in tribally operated facilities. The HRSA began adding Medicare/Medicaid exclusion information to an existing database which PHS agencies are required to query.

Improve the Food and Drug Administration's Inspection Process for Plasma Fractionators:

The Food and Drug Administration (FDA) should ensure that plasma fractionator inspections are conducted uniformly, and that warning letters and reports are issued within established time frames. (CIN: A-03-97-00350)

The FDA is implementing a plan entitled "Team Biologics--A Plan for Reinventing FDA's Ability to Optimize Compliance of Regulated Biologics Industries" to ensure inspection consistency and reporting timeliness.

Improve Blood Establishments' Error and Accident Reporting:

The FDA should ensure that timely error and accident reports are submitted by blood establishments currently required to submit such reports, and should take regulatory action to require that unlicensed blood establishments submit error and accident reports. (CIN: A-03-95-00350)

The FDA is taking corrective actions, including developing and implementing revisions to regulations to require unlicensed blood establishments to submit error and accident reports. The FDA is also using existing systems to identify establishments that do not submit timely reports.

OIG Recommendation	Status
ADMINISTRATION FOR CHILDREN AND FAMILIES AND ADMINISTRATION ON AGING	
<p>Improve the Federal Foster Care Program: The OIG provided options for the Administration for Children and Families (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)</p>	<p>The ACF concurred and has field-tested its redesigned titles IV-B and IV-E child welfare reviews. A draft notice of proposed rulemaking is currently in preliminary clearance. In addition, the child welfare waiver demonstrations are allowing several States to test alternative approaches to the title IV-E requirements.</p>
<p>Develop Effective Practices for Facility Purchases by Head Start Grantees: The ACF should work to develop effective practices for handling facility purchases by Head Start program grantees, particularly in the areas of review and approval of purchase requests, and accounting for facility purchases. (CIN: A-09-94-00085)</p>	<p>The ACF agreed with OIG’s recommendations.</p>
GENERAL OVERSIGHT	
<p>Update 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 Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (CIN: A-01-92-01528)</p>	<p>The Department is revising hospital cost principles to be consistent with OMB Circulars.</p>
<p>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 (PRB) 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)</p>	<p>The OMB has revised Circular A-87 to limit PRB costs to the amount funded, but has no plans to revise Circular A-21. However, the Department has instructed negotiators that PRB costs claimed under Circulars A-21 and A-122 should be treated in the same manner as the provisions of Circular A-87.</p>

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 \$13.9 million.

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

CIN: A-09-97-47397	Santa Barbara County California: Documentation was provided to support questioned costs of \$159,900.
CIN: A-04-94-02080	Finalization of Blue Cross/Blue Shield of Florida Data Match: Total estimated overpayments were reduced by \$83,522.

Not detailed are revisions to previously disallowed management decisions totaling \$5,046.

³ Included in the management decisions during the period are \$50,705 of disallowed costs attributable to audits performed by the Defense Contract Audit Agency.

⁴ 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-06-97-00031	Review of AMP-Searle, Chicago, October 1997, \$28,000,000
CIN: A-05-97-00028	Follow-up Review of Medicaid Overpayments, February 1998, \$20,537,319
CIN: A-09-97-44262	State of California, April 1997, \$7,419,900
CIN: A-09-96-00066	CA Dept of Social Services-Foster Care, September 1997, \$6,611,640
CIN: A-03-91-00552	National Independent Living Program, March 1993, \$6,529,545 (Related recommendation of \$10,161,742 outstanding on Table II)
CIN: A-10-97-48849	State of Oregon, July 1997, \$6,379,395
CIN: A-07-92-00578	Blue Cross/Blue Shield of Texas Incorporated, Unfunded Pension Costs, October 1992, \$6,244,637
CIN: A-07-97-01213	Travelers Pension Termination, February 1998, \$5,624,747
CIN: A-04-96-04575	Audit of ATSDR's Superfund Accounting, June 1997, \$5,360,000
CIN: A-07-97-01028	Review of Training Costs-Kansas, August 1997, \$5,136,647
CIN: A-04-97-04599	Audit of ATSDR's Superfund Accounting, September 1997, \$4,800,000
CIN: A-01-97-46859	State of Massachusetts, May 1997, \$4,798,706
CIN: A-04-97-02136	HCFA/OIG Joint Review-Victoria Behavioral Health Center, January 1998, \$4,510,161
CIN: A-07-96-02001	Medicare Part B Administrative Costs at Blue Cross/Blue Shield of Colorado, December 1996, \$4,483,104

CIN: A-05-94-00080 Associated Insurance Medicare Administrative Costs, July 1996, \$3,954,632

CIN: A-09-96-00064 California Hospice-ORT, March 1997, \$3,450,000

CIN: A-05-93-00054 Illinois Associated Insurance Group Contract Audit, October 1993, \$3,355,560

CIN: A-03-94-00029 Veritus Inc., Administrative Cost Audit, February 1998, \$3,140,363

CIN: A-07-93-00633 Pension Segmentation-AETNA Life Insurance Co., October 1993, \$3,011,376

CIN: A-05-93-00013 Michigan Blue Cross and Blue Shield Contract Medicare Audit, April 1993, \$3,010,916

CIN: A-09-98-50183 State of California, March 1998, \$3,000,000

CIN: A-16-97-43135 State of Texas, February 1997, \$2,987,053

CIN: A-07-92-00585 Pension Segmentation Blue Cross/Blue Shield of California, January 1994, \$2,973,504

CIN: A-01-95-00504 Medicare Parts A&B Administrative Costs-AETNA, January 1996, \$2,938,223

CIN: A-04-98-02147 HCFA/OIG Review Health Management Network Inc., January 1998, \$2,899,083

CIN: A-01-96-00508 Medicare Administrative Costs Parts A&B and Travelers, March 1996, \$2,803,260

CIN: A-07-96-01185 Blue Cross/Blue Shield Rocky Mountain Pension Segmentation, June 1997, \$2,743,438

