Department of Health and Human Services

Office of Inspector General

Semiannual Report

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Office of
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ACRONYMS

AARP	American Association of Retired Persons
ACF	Administration for Children and Families
ACR	adjusted community rate
ADR	adverse drug reaction
AHRQ	Agency for Healthcare Research and Quality
ALJ	administrative law judge
AoA	Administration on Aging
ASMB	Assistant Secretary for Management and Budget
ATSDR	Agency for Toxic Substances and Disease Registry
AWP	average wholesale price
BBA	Balanced Budget Act of 1997
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CIN	common identification number
CMP	civil monetary penalty
CSE	child support enforcement
CY	calendar year
DME	durable medical equipment
DOJ	Department of Justice
DRG	diagnosis-related group
ESRD	end stage renal disease
FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FFP	Federal financial participation
FI	fiscal intermediary
FY	fiscal year
GME	graduate medical education
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHA	home health agency
HHS	Department of Health and Human Services
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
IDPN	intradialytic parenteral nutrition
IHS	Indian Health Service
IME	indirect medical education
MCO	managed care organization
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
OBRA	Omnibus Budget Reconciliation Act
OCSE	Office of Child Support Enforcement
OMB	Office of Management and Budget
OPDIV	operating division
PATH	physicians at teaching hospitals
PHS	Public Health Service
PIN	provider identification number
PPS	prospective payment system
PRO	peer review organization
PSC	Program Support Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children’s Health Insurance Program
SNF	skilled nursing facility
TANF	Temporary Assistance for Needy Families
UPIN	unique physician identification number
UPN	universal product number

FOREWORD

As we move through this period of transition to a new administration, the Office of the Inspector General welcomes the opportunity to work with the Department and Congress in our long standing effort to protect the integrity of HHS's programs and their beneficiaries.

In fulfilling our responsibilities as independent and objective fact finders, OIG will continue to focus on ways to help our programs function better, at less cost, with reduced risk of fraud and abuse. As examples of OIG work, the highlights which appear on the following pages describe a few of our successes. Among them—improvement in the Medicare fee-for-service improper payment rate; significant trend-setting settlements with major corporations; initial investigations into the complexities of tissue banking and tissue donor issues; investigations into mental health services in nursing homes and psychiatric care hospitals; and continuing work in child support enforcement.

Though these highlights demonstrate both the scope and breadth of OIG accomplishments, they are but a few of the many examples contained in this report which collectively speak to OIG's commitment to achieving economy, efficiency and effectiveness of operations and services to beneficiaries.

Michael F. Mangano
Acting Inspector General

HIGHLIGHTS

INTRODUCTION

This section highlights the most noteworthy recent accomplishments of the Department of Health and Human Services (HHS) Office of Inspector General (OIG).

STATISTICAL ACCOMPLISHMENTS

For the first half of Fiscal Year (FY) 2001, OIG reported savings of $10 billion, comprised of $9.5 billion in implemented recommendations and other actions to put funds to better use, $335 million in audit disallowances and $249 million in investigative receivables. (See Appendix A and "Resolving Office of Inspector General Recommendations, A. Questioned Costs" and "Investigative Prosecutions and Receivables" in the General Oversight chapter for details.)

In addition, for the first half of the fiscal year, OIG reported 1,610 exclusions of individuals and entities for fraud or abuse of the Federal health care programs and/or their beneficiaries, 213 convictions of individuals or entities that engaged in crimes against departmental programs, and 209 civil actions. (See "Fraud and Abuse Sanctions" in the Health Care Financing Administration [HCFA] chapter and "Investigative Prosecutions and Receivables" in the General Oversight chapter.)

FINANCIAL STATEMENT AUDIT

During FY 2000, the Department achieved an important milestone in financial accountability. In its fifth annual audit of the HHS financial statements, OIG for the second year issued an unqualified, or "clean," opinion. This opinion means that the Department successfully resolved previously reported opinion issues and that the FY 2000 statements fairly presented financial information.

However, OIG found that the Department's financial systems and reporting needed further improvement. An integrated accounting system was still lacking, and accounts were not reconciled and analyzed throughout the year to ensure the accuracy of reported amounts or to identify emerging problems. This deficiency and continuing problems in Medicare electronic data processing controls were reported as material weaknesses.

The OIG also issued its fifth report on the Medicare fee-for-service payment error rate. Based on a statistically valid sample, improper payments totaled an estimated $11.9 billion, or about 6.8 percent of the $173.6 billion in FY 2000 processed fee-for-service payments. While this year's estimate is lower than last year's, OIG cannot conclude that the current estimate is statistically different. This year's estimate is about half that for FY 1996, when OIG developed the first national error rate. (See pages 2, 3 and 65.)

SIGNIFICANT INVESTIGATIVE RESULTS

Through joint investigations with the FBI and other partners in law enforcement, OIG continues to achieve significant investigative results. Following are some of the major cases in which OIG achieved such results during this reporting period.

☐ The Healthcare Corporation

Two subsidiaries of HCA - The Healthcare Corporation (formerly known as Columbia/HCA Healthcare Corporation), a large national hospital chain, pleaded guilty to multiple Medicare offenses in several judicial districts and was fined $95 million. The investigation found wrongdoing in the company's billings to Medicare for inpatient hospital services, laboratory tests, and home health services, and in the company's Medicare cost reports. The Government also determined that HCA engaged in kickbacks in transactions related to acquisition of home health agencies and in its dealings with referring physicians. (See page 13.)

☐ Durable Medical Equipment Manufacturer

In California, the Government entered into a $60 million dollar global settlement with a durable medical equipment manufacturer. The manufacturer engaged in corporate misconduct that misled both the public and the Food and Drug Administration (FDA). The global settlement resolved this California corporation's criminal, civil and administrative exclusion liability stemming from defects in the blood glucose monitoring systems the corporation produced between May 1996 and late 1997. The corporation allegedly knew about the defects but failed to disclose them either to customers or to the FDA in order to obtain FDA approval to sell the device. The corporation also entered into a 3-year corporate compliance agreement with OIG and a 3-year compliance agreement with the FDA. (See pages 22-23.)

MEDICAID ENHANCED PAYMENTS

Acting at HCFA's request, OIG found that some States were exploiting a provision in Medicaid's "upper payment limit" regulations governing enhanced payments to certain providers such as city- and county-owned hospitals and nursing homes. The States would require these public providers to return the bulk of their enhanced payments to the State governments through intergovernmental transfers. Once the payments were returned, the States used the funds for other purposes, some of which were unrelated to Medicaid. The Federal loss resulting from this practice is estimated in the billions of dollars. The HCFA acted quickly on OIG recommendations for regulatory change. The OIG's five reports issued this period covered practices by Pennsylvania, Nebraska, Alabama, Washington and Illinois. (See pages 42-44.)

PRESCRIPTION DRUGS

The following major settlement and report were finalized during this period.

☐ **Bayer Corporation**

In the first settlement of its kind, the Bayer Corporation, a major pharmaceutical manufacturer, agreed to pay the Government $14 million and to enter into a comprehensive 5-year corporate integrity agreement to resolve its civil and administrative liabilities associated with drug price reporting practices for six of its drugs. Specifically at issue were the average wholesale prices (AWPs) that Bayer reported for six of its drugs and misrepresentations that Bayer made to State Medicaid programs and to HCFA. This corporate integrity agreement is unique because, for the first time, it requires Bayer to affirmatively undertake certain drug price reporting obligations, including an obligation to provide certified pricing data directly to the Medicaid programs for all Bayer products reimbursed by Medicaid. Depending on the various State-specific reimbursement parameters, the State Medicaid programs may be able to use this certified pricing data to set more appropriate reimbursement levels for drugs. (See page 23.)

☐ **Medicare Overpayment**

Over the past 5 years, OIG inspections have consistently shown that HCFA is paying significantly more for Medicare prescription drugs than are other public and private organizations. In the latest study, OIG found that Medicare and its beneficiaries would save $1.6 billion a year if 24 drugs were reimbursed at amounts available to the Department of Veterans Affairs. By paying the actual wholesale prices available to physicians and suppliers for these 24 drugs, $761 million a year would be saved. Or, Medicare would save $425 million a year on these drugs by obtaining rebates equal to those in the Medicaid program. (See page 39.)

TISSUE BANKING

In January, the OIG published two inspection reports and testified before a congressional committee on the emerging issue of tissue banking and Government oversight. These reports indicated that the altruistic motives of donor families are the foundation of tissue banking—families expect that the donation will be used to enhance the lives of others and that the donor will be respected. The OIG encouraged joint action among tissue banks, donor families and the Government to develop guidelines regarding the exchange of information with families and the obtaining of their consent at the time of donation. Concerning the oversight of tissue banks, OIG identified situations that indicate the need for vigilance in this area.

The OIG recommended and FDA agreed to expedite the publication of its proposed regulatory agenda requiring registration of tissue banks, enhanced donor screening and testing, the use of good tissue practices and the establishment of a realistic, yet aggressive, date to complete an initial inspection of all tissue banks and determine an appropriate minimum cycle for such inspections. (See page 50.)

MENTAL HEALTH SERVICES

The OIG recently re-evaluated Medicare’s payments for mental health services provided in nursing homes. The study showed 39 percent of psychiatric services in nursing homes were

either medically unnecessary, had no mental health documentation or were questionable. Based on these findings, OIG recommended that HCFA strengthen the billing process for psychiatric services in nursing homes by working to develop better guidelines for such services and identifying a specific psychological testing instrument. Implementing these recommendations could result in a potential savings of $30 million a year. (See page 32.)

The OIG also reviewed psychiatric care hospitals for costs associated with providing outpatient psychiatric services. In an audit of States with the largest dollar volume of outpatient psychiatric services nationwide, OIG found that a large percentage of charges did not meet Medicare criteria for reimbursement. Based on this statistical sample, OIG estimated that for 1998, psychiatric care hospitals in these locations submitted claims to Medicare totaling more than $57 million for unallowable or unsupported psychiatric services. (See page 7.)

CHILD SUPPORT ENFORCEMENT

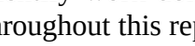
In addition to its audit and inspection work in the area of child support enforcement, OIG has made the detection and prosecution of absent parents who fail to pay court-ordered child support a priority. The OIG has worked with the Office of Child Support Enforcement (OCSE), the FBI, the U.S. Marshals Service and other Federal, State and local partners to develop programmatic and operational procedures to expedite the collection of child support and to bring to justice those who willfully disregard their obligations. Since 1995, OIG has opened 1,391 investigations of child support cases nationwide which have resulted in 393 convictions and court-ordered restitution and settlements of over $22.8 million.

☐ Investigative Task Forces

In 1998, OIG and OCSE initiated “Project Save Our Children,” a criminal child support initiative made up of multiagency, multijurisdictional investigative task forces. The task forces bring together enforcement units from different States within the following geographical regions: the Midwest, Mid-Atlantic, Southwest, Northeast, Southeast and West Coast. The task forces are 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; their goal is to create streamlined systems of referral, investigation and prosecution that will bring to justice the most egregious offenders.

At this point, the task force units have received over 3,200 cases from the States. As a result of the work of the task forces, 133 Federal arrests have been executed and 90 individuals sentenced. The total recovered amount related to Federal investigations is $3.8 million. There have been 289 arrests on the State level and 217 convictions or civil adjudications to date, resulting in $9.7 million in restitution. (See page 55.)

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 

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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: **http://www.hhs.gov/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 certain low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for Supplemental Security Income or the former Aid to Families with Dependent Children program. 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 State Children's Health Insurance Program (SCHIP), created under Title XXI of the Social Security Act, expands health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage. The SCHIP 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 (GME).

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 (HHAs), 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 HHAs; 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 almost 83 percent of Department of Health and Human Services (HHS) outlays. In addition to issuing an opinion on the statements, OIG assesses compliance with Medicare laws and regulations and the adequacy of internal controls.

Improper Fiscal Year 2000 Medicare Fee-for-Service Payments

Performance Measure

The OIG reported that improper payments under Medicare's fee-for-service system totaled an estimated $11.9 billion during Fiscal Year (FY) 2000. This year's estimate is the lowest to date and about half of the $23.2 billion that was estimated for FY 1996, when OIG developed the first national error rate. While this year's estimate is lower than last year's, OIG cannot conclude that the current error rate is statistically different.

The OIG developed the estimate of improper payments with the support of medical experts who together reviewed a comprehensive, statistical sample of Medicare fee-for-service claims expenditures and supporting medical records to determine the accuracy and legitimacy of the claims.

The OIG believes that since the first error rate of 1996, HCFA has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, it clearly shows that the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly and documented properly. As in past years, OIG estimated that over 90 percent of the FY 2000 fee-for-service payments met Medicare reimbursement requirements.

While OIG's 5-year analysis indicates continuing progress in reducing improper payments, there are indicators that unsupported and medically unnecessary services have been and continue to be pervasive problems. These two error categories accounted for over 70 percent

of the total improper payments over the 5 years. The HCFA needs to sustain its efforts to maintain progress in reducing these improper payments. (A-17-00-02000)

Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 2000

Performance Measure

In its audit report on HCFA's FY 2000 financial statements, OIG issued an unqualified opinion of the statements, namely that they present fairly, in all material respects, HCFA's financial position, its net costs, changes in net position, budgetary resources and reconciliation of net costs to budgetary obligations as of September 30, 2000, in conformance with generally accepted accounting principles. However, the audit found that material weaknesses continue in financial analysis and regional and central office oversight, as well as in electronic data processing (EDP) controls.

Overall, the Medicare contractors have made significant improvements in maintaining supporting records for Medicare activities and yearend balances. However, because the contractors lack a formal, integrated accounting system to accumulate and report financial information, they use ad hoc, labor-intensive reports which increase the risk of material misstatement or omission. In addition, Medicare contractor controls over accounts receivable continue to need improvement.

At HCFA's central office, procedures were implemented which resulted in adjustments to accounts receivable balances reported by the contractors. However, these procedures did not ensure that accounts receivable activity included in the contractor financial reports were properly supported by detailed transactions. In addition, the HCFA central office did not have formal procedures documenting financial statement and financial reporting analysis functions, and regional offices did not perform certain procedures to help ensure that financial information provided by the contractors was reliable, accurate and complete.

Further, OIG again found that weaknesses continue in EDP general controls at the Medicare contractors, as well as in application controls at the contractors' shared systems. The HCFA concurred with OIG's recommendations and is in the process of taking corrective action. (A-17-00-02001)

Internal Controls at a Medicare Contractor

As part of a pilot project, OIG evaluated a Medicare contractor's internal controls and financial management of cash and accounts receivable. The review identified several weaknesses, including uncollected overpayments in excess of $750,000, lost monthly income of $23,000 and inadequate reporting of accounts receivable resulting in a $3.3 million overstatement for two quarters, as well as material errors in two quarterly financial statements. The latter resulted in misstatements of at least $51 million. The OIG made specific recommendations to the contractor and pointed out that the review demonstrated the

need to provide Medicare contractors ongoing and in-depth technical assistance. (A-01-00-00535)

Managed Care Payments After the Balanced Budget Act of 1997

The Balanced Budget Act (BBA) of 1997 established the Medicare+Choice (M+C) program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries. The BBA also modified the payment methodology under the M+C program in order to correct excess payments, reduce geographic variations in payments and align managed care organization (MCO) payments to reflect the health status of beneficiaries. Many MCO industry representatives now claim that the payment changes brought about by BBA were too severe and resulting payments are inadequate. Among the reasons cited by the industry are the unintended consequences of higher-than-anticipated inflation, the growing gap in funding between the M+C program and the fee-for-service program and administrative actions taken by HCFA affecting payments. To address these issues, OIG examined data submitted by MCOs and findings from previous reports and studies by various agencies. The OIG report revealed the following significant problems: the basis on which the monthly capitation payment amounts were calculated was flawed; Medicare payments were being used to fund unnecessary administrative costs and excess profits; investment income was not accounted for by MCOs in the Medicare payment formula; and improper payments were made to MCOs for erroneously classified beneficiaries. The cumulative impact is that MCO payments for CY 2000 will be about 95 percent of the average amount paid in the Medicare fee-for-service (FFS) sector. Since MCO payments were established at 95 percent of FFS to account for assumed efficiencies in the MCO sector, the net effect is that MCOs will be paid more than the Congress originally intended. This is in stark contrast to the industry's assertion that it was being adversely impacted by the BBA provision.

Therefore, OIG recommended that HCFA consider all the related OIG recently completed information to modify the present monthly rates to a level fully supported by empirical data. The HCFA agreed with the overall finding that MCO payments are adequate to fund the Medicare package of covered services. (A-14-00-00212)

Medicare Payments for Beneficiaries Reported as Institutionalized

Medicare pays a higher capitation rate for Medicare beneficiaries who are institutionalized than for those who are not. In this report, OIG noted that, between January 1997 and December 1999, a Pennsylvania health plan claimed the higher rate for beneficiaries who were not institutionalized. Based on a statistical sample of claims, OIG estimated that overpayments totaled $306,269 over the 3-year period.

In addition to financial adjustments, OIG recommended that the plan strengthen internal controls for identifying, monitoring and billing the Medicare program for institutional status beneficiaries. The plan agreed that errors occurred within the time frame examined but did not agree to financial adjustment. (A-03-00-00010)

The Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act (EMTALA), passed in 1986, addressed the problem of "patient dumping," a term which refers to situations wherein hospitals fail to screen, treat or appropriately transfer emergency patients. The Act requires that Medicare-participating hospitals provide emergency services regardless of an individual's ability to pay and prohibits them from delaying examination or treatment to inquire about an individual's method of payment or insurance status. The OIG issued the following two reports on this subject during this reporting period:

A. Survey of Hospital Emergency Departments

Performance Measure

The first report described the results of a mail and telephone survey of emergency department managers, doctors, nurses and registration staff, as well as on-call physicians. The OIG found that most emergency department staff were familiar with EMTALA but were unaware of recent policy changes. Private managed care reimbursement practices created special problems in hospitals receiving payment for services required under EMTALA.

The OIG concluded that additional efforts should be made to communicate policy decisions, and legislation compelling managed care plans to reimburse hospitals for EMTALA-related services should be supported. (OEI-09-98-00220)

B. The Enforcement Process

Performance Measure

In this report, OIG examined the mechanisms by which the Federal Government enforces EMTALA. The OIG found that enforcement was compromised by long delays and inadequate feedback, as well as by inconsistency in enforcement across HCFA regions. Tracking systems were inadequate and peer review was not always obtained before HCFA considered terminating a hospital.

The OIG recommended that HCFA increase its oversight of regional offices, improve data collection and access and establish an EMTALA technical advisory group. The HCFA concurred with these recommendations. (OEI-09-98-00221)

Medicare Reimbursement for Critical Care Services

The HCFA, as well as local carriers and practitioners, has voiced concerns about exploitation of critical care codes. However, based on an analysis of claims in 1998 and 1999, OIG found few problems with this aspect of the Medicare program. Ten physician

specialties, all of which could be expected to provide critical care, received 90 percent of Medicare's reimbursement for critical care, while non-physician practitioners accounted for less than 0.09 percent. Medicare carriers were not paying for services that should be bundled into critical care codes. Payments for services beyond the first hour on a given day without a corresponding bill for the first hour on that day dropped 74 percent between 1998 and 1999. The OIG believes that the few problems identified can be efficiently corrected by HCFA requesting carriers to refine payment system edits and clarify or correct local payment policy statements. There were no recommendations issued. (OEI-05-00-00420)

Implementation of Medicare's Postacute Care Transfer Policy

Medicare's postacute care transfer policy provides for reduced inpatient payment rates when PPS hospitals discharge beneficiaries in 10 specified diagnosis-related groups (DRGs) to certain postacute care settings; i.e., skilled nursing facilities, PPS-exempt hospitals (or units within a hospital) and home health agencies.

A. Blue Cross and Blue Shield of Georgia

In this report, OIG estimated, based on a statistical sample, that Georgia hospitals were overpaid about $890,000 in FY 1999 for claims involving these 10 DRGs because the hospitals erroneously coded discharges as discharges to homes rather than discharges to postacute care settings.

Among other things, OIG recommended that HCFA establish edits in its common working file to compare beneficiary inpatient claims potentially subject to the postacute care transfer policy with subsequent postacute claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim. The HCFA concurred with the recommendations. (A-04-00-01201)

B. First Coast Service Options

In this report, OIG estimated that hospitals serviced by the Medicare fiscal intermediary First Coast Service Options received $2 million in excessive payments in FY 1999 because the hospitals incorrectly coded bills as if the beneficiaries were discharged to homes when the beneficiaries had actually been transferred to postacute care settings.

In addition to recommending edits in the common working file to detect this type of erroneously coded claim, OIG recommended several interim measures to HCFA, including issuing a memorandum alerting fiscal intermediaries to the problems identified in this review. The HCFA concurred with the recommendations. (A-04-00-02162)

Outpatient Psychiatric Services

Medicare reimburses psychiatric care hospitals for reasonable costs associated with providing outpatient psychiatric services. The OIG conducted a review in nine States and the District of Columbia and two audits of specific acute-care hospitals.