CIN: A-05-97-00005 Administrative Costs Claimed Under Medicare Parts A&B, February 1998, \$2,569,067

CIN: A-04-97-02137 HCFA/OIG Joint Review-Jerome Feldman CMHS's Partial Hospitalization, \$2,554,314

CIN: A-07-92-00579 Blue Cross/Blue Shield of Michigan Inc., Unfunded Pension Costs, October 1992, \$2,535,698

CIN: A-05-92-00026 Associated Insurance Co. Medicare Administrative Costs, February 1992, \$2,530,409

CIN: A-04-97-02137 HCFA/OIG Joint Review Silver Spring Health Center, January 1998, \$2,382,527

CIN: A-02-91-01006 Blue Shield of Western New York Medicare Administrative Costs, September 1991, \$2,379,239

CIN: A-09-95-00074 ORT-Home Health Professionals-Pasadena, February 1997, \$2,151,179

CIN: A-06-97-46119 Arkansas Dept. of Human Services, August 1997, \$2,054,508

CIN: A-02-93-02001 Manpower Demonstration Corp., October 1994, \$2,024,444

CIN: A-05-97-00029 Follow-up Audit of Healthwin Hospital, November 1997, \$2,000,000

CIN: A-06-96-00009 New Mexico Blue Cross/Blue Shield Administrative Costs, November 1997, \$1,879,366

CIN: A-03-97-00200 Virginia Medicaid Laboratory Fee Schedules, January 1998, \$1,629,750

CIN: A-06-96-00008 Arkansas Blue Cross/Blue Shield Administrative Costs, September 1996, \$1,442,193

CIN: A-04-96-00105 OCS Discretionary Grants Awarded to Delta Foundation, December 1997, \$1,430,000

CIN: A-02-96-42454 City of New York HRA Agency for Child Development, May 1996, \$1,410,441

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

CIN: A-05-95-00042 Blue Cross/Blue Shield Administrative Costs-Contract Audit, December 1995, \$1,333,598

CIN: A-02-98-52102 Puerto Rico Family Dept. Of Children and Families, March 1998, \$1,321,656

CIN: A-02-96-01016 Empire Administrative Costs, April 1997, \$1,296,098

CIN: A-07-93-00700 Blue Cross/Blue Shield of Massachusetts Unfunded Pension Cost Audit, May 1994, \$1,290,740

CIN: A-04-97-02132 Florida CMHS's Partial Hospital Programs, January 1998, \$1,277,591

CIN: A-07-96-01194 Pension Community Mutual Segmentation, July 1997, \$1,263,188

CIN: A-10-97-47406 State of Idaho, April 1997, \$1,262,577 (Related recommendation of \$5,900,000 outstanding on Table II)

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

CIN: A-07-93-00634 Pension Segmentation-Travelers Insurance Co., October 1993, \$1,218,963

CIN: A-02-98-51817 Municipality of Ponce, Puerto Rico, March 1998, \$1,155,022

CIN: A-02-94-01029 Hospice Eligibility Review in Puerto Rico-ORT, June 1995, \$1,070,814

CIN: A-07-94-00763 Health Care Services Corporation, Pension Segmentation, August 1994, \$1,055,458

CIN: A-05-94-00047 Nationwide Insurance-Medicare Part B Administrative Costs, September 1995, \$1,049,309

CIN: A-06-95-00035 Fees Retained by Child Placing Agencies, February 1996, \$988,680

CIN: A-09-94-01010 Closeout Audit of Stratagene, March 1994, \$983,208

CIN: A-09-98-49528 Hawaii Dept. of Human Services, October 1997, \$952,016

CIN: A-05-92-00060 Contractor Audit of Blue Cross and Blue Shield Administrative Costs, February 1993, \$879,609

CIN: A-09-96-00088 The Care Providers HHA, August 1997, \$877,111

CIN: A-02-94-01022 Blue Cross/Blue Shield NJ Administrative Cost Medicare, September 1997, \$864,851

CIN: A-07-93-00701 Blue Cross/Blue Shield of Massachusetts-Pension Costs Charged Audit, July 1994, \$839,740

CIN: A-04-96-02122 Review of Medical Therapy Inc., September 1997, \$761,849

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

CIN: A-07-96-01195 Pension-New Mexico Segmentation, February 1997, \$700,952

CIN: A-07-93-00699 Blue Cross/Blue Shield of Massachusetts-Pension Segmentation Audit, April 1994, \$658,471

CIN: A-02-96-01015 Empire Administrative Costs Part A, April 1997, \$652,492

CIN: A-04-98-02148 HCFA/OIG Review Florida Behavioral Network, Inc., January 1998, \$645,627

CIN: A-07-96-01178 Medicare Pension Costs-Blue Cross/Blue Shield of Michigan, November 1996, \$631,248

CIN: A-04-94-01078 Monitoring Administrative Cost-Medicare Part B, Blue Cross/Blue Shield of South Carolina, July 1994, \$594,092

CIN: A-04-93-01069 Monitoring Administrative Cost Audit Medicare Part A-Blue Cross/Blue Shield of South Carolina, July 1994, \$590,844

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

CIN: A-02-97-47130 Middlesex County Economic Opportunities, June 1997, \$578,550

CIN: A-07-97-01207 Unfunded Pension Community Mutual, July 1997, \$571,413

CIN: A-03-97-00009 Peer Review Systems Inc.-Ohio, March 1997, \$545,405

CIN: A-07-96-01198 Rocky Mountain Unfunded Pension, February 1997, \$543,421

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

CIN: A-03-93-16229 State of Pennsylvania, March 1992, \$496,876

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

CIN: A-06-93-00042 Blue Cross /Blue Shield of Texas Administrative Costs- Medicare Parts A&B, January 1993, \$434,134

CIN: A-07-96-01188 Pro Closeout-Doshi CPA, August 1996, \$432,698 (Related recommendation of \$5,667 outstanding on Table II)

CIN: A-07-97-01235 Doshi-Texas, June 1997, \$424,255 (Related recommendation of \$51,334 outstanding on Table II)

CIN: A-09-98-49239 Hermandad Mexicana Legal Center, November 1997, \$419,364

CIN: A-05-95-00034 Blue Cross/Blue Shield-Medicare Part A Administrative Costs, February 1996, \$416,524

CIN: A-09-96-00089 Monitoring of CPA Med Care Plus HHA, August 1997, \$389,497

CIN: A-04-96-01136 HCFA Survey Team-Savannah ORT, December 1996, \$354,537

CIN: A-04-97-02139 HCFA Review-Community Outreach, January 1998, \$352,061

CIN: A-05-92-00126 Wisconsin Westcap Head Start ACF Request, March 1993, \$347,576

CIN: A-03-97-00587 Little Neighborhood Centers, September 1997, \$328,757

CIN: A-09-96-00096 Mojave HHA Cost Report, July 1997, \$327,304

CIN: A-05-93-25697 West Central Wisconsin Community Action Agency, August 1993, \$324,759

CIN: A-04-96-01150 ORT Review of Flagship Convention Center, Newport CA., April 1997, \$287,564

CIN: A-10-97-49306 State of Alaska, September 1997, \$287,125

CIN: A-04-96-01129 Participating Part of HCFA Survey Team-American Transportation Care-ORT, February 1997, \$284,378

CIN: A-06-97-44962 KI Bois Community Action Foundation, April 1997, \$282,803

CIN: A-05-96-00069 CPA Audit of Hooper Holmes HHS, February 1998, \$280,515 (Related recommendation of \$17,555 outstanding on Table II)

CIN: A-04-96-00107 Review of Selected Head Start Grant Costs, May 1997, \$270,863

CIN: A-09-94-30178 State of Arizona, June 1994, \$267,021

CIN: A-09-96-39178 Arizona Affiliated Tribes Inc., April 1996, \$258,824

CIN: A-07-93-00710 Blue Cross/Blue Shield of Connecticut-Unfunded Pension Cost Audit, March 1994, \$237,392

CIN: A-04-97-01152 Closeout Audit-Michigan PRO, June 1997, \$228,630

CIN: A-04-96-01134 Participating Part of HCFA Survey Team-Colonade Medical, February 1997, \$220,483

CIN: A-09-96-00094 Monitoring of Dynasty HHA Cost Report, July 1997, \$217,720

CIN: A-05-91-00064 Nationwide Administrative Costs Contract Audit, October 1991, \$211,422

CIN: A-09-95-34788 State of Arizona, August 1995, \$209,462

CIN: A-05-96-00052 ORT-Ancillary Costs, Northwest Community Hospital, June 1997, \$206,508

CIN: A-03-98-00014 Connecticut Pro Inc., February 1998, \$202,662

CIN: A-06-96-00064 ORT Skilled Nursing Research at Methodist Hospital, January 1997, \$200,000

CIN: A-05-97-00006 Wayne State University, NIH Request, June 1997, \$195,809

CIN: A-10-96-00007 Idaho Migrant Council Head Start, March 1997, \$192,981

CIN: A-06-97-47756 State of Louisiana, May 1997, \$189,101

CIN: A-05-94-29229 West Central Wisconsin Community Action Agency Inc., March 1994, \$167,977

CIN: A-05-96-00031 WIPRO Equipment Depreciation, August 1996, \$167,033

CIN: A-04-98-49312 State of North Carolina, November 1997, \$164,792

CIN: A-03-97-00016 Quality Improvement Pro Inc./Puerto Rico, February 1998, \$158,925

CIN: A-04-98-49312 State of North Carolina, November 1997, \$153,022

CIN: A-09-92-06850 Santa Ysabel Band of Mission Indians, September 1992, \$151,081

CIN: A-06-98-51473 Chaves County Community Action Program, March 1998, \$148,751

CIN: A-04-96-01147 ORT Review of Parker Jewish Geriatric Center, April 1997, \$140,188

CIN: A-04-98-49864 Head Start of Alamance and Caswell Counties, February 1998, \$137,631

CIN: A-05-92-00048 Wisconsin Physicians Services Pension Medicare vs. Erisa, October 1992, \$130,577 (Related recommendation of \$2,068,964 outstanding on Table II)

CIN: A-07-97-02500 Pension Segmentation BC/BS Connecticut, March 1998, \$122,548

CIN: A-07-93-00709 Blue Cross/Blue Shield of Connecticut-Pension Segmentation Audit, April 1994, \$119,472

CIN: A-02-97-47931 Puerto Rico Administration For Families and Children, May 1997, \$115,225

CIN: A-03-95-03329 Henderson Associates, March 1997, \$111,289

CIN: A-02-96-01001 VNS of NY Home Care, September 1997, \$110,841

CIN: A-02-96-02001 International Rescue Committee-Refugee Program, January 1998, \$108,604
(Related recommendation of \$90,528 outstanding on Table II)

CIN: A-06-98-50301 Community Council of Reeves County, December 1997, \$107,609

CIN: A-03-98-03300 Raymond Maria Group, March 1998, \$102,476

CIN: A-09-98-00051 Colorado Foundation for Medicare Care, January 1998, \$97,858

CIN: A-10-97-00003 BCWAAK Administrative Costs Remote Network Activities FY93&94, February 1998, \$94,643

CIN: A-06-96-43195 Pueblo of Isleta, June 1996, \$92,969

CIN: A-07-95-01164 Medicare Administrative Costs-General American, December 1995, \$89,929
(Related recommendations of \$16,632 outstanding on Table II)