A. Ten Location Review

For Calendar Year (CY) 1998 review, OIG selected claims from psychiatric care hospitals in California, Connecticut, the District of Columbia, Florida, Illinois, Louisiana, Massachusetts, New York, Pennsylvania and Texas—the locations with the largest dollar volume for outpatient psychiatric services nationwide. In reviewing 200 claims totaling $180,153 from these locations, OIG concluded that $75,413 of the charges did not meet Medicare criteria for reimbursement. The claims identified were not documented in accordance with Medicare requirements and/or not reasonable and necessary. Based on this statistical sample, OIG estimated that for CY 1998 psychiatric care hospitals in these locations submitted claims to Medicare totaling more than $57 million for unallowable or unsupported psychiatric services.

The OIG recommended that HCFA require Medicare fiscal intermediaries (FIs) to increase post-payment review of outpatient psychiatric service claims; require FIs to initiate recovery of payments for claims found in error; and further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, educational sessions and newsletters. The HCFA concurred with all recommendations. (A-01-99-00530)

B. Illinois Hospital

In this report, OIG pointed out that significant numbers of outpatient psychiatric claims by an Illinois hospital for the 15-month period ending November 30, 1997, did not meet Medicare reimbursement requirements. Based on a statistical sample, OIG estimated that unallowable charges totaled nearly $1.9 million for the above period. Specifically, many outpatient psychiatric services were not medically necessary, not supported by medical records or without any medical record. The OIG identified an additional $97,494 in other unallowable costs for meals, patient transportation and other unsupported costs.

The OIG recommended that the hospital work with its FI to make appropriate financial adjustments. Additionally, OIG recommended that the hospital strengthen its controls and procedures to ensure that charges for outpatient psychiatric services are covered and documented in accordance with Medicare requirements and that it develop procedures to exclude unallowable costs from its Medicare cost reports. The hospital concurred with the recommendations to establish procedures and controls to ensure outpatient and cost report compliance. (A-05-00-00034)

C. New York Hospital

An OIG review of a New York hospital concluded that many of the outpatient psychiatric services claimed did not meet Medicare criteria for reimbursement. The OIG estimated that, based on a review of statistically selected claims, at least $2,261,155 in such charges for CY 1997 were unallowable. Specifically, charges for outpatient psychiatric services lacked sufficient patient treatment plans, lacked sufficient medical record documentation and/or were not reasonable and necessary.

In addition to an appropriate financial adjustment, OIG recommended that the hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are reasonable, necessary and properly documented in accordance with Medicare regulations and guidelines. (A-02-99-01010)

Outpatient Rehabilitation Facilities

As part of a national study to determine whether outpatient physical therapy, occupational therapy and speech pathology services were being provided and billed in accordance with Medicare requirements and whether costs reported on the CY 1997 cost report were allowable, OIG conducted audits of the following facilities:

A. Michigan Facility

This final report points out that a Michigan rehabilitation facility claimed payment for outpatient rehabilitation services that did not meet Medicare criteria for reimbursement. Specifically, OIG identified charges for outpatient rehabilitation services that were not reasonable and medically necessary for the beneficiary's condition or were inadequately documented. The OIG review of a statistical sample resulted in an estimate of at least $190,399 paid to the facility for unallowable charges. The OIG also identified additional unallowable costs of $313,220 in unreasonable owner's compensation, contracted costs for which there was not sufficient documentation and other miscellaneous unallowable expenses on the facility's CY 1997 Medicare cost report.

The OIG recommended that the facility work with its fiscal intermediary to make financial adjustments. In addition, OIG recommended stronger controls and procedures to ensure that claims for services are reasonable, necessary and properly documented and to exclude nonreimbursable costs from Medicare cost reports. The facility concurred with the recommendation regarding procedures and controls. (A-05-99-00062)

B. New Jersey

A New Jersey facility claimed payment for outpatient services that did not meet the Medicare criteria for reimbursement. The OIG identified charges for outpatient rehabilitation services that were not reasonable and necessary, lacked sufficient patient treatment plans and/or were not properly supported by medical record documentation. Based on a statistical

sample, OIG estimated that at least $241,774 was claimed by the facility for unallowable charges. The OIG also identified unallowable costs of $56,034 in owner's compensation and miscellaneous unsupported costs on the facility's CY 1997 Medicare cost report. During the audit, this facility voluntarily left the Medicare program. (A-02-99-01026)

C. Texas Facility

A Texas facility claimed payment for outpatient rehabilitation services that did not meet Medicare eligibility and reimbursement requirements. Specifically, the Medicare contractor's medical review personnel identified claims for outpatient rehabilitation services that were not reasonable and necessary, authorized by a physician or supported by medical records. In many cases the facility could not locate any medical records for a claim. As a result, OIG estimated, based on a statistical sample, that at least $3.1 million was paid to the facility for improper charges for FY 1998. The OIG recommended that the fiscal intermediary apply the appropriate financial adjustment during settlement of the facility's FY 1998 cost report. However, the facility is no longer in operation and along with its parent corporation has filed for bankruptcy under Chapter 11. (A-06-99-00057)

Major Hospital Initiatives

The OIG has launched five national projects involving civil actions at hospitals that were falsely billing the Medicare program. Three 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 teaching physicians and to ensure that all claims for physician services accurately reflect the level of service provided to the patient.

Medicare, under Part A of the program, pays the direct costs of training residents through graduate medical education (GME) payments. Medicare also pays an additional amount in recognition of the additional costs associated with training residents, also known as indirect medical education (IME) payments. These payments can total over $100,000 per resident per year. Medicare paid approximately $8 billion to teaching hospitals in 1999 for the cost of training residents. The Medicare payments described above include payments to teaching physicians for their role in supervising residents.

The fundamental tenet of the PATH initiative is that in order to receive a separate payment 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 resident furnished the care.

Physicians claiming reimbursement for services performed by the 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 which result in unwarranted losses 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, eight 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 $98.7 million. As a condition of settlement, most of these institutions have also implemented compliance programs to prevent and detect future improper claims. Reviews completed at four 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, and reviews at two institutions resulted in administrative overpayment settlements, totaling $565,360, with the carriers.

Separately, eight investigations not part of the PATH initiative, but which included billings for teaching physicians, concluded in False Claims Act settlements totaling over $41.1 million. In all of these cases, the providers also entered into corporate integrity agreements with OIG.

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 3-Day Window Project

In 1995, OIG and the Department of Justice (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, double billing for the outpatient service. In addition, the project seeks to

recover for those services rendered to beneficiaries during the inpatient admission that should be included in the 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. The project is primarily coordinated by the U.S. Attorney's Office for the Middle District of Pennsylvania. As of the end of the reporting period, settlements had been executed with 2,799 hospitals and over $73 million had been recovered.

One of the most important aspects of this project is the stipulation in each settlement agreement that each hospital will ensure compliance with proper billing for inpatient and outpatient services. Such compliance measures are designed to prevent and detect erroneous billing. It is hoped that the deterrent effect of possible civil actions, along with promised compliance, will remove this source of improper claims.

C. Hospital Outpatient Laboratory Project

The OIG, DOJ and multiple States joined forces to target false or fraudulent Medicare and Medicaid claims in hospital outpatient laboratories. Based on the results of a project begun in Ohio by OIG, DOJ, the State of Ohio and the Medicare FI, U.S. Attorneys' Offices in other States began their own investigations. This project involved 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 stemmed from the improper unbundling and double billing of laboratory tests and, in certain cases, the billing for certain tests that were not medically necessary. The investigations have also shown numerous instances of billing for additional blood count indices that were not ordered by physicians and were not medically necessary.

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 chemistry tests using a bundled code. The Medicare payment for blood chemistry panels is significantly less than the payments for each test billed separately.

The OIG, DOJ and, in some districts, authorities from other Federal programs, such as TRICARE (the health care benefits program for current and former military employees) and Federal Employees Health Benefits Program (FEHBP), worked together on the national project to provide targeting data to the U. S. Attorneys' Offices interested in pursuing this recovery initiative in their districts. The OIG also collaborated with DOJ to produce a model

settlement agreement including compliance measures which was disseminated to all participating districts throughout the United States.

Thus far, 288 hospitals have entered settlements, totaling more than $63 million, in the Hospital Outpatient Laboratory Project. More hospitals are expected to settle in the near future.

D. PPS Patient Transfer Project

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 receives a graduated per diem payment based on the length of stay and the DRG for the case, but no more than the full DRG payment amount; the hospital receiving the transferred patient is paid the full DRG payment amount.

The OIG found, however, that since 1986 many transferring hospitals inappropriately claimed 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 $232 million. Currently, OIG is working with U.S. Attorneys' offices nationwide, along with HCFA, on this continuing problem. The HCFA is preparing a program memorandum to address the collection of overpayments. To date, OIG has settled PPS cases with three hospitals, totaling over $2.2 million. In addition, reviews at three institutions resulted in administrative overpayment settlements in the amount of $1,144,135.

E. Pneumonia Upcoding

Medicare inpatient hospital stays are reimbursed based on the DRG that is assigned to the patient's stay. The determination of the appropriate DRG for a particular case depends upon the hospital's assignment of diagnosis code(s) and procedure codes from the International Classification of Diseases, 9th Revision, Clinical Modification to the inpatient stay. Most pneumonia cases are grouped into one of four DRGs, one of which results in significantly higher payment to the hospital than do the others. Most pneumonia cases are grouped into the lower-paying DRGs. The OIG found that a small percentage of hospitals across the country have assigned a disproportionate number of pneumonia cases diagnosis codes that result in a discharge being assigned the higher paying DRG. Review of the medical records has demonstrated that most of the cases should have been assigned a diagnosis code that would result in assignment of a lower-paying DRG.

The OIG is currently investigating the coding for pneumonia at over 100 hospitals. To date, 23 hospitals have settled their liability for such coding by paying over $23.7 million and agreeing to corporate integrity requirements.

Other Hospital Investigations

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

- Columbia Homecare Group, Inc. (CHG) and Columbia Management Companies, Inc. (CMC), pleaded guilty to multiple Medicare offenses in several judicial districts and were fined $95 million. The guilty pleas were entered pursuant to a plea agreement with CHG's and CMC's parent company, HCA - The Healthcare Corporation (formerly known as Columbia/HCA Healthcare Corporation), a large national hospital chain. CHG pleaded guilty to: (1) one count of receiving unlawful remuneration in violation of the kickback statute for home health acquisitions in the Northern District of Georgia; (2) one count of conspiracy for home health acquisitions in the Southern District of Florida; and (3) one count of conspiracy for home health acquisitions in the Middle District of Florida. CMC pleaded guilty to: (1) eight counts of making false statements and representations for cost report fraud in the Middle District of Florida; (2) one count of conspiracy for diagnosis-related group (DRG) upcoding in the Middle District of Tennessee; and (3)one count of conspiracy related to kickbacks to physicians in the Western District of Texas.

  The OIG and HCA have entered into a comprehensive 8-year corporate integrity agreement (CIA) that is unprecedented in the scope and detail of its auditing provisions. HCA has also agreed to pay the United States $745 million in a civil settlement. When the civil settlement becomes final (expected to occur during the second half of FY 2001, it will resolve five issues: (1) upcoding of DRGs; (2) hospital lab unbundling and billing for medically unnecessary lab tests; (3) kickback and cost report (e.g., related party) violations arising from a series of acquisitions of home health agencies; (4) charging marketing costs as home health community education; and (5) billing for non-covered home health services.

- The U.S. Attorney's Office in New York entered a stipulation and order of settlement and dismissal to settle a civil case against a medical center. The medical center agreed to pay the Government $1.25 million to resolve its civil liability for obtaining an overpayment from Medicare relating to ancillary pharmacy billings. The complaint filed alleged that the medical center submitted claims and received payment for ancillary pharmacy items not covered under Medicare. In addition, the medical center agreed to enter into an institutional compliance agreement to supplement its existing compliance plan.

- A medical center agreed to pay the Government $1.2 million and to enter into a 5-year corporate integrity agreement to resolve a qui tam suit filed in Georgia. From July 1995 to October 1998, the medical center improperly submitted claims for 1-day hospital admissions; improperly upcoded DRGs; and improperly included on cost reports the salary expenses for a nurse who did not perform 100 percent of her time on reimbursable patient care. Additionally, a physician named in the qui tam suit paid the Government $9,383 to settle allegations against him; and a second physician paid $5,715 to settle a civil action against him for similar misconduct. Although a registered nurse (RN) is not qualified to perform histories and physicals, the physicians improperly used an RN at the medical center to perform these services for their hospital patients.

- In Pennsylvania, a small rural hospital and a medical practice providing anesthesia services to the hospital agreed to pay the Government a total of $700,000. The settlements resolved allegations that from 1993 to 1998 the hospital and medical practice were not billing anesthesia services in compliance with Medicare rules governing their coding, documentation and reimbursement. The settlement agreement with the hospital also provided for the hospital to continue implementing its existing corporate compliance program.

- A Kentucky hospital agreed to pay the Government $226,164 for allegedly submitting improper claims between May 1996 and February 1999. The settlement agreement resolves the hospital's liability for submitting false claims to Medicare and Medicaid for more expensive cardiac catheters than were actually used at the hospital's cardiac catheterization laboratories. The settlement agreement also requires the hospital to make a good faith attempt to adjust the patient accounts of Medicare beneficiaries whose copayments may have been inflated due to the hospital's improper claims. The hospital also agreed to abide by extensive compliance obligations for a 3-year period.

Industry Guidance

The OIG has continued to issue advisory opinions, special fraud alerts, special advisory bulletins and other guidance as part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry. For the period from October 1, 2000, through March 31, 2001, OIG accepted nine advisory opinion requests and issued six advisory opinions. In accordance with the Health Insurance Portability and Accountability Act of 1996 (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. The OIG received 3 timely filed responses to the December 2000 notice.

Criminal Fraud

One of the most common types of fraud perpetrated against Medicare, Medicaid and other Federal health care programs involves the filing of false claims or statements. Such false claims may be pursued civilly under the False Claims Act (for example, the hospital initiatives described in pages 9-12). In appropriate cases, false claims may also be prosecuted criminally as Federal offenses such as mail fraud, wire fraud, false statements and various health care fraud offenses. The successful resolution of these matters often results from combining investigative efforts and resources with the FBI and other law enforcement agencies. Following are descriptions of criminal prosecutions which resulted from the investigation of both false claims-related offenses and other health care-related offenses during this period:

- A physician and three others were sentenced in Washington following guilty pleas to health care fraud, mail fraud and conspiracy. The physician was sentenced to 35 months imprisonment, 3 years probation and payment of $470,710 in restitution. One individual was sentenced to 6 months home detention, 5 years probation and payment of $30,000 in restitution. The second individual was sentenced to 10 months home detention, 5 years probation and payment of $30,000 in restitution; and the third was sentenced to 5 years probation, 500 hours of community service and payment of $10,000 in restitution. The defendants were owners and operators of clinics located throughout the greater Seattle, Washington, area. The clinics provided noncovered services such as acupuncture, nutrition counseling and massage therapy but billed Medicare and other insurers for physician office visits.

- A Michigan chiropractor was sentenced, for health care fraud and mail fraud, to 18 months confinement in a community correctional facility, 3 years supervised release and payment of $343,771 in restitution. As the owner of a medical center in Michigan, the chiropractor submitted claims to Medicare and a private insurer using another physician's PIN in order to bill for services outside his field of chiropractic medicine.

- The owner of a rehabilitation and wellness clinic in Texas was sentenced to 24 months confinement and payment of $186,622 in restitution. A registered nurse employed by the clinic was also sentenced to 21 months confinement and payment of $124,000 in restitution. The defendants defrauded Medicare and Medicaid by billing physical therapy and psychological services provided by unsupervised, unlicensed clinic employees as though

directly supervised by a physician. To perpetrate the scheme, the defendants used a physician's signature stamp and photocopies of a physician's signature on patient evaluation and prescription forms.

- In New York, a clinical social worker was sentenced to 2 years incarceration, 3 years supervised release and payment of restitution totaling $171,235 to Medicare and a private insurer for health care fraud. The social worker, who is also a retired probation officer, billed both insurers for psychotherapy services not rendered to several elderly beneficiaries. He also improperly billed and received reimbursement for psychotherapy services he purportedly provided to his mother; billing for services on behalf of an immediate family member is against both insurers' regulations and represents a professional conflict of interest.

- In Arizona, a woman was sentenced to 15 months imprisonment (with 12 months time served), 3 years probation and payment of more than $88,000 in restitution for fraud and related activity in connection with identification documents and false statements relating to health care matters. The woman stole the identity of a person in Vermont more than 3 years ago; she then incurred medical bills across the country in the victim's name by feigning illness in an effort to obtain drugs. Due to her actions, the Arizona Medicaid program alone incurred more than $51,000 in medical expenses, including a medical helicopter ride from a remote Arizona town to a regional medical facility.

- A Maryland podiatrist was sentenced to 6 months home detention, 2 years probation and $3,100 in fines for mail fraud. The podiatrist submitted false claims to Medicare and TRICARE by billing for noncovered whirlpool treatments and by billing under evaluation and management codes when he actually provided routine foot care. In an earlier civil settlement, the podiatrist agreed to pay the Government $301,000. He also agreed to be permanently excluded and to surrender his medical license.

- In Pennsylvania, a physician was sentenced to 13 months incarceration, 3 years supervised release and $3,300 in fines for mail fraud and health care fraud. In 1990, the physician was also convicted of Medicaid fraud in New York for his role in submitting false claims for DME supplies not provided to patients. As a result of this conviction, the physician was sanctioned from participating in the Medicare and Medicaid programs for a 5-year period effective January 1992. After serving 3 years probation, the physician relocated from New York to Pennsylvania where he entered into residency training at a medical school. In 1996, he became a licensed Pennsylvania

physician able to participate in various health insurance plans, including Medicare and Medicaid. The physician failed to disclose to Medicare, Medicaid, his employers, the licensing board and various private health insurance plans that he was both a convicted felon and an excluded provider. He created false histories of his past by disseminating fraudulent resumes concealing his prior criminal conviction.

- A New York chiropractor was sentenced to 27 months imprisonment, 3 years probation and payment of $133,171 in restitution for false claims and mail fraud. Along with several of her employees and patients, the chiropractor submitted false claims for chiropractic and physical therapy treatments. The chiropractor entered into agreements with her office staff through which the workers billed for treatments for themselves and other family members that were not rendered. The physical therapy treatments were billed under the provider number of a physician who shared office space with the chiropractor. The chiropractor then cashed the insurance reimbursement checks against a joint account she shared with the physician. The chiropractor and her employees split the proceeds from the reimbursement checks. The chiropractor also billed Medicare and private insurance companies for physical therapy and chiropractic services when she actually provided massage therapy.

- A Pennsylvania podiatrist was sentenced to 6 months home detention and 18 months probation for obstruction of a Federal audit. During a Medicare Review Audit of the podiatrist's patient records, a consultant found that the physical therapy modalities the podiatrist billed were medically unnecessary. Moreover, the modalities billed were so excessive that patients would have been severely burned or harmed if they actually received the services documented in the podiatrist's records and billed to Medicare. During the course of a subsequent audit, the podiatrist admitted that he fabricated the patient records furnished to Medicare review for purposes of the audit. Based on his plea to obstruction of a Federal audit and the fact that he is $187,000 in default on a HEAL loan, the podiatrist will also be excluded from the Medicare program.

Kickbacks

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

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

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

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

Violators are subject to criminal penalties and to exclusion from participation in Federal health care programs. They may also be subject to civil monetary penalties (CMPs). The following cases are examples of anti-kickback enforcement actions:

- In Michigan, the Government settled a civil False Claims Act case as part of a global resolution to a matter involving an osteopathic physician allegedly involved in several fraudulent schemes concerning nursing home patients. Through these schemes, the osteopath allegedly submitted false claims to Medicare for services furnished to residents in nursing homes that were either upcoded or never provided. As part of the settlement agreement, he agreed to pay the Government $2 million and the State of Michigan $47,751. The osteopath also allegedly accepted kickbacks for referring residents (ineligible for hospice services) of nursing homes he owned to a hospice for which he was the medical director.

- A Florida physician was sentenced to 144 months imprisonment for conspiracy to dispense and distribute controlled substances outside the course of professional medical practice. She was also sentenced to 57 months imprisonment for conspiracy to defraud the Medicare program and 10 months for conspiracy to solicit and receive kickbacks in return for ordering Medicare services and for referring Medicare beneficiaries. In addition to these sentences, which are to be served concurrently, the physician was also sentenced to 5 years supervised release and payment of $229,384 in restitution. In December 1999, a 351-count superseding indictment charged her with both drug related offenses and health care fraud related offenses. The indictment alleged that the physician routinely wrote large quantities of prescriptions for highly addictive pain medication, billed Medicare for services not provided and upcoded patients' office visits. A second individual was also sentenced to serve 192 months imprisonment and 5 years supervised release and was ordered to pay a total of $56,400 in fines for drug-related offenses. Through his pharmacy, the individual

dispensed in excess of one million doses of highly addictive pain medication based upon prescriptions written by the physician. Furthermore, the individual knowingly filled hundreds of invalid prescriptions that the physician had prewritten and which contained false information.

- A New York cardiologist paid $30,000 and entered into a 3-year physician integrity agreement to resolve OIG's CMP law case against him for payment of kickbacks. The cardiologist made a series of small payments to an internist to induce the internist to refer his patients, including Medicare beneficiaries, to the cardiologist for diagnostic testing. The OIG initiated the action based upon its CMP authority for remuneration offered, paid, solicited or received after August 5, 1997.

- A Georgia DME company owner was sentenced to 2 years probation, 4 months home confinement and payment of $8,100 in restitution for illegal kickback activity. The DME company owner paid kickbacks to a podiatrist in return for the referral of patients requiring lymphedema pumps. In August 2000, the podiatrist was also sentenced for violating the anti-kickback statute.

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 1,819 administrative sanctions, in the form of program exclusions or civil actions, on individuals and entities for engaging in fraud or abuse or other activities deemed to be a risk to Federal health care programs and/or their beneficiaries.

A. Program Exclusions

Title XI of the Social Security Act provides a number of bases for excluding individuals and entities from participation in Medicare, Medicaid and other 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 to practice 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 or unnecessary services. Exclusions may also be imposed on those convicted of a misdemeanor for private insurance fraud or of obstruction of an investigation and on individuals who have failed to repay health education assistance loans (HEALs). (See page 51 for further information on exclusions for HEAL defaults.)

During this reporting period, OIG imposed exclusions on 1,610 individuals and entities. The following are examples of some of the exclusions that were imposed:

- A Florida registered nurse was excluded for 25 years based on her conviction for participating in a conspiracy by HHAs to fraudulently submit Medicare claims and her previous 10-year exclusion from Medicare, Medicaid and all Federal health care programs (instituted after an earlier conviction for a program-related offense). In the scheme which led to her second conviction and exclusion, she allowed her name to be used on fraudulent claims, even though she had neither seen nor provided care to the patients. The court ordered her to serve 18 months in prison and pay more than $19,000 in restitution.

- In Tennessee, a chiropractor was excluded for 15 years based on his patient abuse and health care fraud convictions. His first conviction resulted from his plea of nolo contendere to sexual battery. The court ordered him to be incarcerated for 109 days. His second conviction was for submitting a claim for physical therapy services not performed by a physical therapist. This time the court sentenced him to 8 months in jail and ordered him to pay approximately $9,000 in restitution.

- After being convicted for his role in a scheme to defraud the Maine Medicaid program and the Social Security Administration, a disabled Medicaid recipient was excluded for 5 years. This individual submitted false claims for himself and another individual for transportation and medical services that were not provided to them. The court ordered him to pay restitution in excess of $44,000.

- A 25-year exclusion was implemented against a physician who was convicted twice in Florida. His first conviction was for practicing medicine without a license. The doctor, who had also been convicted previously in New York for the same offense, was ordered by the court to spend 1 year in jail and pay restitution of $24,000. His second Florida conviction involved health care and mail fraud. The physician was found guilty of executing a scheme for obtaining fraudulent medical school documents which, in turn, enabled him to become a licensed Florida physician. He then represented himself to be a qualified and validly licensed physician and thus was able to bill health care programs through the mail for services he provided to patients. The court ordered him to be incarcerated for 39 months and pay almost $5 million in restitution.

- An individual was excluded for 5 years based on his conviction for health care fraud and the unlawful acquisition and distribution of controlled substances. He used the Maine Medicaid program to pay for controlled substances which he then unlawfully distributed. The court sentenced him to 18 months in jail and ordered him to pay over $1,000 in restitution.

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 or if the patient requests to be transferred after being advised of the inherent risks. 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 small hospitals (less than 100 beds) and up to $50,000 against larger hospitals (100 beds or more) for each instance in which the hospital negligently violated any of the section 1867 requirements. In addition, OIG may impose a CMP of up to $50,000 against a responsible physician, including an on-call physician, for each negligent violation of any of the section 1867 requirements.

Between October 1, 2000, through March 31, 2001, OIG collected $325,250 in settlement amounts from 15 hospitals and physicians. The following is a sampling of the alleged violations involved in the FY 2001 Patient Anti-Dumping Statute settlements from this reporting period:

- An Oklahoma hospital settled for $40,000 an allegation that it refused to accept the appropriate transfer of a patient who had been critically injured in an automobile accident and required emergency vascular surgery. The transferring hospital did not have the specialized capabilities or facilities that were required to treat the life-threatening injury to the patient's abdominal aorta. After numerous calls to hospital emergency rooms and

physicians, the patient was eventually transferred to a hospital where surgery was performed in an unsuccessful attempt to save his life.

- An Ohio physician agreed to pay $20,000 for an allegation that he failed to stabilize an individual who had an unstable emergency medical condition. Hours after being discharged from the emergency room, the patient presented to another hospital where he was admitted and treated for 10 days.

- A Utah hospital settled for $40,000 an allegation that it inappropriately transferred a high risk obstetrics patient. The patient had been transferred to the hospital via an ambulance. She was being prepared for delivery when the patient's insurance company related that it would not pay for delivery at that hospital. As a result, the patient was transferred yet again to another hospital where she immediately had an abrupted delivery.

- A Missouri hospital agreed to pay $40,000 for allegations that it denied screening exams to two patients because their primary care physicians apparently denied payment authorization for treatment. In addition, one patient was not transferred in complete compliance with EMTALA transfer requirements.

- A Virginia hospital paid $30,000 to settle an allegation that it inappropriately transferred a patient to a psychiatric hospital without completing an appropriate medical screening of his physical complaints or providing stabilizing treatment.

C. Civil Penalties for False Claims

Under the civil monetary penalties (CMP) authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers and others who submit false or improper claims to Medicare and other Federal health care programs. 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 a provider in the Medicare program. The integrity programs established by these agreements are designed to prevent a recurrence of the fraudulent activities that gave rise to the case at issue. The Government, with the assistance of OIG and often the FBI and other law enforcement agencies, recouped more than $99.8 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 the following:

- Based upon a cooperative effort among the FDA, DOJ and OIG, the United States entered into a global settlement for $60 million with a California

corporation that develops, designs, manufactures, distributes and sells blood glucose monitoring systems. The global settlement involved a misdemeanor guilty plea and resolved the company's criminal liability for certain FDA reporting violations and its civil liability under the False Claims Act and CMP law for introducing and delivering into interstate commerce an adulterated and misbranded medical device for which Federal and State health care programs (including Medicare, VA and TRICARE) paid. This settlement also resolved the company's administrative exclusion liability.

To resolve concerns related to future compliance issues, the FDA required as part of Special Conditions of Probation that for the next 3 years the company engage in extensive training, review and reporting requirements. In addition, in exchange for OIG's exclusion release (the misdemeanor plea did not result in a mandatory exclusion) and to address Federal health care program compliance concerns, the company entered into a 3-year corporate compliance agreement that supplements the FDA compliance requirements.

- In the first settlement of its kind with a major drug manufacturer, the United States recently settled a qui tam False Claims Act case with the Bayer Corporation. Under the terms of a settlement negotiated by a team of Federal and State law enforcement officials, Bayer agreed to pay $14 million and enter a comprehensive 5-year corporate integrity agreement with OIG to resolve its liability to the Medicaid program. Through the settlement, Bayer resolved its liability under the False Claims Act, CMP law and the Medicaid Rebate statute for its conduct in connection with six of its drugs (the qui tam drugs) between January 1993 and August 1999. Bayer allegedly (1) knowingly set and reported average wholesale prices (AWPs) for the qui tam drugs at levels far higher than the actual acquisition cost of the majority of its customers and caused those customers to receive excess Medicaid reimbursement; (2) made misrepresentations to the Medicaid programs of certain States; and (3) knowingly misreported and underpaid its Medicaid Rebates for the qui tam drugs.

  This corporate integrity agreement is unique because it requires Bayer to affirmatively undertake certain drug price reporting obligations, including (for the first time) an obligation to provide certified pricing data directly to the Medicaid programs for all Bayer products that are reimbursed by Medicaid. Ideally, the State Medicaid programs will be able to use this certified pricing data to set more appropriate reimbursement levels for drugs.

- An HMO in Illinois entered into a $2.9 million settlement agreement and a corporate integrity agreement to resolve allegations of defrauding Medicare. The investigation began in 1998 after an audit by OIG showed that the HMO was falsely reporting the status of Medicare beneficiaries. As a result of upcoding beneficiaries to an institutionalized status, the HMO was receiving approximately double the monthly capitation rate paid to an HMO by Medicare. In order to qualify for this higher monthly capitation rate, the beneficiary must have been in an institution, such as a hospital, nursing home, or psychiatric facility for 30 consecutive days.

- In Arizona, a clinical laboratory agreed to pay the Government $1.5 million to resolve a qui tam suit. The laboratory also agreed to maintain its current compliance program for the next 3 years following execution of the settlement. The relator alleged that, from the 1980's to the present, the laboratory submitted false claims for medically unnecessary and unordered lab tests. The investigation determined that, between 1989 and 1993, the laboratory marketed, sold, priced and billed Federal health care programs for apolipoprotein tests (APOs) as part of the laboratory's lipid profile and executive profile lab tests. The laboratory knew the APOs were not specifically ordered by a physician and were not medically necessary.

- Five physician groups in multiple jurisdictions settled allegations arising from a qui tam law suit, which revealed that they employed a billing agency that submitted upcoded emergency room services to Medicare, Medicaid, TRICARE and FEHBP on their behalf. Under the terms of the settlement agreement, the physician groups have agreed to pay a combined total of $581,303. In addition, one of the physician groups entered into a corporate integrity agreement.

- In California, the estate of a deceased physician entered into a settlement agreement with the Government to resolve his civil liability for improper Medicare claims submitted from July 1996 through December 1996. The Government will recover $403,838 from the estate. The physician, who owned three medical clinics in California, died in a car accident in March 1999. The estate is resolving his liability for billing Medicare for procedures and services not authorized, not medically necessary, not rendered or upcoded. The estate also agreed to waive $43,838 in withheld Medicare funds.

- Two physicians located in Texas have agreed to pay a combined amount of $182,986 to resolve their respective liabilities under the False Claims Act, CMP law, and OIG's exclusion authority. The physicians were alleged to

have admitted Medicare beneficiaries to a hospital when hospitalization was not medically necessary. Both physicians have agreed to be permanently excluded from participating in any Federal health care programs.

- Two licensed clinical social workers, employees of a hospice facility that previously settled a case with OIG, located in Michigan agreed to pay a total of $110,000 to resolve allegations that one of the clinical social workers made false certifications of terminal illnesses, while the other falsified patients' psychosocial assessments.

- A former anesthesiologist practicing in Maine and an anesthesia practice agreed to pay the Government $79,000 to resolve their civil liability under the False Claims Act and the CMP law. Between 1993 and 1996, the former anesthesiologist submitted improper claims to Medicare, Medicaid and TRICARE for anesthesia services which did not meet the minimum criteria for the categories of service billed. In several instances, the anesthesiologist billed for services performed by certified registered nurse anesthetists (CRNAs) as though he personally provided the service. In other instances, the anesthesiologist was not even in the hospital at the time the CRNA rendered the service. Additionally, in 1997 the anesthesiologist submitted claims to Medicare, Medicaid and TRICARE for services provided by physicians who were paid by the hospital. As part of the settlement, the anesthesiologist must annually certify that he is not involved in the submission of claims to Federal health care programs.

- A behavioral health company in Louisiana agreed to pay the Government $50,000 to resolve its civil monetary penalty liability for alleged misconduct by the company's predecessor owner. The facility allegedly submitted false claims for medically unnecessary psychiatric hospital services, as well as for poor quality services. The settlement figure represents the amount billed to care for Medicare patients an expert determined were inappropriately admitted. In addition, the company entered into a 3-year corporate integrity agreement with OIG.

D. Compliance Activities

The existence of an "effective" compliance program can offer an organization certain credit under the Federal Sentencing Guidelines which would ameliorate a sentence in a criminal matter. This and other benefits have served to encourage the private sector to develop methods to prevent the submission of improper claims and inappropriate conduct and to detect violations of Federal fraud and abuse laws, including the False Claims Act and the CMP law. The OIG has already initiated significant outreach efforts with the private sector to encourage these compliance endeavors.

The OIG continues in its efforts to promote voluntarily developed and implemented compliance programs by providing guidance for the various sectors of the health care industry. To this end, OIG has developed and released compliance program guidance for clinical laboratories, hospitals, HHAs, third-party billing companies, DME, prosthetics and orthotics suppliers, hospices, Medicare+Choice organizations that offer coordinated care plans, nursing homes, and individual and small group physician practices. The OIG is currently working on compliance guidance for ambulance service providers.

With respect to guidance and outreach to the physician community, OIG obtained significant input from physicians regarding its compliance program guidance for individual and small group physician practices. The physician guidance highlights the seven elements of effective compliance programs set forth in the Federal Sentencing Guidelines. However, OIG adapted these seven elements to reflect the staffing and financial constraints faced by many individual and small group physician practices. The guidance contains four main risk areas: coding and billing; reasonable and necessary services; documentation, including medical record documentation and HCFA 1500 forms; and kickbacks, inducements and self-referrals. The guidance is intended to serve as a useful resource for physician practices and includes several appendices providing additional information. These appendices contain additional risk areas that physician practices should be familiar with; summaries and examples of civil, administrative and criminal statutes related to the Federal health care programs; carrier contact information; and a listing of related Internet resources.

As noted in the Federal Sentencing Guidelines, the seven fundamental elements of an effective compliance program are the following: 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.

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 waste, fraud and abuse, are available on the Internet at http://www.hhs.gov/oig in the "Compliance Tools" and "Fraud Detection & Prevention" sections.

In addition to developing compliance program guidance which promotes the voluntary adoption of compliance measures by private industry, OIG monitors compliance and integrity obligations imposed on health care providers as part of global fraud settlements of OIG investigations and audits. These compliance obligations are typically negotiated through an agreement commonly referred to as a corporate integrity agreement. When negotiating these integrity agreements, OIG takes into account an entity's existing voluntary compliance program, if any. Presently, OIG is monitoring approximately 500 corporate

integrity agreements. These agreements cover the range of providers from small physician offices to large hospitals and laboratory corporations. The duration of most current corporate integrity agreements is 5 years and these agreements require the provider to take substantial measures to ensure that the organization is operating within HCFA rules and regulations and the parameters established by the corporate integrity agreement. A material failure to adhere to the corporate integrity agreement could result in financial penalties or exclusion of the provider.

To assist with efforts to verify compliance with the terms of the corporate integrity agreements, OIG staff conducts on-site visits to certain entities and providers subject to the compliance obligations. The OIG has approximately 25 site visits scheduled for FY 2001. These site visits generally involve meeting with compliance staff and management, employee interviews, a claims review and a detailed discussion of assertions made in annual reports submitted to OIG by the provider. Site visits often verify compliance with the corporate integrity obligations, but they have also uncovered and confirmed instances of noncompliance, including improper claims reviews and the provider's placement of prohibited costs related to a false claims settlement agreement on provider cost reports.

As one of its six task orders awarded to program safeguard contractors, in November 1999 HCFA contracted with TriCenturion, LLC, a new company formed by three current Medicare contractors (Blue Cross Blue Shield of Florida, Blue Cross Blue Shield of South Carolina and TrailBlazer Health Enterprises) to assist OIG in its monitoring of providers subject to corporate integrity agreements. In the following contract year, TriCenturion will perform approximately 30 on-site reviews of providers subject to corporate integrity agreements to assist OIG in determining if providers are billing in compliance with applicable Medicare laws. In addition, OIG staff is working closely with HCFA and TriCenturion on this important project. This effort will complement the site visits conducted by OIG's compliance unit staff.

Provider Self-Disclosure Protocol

In keeping with a longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, on October 21, 1998, OIG issued a set of comprehensive guidelines for voluntary self-disclosures. These guidelines, known as the Provider Self-Disclosure Protocol, can be found on OIG's Internet site (http://www.hhs.gov/oig) or as published in 63 Federal Register 58,399 (October 30, 1998).

Essentially, the Protocol guides providers and suppliers through the process of structuring a disclosure to OIG of matters uncovered that are believed to constitute potential violations of Federal criminal, civil and/or administrative laws (as opposed to innocent mistakes that may have resulted in overpayments). Pursuant to the Protocol, an appropriate submission would include a thorough internal investigation as to the nature and cause of the matters uncovered

and a reliable assessment of their economic impact (e.g., an estimate of the losses to the Federal health care programs).

Unlike prior voluntary disclosure procedures (e.g., Voluntary Disclosure Pilot Program), there are no limitations as to the type of provider or supplier that can avail itself of the Protocol's guidance or with respect to geographical location. Nor is the fact that a provider or supplier is under investigation by another Government agency an automatic bar to submissions under the Protocol. The OIG evaluates each submission to determine the appropriate course of action. To date, OIG has received 119 submissions. They are comprised of a variety of issues and types of providers throughout the country.

Among the benefits experienced by disclosing providers is the allocation of investigative resources that can contribute to an expeditious inquiry and a prompt resolution of the matter. Additionally, disclosing providers that demonstrate the effectiveness of their compliance programs and that, as part of the resolution of the matter, agree to continue such compliance activities may avoid entering into a corporate integrity agreement with OIG. In those cases where objective evidence of a comprehensive compliance program exists and OIG believes a corporate integrity agreement is necessary, OIG may make significant concessions in the term of a corporate integrity agreement or the role of the independent review organization.

Overall, the Protocol provides helpful guidance to providers and the community at large concerning how to achieve resolution of identified misconduct through a cooperative and open relationship with the Government. To date, self-disclosure cases have resulted in 18 recoveries and 13 settlements collectively totaling over $40 million.

Monitoring Part B Therapy for Skilled Nursing Facility Patients

The OIG continued to monitor the effects of the Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement Act of 1999 (BBRA) on therapy services provided to Medicare beneficiaries in skilled nursing facilities (SNFs.) The BBRA suspended the Medicare reimbursement caps on Part B physical, occupational and speech therapy that were imposed by the BBA. In addition, the BBRA mandated that the Department of Health and Human Services conduct focused medical reviews on Part B therapy services and provide reports to Congress in the years 2001 and 2002. The OIG continued to gather and analyze information and data that will assist HCFA in responding to the congressional mandate. The implementation of monetary caps on therapy services in SNFs coincided with a dramatic decrease in Part B therapy charges during 1999. However, preliminary reports indicated that the Department could expect a rebound in SNF Part B therapy charges in 2000 and 2001 based in part on the moratorium on the caps and the persistent, inadequate contractor oversight of billing practices and medical necessity of Part B therapy.

The OIG recommended that HCFA ensure that adequate medical reviews of Part B therapy in SNFs are conducted. The OIG also recommended that HCFA continue to work to improve

therapy providers' understanding of billing procedures and the medical necessity guidelines for Part B therapy. (OEI-09-99-00550)

Skilled Nursing Facility Claims Lacking 3-Day Stay Requirement

A Medicare skilled nursing facility (SNF) claim generally qualifies for reimbursement only if the SNF stay was preceded by an inpatient hospital stay of at least 3 days, and the hospital discharge was within 30 days of the admission. Based on a statistical sample, this OIG report estimated that Medicare inappropriately paid Illinois providers $900,000 for SNF services during CY 1996 because of instances in which the 3-day hospital stay requirement was not met. The fiscal intermediaries that reviewed medical records and data for the sampled claims concurred and indicated they would request refunds for each incorrect payment identified.

The OIG recommended that HCFA monitor the intermediaries' recovery actions, report the results through the normal audit resolution process, issue a program memorandum to advise all fiscal intermediaries and SNFs of the results of the OIG review and consider having the FIs perform a review of the 3-day hospital stay requirement as part of their payment safeguard activities. The HCFA concurred with the recommendations. (A-05-99-00018)

Fraud Involving Nursing Homes

Nursing facilities and their residents have become common targets for fraudulent schemes through which health care providers, medical professionals, nursing facility staff and others associated with the operation of nursing homes improperly bill Medicare and Medicaid. Through such arrangements, Federal health care programs are billed for medically unnecessary services and for services either not rendered, or not rendered as described. Examples of cases involving nursing facilities and their residents follow:

- A retired optometrist agreed to pay the Government $500,000 to settle allegations that he submitted improper Medicare claims for comprehensive consultations in Maryland long term care facilities from July 1994 through December 1995. The consultations under which the optometrist billed required an opinion requested by a physician or other appropriate source, a detailed history, a detailed examination and medical decision-making of low to high complexity. A review of the optometrist's patient records showed that the claims he submitted were actually for routine eye care that included medical screening examinations for glaucoma and cataracts—services not covered under Medicare.

- The CEO of a Medicare provider of diagnostic services to Michigan nursing homes was sentenced to 15 months incarceration, 2 years supervised release, payment of $177,424 in restitution and a $40,000 fine for

committing health care fraud. The CEO ordered billing personnel to submit Medicare reimbursement claims for post-symptom electrocardiogram procedures that he knew were not performed.