CIN: A-10-98-51510 State of Idaho, March 1998, \$87,000

CIN: A-02-95-34278 Puerto Rico Department of Health, June 1995, \$86,064

CIN: A-02-95-34279 Puerto Rico Department of Health, June 1995, \$85,266

CIN: A-04-96-38655 State of North Carolina, April 1996, \$83,237

CIN: A-01-96-00505 CFO Audit of HCFA Financial Statements, July 1997, \$80,236

CIN: A-05-97-48402 Montgomery County Community Action Agency, July 1997, \$79,374

CIN: A-04-96-01137 HCFA Survey Team-Daytona Nursing-ORT, December 1996, \$76,130

CIN: A-05-97-48530 Jackson Vinton Community Action Inc., July 1997, \$75,392

CIN: A-07-95-01159 Unfunded Pension Costs Nebraska Blue Cross/Blue Shield, January 1996, \$73,509

CIN: A-09-98-50884 Fresno County Economic Opportunities Commission, January 1998, \$70,023

CIN: A-09-97-48489 Pascua Yaqui Tribe of Arizona, June 1997, \$68,736

CIN: A-09-93-00091 Walter McDonald Indirect Cost Rate Audit, June 1994, \$68,663

CIN: A-02-97-43765 Arizona Affiliated Tribes Inc., September 1996, \$66,526

CIN: A-02-95-34275 Puerto Rico Department of Health, June 1995, \$64,841

CIN: A-08-97-46601 Ute Indian Tribe, April 1997, \$62,865

CIN: A-09-98-52225 Nevada Indian Environmental Coalition, March 1998, \$61,645

CIN: A-05-96-00072 Michigan Department of Community Health/Medicaid Lab Services, August 1997, \$59,956

CIN: A-05-96-00051 ORT Assist-Ancillary Costs St. Joseph, June 1997, \$58,008

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

CIN: A-09-97-00059 Health Services Advisory Group-Arizona PRO, May 1997, \$57,925

CIN: A-04-96-01125 Participating Part of HCFA Survey Team-Rosemont-ORT, February 1997, \$55,306

CIN: A-10-97-47406 State of Idaho, April 1997, \$55,012

CIN: A-05-98-51855 Stark County Community Action Agency, March 1998, \$54,933

CIN: A-07-97-01206 Unfunded Pension-Alaska, March 1997, \$54,000

CIN: A-07-98-50741 Citizen Housing Information Council, March 1998, \$52,758

CIN: A-04-97-48932 Gaston Community Action Inc., July 1997, \$52,720

CIN: A-05-98-51302 Kootasca Community Action Inc., February 1998, \$52,000

CIN: A-09-96-41388 Fresno County Economic Opportunities Commission, February 1998, \$50,040

CIN: A-09-95-00095 Health Services Advisory Group, Inc., December 1995, \$49,585 (Related recommendation of \$1,389,723 outstanding on Table II)

CIN: A-03-93-03306 Survey Research Association, December 1993, \$48,779

CIN: A-02-95-34276 Puerto Rico Department of Health, June 1995, \$46,842

CIN: A-05-96-40815 Two Rivers Head Start, February 1996, \$44,349

CIN: A-10-97-49011 State of Washington, July 1997, \$41,772

CIN: A-03-97-44742 Association of Teachers of Preventive Medicine, February 1998, \$37,260

CIN: A-06-95-00037 Research Training for DHHS Oklahoma, October 1996, \$36,563

CIN: A-07-98-02030 Doshi, November 1997, \$35,703

CIN: A-07-97-01218 Doshi, March 1997, \$33,752

CIN: A-06-97-47794 Gulf Coast Community Services Association, July 1997, \$32,619

CIN: A-07-97-01199 Blue Cross/Blue Shield of New Mexico Unfunded Pension Costs, February 1997, \$31,372

CIN: A-09-96-42547 Maricopa County Arizona, April 1996, \$30,766

CIN: A-09-98-49616 State of Arizona, November 1997, \$29,746

CIN: A-05-97-48015 Hoosier Valley Economic Opportunity Corp, May 1997, \$29,004

CIN: A-10-96-41391 Klamath Family Head Start, April 1996, \$26,530

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

CIN: A-05-98-52065 Sokaogon Chippewa Community Mole Lake Band, March 1998, \$22,029

CIN: A-02-97-44455 Community Action Agency of Franklin Co., December 1996, \$21,395

CIN: A-05-96-39685 Michigan Family Resources, December 1995, \$20,799

CIN: A-06-97-48531 State of Texas, July 1997, \$20,697

CIN: A-05-96-43041 Hoosier Valley Economic Opportunity Corp., June 1996, \$20,438

CIN: A-04-97-01163 VIMI Medicare Pro Contract Audit, September 1997, \$18,758

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

CIN: A-03-97-00007 Nebraska Health Care Quality Foundation, March 1997, \$17,045

CIN: A-03-98-51186 Council of the Southern Mountains West Virginia, February 1998, \$16,700

CIN: A-01-97-44143 Brandeis University, January 1997, \$16,602

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

CIN: A-03-97-00008 Nebraska Health Care Quality Foundation-Vermont, March 1997, \$14,596

CIN: A-09-96-00050 HCFA CFO 1996, November 1996, \$13,924

CIN: A-07-95-01175 Mutual of Omaha-Administrative Costs, August 1996, \$13,564

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

CIN: A-03-98-50338 National Medical Association, February 1998, \$12,968

CIN: A-01-97-45487 ABT Associates, January 1997, \$12,950

CIN: A-09-95-00091 Walter McDonald and Associates, Direct Cost Audit, September 1995, \$11,812

CIN: A-01-97-48573 New Opportunities for Waterbury Inc., July 1997, \$10,675 (Related recommendation of \$122,126 outstanding on Table II)

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

CIN: A-04-97-49204 State of Tennessee, September 1997, \$10,269

CIN: A-02-98-49841 Society for Seamens Children Inc, December 1997, \$10,000

CIN: A-10-97-00002 Group Health Institutionalized, November 1997, \$9,769

CIN: A-10-97-48639 Nooksack Indian Tribe, August 1997, \$9,440

CIN: A-06-97048284 East Texas Family Services, August 1997, \$9,130

CIN: A-04-97-01153 MS Foundation-Medicare Pro Audit, September 1997, \$9,070

CIN: A-04-98-49581 Mid-South Foundation for Medical Care Inc., January 1998, \$8,938