- The OIG and the U.S. Attorney's Office for the Eastern District of Pennsylvania announced court approval of a consent order and judgment settling certain civil False Claims Act claims against a nursing home corporation. The consent order and judgment addressed the alleged provision of inadequate nursing care to certain residents of one of the corporation's skilled nursing facilities. The Government alleged the corporation submitted, or caused to be submitted, claims for services rendered to certain identified residents in deliberate ignorance and/or reckless disregard of the truth of those claims regarding its failure to provide: adequate nursing care to those identified residents with decubitus ulcers (pressure ulcers); adequate assessments of each identified resident's functional capacity and needs; adequate participation and intervention by physicians for identified residents; adequate staffing levels, supervision and training of staff as to identified residents; and adequate, complete and accurate medical and nursing documentation. The consent order and judgment provides for: (1) payment to the Government of $90,000; (2) retention of a third-party consultant selected by the Government and paid for by the corporation, with an annual budget of up to $100,000. The consultant will address quality of care issues and review compliance with the terms of the consent order and judgment; (3) adherence to specific protocols and standards of care to ensure provision of quality services to residents; (4) training of all professional and direct care staff on the requirements of the consent order and judgment; and (5) retention of jurisdiction of the action by the Court for all purposes under the consent order and judgment for at least one year and one month, and continuing thereafter until the corporation has fully and faithfully implemented all provisions of the order, and until the action is dismissed.

- An Indiana woman was sentenced for mail fraud to 4 months imprisonment, 4 months home confinement, 3 years probation and payment of $61,916 in restitution. The woman forged two occupational therapy licenses for her own use after taking copies of actual licenses from a local hospital. For over two years, the woman, who had no medical training, worked in an Indiana nursing home treating disabled Medicare beneficiaries. The costs of her salary and the services she provided were ultimately billed through the nursing home's cost report and paid by the Medicare program. This criminal case resulted from the OIG Self-Disclosure Program.

- The OIG and the U.S. Attorney's Office for the Eastern District of Pennsylvania announced settlement of a False Claims Act case against a Philadelphia nursing facility. The case was initiated as a result of a history of quality of care problems at the facility. However the focus of the False Claims Act investigation and the basis for damages was the egregious care provided to one resident alleged to have received poor care with respect to wound care and nutrition monitoring. The nursing facility agreed to: (1) payment to the Government of $60,000; (2) a commitment to spend not less than $100,000 over the next 2 years to improve the environmental aspects of the facility and the quality of life of the residents; (3) retention of an outside monitor selected by the Government and paid for by the facility to address quality of care issues and review compliance with the agreement for a one-year period; (4) implementation of a weight monitoring program and provision of wound care treatment utilizing the published guidelines as the foundation for the prediction, prevention and treatment of pressure ulcers on an individualized basis; and (5) implementation of a corporate compliance program that addresses care needs as well as ensuring compliance with all Federal and State laws. The compliance program requirements include an agreement to abide by specific standards of care and protocols, conduct training, implement a compliance plan, and submit annual reports to OIG for the next 3 years.

- In Illinois, a licensed clinical social worker agreed to pay the Government $22,500 and to comply with certain integrity provisions for a 5-year period. The social worker allegedly obtained a Medicare provider number which he permitted another individual to use. The other individual, who was not a licensed provider, used the provider number to bill Medicare for counseling services he purportedly provided to nursing home patients. The services provided were not medically necessary and not appropriately documented. The social worker received 10 percent of the funds reimbursed by Medicare as a result of this billing misconduct.

Nursing Home Resident Assessment

The Nursing Home Reform Act mandates that nursing homes use the Resident Assessment Instrument to capture pertinent information concerning residents. The minimum data set (MDS), a component of the resident assessment, contains a standardized set of essential clinical and functional status measures which in turn are used to classify residents into Resource Utilization Groups (RUGs). RUGs flow from the MDS and, under the PPS, drive Medicare reimbursement to nursing homes. Under the PPS, SNFs are required to classify residents into 1 of 44 RUGs. The OIG issued the following two reports addressing these assessments:

A. Quality of Care

Performance Measure

In this report, OIG indicated that nursing homes generally follow a systematic process when performing the assessment. However, OIG found that 17 percent of the fields on the assessment instrument contained information which differed from that found in the rest of the medical record. Furthermore, 14 percent of specific assessment protocols which should have been triggered by the overall assessment were not triggered. One-quarter of the protocols were not addressed in the residents' plans of care. For those residents who had plans of care, the plans were being followed. The OIG recommended that HCFA clarify MDS elements and provide enhanced and coordinated training concerning MDS. (OEI-02-99-00040)

B. Resource Utilization Groups

Performance Measure

The OIG found significant problems in the area of RUG coding. When compared to the rest of the medical record, 76 percent of the cases reviewed demonstrated discrepancies—46 percent were coded higher and 30 percent were coded lower. Because these discrepancies consisted of both upcoding and downcoding, they might be indicative of a problem inherent in the assessment instrument as opposed to the result of deliberate miscoding. In addition to the recommendations in A. above, OIG recommended that HCFA require an audit trail for MDS validation. (OEI-02-99-00041)

Medicare Payments for Psychiatric Services in Nursing Homes: A Follow-up

Based on a broad review of nursing home psychiatric services in the first 6 months of 1999, OIG found that 39 percent of these services were medically unnecessary, had no mental health documentation or were questionable. Psychological testing was the most problematic of the services reviewed: more than one third of these tests were medically unnecessary and administered with instruments the reviewer considered questionable, and tests were often too long, too frequent or not necessary. Further, while carrier policies now specifically address psychiatric services in nursing homes, utilization guidelines are inconsistent and unclear.

The OIG recommended that HCFA strengthen the billing process for psychiatric services in nursing homes by working with carriers to develop guidelines for the appropriate frequency and duration of such services, identify specific psychological testing instruments and take advantage of the MDS. The OIG estimated that implementing these recommendations would result in potential savings of as much as $30 million a year. The HCFA concurred with the recommendations. (OEI-02-99-00140)

Younger Nursing Facility Residents With Mental Illness

Nursing facilities have traditionally been the "last refuge" for individuals with mental illness. Federal nursing facility regulations stipulate that when evaluating an individual with

mental illness for nursing facility placement, evaluators must ascertain the most appropriate treatment setting for the individual. The preadmission screening and resident review (PASRR) is the primary mechanism used to ensure appropriate nursing facility placement and treatment. Both Medicaid and Medicare impose limitations on coverage for the long-term nursing home care of mentally ill persons from ages 22-64, and these residents were the focus of the following reports:

A. Preadmission Screening and Resident Review Implementation and Oversight

Performance Measure

The results of this OIG report revealed that the systems intended to ensure that mentally ill nursing home patients are correctly diagnosed and appropriately treated were not working and that patients were not receiving the services needed. In particular, PASRRs did not comply with Federal requirements. States may be violating the intent of the Federal requirement to define and provide specialized mental health services for these patients, and PASRR systems functioned with little State and Federal oversight.

The OIG recommended that HCFA improve the States' capacity to identify and ensure appropriate placement of mentally ill persons and improve PASRR oversight. The OIG also recommended that HCFA strengthen reassessment/referral processes and Federal monitoring and oversight. The HCFA concurred. (OEI-05-99-00700)

B. An Unidentified Population

Performance Measure

The study also found that the number of individuals with a mental illness in the 22-64 age group who reside in nursing facilities cannot be conclusively determined; Medicaid expenditures cannot be validated; and States do not know where these individuals are receiving long-term care.

The OIG recommended that HCFA undertake a series of steps to address these problems and improve the ability of both States and HCFA to produce accurate nursing facility information and to monitor care and treatment of Medicaid nursing facility residents. In addition, OIG recommended that HCFA undertake steps to make this information available for State and HCFA use in responding to the Olmstead Supreme Court Decision to ensure that individuals with a mental illness are placed in the "most integrated and least restrictive setting appropriate." The HCFA agreed with the recommendations. (OEI-05-99-00701)

New York's Claims for Residents in Institutions for Mental Diseases

This report followed up on HCFA's actions regarding previous OIG recommendations related to improper Medicaid claims for residents in institutions for mental diseases. The OIG previously recommended that New York cease claiming Federal financial participation for patients between the ages of 22 and 64 in adult psychiatric centers (identified by the

State as institutions for mental diseases) when they are temporarily released to general acute care hospitals. Federal financial participation is not allowed for these patients, an exclusion that continues during their temporary release. The current review found that New York continued to make such claims totaling approximately $19.6 million (Federal share) for the 9-year period ending December 31, 1999. The State has since implemented edits and controls which, if maintained, should prevent similar improper claims.

The HCFA concurred with OIG's recommendations to disallow the $19.6 million and to instruct the State to compute and refund the Federal share of any unallowable claims made after December 31, 1999. (A-02-99-01031)

Home Health Agency Fraud

Home health agencies (HHAs) are one of the fastest growing segments of the health care industry because they allow many patients to remain in their own homes at less expense than might be incurred at a hospital or other institution. The OIG identified a number of fraudulent arrangements by which home health care providers, medical professionals and others associated with the operation of HHAs inappropriately billed Medicare and Medicaid. The following cases represent some examples of improper activities related to the provision of home health care services:

- Three owners (a husband, wife and third individual) of an HHA in Oklahoma were sentenced for their roles in a scheme to defraud Medicare. The husband was sentenced to 31 months incarceration, 3 years probation and payment of $532,432 in restitution for conspiracy and Medicare fraud. His wife was sentenced to 4 months incarceration, 3 years probation, 104 hours of community service and payment of $500,000 in restitution for conspiracy. The third individual was sentenced to 8 months incarceration, 3 years probation, 104 hours of community service and payment of $500,000 in restitution for conspiracy. In early 1995, the three owners formed a management company for the purpose of circumventing the Medicare salary caps for HHA owners. The management company's sole source of income was the agency. The husband, who maintained his interest in the agency while associated with the management company, paid himself a salary of $465,000 per year, a portion of which he kicked back to his wife. In addition to the undisclosed related party interest, numerous personal expenses were passed on to Medicare through management fees claimed on the HHA's cost reports.

- In Louisiana, two former owners of an HHA were each sentenced to 5 months incarceration, 5 months in a halfway house, 3 years supervised probation and payment of $329,000 in restitution for committing health care fraud. The two admitted to forming a shell management company through

which they submitted $135,643 in fraudulent management invoices to the HHA for Medicare reimbursement. They also failed to properly fund $76,228 to the pension plan and fraudulently claimed $116,692 in bonuses.

- A national HHA agreed to pay the Government $170,000 for improper claims submitted in relation to its 1993 acquisition of a Medicare certified agency in Pennsylvania. The purchase provided the agency's former owner with a 2-year consulting agreement. The consulting agreement called for the former owner to provide consulting services to the HHA in return for $8,750 monthly. During the time he was a paid consultant, the former owner performed no consulting services which qualified for Medicare reimbursement. The agency, however, included the consulting costs in its Medicare cost reports and received reimbursement for them. The HHA also allegedly created false invoices to support the consulting services billed to Medicare.

- In Minnesota, an accounts receivable clerk for an HHA was sentenced to 41 months incarceration, 3 years supervised release and payment of $124,012 in restitution for theft of health care funds and money laundering. The clerk embezzled 19 checks from the agency after using an alias to open a bank account under the HHA's name. He withdrew money from the agency's bank account and deposited it into another business account he had previously opened.

- In Massachusetts, a licensed practical nurse was sentenced to 1 year probation, payment of $1,693 in restitution, $3,100 in fines and 150 hours of community service for health care fraud. The nurse defrauded Medicare by submitting skilled nursing notes for visits to patients she had not made. Her employer, an HHA unaware of the fraud, used these fraudulent nursing notes to submit claims to Medicare for reimbursement. The nurse resigned from her nursing position when the scheme was discovered.

Contractors' Pension Segmentation

Medicare pays a portion of the annual contributions made by contractors to their pension plans. The HCFA incorporated pension segmentation requirements into Medicare contracts beginning with FY 1988; contractual language specifies segmentation requirements and provides for the separate identification of the pension assets for a Medicare segment. The following case is an example.

- A Medicare Part B contractor was allowed to claim Medicare reimbursement for its Medicare employees' pension costs. Regulations and the Medicare contract provided, however, that pension gains that occur

when a Medicare segment of a pension plan closes should be credited to the Medicare program. The contractor was terminated in 1998, and a review by OIG identified over $3.5 million in excess Medicare pension assets at the time of termination. The OIG methodology and calculations were reviewed by HCFA's actuarial staff. The OIG recommended that the contractor remit the excess to the Medicare program. The contractor agreed with the computations, but further comment is pending negotiations with HCFA concerning resolution of contract termination issues. (A-07-00-00109)

Separately Billed End Stage Renal Disease Tests Included in the Composite Rate

An OIG review of the payment system for billed laboratory services provided to end stage renal disease (ESRD) beneficiaries identified a control weakness with the reimbursement for these tests. Based on a statistical sample of laboratory claims, OIG estimated that over $6 million was improperly paid for services provided to ESRD beneficiaries during CYs 1995-1997. The OIG analysis showed that hospital laboratories were reimbursed separately for services that were included in the dialysis facility's composite rate. The OIG also found that separate payments were made for additional profile tests performed in conjunction with the monthly testing included in the composite rate. Other errors identified included improper coding, unbundled claims and lack of documentation for services claimed.

The OIG recommended that HCFA require Medicare contractors to provide education concerning billing practices to all ESRD providers and hospital laboratories. The OIG also recommended that HCFA monitor for proper billing and conduct detailed post-payment reviews. The OIG estimated that, if implemented, these recommendations would result in savings of more than $2 million annually. The HCFA generally concurred with the recommendations. (A-01-99-00506)

Laboratory Test Performance

In a prior audit, OIG indicated that Medicare carriers overpaid independent clinical and physician laboratories by over $50 million for chemistry, hematology and urinalysis tests during the 2-year period ending June 30, 1995. This follow-up audit showed significant improvements; overpayments decreased to approximately $31 million for such tests for the 2-year period ending December 31, 1997. However, certain carriers still did not have adequate procedures and controls (including edits) for detecting and/or preventing inappropriate payment for laboratory tests. In addition to recommending financial adjustments, OIG recommended that HCFA ensure that carriers implement controls to preclude such overpayments. The HCFA concurred. (A-01-99-00522)

Hyperbaric Oxygen Therapy Use

Originally developed for the treatment of decompression sickness, Hyperbaric Oxygen Therapy (HBO2) is primarily an adjunctive treatment for the management of select non-healing wounds. An OIG review of the use and appropriateness of HBO2 between July 1, 1997, and July 1, 1998, determined that $19.1 million (of approximately $49.9 million allowable charges for outpatient hospitals and physicians) was paid for inappropriate or excessive treatments. An additional $11.1 million was paid for treatments that lacked appropriate testing or monitoring. These reimbursements resulted from confusion over or abuse of the current coverage policy, medical opinions that did not align with HCFA guidelines, inconsistent application of coverage criteria and inadequate documentation. A failure by contractors to implement appropriate edits and medical review standards further contributed to inappropriate payments. In an effort to resolve these problems, OIG recommended that HCFA review its national coverage for HBO2, strengthen policy guidance and improve contractor oversight. The HCFA generally concurred with these recommendations. (OEI-06-99-00090)

Balance Billing for Medical Equipment and Supplies

In 1999, Medicare beneficiaries paid $41 million above the Medicare allowed amounts for medical equipment and supplies. Most beneficiaries surveyed in this study were unaware of the differences in assigned and non-assigned claims and participating and non-participating suppliers. Based on a review of 1999 claims data, OIG found that ostomy supplies have a higher non-assigned rate than supplies overall. In this report, OIG recommended that HCFA educate beneficiaries regarding ways to reduce financial liability for medical equipment and supplies and re-evaluate Medicare fee schedules for ostomy supplies. HCFA concurred. (OEI-07-99-00510)

Fraud Involving Durable Medical Equipment Suppliers

The durable medical equipment (DME) industry has consistently suffered from waves of fraudulent schemes through which Federal health care programs are 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. During this reporting period, OIG obtained settlements and convictions of DME suppliers for a variety of schemes as demonstrated by the following examples:

- A California man was sentenced to 71 months incarceration, 3 years supervised release, payment of $2.5 million in restitution and a $2,200 special assessment for his role in a DME fraud scheme. Through his operation of two DME companies, the man submitted false claims to Medicare for supplies not provided. At the time of his arrest numerous items, including three vehicles, two grand pianos, jewelry, artwork, over

1,000 bottles of wine, a pool table, approximately $17,000 in currency and an escrow account containing more than $120,000, were seized; the total value of the seizures was estimated at $340,000.

- A Federal judge in New York approved the civil settlement between a DME company and the Government, whereby the company agreed to pay $900,000 for allegedly upcoding lymphedema pumps on Medicare claims. Between 1989 and 1994, the company submitted over 350 upcoded Medicare claims for lymphedema pumps in order to receive a higher rate of reimbursement from the program. To support these inflated costs, the DME company improperly used "formula" language, rather then unique descriptions of individuals' true conditions, on its certificates of medical necessity. As part of the civil settlement, the company must also implement a 5-year corporate compliance program to ensure proper Medicare billing procedures.

- The owner/operator of several DME companies in New York was sentenced to 5 years probation, including 2 years home detention to be served concurrently for mail fraud and conspiracy. He must also pay $800,000 in restitution before the end of his probation period and forward all proceeds from the sale of property by a specified date. In addition, he must comply with psychiatric treatment and serve 400 hours a year of community service after completing home detention. One of his DME companies billed Medicare over $6.5 million for wound care supplies from May 1994 through mid-1995; more than 50 percent of these billings were fraudulent. Previously, the company owner/operator was also convicted of defrauding New York State Medicaid and ordered to repay the program $1 million. In order to repay Medicaid, he defrauded Medicare by funneling funds from his DME company to New York State Medicaid through another company he owned.

- A California DME company owner/operator was sentenced to 33 months imprisonment, 3 years probation and a $1,000 assessment for wire fraud. The DME company owner/operator was also ordered to pay $385,332 in restitution jointly and severally with an additional subject in this case; the additional subject must also pay a $4,000 assessment. Through his company, the owner/operator billed for saline solution and irrigation syringes which he never provided to Medicare beneficiaries residing in SNFs.

- In New Jersey, the co-owners of a DME company that supplied hospital beds to residents of SNFs were sentenced for their roles in a scheme to

defraud Medicare. One was sentenced to 1 year and a day incarceration, payment of $200,000 in restitution and 3 years supervised release. The other, who previously agreed to pay the Government $1 million in a civil settlement, was sentenced to 5 years supervised release. The co-owners filed false Medicare claims representing that the beneficiaries resided in their homes when they actually resided in SNFs; Medicare regulations do not allow payment for specialty beds in a SNF. In addition, they billed for air fluidized beds, when they actually provided low air loss beds reimbursed at a significantly lower rate.

- In Pennsylvania, the former owner of a now defunct DME company was sentenced to 8 months incarceration, 2 years supervised probation and a $30,000 fine. The former DME company owner paid a physician $85,000 in kickbacks to induce him to order wound care supplies billed to Medicare. The former owner also committed a misdemeanor violation of FDA regulations involving the interstate transport of misbranded medical devices. In the second scheme, he owned a company that manufactured hydrogel wound care dressings which were labeled and packaged as “sterile” but not actually tested for sterility. In an earlier civil settlement, the former owner agreed to pay the Government $255,000 and accepted a 15-year exclusion from Federal health care programs. He was the last to be sentenced in a 10-year investigation of the company, which resulted in the conviction of six other individuals as well.

- In Indiana, a DME company owner was sentenced to 6 months home detention, 5 years probation, 450 hours of community service, payment of $14,243 in restitution and $1,600 in fines for presenting false claims to the Government. The owner misrepresented the point of service code on numerous claims he filed for pressure mattresses provided to Medicare beneficiaries in SNFs. Medicare pays for pressure mattresses for beneficiaries who reside at home or in custodial care facilities; however, it does not cover these items when provided to beneficiaries in SNFs.

Medicare Reimbursement of Prescription Drugs

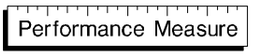
This report updated earlier studies that concluded Medicare pays too much for prescription drugs. The OIG found that to still be the case—the amount of excessive payments is rising. This report compared Medicare reimbursement of prescription drugs to costs incurred by the Department of Veterans Affairs (VA), the physician/supplier community and Medicaid. The OIG found that Medicare and its beneficiaries would save $1.6 billion a year if 24 drugs were reimbursed at the same amounts as they are to the VA; or $761 million a year by paying the actual wholesale prices available to physicians and suppliers for these 24 drugs; or $425 million a year by obtaining rebates equal to those in the Medicaid program. The

OIG also found that Medicare carriers were not establishing consistent drug reimbursement amounts for certain drugs. The OIG recommended that HCFA continue to seek administrative and legislative remedies to reduce excessive drug reimbursement amounts and that it require all carriers to reimburse a uniform amount for each drug. The HCFA concurred with these recommendations. (OEI-03-00-00310)

Inconsistent Medicare Data Concerning Carrier Payment Dates

One of the Medicare processing standards that must be met includes a "payment floor" standard which requires carriers to hold payment of electronic claims for 13 days starting on the day after the claim is received, which translates to a 14-day floor standard. In reviewing HCFA's National Claims History File data, OIG found that Medicare paid over 80 percent of Part B claims prior to the 14-day floor requirement. However, according to HCFA's Contractor Reporting of Operational and Workload Data (CROWD) system, payments for less than 1 percent of these Part B claims were made prior to the 14-day floor requirement. Information from both HCFA and carrier staff indicated that data from the National Claims History File may not accurately reflect the carriers' actual date of payment. The OIG recommended that HCFA define for carriers which data should be entered into the scheduled payment date field and how it should be calculated, revise the current variable definition in the National Claims History File and determine the accuracy of information contained in the CROWD system. The HCFA has initiated a review to resolve this inconsistency. (OEI-03-00-00350)

Federally Funded Health Centers and Low-Income Children's Health Care



The State Children's Health Insurance Program (SCHIP) was created by The Balanced Budget Act of 1997 and targets children in low-income families with the intent of providing States with an opportunity to design health care delivery systems similar to that available through private insurance. An OIG review of a broad sample of federally-funded health care centers revealed that, as of February 2000, 73 percent of the centers had children enrolled in SCHIP. The report indicated that centers receiving State enrollment training were almost four times more likely to enroll children than those that did not receive training. Health center enrollment success was also related to the availability of outstationed eligibility workers or a presumptive eligibility site designation.

The OIG recommended that HCFA encourage States to provide enrollment training, increase the number of health centers with oustationed eligibility workers, promote appropriate inclusion of health centers and expand reimbursement to include enabling services. The HCFA generally concurred with these recommendations. (OEI-06-98-00321)

State Children's Health Insurance Program

In two related inspections on SCHIP (see preceding entry), OIG found that the 13 States operating SCHIP-only programs were not enrolling Medicaid children in SCHIP. These States were enrolling SCHIP children appropriately and providing a smooth transition between the SCHIP and Medicaid programs. Sampled States also reported reductions in the number of uninsured children and mixed success in meeting other goals. However, the reports relied heavily on enrollment data and tended to use descriptive information in lieu of evaluation. In addition, State evaluations had conceptual and technical weaknesses.

The OIG recommended that HCFA identify a core set of evaluation measures and develop a more specific framework for the content and structure of the reports States are required to submit to the Department. The OIG also recommended that HCFA and HRSA provide guidance and assistance to States in conducting useful evaluations of their SCHIPs. (OEI-05-00-00240, OEI-05-00-00241)

Transportation Fraud

Common Medicare and Medicaid fraud schemes associated with transportation and ambulance companies involve the submission of claims for transporting patients to a hospital when the patients are really taken to other facilities 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 examples of transportation fraud were resolved during this reporting period:

- Three hospitals, one located in Florida and two located in Texas, agreed to pay $8.7 million to settle allegations relating to the hospitals' inclusion of certain management fees for ambulance services on its cost reports. The allegations claimed that the fees paid to the ambulance management companies were not reasonable and not entirely related to patient care. As part of the settlement agreement, the parent company of the hospitals agreed to enter into a comprehensive 5-year corporate integrity agreement.

- An Illinois ambulance company agreed to pay the Government $2.1 million to settle allegations that the company submitted improper claims for ambulance transports not covered by Medicare or Medicaid. From September 1991 through July 1997, the company allegedly used its ambulances to transport Medicare and Medicaid beneficiaries to and from their residences and nursing homes for scheduled medical appointments or routine hospital visits. In submitting electronic claims for payment, the company improperly represented these transports as medically necessary and as provided to patients who could only be moved by stretcher. As part

of the settlement agreement, the company also entered into a 3-year corporate integrity agreement with OIG.

- In Missouri, the former president of an ambulance company agreed to pay the Government $325,000 for his role in improperly billing Medicare for ambulance transports. The former president was also sentenced for false claims to more than 1 year in jail and 3 years probation. He was also ordered to pay a $250,000 fine and $1,243 in restitution. The ambulance company previously agreed to pay the Government $5.4 million to settle allegations of "ticket managing." The investigation revealed that the company engaged in a scheme through which it billed for medically unnecessary ambulance trips and for noncovered ambulance trips to doctors' offices.

Birth Certificate Fraud

The Immigration Reform and Immigrant Responsibility Act of 1996 required the Secretary to present to Congress a document delineating ways to reduce fraudulent acquisition and use of birth certificates. Consequently, at the Department's request, OIG examined the issue of fraud associated with birth certificates. The OIG found that fundamental, irreconcilable conflicts surround the purposes and uses of birth certificates. They continue to be used as "breeder documents" with which to obtain drivers' licenses, credit cards and other documents of identification. They are easy to acquire and to counterfeit. Birth certificate fraud is hard to detect and, when detected, seldom prosecuted. Even State practices lend themselves to opportunities for fraud. Efforts to restrict access to these documents might improve their usefulness in establishing identity but could diminish their value for the original purpose of certifying a birth.

State vital record agencies and other issuing entities suggested, among other things, reducing the number of issuing entities, establishing national requirements for security paper on which the document is printed, and introducing biometrics into the birth certificate process. In addition, OIG suggested that Federal and State program managers should reassess the documents they will accept as proof of identity. (OEI-07-99-00570)

Medicaid Enhanced Payments to Public Providers

At HCFA's request, OIG audited States' use of enhanced Medicaid payments and intergovernmental transfers as a means of avoiding Federal/State matching requirements. States are allowed to make enhanced payments (in addition to regular Medicaid payments) to city and county governments and other public providers as long as the State's aggregate payment does not exceed the amount that would have been paid under Medicare (referred to as the upper limit).

The OIG generally found, however, that these enhanced payments were not based on the actual cost of providing services to Medicaid beneficiaries or directly related to increasing the quality of care provided by public facilities that received the enhanced payments. Nor were they being retained by the facilities to provide services to Medicaid-eligible individuals. Instead, the bulk of the enhanced payments were returned to the States through intergovernmental transfers. The OIG recommended that HCFA move as quickly as possible to issue regulatory changes involving the upper payment limit calculation. The HCFA concurred and on January 12, 2001, issued revisions to the upper payment limit regulations that included transition periods to gradually phase in the new regulations.

The OIG issued the following five final reports on this subject during this 6-month period.

A. Pennsylvania

From 1992 through 1999, Pennsylvania reported $5.5 billion in enhanced payments to county nursing facilities. These payments generated $3.1 billion in Federal matching funds without any corresponding increase in services to the Medicaid residents of these facilities. Under the enhanced payment program, counties obtained bank loans and transferred the borrowed amounts to the State, which immediately transferred the funds back to the counties as Medicaid enhanced payments. The counties used their enhanced payments to pay the bank loans that initiated the transactions. The State claimed, received and kept Federal matching funds based on the enhanced payments.

Based on HCFA's revised upper payment limit rule, OIG estimates savings to the Federal Government of $2.4 billion during the regulation transition period. Once the regulatory changes are fully implemented, OIG estimates additional Federal savings of $731 million annually, totaling a savings of $3.7 billion over 5 years. (A-03-00-00203)

B. Nebraska

From 1998 through 2000, Nebraska made enhanced payments to public nursing facilities totaling $227 million, generating about $139 million in Federal matching funds. Of the $227 million, providers retained about $1.5 million and about $225.5 million was returned to the State for other uses. Of the funds transferred back to the State, the State share of the enhanced payments, totaling about $88 million, was returned to the Nebraska General Fund and the remaining $137.5 million in Federal matching funds was designated for the Nebraska Health Care Trust Fund.

Using HCFA's revised upper payment limit rule, OIG estimated savings to the Federal Government of $142 million during the regulation transition period. Once the regulatory changes are fully implemented, OIG estimated additional Federal savings of $44 million annually, totaling a savings of $220 million over 5 years. (A-07-00-02076)

C. Alabama

During 1999 and 2000, Alabama made enhanced payments to public nursing facilities totaling about $83.5 million (Federal share $58.5 million). The bulk of these payments (96.5 percent) were not retained by the facilities but were returned to the State Medicaid agency for other uses. Consequently, the State received Federal Medicaid funds without the required State match.

Using HCFA's revised upper payment limit rule, OIG estimated savings of $44 million to the Federal Government during the regulation transition period. Once the regulatory changes are fully implemented, OIG estimated additional Federal savings of $29.5 million annually, totaling a savings of $147.5 million over 5 years. (A-04-00-02165)

D. Washington

During State FY 2000, Washington made enhanced payments to public nursing facilities totaling $147 million. Over 86 percent of this amount was returned to the State. Most of the funds were apparently designated or used for State health care needs, regardless of Medicaid eligibility.

Using HCFA's revised rule, OIG estimated savings to the Federal Government of $110 million during the transition period. Once the regulatory changes are fully implemented, OIG estimated additional Federal savings of $73 million annually, totaling a savings of $365 million over 5 years. (A-10-00-00011)

E. Illinois

During State FYs 1991 through 2000, Illinois made enhanced payments to three Cook County hospitals and associated clinics of about $5.9 billion. About $3 billion of this amount was a return of funds that were initially transferred from the county to the State. Over $866 million of the remainder (i.e., the Federal share) was deposited in the State's General Revenue Fund.

Using HCFA's revised upper payment limit rule, OIG estimated savings to the Federal Government of about $1.2 billion during the regulation transition period. Once the regulatory changes are fully implemented, OIG estimated additional Federal savings of $374 million annually, totaling a savings of about $1.9 billion over 5 years. (A-05-00-00056)

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. The Partnership Plan was developed to foster these joint review efforts and provide broader coverage of the Medicaid program. 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 in 23 States. Extensive sharing of audit ideas, approaches and objectives has taken place between Federal and State auditors. Completed reports have resulted in identifying potential program savings of $188.7 million, of which over $39 million in Federal and State overpayments has been recovered.

During this reporting period, a report issued by the Ohio State Auditor indicated that a transportation service company was unable to provide documentation for a statistical sample of services billed from January 1, 1996, through March 31, 2000. Due to the lack of documentation—no support that trips occurred, missing physician certifications regarding the medical necessity of trips, and other evidence—the State Auditor questioned $1,001,675 (Federal share approximately $590,000).

The State Auditor recommended that the State determine whether the overpayments constitute fraud and abuse, initiate proceedings to recoup all or part of the overpayments and consider termination of the provider's Medicaid agreement. The case was referred to the Ohio Medicaid Fraud Control Unit for investigation and possible legal action. (A-05-00-00091)

Credentialing of Medicaid Providers: Fee-For-Service

One-half of the States are not collecting all the enrollment and credentialing information required by HCFA, according to this OIG report. The verification of providers exclusion status is incomplete. States are accepting provider enrollment statements without independently verifying the accuracy of the information. Only two-thirds of the States make use of information available from external sources to enhance their credentialing processes. Most States have not established aggressive post-credentialing activities. Among other things, OIG recommended that HCFA strengthen enrollment, re-enrollment and credentialing requirements for providers to address these problems. (OEI-07-99-00680)

Medicaid Fraud

At present, 47 States and the District of Columbia have established Medicaid fraud control units (MFCUs). The MFCUs conduct investigations and prosecute providers charged with defrauding the Medicaid program or persons charged with patient abuse and neglect. As required by the Omnibus Budget Reconciliation Act of 1993, three States—Idaho, Nebraska and North Dakota—have sought and received waivers from the requirement that all States operate MFCUs.

The Inspector General is delegated the authority to annually certify each MFCU as eligible to receive Federal grant funds under the Medicaid fraud control program. The MFCUs receive 90 percent Federal funding for the first 3 years of operation and 75 percent thereafter. During FY 2001, OIG is providing oversight for and administration of

approximately $104.1 million in funds granted by HCFA to the units to facilitate their mission.

Since the inception of the Medicaid fraud control program, the MFCUs have successfully convicted thousands of Medicaid providers and have recovered hundreds of millions of program dollars. Although most Medicaid fraud cases are investigated by the units, OIG works with the units and/or other law enforcement agencies on such cases as well. The following instances of OIG's successful efforts in Medicaid fraud cases bear noting:

- A physiatrist was sentenced to 5 years probation and payment of approximately $1.4 million in total restitution to the Medicare program and the New York State Medicaid program for his scheme to bill for services not rendered. From 1993 to 1995, the physiatrist provided services at four nursing homes and had a private practice. During that time, he obtained the patient rosters at the nursing homes and systematically billed Medicare and Medicaid for a battery of tests he did not perform on residents. He also billed in this manner for patients of his private practice. The investigation revealed that thousands of the tests and procedures he billed, and received reimbursement for, were neither performed nor ordered by the attending physicians.

- A for-profit corporation licensed in Pennsylvania to provide skilled nursing care to severely disabled children, its affiliated entities and its principal operator agreed to pay the Government more than $1.3 million for allegedly submitting false Medicaid claims. This qui tam suit involved allegations that community residential programs for persons with developmental disabilities engaged in cost report fraud by double billing and by seeking payment for services not provided, for related party expenses and for the personal expenses of the facility's principal operator. Additionally, the principal operator agreed to a 5-year exclusion. The programs, which operate as three separate entities, will also enter into 5-year corporate integrity agreements with OIG.

- Through a joint investigation with the Rhode Island MFCU and the FBI, a hospital agreed to pay the Government $750,000 in order to settle its liability under the False Claims Act and CMP Law. The investigation focused on allegations that the hospital did not make any attempt to repay an overpayment it received due to a malfunctioning computer program. The computer program caused the hospital to bill Medicare and Medicaid for laboratory panel tests which were not rendered. As a result, the hospital received funds from Medicare and Medicaid to which it was not entitled. From 1989 through 1996, the hospital allegedly submitted claims for

outpatient laboratory tests that incorrectly stated the number of tests rendered and the number of panels of such tests rendered.

- A hospital located in Oklahoma entered into a settlement agreement for $700,001 to resolve allegations that the hospital billed Medicaid for services related to inpatient psychiatric and chemical dependency treatment by or at the medical direction of and/or on the prescription of a psychiatrist who had previously been excluded from the Federal health care programs and whose exclusion was still in effect at the time the claims were submitted. A corporate integrity agreement was not imposed. Instead, for the next 5 years, the hospital must perform quarterly screenings of OIG's exclusion list and also report to OIG upon finding overpayments and/or material deficiencies of any kind.

- As the result of a joint investigation with the Washington and Oregon MFCUs, the former billing manager of a DME company in Washington was sentenced to 2 years probation and ordered to pay $3,100 in fines for conspiracy to commit mail fraud and health care fraud. In order to obtain more money from health care benefit programs, the billing manager and her co-conspirators at the company routinely upcoded claims, falsified certificates of medical necessity and billed Medicare and Medicaid for items not delivered. In addition, the company was sentenced in Washington and ordered to pay $400,000 in restitution for mail fraud in relation to the health care fraud scheme; the DME company had been previously prosecuted and sentenced in Oregon for similar misconduct.

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 (OPDIVs) 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 OPDIVs within the Department include: the National Institutes of Health (NIH), to advance our knowledge through research; the Food and Drug Administration (FDA), to assure the safety and efficacy of marketed food, drugs, biological products and medical devices; the Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; the Health Resources and Services Administration (HRSA), to support the development, distribution and management of health care personnel and other health resources and services; the Indian Health Service (IHS), to improve the health status of Native Americans; the Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Healthcare Research and Quality (AHRQ), 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, health services to Indians, 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 OPDIVs. 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.

Human Tissue Donation and Banking Issues

Human tissue is an important resource in myriad medical treatments. In 1999, more than 20,000 donors—compared to perhaps 6,000 in 1995—provided cadaveric tissue, and tissue banks distributed over 750,000 allografts for transplantation in 1999. In response to concerns which have arisen about both the donation process and banking oversight, OIG conducted the following two studies.

A. Informed Consent in Tissue Donation

In this report, OIG revealed that the foundation of tissue banking lies in the altruistic motives of donor families. However, the reality of the tissue banking industry as it has expanded gives rise to concerns regarding family assumptions. Families expect, for example, that the donation will be used to enhance the life of another and that the donor will be respected. The unique nature of the donation warrants that steps above and beyond those that would apply to other business or philanthropic enterprises be taken. Therefore, OIG recommended joint action among tissue banks, donor families and government agencies to develop guidelines regarding the exchange of information with families and the obtaining of their consent at the time of donation. (OEI-01-00-00440)

B. Oversight of Tissue Banking

In this companion report, OIG indicated that the oversight of tissue banking takes place at three levels. At the Federal level, FDA focuses on preventing transmission of communicable diseases by requiring donor screening and testing. At the State level, only New York and Florida license and inspect tissue banks. The American Association of Tissue Banks conducts a voluntary accreditation program, but it accredits fewer than half of the Nation's tissue banks. The absence of known new cases of disease transmission since the early 1990s points to significant strengths in the current system. Nevertheless, OIG identified situations indicating the need for continued vigilance.

OIG recommended that FDA expedite the publication of its proposed regulatory agenda requiring registration of tissue banks, enhanced donor screening and testing and the use of good tissue practices. In addition, OIG recommended that FDA set a realistic, yet aggressive, date to complete an initial inspection of all tissue banks and determine an appropriate minimum cycle for such inspections. (OEI-01-00-00441)

Transfer of NIH Technologies to the Private Sector

At the request of a Member of Congress, OIG reviewed the NIH process for licensing technologies developed in its laboratories to the private sector for further development so that products could be brought to the public. The NIH intramural budget for FY 2000 was

about $1.7 billion, or about 10 percent of its total budget of $17.8 billion. The OIG found that few of the thousands of prescription drug and biological products on the market originated in NIH's laboratories. With the notable exception of Taxol, products that were developed in NIH laboratories generally required years of additional development by the private sector before they could be approved for marketing by FDA. As of September 1999, only 13 prescription therapeutic drugs and vaccines containing technologies developed at NIH intramural laboratories were on the market. (A-15-99-50003)

AIDS Drug Assistance Program Cost Containment Strategies

Drug assistance programs (ADAPs) were established by the Ryan White Comprehensive AIDS Resource Emergency Act to provide medications to low-income individuals living with HIV/AIDS who have limited or no coverage from private insurance or Medicaid. One of the principal methods through which ADAPs contain drug costs is the 340B drug pricing program. This program provides drug price ceilings to ADAPs that purchase their drugs through a central purchaser as well as certain other federally funded entities. The program also provides a rebate option for ADAPs without a central purchaser.

The OIG report on cost containment strategies for the ADAP revealed that the ceiling prices limiting drug expenditures for program grantees are, on average, 16 percent higher than the Federal ceiling prices for the Departments of Veterans Affairs and Defense, the Public Health Service and the U.S. Coast Guard (Big 4). If allowed access to the Big 4 ceiling prices, ADAP grantees could have saved $75.5 million in Federal funds in 1999.

The OIG recommended that HRSA seek legislation to change the ceiling price calculation for the ADAP and other eligible entities covered by the 340B drug pricing program to the calculation used by the Big 4 agencies. Additionally, OIG recommended that HRSA continue to work toward direct purchase discounts for rebate and non-participating ADAPs. The HRSA concurred with these recommendations. (OEI-05-99-00610)

Exclusions for Health Education Assistance Loan Defaults

Through the Health Education Assistance Loan (HEAL) program, HRSA guarantees commercial loans to students seeking education in a health-related field of study. The students are allowed to defer repayment of these loans until after they have graduated and begun to earn an income. Although the Department's Program Support Center (PSC) takes all steps that it can to ensure repayment, 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, Medicaid and all Federal health care programs for nonpayment of these loans. During this 6-month period,

192 individuals and related entities 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 whereby the exclusion is stayed while they pay specified amounts each month to satisfy their debt. If they default on these settlement agreements, they can then be excluded until their entire debt is repaid, and they cannot appeal these exclusions. Some health professionals, upon being notified of their exclusion, immediately repay their HEAL debt.

After being excluded for nonpayment of their HEAL debts, a total of 1,371 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debt. This figure includes the 88 individuals who have entered into such a settlement agreement or completely repaid their debt during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals over $93 million. Of that amount, over $6.4 million is attributable to this reporting period. The following are examples of some of these settlements:

- After he was excluded from participation in Medicare, Medicaid and all Federal health care programs, a Texas physician entered into a settlement agreement to repay his HEAL debt of more than $295,000.

- In Indiana, an osteopath entered into a settlement agreement to repay his HEAL debt of more than $235,000.

- A Texas osteopath agreed to repay his HEAL debt of approximately $169,000.

- After being notified she was excluded, a Wisconsin chiropractor agreed to repay her HEAL debt of almost $146,000.

- A Maine psychologist entered into a settlement agreement to repay her HEAL debt of approximately $130,000.