CIN: A-09-97-48966 Karidat, July 1997, \$8,905

CIN: A-02-95-34277 Puerto Rico Department of Health, June 1995, \$8,486

CIN: A-06-97-47803 Cheyenne Arapaho Tribes of Oklahoma, May 1997, \$8,321

CIN: A-04-96-04211 University of Alabama, October 1997, \$8,035

CIN: A-07-97-01231 Prowest-Doshi Washington, June 1997, \$8,027 (Related recommendation of \$163,552 outstanding on Table II)

CIN: A-06-97-47756 State of Louisiana, May 1997, \$7,470

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

CIN: A-03-96-38803 Skyline Government Services Corp., November 1995, \$7,285

CIN: A-07-97-01230 OFMQ-Doshi Oklahoma, June 1997, \$7,168

CIN: A-01-97-49174 Brandeis University, August 1997, \$7,068

CIN: A-09-96-00095 A Plus HHA Cost Report, July 1997, \$7,062

CIN: A-02-97-44269 Puerto Rico Dept. of Anti-Addiction Services, October 1996, \$6,586

CIN: A-06-96-40858 Caddo Community Tribe, February 1996, \$6,557

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

CIN: A-08-97-43975 Oglala Sioux Tribe, October 1996, \$6,494

CIN: A-07-95-01167 Pension Costs Claimed Nebraska Blue Cross/Blue Shield, January 1996, \$6,075

CIN: A-01-97-48251 State of Connecticut, June 1997, \$6,035

CIN: A-02-96-02001 International Rescue Committee-Refugee Program, January 1998, \$6,027

CIN: A-06-97-48062 Ser-Jobs for Progress National Inc., May 1997, \$5,924

CIN: A-10-98-50308 Coastal Community Action Program, December 1997, \$5,274

CIN: A-05-98-51316 Community Action Program Inc. of Western Indiana, February 1998, \$5,202

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

CIN: A-03-97-47731 State of Delaware, May 1997, \$5,035

CIN: A-05-97-48671 Stockbridge Munsee Community, July 1997, \$4,968

CIN: A-09-97-48829 Community Action Commission of Santa Barbara County, August 1997, \$4,809

CIN: A-09-97-44435 Commonwealth of Northern Mariana Islands, October 1996, \$4,767

CIN: A-07-95-01123 Review of CPA Administrative Costs-Blue Cross/Blue Shield of Kansas City, May 1995, \$4,045

CIN: A-02-93-26106 Second Street Youth Center Foundation Inc., July 1993, \$3,989

CIN: A-04-97-01162 HMSA Medicare Pro Contract Audit, September 1997, \$3,871

CIN: A-07-97-01233 Prowest Idaho, June 1997, \$3,835 (Related recommendation of \$41,301 outstanding on Table II)

CIN: A-05-96-38947 American Association of Cardiovascular and Pulmonary, December 1995, \$3,827

CIN: A-09-95-39056 Hawaii Dept of Health, September 1995, \$3,601

CIN: A-05-98-50224 West Central Wisconsin Community Action Agency, January 1998, \$3,389

CIN: A-06-98-50840 St. Martin Iberia Lafayette Community Action Agency, February 1998, \$3,362

CIN: A-03-95-03318 Trans Management System, May 1996, \$3,016

CIN: A-06-98-52039 Natchitoches Outpatient Medical Center, February 1998, \$2,700

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

CIN: A-07-98-50741 Citizen Housing Information Council, March 1998, \$2,678

CIN: A-02-97-49366 Seneca Nation of Indians, September 1997, \$2,655

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

CIN: A-08-98-51815 Standing Rock Sioux Tribe of North Dakota, March 1998, \$2,604

CIN: A-03-97-43996 Actuarial Research Corp., October 1996, \$2,561

CIN: A-01-97-47552 State of New Hampshire, May 1997, \$2,184

CIN: A-07-97-01221 Pro Closeout-Doshi CPA, March 1997, \$2,096

CIN: A-03-96-44076 St. Paul's College, August 1996, \$2,029

CIN: A-07-97-01233 Prowest-Doshi Idaho, June 1997, \$1,473 (Related recommendation of \$21,218 outstanding on Table II)

CIN: A-04-96-01161 Medicare Pro Contract, State of South Carolina, July 1997, \$1,294

CIN: A-09-94-01022 Intelligegnetics, October 1994, \$-12,400

CIN: A-09-96-00054 Blue Cross of California Administrative Costs, August 1996, \$-1,653,079

B. The following audits were resolved after September 30, 1998:

CIN: A-01-97-45487 ABT Associates Inc., January 1997, \$2,681

C. The following audits will be closed after completion of the contractor termination audit and resolution of pending lawsuits:

CIN: A-05-94-00064 Michigan Blue Cross/Blue Shield, Audit of Administrative Costs, June 1996, \$15,609,718

CIN: A-07-96-01176 Medicare Excess Pension Assets-Blue Cross/Blue Shield of Michigan, November 1996, \$11,904,263

CIN: A-05-96-00058 Closeout Audit of Blue Cross/Blue Shield of Michigan, December 1997, \$5,226,443

CIN: A-05-95-00059 Audit of Administrative Costs-Blue Cross/Blue Shield of Michigan, January 1997, \$1,787,345

CIN: A-05-93-00057 Michigan Blue Cross and Blue Shield of Michigan Contract Audit, July 1993, \$1,409,954

CIN: A-03-91-02004 West Virginia Blue Cross Administrative Costs FYs 1985/1990 and Termination Costs, November 1992, \$25,200

D. Reports in Litigation:

CIN: A-03-91-02004 West Virginia Blue Cross, November 1992, \$7,556

Table II

¹ The opening balance was adjusted upward to reflect a revaluation of recommendations of \$954,000.