Superfund Activities—National Institute of Environmental Health Sciences

The National Institute of Environmental Health Sciences (NIEHS) receives funds through an interagency agreement with the Environmental Protection Agency to carry out health-related and other functions mandated by the Superfund legislation. As required by statute, OIG audited Superfund financial activities at NIEHS. During FY 1999, its obligations of Superfund resources totaled about $62.9 million, and disbursements totaled about $55.4

million of the funds obligated during and prior to the same fiscal year. The OIG concluded that NIEHS administered the fund according to the Superfund legislation. (A-04-00-04230)

Fiscal Year 1999 Financial Statement Audit of the Indian Health Service

Performance Measure

In support of its audit of the consolidated Departmentwide financial statements for FY 1999, OIG contracted with an independent accounting firm to audit the IHS financial statements. The auditor's opinion on the IHS statements was qualified for two reasons. First, IHS could not completely reconcile its "Fund Balance with Treasury" as reflected in its general ledger to that reported by the Department of the Treasury at September 30,1999. The IHS subsequently reduced its general ledger by approximately $142 million to agree with amounts reported by Treasury. Second, the auditor was unable to determine whether the amount IHS reported in its general ledger account "Deferred Revenue (governmental)" was correctly stated. The IHS adjusted its general ledger by approximately $115 million so that the account agreed to its subsidiary report of September 30, 1999. Records were unavailable to assess the propriety of the adjustment. In addition, the auditor reported three material internal control weaknesses—one of which was the lack of a fully functioning, integrated financial reporting system capable of producing reliable financial statements. This weakness was reported in conjunction with the accounting service provided to IHS by the Program Support Center. (A-17-00-00004)

Misuse of Grant Funds

Resolution of charges of misuse of HHS grant funds occurred in the following example during this reporting period:

- In New York, a partner in a small advertising firm was sentenced to 2 years probation and payment of $3,600 in restitution for mail fraud. The firm provided advertising, marketing and related services to an HHS grantee that received funding from SAMHSA. The partner knowingly caused the advertising firm to send invoices by mail to the grantee for goods and services that were not provided; the partner then converted a portion of the resulting funds to his own personal use.

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. Some of 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.

With respect to TANF, OIG continues 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 families and has issued a number of reports in this area. These reports have addressed quality-of-care issues and have focused on ways to increase the efficient use of program dollars; more effective program implementation; better coordination of programs among the Federal, State and local governments; and States' financial management practices.

The Administration on Aging (AoA) 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. Socially and economically disadvantaged elderly and low-income minority elderly are targeted for assistance, including supportive services, nutrition services, education and training, low-cost transportation and health promotion. 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.

Child Support Enforcement: Investigations

The U.S. Attorney General has made enforcement of the Child Support Recovery Act of 1992 a top Department of Justice (DOJ) priority. The Act made it a Federal misdemeanor 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. A 1998 amendment to this Act created two other felony provisions for the most egregious first-time violations.

The OIG has also made the investigation of these matters a high priority. The OIG and the Office of Child Support Enforcement (OCSE) are the sponsors of Project Save Our Children: six multiagency, multijurisdictional investigative task forces whose missions are to identify, investigate and prosecute the most egregious violators of the Federal and State child support laws in the regions covered by the task forces. The task forces are comprised of personnel from OIG Office of Investigations, FBI, U.S. Marshals Service, U.S. Attorneys Offices, DOJ, 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 forces are 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 investigative units in each of the States 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 forces are the screening units located in each task force region and staffed by analysts and auditors from both OIG and OCSE. The units receive child support cases from the States, conduct preinvestigative analyses of these cases through the use of information databases and then forward the cases to the investigative task force units where they are assigned and investigated. This streamlines 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.

The task forces cover the Midwest, Mid-Atlantic, Northeast, Southwest, Southeast and West Coast regions. The Midwest task force is headquartered in Columbus, Ohio, and includes the States of Illinois, Michigan, Ohio and Indiana. Headquartered in Baltimore, Maryland, the Mid-Atlantic task force area places special emphasis on the States of Maryland, Virginia, Pennsylvania, Delaware, West Virginia and the District of Columbia. In the Northeastern task force area, investigative efforts are headquartered in New York City, with special emphasis on the States of New York and New Jersey. For the Southwestern area, headquartered in Dallas, Texas, efforts focus especially on the States of Texas, Louisiana and Oklahoma. The Southeast task force, headquartered in Atlanta, Georgia, concentrates its

efforts on Florida, Georgia, Alabama, Mississippi and North Carolina. Efforts of the West Coast task force area are directed at the States of California, Oregon, Washington and Arizona, with headquarters located in Sacramento, California.

Examples of the Federal arrests, convictions and sentences resulting from OIG's enforcement work, both inside and outside the task force areas, during this reporting period include the following:

- A former professional basketball player was sentenced to 6 months imprisonment, 1 year probation and $1,100 in fines for failure to pay child support. The former basketball player, who currently resides in Arizona, was charged in March 2000 with owing more than $46,706 in overdue support for his 15-year-old son living in Massachusetts. He also owed a total of $113,504 in four other child support cases. Prior to sentencing, he paid a total of $160,210 to become current on all five child support orders. At sentencing, he was ordered to remain current and comply with all five support orders for his minor children who reside in multiple jurisdictions. Additionally, he also pleaded guilty and was sentenced in August 2000 for failing to pay support for two other children who live in Georgia.

- In Nevada, a man was sentenced to 9 months imprisonment and 1 year probation for failure to pay child support. He was also ordered to pay more than $140,000 in overdue child support and to remain current in his support payments of $999 a month. The man evaded efforts to locate him by stealing a social security number and manufacturing a social security card under his alias; he used this card to work and to obtain credit.

- In Iowa, a man was sentenced to 4 months prison (time served), 4 months in a community correctional facility, 1 year supervised release and payment of $132,284 in restitution for failure to pay child support. In February 2000, he was indicted on seven counts of failure to pay child support for seven children by six different mothers. At the time of his sentencing, the judge ordered him to pay past due child support for an eighth child as well. In addition to these children, the State of Wisconsin is in the process of establishing paternity for two more children.

- In Florida, a man was sentenced to 5 years probation and payment of $96,745 in restitution for failure to pay child support. As part of a special condition of his probation, he was ordered to liquidate his sports memorabilia collection and to get a second job. In 1990, the man was ordered to pay $514 a month in support of one child. To avoid his

obligation, he moved frequently, and although he had several jobs, he failed to pay any child support.

- In New York, a man was sentenced to 7 months incarceration (time served), restitution of $18,200 (in addition to the $30,000 he provided at the time of his guilty plea), 1 year supervised release and mandatory alcohol and drug abuse counseling for failure to pay child support. When initially arrested for this violation, the man made statements to agents which threatened his son's safety. The investigation also uncovered that he owned the following assets: three bank accounts; a stock investment account; a large trust fund of which he was a paid trustee; apartments in Brussels, Paris, New York and Arizona; and two New York City warehouses in which the man, an art dealer, stored collections of fine art and sculpture.

- In Indiana, a man was sentenced to 5 years probation and payment of $45,058 in restitution for failure to pay child support. In July 1996, he moved to Florida and stopped paying support for his four children who reside in Indiana. During the investigation, the custodial parent informed OIG that he threatened to use a firearm against her if she tried to enforce the child support order.

- In Louisiana, a man was sentenced to 5 years probation, payment of $40,735 in restitution, a $1,000 fine and drug testing for failure to pay child support. He was also ordered to perform 20 hours a week of community service while not employed. A qualified paralegal, the man remained unemployed to avoid paying child support. He has since found a job as a paralegal earning $30,000 a year.

- In Texas, a man was sentenced to 5 years probation and payment of $34,427 in restitution for failure to pay child support. As an additional condition of probation, he must also pay his current child support obligation of $400 a month for his twin daughters. A licensed architect, the man has been employed at various times in Illinois but leaves employment when a wage garnishment is attempted. This case represents the first CSE prosecution in the Eastern District of Texas.

- In Arizona, a woman was sentenced to 5 years probation and payment of more than $10,000 in restitution for failure to pay child support. The woman currently earns more than $105,000 a year working for an Internet company in New York City.

- In New Hampshire, a man was sentenced to 5 years probation and payment of $7,650 in restitution for failure to pay child support. He was also ordered to pay $275 a week via wage assignment to the State of New Hampshire's Department of Health and Human Services for current and past due child support. The man is a second time offender; the State of New Hampshire also convicted him of failure to pay child support in September 1999.

During this period, OIG investigations of child support cases, nationwide, resulted in 78 convictions and court-ordered restitution of over $3.7 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 often ordered.

Head Start Management Consulting Firm

The OIG reviewed the reliability and appropriateness of costs reported by a management consulting firm contracted to perform Head Start-related activities. The review focused on whether incurred costs reported by the contractor were allowable, applicable to Government contracts, determined under generally accepted accounting principles, and not prohibited by Government regulation or contract.

The review found that the contractor claimed $4.5 million in unallowable costs over a 5-year period because financial and accounting controls were not sufficient to ensure compliance with Federal contract requirements. Unallowable costs included unreasonable compensation costs, undocumented consulting costs paid to the spouse of the firm's president, travel and entertainment costs, and costs that were unsupported by the financial statements.

The OIG recommended that ACF require the contractor to refund $4.5 million and establish financial and accounting controls to ensure compliance with Federal contract requirements. Although ACF agreed with the findings and recommendations, the contractor did not. (A-03-99-03305)

Head Start Grantee: West Virginia

After noting deficiencies during a performance review at a Head Start grantee in West Virginia, ACF requested that OIG review the grantee's grant expenditures, accounting operations and internal controls. Because the grantee received funds from several Federal sources, OIG expanded its review to include all Federal funding.

The review found several accounting and internal control deficiencies. For instance, budgets were overspent, funds were transferred from subsequent year funds and other program funds to satisfy deficits, and time allocations for personnel working on multiple programs were not calculated accurately.

The OIG recommended that the grantee refund $145,680 in inappropriately claimed Head Start funds and suggested several improvements in internal accounting and budget controls to prevent future problems. The grantee generally agreed with OIG's recommendations for internal control improvements but did not agree to refund Federal funds. The ACF concurred with the findings and recommendations. (A-03-00-00551)

Emergency Assistance Program Costs

The Emergency Assistance (EA) program provided temporary financial assistance and supportive services to needy families in emergency situations. The program was eliminated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and replaced with the Temporary Assistance for Needy Families program. Certain States submitted retroactive EA claims that covered periods before TANF's implementation. In many cases, States employed consultants to develop these claims.

The following reports were issued as part of OIG's nationwide review of retroactive EA claims.

A. Kinship Foster Care Costs in New York

An OIG report pointed out that from January 1, 1994, to June 30, 1996, New York retroactively claimed kinship foster care costs as EA costs. In actuality, of those claims, $11.7 million (Federal share $5.8 million) did not meet Federal reimbursement requirements under the EA program. A statistical sample of 100 claims showed that 99 contained costs that were unallowable because they represented services provided outside the 12-month statutory limit for reimbursement under the EA program. The remaining case lacked an authorization form. Since ACF deferred these claims pending this review, OIG recommended that New York reduce its retroactive claim by $11.7 million. The State did not contest OIG's projection. (A-02-99-02001)

B. Nonparticipating Foster Care Costs Claimed by New York

A second OIG report reviewed New York's retroactive EA claim for costs related to Federal nonparticipating (FNP) foster care. In New York, FNP represents maintenance payments for children who live in a foster care setting but are not eligible for assistance under the Federal Title IV-E program. The State's claim covered the period from April 1, 1996, through December 31, 1997.

The OIG's statistical sample of 100 cases found that 74 contained claims that were ineligible for Federal reimbursement. Most (72 of the 74 cases) related to services provided outside the 12-month statutory limit for reimbursement under the EA program. The OIG recommended a financial adjustment of $7.3 million (Federal share $3.6 million). New York did not contest OIG's projection but reserved the right to appeal the amount disallowed. (A-02-98-02002)

C. Costs Claimed for Federal Financial Participation by Pennsylvania

In this report, OIG determined that due to widespread violations of Federal criteria by Pennsylvania, the State was reimbursed at least $42.4 million in Federal funds for unallowable claims for EA services and associated administrative costs. Of 300 claims reviewed, 251 violated Federal requirements and 141 of the 251 contained 2 or more violations. The State circumvented Federal criteria by disregarding such fundamental principles of the EA program as the child's living arrangements prior to applying for assistance, the role of parents or guardians in the application process and the 12-month time period in which services could be provided. The OIG recommended that the State refund the $42.4 million to the Federal Government. The State generally disagreed with these findings and recommendations. (A-03-99-00596)

Foster Care Children Protection in California

The OIG review of California's administration of federally mandated protections provided to foster care children in the State's juvenile justice system revealed significant problems. State plan requirements for the case review system were, in large part, not met. Additionally, one or both of the required judicial determinations pertaining to the child's removal from the home were not always made. These protections were not effective due to a lack of both sufficient oversight by California and State statutes codifying the juvenile delinquency court and probation department procedures for federally mandated protections.

The OIG recommended that the State implement periodic case sampling to ensure that the protections are provided and furnish oversight and technical assistance to county probation departments regarding the proper administration of Federal foster care requirements. The State concurred with these recommendations. (A-09-99-00057)

Maine's Licensing of Foster Care Homes

The OIG review of Maine's foster care licensing indicated that the State needed to make more timely reviews of license applications and renewals. The 60 sampled foster care homes had pending license renewals (some of which included temporary or provisional licenses) of 3 years or more and averaged 4.3 years. Of the 60 homes sampled, 31 did not meet one or more safety requirements. Specifically, 14 homes had fire code violations, 4 had bacteria in the water supply and 13 had allegations of abuse or neglect of foster care children. These problems were primarily the result of insufficient inspection resources and ineffective procedures, including the failure to use computer technology to automatically flag homes needing safety inspections or license renewals.

The OIG recommended that Maine implement a corrective action plan to resolve the licensing of its foster homes in accordance with its own licensing standards. The OIG also recommended that the State improve procedures to ensure that licensing standards—including monitoring to ensure early identification and prevention of safety

issues—are consistently met. State officials concurred with and are working to implement these recommendations. (A-01-00-02500)

Connecticut's Oversight of Child Care Facilities

An OIG report, requested by a Member of Congress, pointed out weaknesses in Connecticut's licensing and monitoring of child care facilities. The State's inspection and reporting process needed improvement, especially in the areas of quarterly visits required by State law, reporting results and documenting supervisory reviews. In one case, a facility was inspected only 4 times from October 1995 to October 1999, during which 17 inspections should have been performed. The OIG noted instances wherein inspectors reported that certain licensing requirements had been met when documented evidence suggested otherwise. In other cases operating licenses were issued and reissued to certain facilities in spite of serious deficiencies identified by license inspectors in current and previous inspections. Recommendations called for improvements in meeting the State's licensing and oversight responsibilities. The State concurred and is in the process of taking corrective action. (A-01-00-02504)

Texas State Audit of Foster Care Contracts

As part of the Inspector General's partnership efforts with States to expand audit coverage of foster care programs, the Texas State Auditor conducted an audit with the assistance of OIG. The State Auditor's report identified gaps in the State's oversight of foster care contracts which could be serious enough to undermine its efforts to ensure the safety of children in its care and its efforts to ensure that contractors comply with contract requirements. The report noted other problems: the foster care rate methodology was based upon a number of untested assumptions; the State lacked adequate assurance concerning accuracy of cost reports submitted by foster care providers; and it had not implemented policies and procedures to verify that child-placing agencies were paying foster homes the required minimum amount for maintenance. The State agreed with the State Auditor's findings and is taking action to correct the weaknesses identified in its administration of foster care contracts. Action by ACF is pending resolution of the findings through the State audit process. (A-06-00-00046)

Foster Care: Maryland

At the request of a Member of Congress, OIG conducted a limited-scope review to determine whether Maryland had claimed Title IV-E foster care funds for children residing in detention-type facilities commonly referred to as "boot camps." Federal foster care funds are not allowable for children in detention facilities. While the review disclosed that the State did not claim funds for children residing in such facilities, isolated payment errors associated with several cases were noted. The OIG provided information on these errors to State officials who agreed to review the cases and make financial adjustments if appropriate. (A-03-00-00553)

Voluntary Contributions Not Used to Expand Services for the Elderly

Current AoA regulations permit States to use voluntary contributions to meet cost-sharing or matching grant requirements. This use of contributions is contrary to the Older Americans Act which requires that voluntary contributions be used to increase services (such as congregate and home-delivered meals, transportation and in-home support) to the elderly. According to their financial status reports, 28 States and the District of Columbia erroneously used $155.4 million, or 37 percent of the total $421.5 million in voluntary contributions received in FYs 1996 and 1999, to meet their grant matching requirements.

The OIG recommended that AoA revise its regulations to stop this practice. The OIG also recommended that AoA step up its monitoring of financial status reports to ensure that all available funds are used to satisfy the needs of the elderly. In response to the draft report, AoA agreed with OIG findings and recommendations and outlined corrective actions under way or planned. (A-12-00-00002)

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

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133 which designates HHS as the cognizant audit entity for most States and major research organizations. The 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 became responsible for auditing the Department's financial statements beginning with FY 1996.

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, the Department's performance measurement efforts, standards of conduct and ethics, and Governmentwide audit oversight, including recommending revisions to OMB guidance.

Financial Statement Audit of the Department for Fiscal Year 2000

Performance Measure

As required by the Government Management Reform Act of 1994, OIG audited the departmentwide consolidated and combined financial statements for FY 2000, which include the consolidated balance sheet of the Department, the related statements of net cost and changes in net position, and the combined statements of budgetary resource and financing. This audit encompassed individual audits of nine OPDIVs' financial statements.

The audit report, which appears in the Department's Accountability Report for FY 2000, gives an unqualified opinion on the FY 2000 statements. This means that, for the second year, the Department's FY 2000 statements reliably presented departmental financial information.

While a clean audit opinion assures financial statement users that the information is reliable and fairly presented, it does not provide an assurance on the effectiveness and efficiency of the financial systems used to prepare the statements. The OIG continues to cite as a material internal control weakness the deficiencies in the Department's financial systems and the processes for producing financial statements. The lack of a unified, integrated financial management system and the OPDIVs' failure to routinely reconcile and analyze accounts throughout the year led to major adjustments to OPDIV financial statements as late as February 2001, nearly 5 months after the close of the fiscal year. Continuing problems in controls over Medicare electronic data processing were also reported as a material weakness.

The Department generally agreed with OIG's recommendations for improvements. (A-17-00-00014)

Escheated Warrants: West Virginia

Under Federal regulations, States are required to refund the Federal portion of uncashed and unclaimed checks known as escheated warrants. However, OIG found that for FYs 1997 through 1999 West Virginia did not reimburse the Federal Government at least $586,000 for uncashed canceled checks originally issued with funds from Federal programs. Although complete records were unavailable for the period before FY 1997, OIG determined that uncashed checks totaled approximately $16.7 million from 1990 until the period reviewed. The OIG believes that the Federal share of uncashed checks during this time was greater than the amount calculated for the audit period because Federal funding to the State under the former Aid to Families With Dependent Children program was significantly higher than it is under the present Temporary Assistance for Needy Families program.

The OIG recommended that the Department recover the $586,000 identified during the audit period and consider the findings in the report when negotiating recovery of the Federal portion of escheatments for prior periods. (A-03-00-00460)

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, covered entities are required to have an annual organizationwide audit which includes all Federal money they receive.

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the first half of FY 2001, OIG's National External Audit Review Center (located in Kansas City) reviewed about 1,500 reports that covered over $447.9 billion in audited costs. Federal dollars covered by these audits totaled $96.9 billion, about $52 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.

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 who can take steps 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 audit organizations.

- 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). In addition, OIG offers various training; for example, formal training was provided to certified public accountant societies and State auditor staffs 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.

- The OIG chaired both a work group sponsored by OMB to revise the data collection form for single audit reporting and currently chairs a committee of the President's Council on Integrity and Efficiency to revise the Orange Book which addresses audit cognizance assignments.

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 1,502 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,454
Reports issued with major changes	25
Reports with significant inadequacies	23
Total audit reports processed	1,502

The 1,502 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling $7.5 million as well as 4,702 recommendations for improving management operations. In addition, these audit reports provided information for 101 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 violation of law, regulation, grant conditions, 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 section 5 of the Inspector General Act. These costs are separate from the amount ordered or returned as a result of OIG investigations. (See page 72.)

TABLE I

OFFICE OF INSPECTOR GENERAL

REPORTS WITH QUESTIONED COSTS

	Number	Dollar Value	
		Questioned	Unsupported
A. For which no management decision had been made by the commencement of the reporting period[1]	465	$613,204,000	$132,833,000
B. Which were issued during the reporting period	94	$253,504,000	$2,271,000
Subtotals (A + B)	559	$866,708,000	$135,104,000
Less:			
C. For which a management decision was made during the reporting period[2,3]:	135	$358,860,000	$14,696,000
(i) dollar value of disallowed costs		$334,565,000	65,835,000
(ii) dollar value of costs not disallowed		$23,957,000	$65,915,000
D. For which no management decision had been made by the end of the reporting period	424	$507,848,000	$3,354,000
E. For which no management decision was made within 6 months of issuance[4]	660	$336,076,464	$33,607,000

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

	Number	Dollar Value
A. For which no management decision had been made by the commencement of the reporting period[1]	17	$125,963,000
B. Which were issued during the reporting period	12	$6,312,164,000
Subtotals (A + B)	29	$6,438,127,000
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]	3	$87,521,000
(b) based on proposed legislative action		
Subtotals (a+b)	3	$87,521,000
(ii) dollar value of recommendations that were not agreed to by management	4	$38,000
Subtotals (i + ii)	7	$87,559,000
D. For which no management decision had been made by the end of the reporting period[3]	22	$6,350,568,000

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 the development and publication of regulations addressing the administrative sanction authorities implemented by OIG, e.g., civil monetary penalties (CMPs) and program exclusions, as well as "safe harbor" regulations related to the anti-kickback statute. Among the regulatory initiatives undertaken during the reporting period were the following:

- Proposed Rulemaking on Revisions and Technical Corrections to 42 CFR Chapter V—The rule proposed several revisions and technical amendments to OIG regulations. The rule included revisions or clarifications to the definition of the term "item or service," to the reinstatement procedures relating to exclusions resulting from a default on health education loan or scholarship obligations and to the limitations period applicable to exclusions. In addition, the proposed rule set forth a number of technical corrections to the current regulations (65 FR 63035; October 20, 2000).