² Included in the total recommendations agreed to by management is \$324,275 resulting from the Defense Contract Audit Agency recommendations.

³ Management decisions have not been made within 6 months of issuance on 10 reports.

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

CIN: A-06-91-00089 Audit of CN B Accounts to Detect Status of IHS Cash on Hand, April 1992, \$445,890

CIN: A-07-97-01230 OFMQ, June 1997, \$203,520

CIN: A-05-96-43154 Muskegon Community Action, June 1996, \$130,993

CIN: A-03-97-48996 North Central West Virginia Community Action, August 1997, \$128,919

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

CIN: A-06-96-43307 Nueces County Community Action Agency, June 1996, \$22,667

CIN: A-06-97-45023 Caddo Community Action Agency, November 1996, \$8,880

CIN: A-01-97-00526 Psychiatric Outpatient Services, March 1998, \$7,245

CIN: A-05-95-37812 Northeast Michigan Community Service, August 1995, \$2,191

B. One report remains open pending the resolution of contractor termination costs, termination audit and pending lawsuits:

CIN: A-07-96-01177 Medicare Post Retirement Claims/Blue Cross of Michigan, November 1996,
\$8,978,998

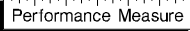
APPENDIX E

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	60
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	62
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	58
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	59
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

Performance Measures

In order to identify work done in the area of performance measurement, the Office of Inspector General (OIG) has labeled some items throughout the semiannual report as performance measures with the symbol . 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.

	Page
Financial Statement Audit of Health Care Financing Administration for Fiscal Year 1997	2
Medicare Beneficiary Satisfaction: 1997	16
Medicare Beneficiaries with Additional Medical Insurance in 1997	16
Physician Perspectives of Medicare Health Maintenance Organizations	18
Beneficiary Perspectives of Medicare Risk Health Maintenance Organizations: 1996	19
Beneficiary Perspectives of Medicare Risk Health Maintenance Organizations - 1996: Beneficiaries with Functional Limitations, Comorbidities and Disabilities	19
Medicare Hospice Beneficiaries: Services and Eligibility	21
Independent Physiological Laboratories	25
Medicaid Managed Care and HIV/AIDS	31
Institutional Review Boards	36
Food and Drug Administration's Citizen Petition Process	36
Cancer Information Service	37
Racial and Geographic Disparity in the Distribution of Organs for Transplantation	37
Health Centers' Access to the National Practitioner Data Bank	38
Use of the 340B Drug Pricing Program	38
Substance Abuse and Mental Health Services Administration's Treatment Improvement Protocols	39
Fiscal Year 1997 Financial Statement Audits	40
State Child Support Enforcement Satisfaction Survey	44
Availability of Health Insurance for Children under the Child Support Enforcement Program: Connecticut	44
Financial Statement Audit of the Administration for Children and Families	50
Business Process Reengineering Pilot	50
Safeguards against Elder Abuse	50
Health Care Antifraud Volunteer Project Performance Measures	51
Financial Statement Audit of the Department for Fiscal Year 1997	54

APPENDIX G

Status of Public Proposals for New and Modified Safe Harbors to the Anti-Kickback Statute

Pursuant to section 205 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Inspector General is required annually to solicit proposals (via Federal Register notice) for modifying existing safe harbors to the anti-kickback statute and for developing new safe harbors and special fraud alerts. In accordance with this requirement, on December 31, 1996, and December 10, 1997, the Office of Inspector General (OIG) published notices in the Federal Register soliciting such proposals. The OIG received 32 timely-filed responses to the 1996 notice and 17 timely-filed responses to the 1997 notice from a cross-section of organizations, associations and other interested parties. Some of these respondents commented generally on areas of concern; others provided detailed proposals for new or modified safe harbor regulations.

The OIG is currently drafting a comprehensive safe harbor rule that will finalize certain proposals for new and clarified safe harbors published in the Federal Register in 1993 and 1994. This rulemaking is in the departmental clearance process and OIG anticipates publication of the final rule in the winter of 1999. A number of respondents to the 1996 and 1997 annual solicitations suggested safe harbors in subject areas already addressed by the 1993 and 1994 notices of proposed rulemaking. Such suggestions (received in response to the annual solicitations) included:

- Investments in ambulatory surgical centers and other facilities where physicians practice, including investment interests held by nonsurgeon and nonphysician investors;
- Investments in facilities in underserved rural areas;
- Benefits offered by hospitals and other entities to retain physicians and other practitioners in the service area;
- Modifications to the existing discount safe harbor;
- Modifications to the existing personal services and equipment leasing safe harbors; and
- Modifications to the existing investment interests safe harbor.

These safe harbor suggestions will be addressed (but not necessarily adopted) in the rulemaking on the 1993 and 1994 proposals.

The OIG is also in the process of promulgating the interim final rule for the shared-risk exception to the anti-kickback statute (section 216 of HIPAA). The parameters of this rule -- which will contain two new safe harbor regulations -- were developed through negotiated rulemaking procedures pursuant to the requirements of HIPAA and the Federal Advisory Committee Act. The Joint Committee Statement of the negotiated rulemaking committee (as well as minutes of committee meetings) is available on the Internet at: <http://www.dhhs.gov/progorg/oig>. This new rule will also address (but not necessarily adopt) certain concerns and proposals for safe harbor protection submitted by respondents to the annual solicitations in the following subject areas:

- Provider sponsored organizations and provider service networks.
- Preferred provider organizations.
- Medicare managed care plans and Health Care Financing Administration managed care demonstration projects.
- State-licensed managed care plans.
- Relationships between managed care organizations and manufacturers relating to use of the manufacturers' products by the managed care organizations' enrollees.

The OIG is continuing to study safe harbor proposals submitted in response to the annual solicitations concerning subject areas other than those addressed in the rulemakings described above. Of course, in crafting safe harbors for a criminal statute, it is incumbent upon OIG to engage in a complete and careful review of the range of factual circumstances that may fall within the

proposed safe harbor subject area, so as to uncover all potential opportunities for fraud and abuse by unscrupulous providers. Having done so, OIG must then determine, in consultation with the Department of Justice, whether OIG can develop regulatory limitations and controls that will be effective in permitting beneficial or innocuous arrangements within the subject area, while at the same time protecting the Federal health care programs and their beneficiaries from abusive practices.

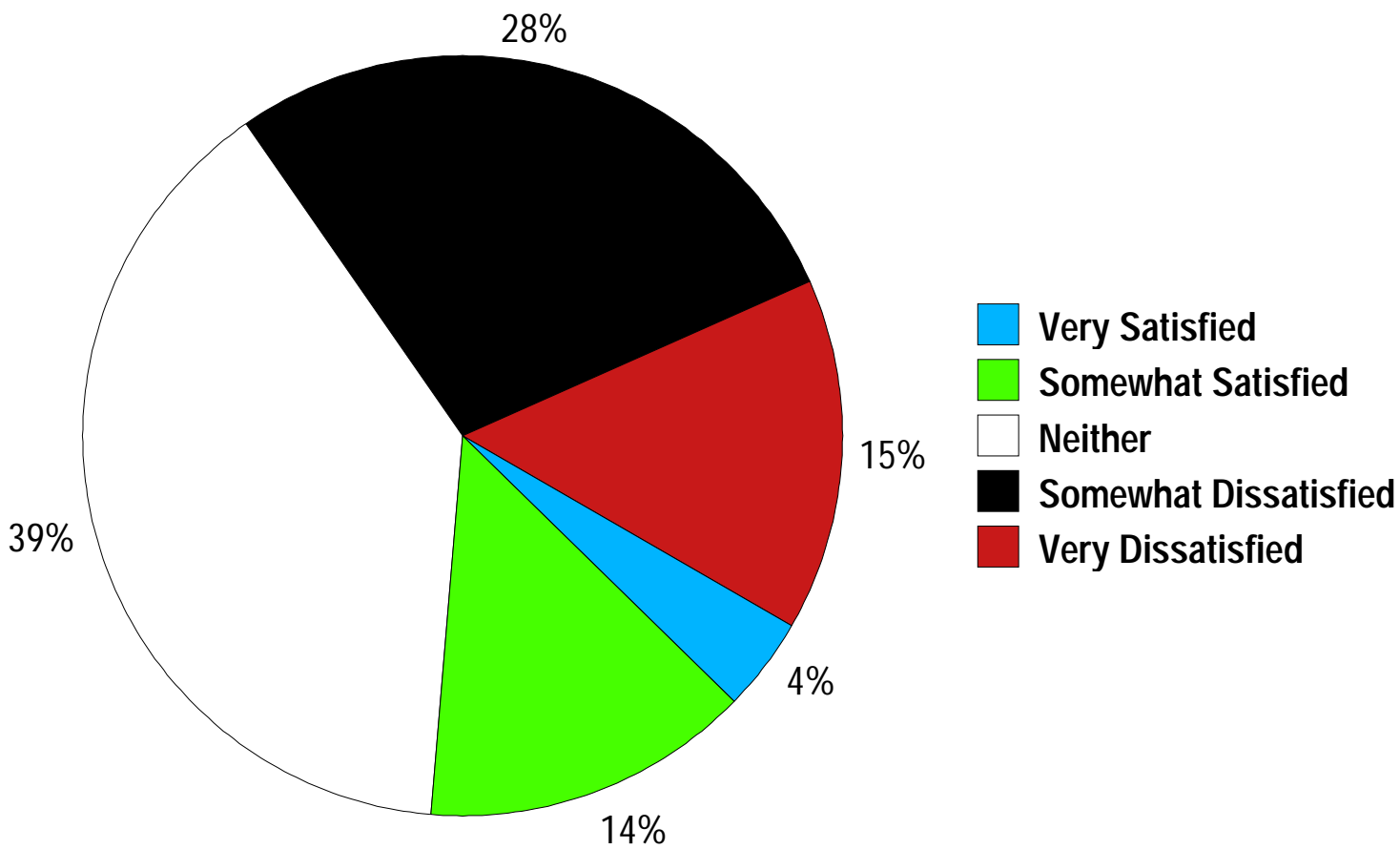
The following safe harbor suggestions (received in response to the annual solicitations) are under review:

- Arrangements between hospitals and emergency medical transport providers pursuant to which the hospitals provide medical supplies and equipment, drugs, and paramedic training and education to ambulance providers without charge. (This practice has been the subject of OIG advisory opinions.)
- Referral of patients for eyeglasses and contact lenses sold by optical stores, regardless of the stores' ownership, and for intraocular lenses furnished during a surgical procedure.
- Arrangements with independent sales representatives and with companies, such as sales service companies, that use their own employed sales force to sell another company's products.
- Continuing education programs sponsored or provided by manufacturers, commercial laboratories and other providers for health care facilities and practitioners with whom they may have referral relationships.
- "*De minimis*" gifts from a provider to a beneficiary who has recommended a new customer to the provider.
- Payments between related entities, including parent companies and wholly-owned subsidiaries.
- Investment interests (as opposed to returns on investment interests protected by existing safe harbors) where the investor is a potential recipient of referrals from the investment entity.
- Loans between parties who may be in a position to make referrals to one another.
- Marketing of managed care plans by independent insurance underwriters.
- Flat rate fees charged to Medicare patients for outpatient surgeries.
- Ownership interests in hospitals held by physicians and group practices, to the extent such ownership is recognized by section 1877 of the Social Security Act (the Stark law).
- Modification of existing safe harbors to conform to the statutory and regulatory exceptions to section 1877 of the Stark law.