- Revised Final Rulemaking on the Reporting of Final Adverse Actions—This rule amended an earlier OIG rule that established a national health care fraud and abuse data collection program for the reporting and disclosing of certain adverse actions taken against health care providers, suppliers and practitioners, and for maintaining a data base of such final adverse actions. The revised rule amended the definition of the term "health plan," as it appeared in 45 CFR 61.3 (65 FR 70506; November 24, 2000).

Also, during this period, OIG published several Federal Register notices that set forth OIG policy and procedures in various areas. These included the publication of:

- Final OIG Compliance Program Guidance for Individual and Small Group Physician Practices (65 FR 59434; October 5, 2000).

- A solicitation for suggestions for developing new and modifying existing safe harbor provisions related to the anti-kickback statute, as well as the issuance of additional OIG Special Fraud Alerts (65 FR 78124; December 14, 2000).

- A notice amending OIG's Health Care Program Violations System of Records under the Privacy Act to include Social Security numbers to assure the proper identification of sanctioned individuals (66 FR 9865; February 12, 2001).

C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process. For example, OIG testified at three hearings during this 6-month period, principally on health care fraud and abuse issues. On several occasions, the testimony concerned OIG recommendations which, if implemented, could produce 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.

Employee Fraud and Misconduct

The OIG has oversight responsibility for the investigation of allegations of wrongdoing by Department employees when it affects internal programs. Most of the persons employed by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities, as illustrated in the following example:

- In Maryland, a former Food and Drug Administration (FDA) employee was sentenced to 2 years probation, 60 hours community service and restitution of $789 for theft of Government property. As the FDA project officer on the mover contract, the employee used contractor personnel to move out of his home and to move FDA surplus furniture to his wife's business office in Virginia. He also used an FDA warehouse to store his personal belongings. The investigation showed that costs associated with these moves were charged to the FDA contract. The employee resigned from Federal service shortly after his arrest for this misconduct.

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 213 successful criminal actions. Also during this period, 782 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 304 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over $249 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.

Appendices

APPENDIX A

Savings Achieved through Policy and Procedural Changes Resulting from Office of Inspector General Audits, Investigations and Inspections October 2000 through March 2001

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. Consistent with OIG policy, savings from the Medicare provisions of the Balanced Budget Act (BBA) of 1997 were adjusted downward to reflect CBO estimates for related provisions of the Balanced Budget Refinement Act (BBRA) of 1999. 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 $9,511 million for this period.

OIG Recommendation	Implementing Action	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
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)	Section 4721 of the BBA of 1997 reformed disproportionate share payments under State Medicaid programs by placing limitations on Federal financial participation.	$3,150
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 prospective payment system (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)	Section 4432 of the BBA of 1997 (as amended by the BBRA of 1999) required 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.	1,930

OIG Recommendation	Implementing Action	Savings in Millions
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)	The database capacity was achieved through the authorization of a data exchange between the Social Security Administration and the Health Care Financing Administration (HCFA) and between the Internal Revenue Service and HCFA. Section 4631 of the BBA of 1997 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.	$1,890
Capital-Related Costs of Hospital Services: Extend congressionally mandated reductions in hospital costs. The 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 4402 of the BBA of 1997 provided for rebasing of capital payment rates for an additional reduction in the rate of 2.1 percent.	1,140
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)	Section 4552(a) of the BBA of 1997 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.	500
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 the Omnibus Budget Reconciliation Act of 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)	Section 4553 of the BBA of 1997 provided for reducing fee schedule payments by lowering the cap to 74 percent of the median for payment amounts, with no inflation update for 1998 through 2002.	500

OIG Recommendation	Implementing Action	Savings in Millions
Payments for Durable Medical Equipment: Excessive Medicare Part B payments for enteral and parenteral nutrition, equipment and supplies should be reduced, or competitive acquisition strategies should be employed. (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230; OEI-06-92-00861)	Section 4551 of the BBA of 1997 froze Medicare payments for enteral and parenteral nutrition and supplies for 1998 through 2002 and simplified the process used to reduce inherently unreasonable prices by 15 percent.	$200
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)	Section 4451 of the BBA of 1997 reduced bad debt payment to providers to 75 percent during FY 1998, 60 percent during FY 1999 and 55 percent in later years.	140
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)	Section 4556 of the BBA of 1997 reduced Medicare payments for drugs, which are paid based on the average wholesale price, by 5 percent.	40

Other	Implementing Action	Savings in Millions
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Retroactive Juvenile Justice and Youth Incentive Costs Claimed to the Emergency Assistance Program The OIG review found that the New Jersey Division of Family Development did not adequately review and test the work of their contractor before submitting claims to the Federal Government for reimbursement of retroactive claims for the juvenile justice and youth incentive programs under the Emergency Assistance Program.	The OIG worked with the Division and provided periodic briefings to its officials on the results of the OIG review. As a result of the review, New Jersey returned $1,959,737 in Federal funds.	$2
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.	19

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.	$4,100
Correct Overstated Managed Care Capitation Rates: The HCFA should seek legislation to correct the overstated base-year rates or eliminate any future increases in managed care capitation rates. (CIN: A-05-99-00025)	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) increased payments to Medicare+Choice organizations but did not modify the base-year amounts due to the overstated actuarial assumptions. The OIG believes that managed care payment rates continue to be excessive.	1,722
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)	The HCFA agreed with the recommendation to mandate Medicare coverage for all State and local government employees but did not agree with the recommendation to make Medicare the secondary payer.	1,559

OIG Recommendation	Status	Savings in Millions
Excessive Medicare Payments for Prescription Drugs: The HCFA should examine its Medicare drug reimbursement methodologies. (OEI-03-97-00290; OEI-03-97-00292; OEI-03-97-00293; OEI-03-97-00390; OEI-03-95-00420; OEI-03-94-00390)	The BBA of 1997 reduced Medicare payments by limiting them to 95 percent of the average wholesale price (AWP). The OIG believes additional corrective action is warranted.	$1,600
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 FY 2001 budget included a proposal to reduce payment updates from 2003 through 2005 and a proposal to reinstate laboratory cost sharing. In addition, the BBA required the Secretary to contract with the Institute of Medicine for a study of Part B laboratory test payments; HCFA may use the results to develop a new payment methodology.	1,130*
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)	The HCFA did not agree with the recommendation. Although the BBA 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. The President's FY 2001 budget would have reduced capital payments and saved $630 million in FY 2001 through FY 2005.	820
Medicaid Payments to Institutions for Mentally Retarded: The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and/or seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)	The HCFA did not concur 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 BBA 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.	683

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

OIG Recommendation	Status	Savings in Millions
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 diagnosis-related group (DRG) rates. The HCFA should seek legislative authority to further modify bad debt policies. (CIN: A-14-90-00339)	The HCFA agreed with the recommendation to include a bad debt factor in the DRG rates. The BBA of 1997 provides for some reduction of bad debt payments to providers. The President's FY 2001 budget proposes to reduce the percentage (from 55 percent to 45 percent) that Medicare pays for bad debts. However, additional legislative changes are needed to implement the modifications that OIG recommended.	$340
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services. (CIN: A-05-89-00055; CIN: A-05-92-00006)	The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services.	210
Graduate Medical Education: Revise the regulations to remove from a hospital's allowable graduate medical education (GME) base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020)	The HCFA did not concur with the recommendations. Although the BBA 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.	157.3
Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing by physicians who submit claims on paper and who have a moderate to high level of interest in making the switch. This effort should be coordinated with efforts to promote further use of electronic data interchange by providers under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996. The HCFA should also begin to plan now for the policy changes that will be necessary to achieve an almost completely paperless environment for processing Medicare claims. These policy changes can include targeting a date when all physicians will be mandated to submit paperless claims, targeting a date when paperless claims submission will become a condition for Medicare participation, or continuing to accept paper claims but imposing a filing fee to cover the incremental cost of doing so. (CIN: A-05-94-00039; OEI-01-94-00230)	The HCFA concurred with OIG's recommendations. The President's FY 2001 budget proposes to allow an assessment of a $1 fee on claims not submitted electronically.	126

OIG Recommendation	Status	Savings in Millions
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)	The OIG is continuing to monitor the Medicaid drug rebate program.	$123
Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)	The HCFA did not concur with the recommendation to further expand the payment window.	83.5
Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)	The HCFA agreed with OIG's findings but stated that further analysis would be required before any legislative changes could be supported.	47.6
Nonemergency Advanced Life Support Ambulance Services: The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513; CIN: A-01-94-00528)	The HCFA issued a final regulation which addresses the coverage of ambulance services and vehicle and staff requirements. The BBA of 1997 required that HCFA link payments to services provided and that the definitions of basic life support and advanced life support ambulance services be subject to negotiated rulemaking. The Negotiated Rulemaking Committee Statement on the Medicare Ambulance Services Fee Schedule was signed in February 2000. The HCFA published the proposed rule, which includes revised physician certification requirements, in the Federal Register in September 2000.	47
Limit Reimbursement for Hospital Beds: The HCFA should take immediate steps to reduce Medicare payments for hospital beds used in the home. This should include the elimination of the higher reimbursement rate currently paid during the first 3 months of rental. (CIN: A-06-91-00080; OEI-07-96-00221; OEI-07-96-00222)	The HCFA concurred with the recommendations and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency is examining payment allowances and methodologies at other payers and is reviewing data to determine if Medicare payments are excessive. However, the BBRA of 1999 imposed a moratorium on the application of HCFA's "inherent reasonableness" authority. Thus, while the moratorium is in place, HCFA may not act on a determination that costs are excessive.	40

OIG Recommendation	Status	Savings in Millions
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)	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 BBA of 1997 requires the Secretary to audit the cost reports of each renal dialysis provider at least once every 3 years. The HCFA planned to begin these audits in FY 1999. Section 222 of the BBRA of 1999 increased each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above the payment for services provided on December 31, 1999, and for services during 2001 by 1.2 percent above the payment for services provided on December 31, 2000.	$22*

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

OIG Recommendation	Status	Savings in Millions
Preclude Improper Medicaid Reimbursement for Clinical Laboratory Services: 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; CIN: A-04-98-01185)	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. Currently, OIG is conducting several follow-up reviews in this area.	$17.8
Medicare Orthotics: HCFA should take action to improve Medicare billing for orthotic devices. HCFA should also require standards for suppliers of custom-molded and custom-fabricated orthotic devices. (OEI-02-99-00120)	The HCFA generally concurred with the recommendations. However, HCFA did not agree to set specific standards for suppliers of custom-molded and custom-fabricated devices.	33
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)	The FY 2002 budget does not include this type of legislative proposal.	9.1
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)	The HCFA agreed with the recommendation, and the BBA of 1997, as amended by the BBRA of 1999, reduces the IME adjustment to 5.5 percent in 2002 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.	to be determined

OIG Recommendation	Status	Savings in Millions
Medicare Secondary Payer - End Stage Renal Disease Time Limit: Extend the Medicare secondary payer (MSP) provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016)	The HCFA was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. Although the BBA 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.	to be determined
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;CIN: A-04-97-01169;CIN:A-04-97-01166;CIN:A-04-97-01170;CIN: A-04-99-01194)	Although the Congress and the Administration included provisions to restructure home health benefits in the BBA of 1997, HCFA still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. Subsequent to implementation of the BBA, OIG's four-State review found that unallowable services continue to be provided because of inadequate physician involvement. 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. The OIG will continue to do work in this area.	to be determined
Establish Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: The HCFA should seek legislation that would require participating drug manufacturers to pay Medicaid drug rebates based on average manufacturer price (AMP) or study other viable alternatives to the current program of using AMP to calculate the rebates. This legislation would have resulted in about $1.15 billion in additional rebates for 100 brand name drugs with the highest total Medicaid reimbursements in Calendar Years 1994-96. (CIN: A-06-97-00052)	The HCFA disagreed with the recommendation to seek a legislative change, believing that such legislation was not feasible at the time. However, HCFA stated that changing AMP to AWP would reduce the administrative burden involved in the AMP calculations and planned a comprehensive study of AWP.	to be determined

OIG Recommendation	Status	Savings in Millions
PUBLIC HEALTH SERVICE OPERATING DIVISIONS		
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)	In the absence of specific authorizing legislation, the Food and Drug Administration (FDA) is precluded by statute from imposing user fees to cover additional functions. The FY 2001 President's budget request for FDA proposes that FDA be given new user fee authority to perform premarket review of direct food additives, food export certificates, and medical device review of 510(k)s.	$75.9
Medicare Rates for Indian Health Service Contracted Health Services: The Indian Health Service (IHS) should revise its legislative proposal to incorporate OIG's updated savings figures and should identify elements to be included in the implementing regulations. Also, IHS should continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates and should strategically identify and pursue other opportunities where lower rates may be negotiated. (CIN: A-15-97-50001)	The IHS concurred with OIG's recommendations. This proposal is on the Department's list of legislative initiatives for 2002. The IHS notes that by applying a 5-percent inflation factor, the savings projection for 2002 would be almost $11 million.	8.2
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)	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.	1.9

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	
Implement Proper Accountability over Billing and Collection of Medicaid Drug Rebates: The HCFA should ensure that States implement accounting and internal control systems in accordance with applicable Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current and complete disclosure of drug rebate transactions and provide HCFA with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (CIN: A-06-92-00029)	The HCFA concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The HCFA issued interim regulations in FY 1996.
Ensure that the Medicare Accounts Receivable Balance Is Fairly Presented: The HCFA should require contractors to implement or improve internal controls and systems to ensure that reported accounts receivable are valid and documented. (CIN: A-17-95-00096; CIN: A-17-97-00097; CIN: A-17-98-00098; CIN: A-17-00-00500)	The HCFA hired consultants to assist in validating the FY 1999 accounts receivable activity and balance, as well as the activity for the first 6 months of FY 2000. The agency also provided training on accumulating and verifying receivable balances. The President's FY 2001 budget included funding to establish financial management controls at the contractors and to hire contractor staff to implement the controls.
Consider Recommended Safeguards over Medicaid Managed Care Programs: The HCFA should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)	The HCFA generally concurred with OIG's recommendations but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.
Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program: The HCFA should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The HCFA should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)	The HCFA did not concur stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP, but did not provide specific written methodology for computing AMP.

OIG Recommendation	Status
Physician Office Surgery: The peer review organizations (PROs) should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)	The HCFA has issued policy guidance and manual instructions to explicitly state that PROs have the responsibility to review all care in physician offices when a beneficiary complains.
Investigate Patient Dumping Complaints: The HCFA should improve its processes for investigating and resolving complaints involving potential violations of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act, commonly referred to as patient dumping. (CIN: A-06-93-00087)	The HCFA concurred with OIG's recommendations.
Medicare Beneficiary Satisfaction with Durable Medical Equipment Regional Carrier Services: 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)	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.
Pressure Reducing Support Services: 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)	The HCFA did not concur.
GENERAL OVERSIGHT	
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)	The Department circulated a draft of hospital cost principles to the National Institutes of Health, and the grants management community submitted comments in August 2000. The Department planned to issue the cost principles by December 1, 2000

APPENDIX D

Notes to Tables I and II

Table I

[1] The opening balance was adjusted upward by $99.5 million.

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

CIN: A-02-99-58335	Puerto Rico Dept. Of the Family: Grantee supplied Documentation to Support Questioned Cost for $224,011.
CIN: A-07-99-54890	State of Iowa: $22,079 was for recipients who were not deceased and was posted in error.
CIN: A-07-99-59813	State of Iowa: $21,211 was never paid from Medicaid Funds. It was posted in error.
CIN: A-10-00-62578	$30,000 was posted in error.

[3] Included are management decisions to disallow $51.1 that was identified in nonfederal audit reports.

[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 are beyond management's control, resolution of the following audits was not completed within 6 months of issuance; however, based upon discussions with management, resolution is expected before the end of the next semiannual reporting period:

CIN: A-07-99-00980	Assist Review of Medicare A/R HCFA RO KCMO, January 2000, $39,730,982
CIN: A-04-00-65030	State of South Carolina, July 2000, $31,755,510
CIN: A-04-98-00122	Emergency Assistance Claims-NC HHS/DIV. Mental Health, September 1999, $25,993,849
CIN: A-05-94-00064	MI BCBS, Audit of Admin. Costs, June 1996, $15,609,718
CIN: A-07-96-01176	Medicare Excess Pension Assets - BC MICH, November 1996, $11,904,263
CIN: A-03-97-00013	BCBSM FY 89-92 Incremental Claim, September 1998, $11,723,785
CIN: A-05-99-00070	Monitoring-Contract Audit of HCSC & Termination, March 2000, $9,921,720
CIN: A-05-00-00045	OIG Partnership: State Auditor Report on Medicaid, May 2000, $8,500,000
CIN: A-09-97-44262	State of California, April 1997, $7,419,900
CIN: A-03-91-00552	Independent Living Program - National, March 1993, $6,529,545
CIN: A-02-99-02001	NYS Review of Retroactive Kinship Claims, September 2000, $5,833,676
CIN: A-07-99-02537	BCBS of Massachusetts, November 1999, $5,270,461
CIN: A-05-96-00058	Closeout Audit of Medicare Contract - BCBS-MI, December 1997, $5,226,443
CIN: A-09-99-57988	NA-State of Arizona, June 1999, $4,950,000
CIN: A-01-97-00516	Admin. Costs - Part A & B, Railroad Retirement Board, June 1999, $4,939,184

CIN: A-07-96-02001 Medicare Part B Admin. Costs at BCBS Colorado, December 1996, $4,483,104

CIN: A-07-98-01263 Denver CMHC, May 2000, $4,447,607

CIN: A-05-94-00080 Associated Ins. Medicare Admin. Costs, July 1996, $3,954,632

CIN: A-07-00-00109 Medicare Contract Term. & Seg. Closing- Galic, September 2000, $3,505,560

CIN: A-06-97-00029 Retention of Fees Child Placing Agencies Louisiana, September 1998, $3,450,173

CIN: A-02-95-01019 Staff Builders Home Office Medicare Cost Review, ORT, August 1998, $3,434,274

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

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

CIN: A-05-98-00042 Administar Ins. Co.- Admin. Costs Audit, September 1999, $3,111,728

CIN: A-05-93-00013 MI-BCBS - Contract Medicare Audit, April 1993, $3,010,916

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

CIN: A-01-95-00504 Medicare Parts A & B Admin. Costs - Aetna, January 1996, $2,938,223

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

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

CIN: A-07-92-00579 BCBS of Michigan Inc - Unfunded Pension Costs, October 1992, $2,535,698

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

CIN: A-07-98-02523 Blue Cross California - FACP, April 1999, $2,408,019

CIN: A-02-91-01006 Blue Shield of Western NY Medicare Admin. Costs Porter, September 1991, $2,379,239

CIN: A-04-97-01166 Review Home Health Services by Staff Builders Home Health, April 1999, $2,300,000

CIN: A-04-97-01170 Review Home Health Services by Medcare Home Health Services, April 1999, $2,200,000

CIN: A-01-99-00501 Psychiatric Outpatient Services Atwaterbury Hospital, October 1999, $2,122,333

CIN: A-04-97-01169 Review Home Health Services by Medtech Home Health Services, April 1999, $1,900,000

CIN: A-06-96-00009 New Mexico BCBS Admin. Cost - Contracted, November 1997, $1,879,366

CIN: A-05-97-00014 Group Health Plan Inc.(Healthpartners) Inst. Benes, June 1998, $1,808,308

CIN: A-05-95-00059 Audit of Admin. Costs - BCBS-Michigan, January 1997, $1,787,345

CIN: A-04-00-66032 State of Florida, August 2000, $1,713,052

CIN: A-04-97-02143 Review Therapy Services in Life Care SNFs in TN, December 1999, $1,638,025

CIN: A-02-97-01039 Medassist - Orthotics Provider Target, November 1999, $1,616,222

CIN: A-06-99-00006 Contract Audit of BCBS Admin. Costs, November 1999, $1,615,063