ACRONYMS

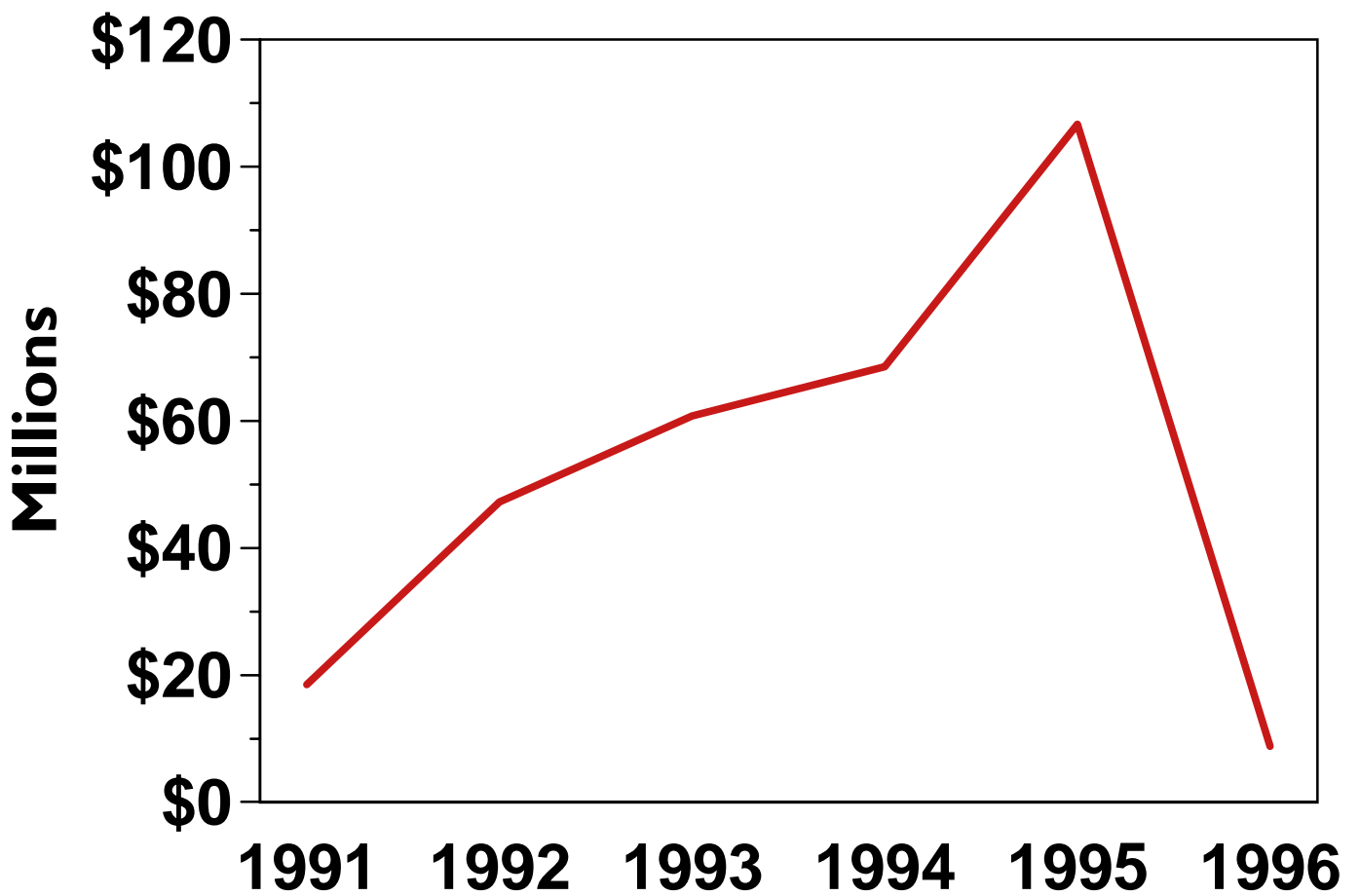
ACF	Administration for Children and Families
AHCPR	Agency for Health Care Policy and Research
AoA	Administration on Aging
ASMB	Assistant Secretary for Management and Budget
ATSDR	Agency for Toxic Substances and Disease Registry
AWP	average wholesale price
CDC	Centers for Disease Control and Prevention
CHAMPUS	Civilian Health and Medical Plan of the Uniformed Services
CHIP	Children's Health Insurance Program
CMP	civil monetary penalty
CSE	child support enforcement
CY	calendar year
DME	durable medical equipment
DMERC	durable medical equipment regional carrier
DOJ	Department of Justice
DRG	diagnosis-related group
DSH	disproportionate share hospital
EA	emergency assistance
EGHP	employer group health policy
ESRD	end stage renal disease
FDA	Food and Drug Administration
FY	fiscal year
GME	graduate medical education
HCFA	Health Care Financing Administration
HCFAC	Health Care Fraud and Abuse Control
HEAL	health education assistance loan
HHA	home health agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPDB	Healthcare Integrity and Protection Data Bank
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
ICF/MR	intermediate care facility for the mentally retarded
IHS	Indian Health Service
IME	indirect medical education
IRB	institutional review board
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
NPRM	notice of proposed rulemaking
OBRA	Omnibus Budget Reconciliation Act
OCSE	Office of Child Support Enforcement
OMB	Office of Management and Budget
PATH	physicians at teaching hospitals
PFCRA	Program Fraud Civil Remedies Act
PHS	Public Health Service
PPS	prospective payment system
PRM	provider review manual
PSC	Program Support Center
SAMHSA	Substance Abuse and Mental Health Services Administration
TANF	Temporary Assistance for Needy Families
TIPS	treatment improvement protocols

PROPORTION OF PHYSICIANS SATISFIED WITH MEDICARE HMOS



[Click on chart to go back](#)

MEDICARE ALLOWED CHARGES FOR MOST EXPENSIVE LYMPHEDEMA PUMPS



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