CIN: A-15-98-00038 Contract Closeout Audit For Cts, Inc., July 1999, $1,590,692

CIN: A-03-96-00012 BCBSM Part B Non-Renewal Costs, August 1998, $1,557,459

CIN: A-06-96-00008	Arkansas BCBS Admin. Cost - Contracted, September 1996, $1,442,193
CIN: A-05-93-00057	MI-BBCBS of MI-Contract Audit, July 1993, $1,409,954
CIN: A-09-96-00064	ORT - Hospice - California, March 1997, $1,350,000
CIN: A-10-91-00011	WPS - Keystone Computer Acquisition, October 1992, $1,346,681
CIN: A-05-95-00042	BCBSA Admin. Costs - Contracted Audit, December 1995, $1,333,598
CIN: A-02-98-52102	NA-Puerto Rico Family Dept. of Children & Families, March 1998, $1,321,656
CIN: A-02-96-01016	Empire Admin. Costs Part B Gardiner, Kamya & Assoc, April 1997, $1,296,098
CIN: A-05-00-00004	New Center Community Mental Health Center, June 2000, $1,181,000
CIN: A-02-99-01016	St. Lukes - Roosevelt Medicare O/P Psychiatric Services, June 2000, $1,175,759
CIN: A-02-97-01026	EDDY VNA (#337152) HHA Eligibility Review, September 1999, $1,131,593
CIN: A-05-98-00050	Follow-up Medicaid Clinical Laboratories, July 1999, $1,097,036
CIN: A-02-94-01029	Hospice Eligibility Review in PR - San German-ORT, June 1995, $1,070,814
CIN: A-09-98-00052	California Medical Review Inc. (CA. Pro), January 1999, $1,067,991
CIN: A-05-94-00047	Nationwide Ins., Medicare Part B Admin. Costs, September 1995, $1,049,309
CIN: A-07-99-01278	ORF-MO, September 2000, $1,042,522
CIN: A-01-98-00500	Payment Edits For Psychiatric at MA Part B Carrier, September 1998, $1,000,000
CIN: A-09-94-01010	Closeout Audit-Cont No. N01-ES-75196 (STRATAGENE), March 1994, $983,208
CIN: A-04-97-02142	Review St.Jude Behav. Health Ctr's Part. Hosp Program, December 1999, $927,845
CIN: A-08-99-55285	NA-South Dakota Urban Indian Health Inc., June 1999, $902,377
CIN: A-08-99-55284	NA- South Dakota Urban Indian Health Inc., June 1999, $902,046
CIN: A-05-92-00060	Contractor Audit - BCBS - Admin., February 1993, $879,609
CIN: A-01-99-00518	Psychiatric Outpatient Services at Danbury Hospital, May 2000, $877,270
CIN: A-02-97-01034	Dr. Pila Foundation Home Care Program (Ponce), September 1999, $857,208
CIN: A-07-98-02533	Travelers FACP, December 1998, $854,214
CIN: A-06-99-00013	Medicare Part A Admin. NM BCBS, December 1999, $817,487
CIN: A-02-98-01040	Niagara Cty Dept. of Health-#337001-HHS Elig Review, December 1999, $807,679
CIN: A-03-99-00008	BCBS of Delaware - Part A, January 2000, $798,939
CIN: A-07-99-00981	Assist Review of Medicare A/R HCFA RO Denver, January 2000, $754,926
CIN: A-05-91-00136	Community Mutual Ins Co. Admin. Costs, August 1992, $720,668
CIN: A-09-97-00078	Physician Billings, Dr. Spencer, January 1999, $683,264
CIN: A-04-99-54416	State of Florida, November 1998, $668,791
CIN: A-04-00-61620	State of North Carolina, March 2000, $664,773

CIN: A-09-99-00083 Blue Shield Termination Costs, December 1999, $659,763

CIN: A-05-00-64226 NA-Illinois Dept. of Public Aid, May 2000, $654,017

CIN: A-02-96-01015 Empire Admin. Costs Part A-Gardiner, Kamya & Assoc, April 1997, $652,492

CIN: A-01-98-00503 Psychiatric Outpatient Services at The Franklin Med Ctr, November 1998, $646,517

CIN: A-06-99-56489 State of Louisiana, January 1999, $634,915

CIN: A-01-99-00535 Audit of M/C Part A Admin. Costs - Anthem BCBS Ct, August 2000, $621,256

CIN: A-09-98-00095 Blue Shield of California, October 1999, $612,569

CIN: A-06-98-00066 ORT Review of Ultimate Home Health Care Inc., October 1999, $602,982

CIN: A-04-94-01078 Monitoring Admin. Cost - Audit Medicare Part B BCBSSC, July 1994, $594,092

CIN: A-04-93-01069 Monitoring Admin. Cost - Audit Medicare Part A BCBSSC, July 1994, $590,844

CIN: A-05-99-04005 Cash Management Review - U of Wisconsin, September 1999, $584,740

CIN: A-04-97-02141 Review St. Francis Behav. Health Ctr's Part. Hosp. Pro., December 1999, $573,506

CIN: A-04-00-60897 State of Florida, March 2000, $558,607

CIN: A-09-99-56858 Hawaii Dept. of Human Services, February 1999, $546,144

CIN: A-03-93-21786 District of Columbia Dept. of Human Services, October 1993, $501,747

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

CIN: A-04-98-01192 Review America's Behav. Health Care's Part. Hospitalization, December 1999, $452,928

CIN: A-07-97-01235 DOSHI - Texas, June 1997, $424,255

CIN: A-09-98-49239 NA-Hermandad Mexicana Nacional Legal Center Inc., November 1997, $419,364

CIN: A-05-97-00013 Pacificare of CA-HMO Institutional Status Project, April 1998, $407,784

CIN: A-06-99-58928 Arkansas Office of Child Support Enforcement, April 1999, $367,273

CIN: A-01-99-57863 State of Connecticut, May 1999, $362,813

CIN: A-04-96-01134 Partic. Part of HCFA Survey Team-Colonnade MCAL-ORT, February 1997, $358,338

CIN: A-04-96-01136 Partic. Part of HCFA Survey Team-Survey Savanah-ORT, December 1996, $354,537

CIN: A-01-99-00502 Psychiatric Outpatient Services at Elliot Hospital, November 1999, $325,674

CIN: A-04-00-64832 NA-State of Mississippi, June 2000, $319,116

CIN: A-09-00-62979 Hawaii Dept. of The Attorney General, March 2000, $311,399

CIN: A-04-97-01175 Keystone Pro, June 1998, $310,787

CIN: A-04-96-01129 Partic. Part HCFA Survey Team - Ameri. Trans. Care (ORT), February 1997, $284,378

CIN: A-05-96-00069 CPA Audit of Hooper Holmes HHA G&A -OI Case Open, February 1998, $280,515

CIN: A-06-97-00015 New Mexico Pro Closeout Audit, September 1999, $268,844

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

CIN: A-03-98-00027 KHPW/Institutional Status/Medicare, November 1998, $263,573

CIN: A-04-99-54767 Anderson-Oconee Head Start Project Inc., October 1998, $254,673

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

CIN: A-05-00-60454 St. Croix Chippewa of Wisconsin, December 1999, $224,452

CIN: A-04-96-01135 Partic. Part of HCFA Survey Washington Manor Nursing - ORT, February 1997, $220,483

CIN: A-09-96-00094 ORT- Monitor CPA Audit of "Dynasty" HHA Cost Report, July 1997, $217,720

CIN: A-05-00-57443 Michigan Family Independence Agency, July 2000, $216,563

CIN: A-01-00-65823 South County Community Action Inc., August 2000, $211,504

CIN: A-05-96-00052 ORT Assist-Ancillary Costs-NW Com. Hospital, June 1997, $206,508

CIN: A-03-98-00014 Connecticut Pro Inc/CCAS/HHS-100-95-0033, February 1998, $202,662

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

CIN: A-01-97-00531 Medicare Admin. Costs - MABCBS, June 1998, $198,950

CIN: A-06-00-57470 Jicarilla Apache Tribe, October 1999, $198,118

CIN: A-05-97-00006 MI - Wayne State U/NIH Request/Romero Grant, June 1997, $195,809

CIN: A-09-99-57168 NA-Santa Ysabel Band of Mission Indians, September 1999, $194,843

CIN: A-05-00-63513 BBF Family Services, March 2000, $183,711

CIN: A-04-99-57581 NA-Harambee Child Development Council Inc., September 1999, $173,256

CIN: A-03-99-00007 Forest Ambulance Service - External, December 1998, $173,189

CIN: A-05-96-00031 WIPro/Equipment Depreciation, August 1996, $167,033

CIN: A-05-00-56834 NA- Springfield Urban League Inc., October 1999, $166,345

CIN: A-07-99-01287 Wellmark Admin. Costs 98, November 1999, $160,626

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

CIN: A-03-98-00034 Freestate HP/Institutional Status/Medicare, March 1999, $156,987

CIN: A-09-00-62575 Hawaii Dept. of The Attorney General, March 2000, $155,339

CIN: A-08-99-60402 State of South Dakota, July 1999, $142,748

CIN: A-07-99-54163 Ponca Tribe of Nebraska, May 1999, $141,475

CIN: A-04-96-01147 ORT Review Parker Jewish Geriatric Ctr, New Hyde, NY, April 1997, $140,188

CIN: A-03-98-00025 Abingdon Ambulance Company - Abingdon, VA, January 1999, $139,325

CIN: A-06-99-58786 Arkansas Dept. of Human Services, March 1999, $137,218

CIN: A-09-99-52846 Inter-Tribal Council of California Inc., February 1999, $136,360

CIN: A-02-98-01002 IPRO Closeout Audit - CPA Contract Monitoring, December 1998, $135,492

CIN: A-06-00-00014 Review of Infusion Therapy Claims at Doctors HealthCare, June 2000, $132,238

CIN: A-02-95-34279 Puerto Rico Dept. of Health, June 1995, $125,473

CIN: A-05-97-00023 Kaiser Foundation - HMO Institutional Status Project, April 1998, $116,096

CIN: A-02-96-02001 International Rescue Committee - Refugee Program, January 1998, $114,631

CIN: A-03-99-00003 AETNA-US Healthcare/Institutional Status/Medicare, July 1999, $113,993

CIN: A-03-95-03329 Henderson Associates/CACS/ASC/282-91-0012, March 1997, $111,289

CIN: A-02-96-01001 VNS of NY Home Care - ORT/HHA Target, September 1997, $110,841

CIN: A-01-00-62266 State of Maine, March 2000, $106,500

CIN: A-04-00-64861 State of North Carolina, June 2000, $105,219

CIN: A-08-00-61777 NA-Turtle Mountain Band of Chippewa Indians, November 1999, $104,590

CIN: A-09-99-59788 Palau Community Action Agency, June 1999, $102,653

CIN: A-02-99-58263 Puerto Rico Office of The Governor Office of Child, July 1999, $101,799

CIN: A-10-00-61811 State of Washington, January 2000, $101,047

CIN: A-09-99-59834 Government of Guam, June 1999, $99,978

CIN: A-05-00-65775 State of Wisconsin, September 2000, $98,586

CIN: A-09-97-00066 Walter McDonald - Indirect Cost Rate Audit, March 1998, $95,733

CIN: A-05-00-65108 NA-Illinois Dept. of Public Aid, July 2000, $95,309

CIN: A-09-98-00065 CSBG DISC. Grant #90EE004901 - Latino Resources, January 1999, $95,102

CIN: A-01-99-00507 Nationwide Ref Outpatient Psychiatric Services at Acute Care Hospitals, March 2000, $94,716

CIN: A-10-97-00003 BCWAAK - Admin. Costs Remote Network Activities FY 93&94, FEBRUARY 1998, $94,643

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

CIN: A-07-95-01164 Medicare Admin. Costs - General American, December 1995, $89,929

CIN: A-01-99-57358 Organix Inc., February 1999, $89,395

CIN: A-06-00-00013 Review of Infusion Therapy Claims at Spring Creek N, June 2000, $89,288

CIN: A-08-99-56914 Rural America Initiatives, July 1999, $87,468

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

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

CIN: A-09-99-56382 Metropolitan Area Advisory Committee, January 1999, $82,600

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

CIN: A-04-94-02080 Finalization of BCBSFL Data Match, June 1995, $79,316

CIN: A-03-98-00008 VA Health Quality Center Review ORG/Pro/CCAS/VA, December 1998, $78,207

CIN: A-08-00-64682 Inter-lakes Community Action Inc., June 2000, $77,011

CIN: A-04-00-65037 Coastal Community Action Inc., August 2000, $76,235

CIN: A-04-96-01137 Partic. Part of HCFA Survey Team-Daytona Nursing - ORT, December 1996, $76,130

CIN: A-09-00-60032 Lovelock Paiute Tribe, December 1999, $74,187

CIN: A-09-99-56272 NA-Rincon San Luiseno Band of Mission Indians, September 1999, $71,017

CIN: A-06-00-62331 City of Houston Texas, January 2000, $70,044

CIN: A-01-97-00520 CFO Audit of HCFA's Financial Statements, July 1998, $69,031

CIN: A-09-00-60444 Yomba Shoshone Tribe, December 1999, $64,030

CIN: A-05-99-00045 Kaiser Health Plan of Ohio - Institutional Status, May 2000, $61,177

CIN: A-05-96-00072 MI Dept. of Community Health/Medicaid Lab Services, August 1997, $59,956

CIN: A-03-99-00200 PSU-Geisinger/Physician Credit Balances/Medicaid, December 1999, $59,051

CIN: A-02-00-62534 City of New York, New York, January 2000, $58,309

CIN: A-07-92-00526 MMIS Enhanced FFP Costs, July 1992, $58,149

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

CIN: A-09-97-00059 Health Services Advisory Group, Inc Pro-AZ, May 1997, $57,925

CIN: A-09-99-56270 NA-Rincon San Luiseno Band of Mission Indians, September 1999, $57,636

CIN: A-08-99-54138 Rosebud Sioux Tribe, November 1998, $56,223

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

CIN: A-04-00-64899 NA-State of Tennessee, July 2000, $55,129

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

CIN: A-10-00-62761 Burns Paiute Indian Tribe, February 2000, $53,516

CIN: A-08-00-60687 South Dakota Foundation For Medical Care, November 1999, $52,536

CIN: A-06-99-59854 State of Louisiana, August 1999, $51,788

CIN: A-09-95-00095 Health Services Advisory Group, Inc (HSAG), December 1995, $49,585

CIN: A-03-93-03306 Survey Research Assoc. CACS NO1-ES-45067, December 1993, $48,779

CIN: A-02-95-34276 Puerto Rico Dept. of Health, June 1995, $46,922

CIN: A-08-00-57179 NA-Turtle Mountain Band of Chippewa Indians, November 1999, $45,422

CIN: A-04-99-60712 Coastal Community Action Inc., September 1999, $44,000

CIN: A-09-99-52845 Inter-Tribal Council of California Inc., February 1999, $43,315

CIN: A-09-99-57306 Picayune Rancheria of The Chukchansi Indian Tribe, September 1999, $43,159

CIN: A-07-00-64873 State of Nebraska, May 2000, $42,824

CIN: A-03-99-00017 PSU-Hershey/Physician Credit Balances/Medicare, December 1999, $41,712

CIN: A-09-00-60443 Yomba Shoshone Tribe, January 2000, $41,373

CIN: A-02-95-34275 Puerto Rico Dept. of Health, June 1995, $37,515

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

CIN: A-02-99-59166 Cypress Hills Child Care Corp., September 1999, $36,935

CIN: A-07-98-53295 Winnebago Tribe of Nebraska, September 1998, $36,808

CIN: A-10-00-63008 State of Idaho, March 2000, $36,800

CIN: A-08-00-65136 State of South Dakota, June 2000, $36,380

CIN: A-03-99-57965 NA-District of Columbia Dept. of Human Services, February 1999, $35,975

CIN: A-07-98-02030 DOSHI - CPA Report, November 1997, $35,703

CIN: A-02-00-65502 Abyssinian Development Corp., August 2000, $34,737

CIN: A-04-00-65587 Taylor County District School Board, September 2000, $33,827

CIN: A-07-97-01218 DOSHI - Utah/Nevada FMC, March 1997, $33,752

CIN: A-05-00-62763 Upper Midwest American Indian Center, January 2000, $33,127

CIN: A-03-99-00004 PSU-Geisinger/Physician Credit Balances/Medicare, December 1999, $32,165

CIN: A-07-97-01199 BCBS New Mexico Unfunded Pension Cost, February 1997, $31,372

CIN: A-06-00-59472 Pueblo of Acoma, April 2000, $31,259

CIN: A-06-00-66017 Northcentral Arkansas Development Council Inc., September 2000, $30,813

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

CIN: A-03-00-63919 Mingo County Economic Opportunity Commission Inc., March 2000, $30,453

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

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

CIN: A-03-00-65199 Association of American Medical Colleges, September 2000, $28,716

CIN: A-03-98-03301 AAUAP - Incurred Cost Review - HHS 105-95-7011, APRIL 1998, $28,289

CIN: A-08-00-65151 Rocky Boy School District No. 87J & L, July 2000, $28,139

CIN: A-03-00-64076 National Medical Association, April 2000, $27,106

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

CIN: A-05-00-60452 St. Croix Chippewa of Wisconsin, December 1999, $26,363

CIN: A-04-00-62745 Pasco County District School Board, January 2000, $26,358

CIN: A-03-92-00033 Blue Cross of West Virginia Termination, November 1992, $25,200

CIN: A-06-00-00020 Review of Infusion Therapy Claims at Vista Continuing, June 2000, $25,008

CIN: A-08-00-59365 Three Affiliated Tribes, December 1999, $24,745

CIN: A-10-00-58628 NA-Kuigpagmiut Inc., November 1999, $24,596

CIN: A-04-00-64117 State of Alabama, April 2000, $23,911

CIN: A-03-00-00004 Guthrie Clinic/Physician Credit Balances/Medicare, December 1999, $23,759

CIN: A-08-00-60654 Spirit Lake Tribe, January 2000, $22,031

CIN: A-07-99-01288 Wellmark Medicare Admin. Costs, November 1999, $21,513

CIN: A-04-00-01206 BCBSNC - Medicare Part A Admin. Cost Audit-Carmichael, September 2000, $21,302

CIN: A-03-00-65163 George Washington U., September 2000, $20,879

CIN: A-07-99-01290 Moh Admin. Costs, November 1999, $20,548

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

CIN: A-04-00-62452 Clarksville - Montgomery County Community Action A, January 2000, $19,114

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

CIN: A-03-00-61948 Mingo County Economic Opportunity Commission Inc., January 2000, $18,703

CIN: A-03-00-00200 Guthrie Clinic/Physician Credit Balances/Medicaid, December 1999, $18,318

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

CIN: A-01-00-61896 Jewish Family Service of Stamford Inc., December 1999, $18,027

CIN: A-09-99-59787 Palau Community Action Agency, June 1999, $17,612

CIN: A-03-99-00201 PSU- Hershey/Physician Credit Balances/Medicaid, December 1999, $17,584

CIN: A-03-97-00007 NE Health Care Quality Foundation/ccas/n Hampshire, March 1997, $17,045

CIN: A-01-99-55594 State of Vermont, November 1998, $16,623

CIN: A-01-97-44143 Brandeis U., January 1997, $16,602

CIN: A-05-00-60814 Childrens Hospital of Michigan Inc., November 1999, $16,191

CIN: A-10-00-62940 Lutheran Social Services of Washington & Idaho, February 2000, $15,900

CIN: A-01-00-65091 State of Vermont, July 2000, $15,853

CIN: A-10-00-59080 Norton Sound Health Corp., December 1999, $15,000

CIN: A-04-99-01200 OIG-HCFA Joint Review of Gem Physical Therapy Inc., December 1999, $14,604

CIN: A-03-97-00008 NE Health Care Quality Foundation/CCAS/Vermont, March 1997, $14,596

CIN: A-07-99-60332 State of Nebraska, July 1999, $14,209

CIN: A-06-98-54189 City of Houston Texas, July 1998, $14,146

CIN: A-09-96-00050 CFO - HCFA 1996, November 1997, $13,924

CIN: A-10-00-63684 Hoh Indian Tribe, April 2000, $13,602

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

CIN: A-07-99-57985 State of Kansas, February 1999, $13,550

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-01-98-00531 Medicare Cr Bal Recoup ESRD FAC Florida BlueCross, January 2000, $12,432

CIN: A-09-00-61853 Fresno Indian Health Association Inc., March 2000, $11,963

CIN: A-04-99-59501 Chapel Hill-Carrboro City Board of Education, June 1999, $11,256

CIN: A-08-00-56759 South Dakota Urban Indian Health Inc., November 1999, $10,933

CIN: A-09-00-62572 NA-Fresno Indian Health Association Inc., February 2000, $10,720

CIN: A-06-00-65377 Osage Nation, September 2000, $10,652

CIN: A-06-00-64997 State of Oklahoma, May 2000, $10,348

CIN: A-10-99-59863 Coastal Community Action Program, September 1999, $10,187

CIN: A-07-00-63881 Santee Sioux Tribe of Nebraska, April 2000, $10,187

CIN: A-05-00-57466 Sault Ste. Marie Tribe of Chippewa Indians, October 1999, $10,000

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

CIN: A-10-00-62578 State of Alaska, February 2000, $9,159

CIN: A-10-00-63241 Lutheran Social Services of Washington & Idaho, February 2000, $9,053

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

CIN: A-07-97-01231 PROWEST-DOSHI Washington, June 1997, $8,027

CIN: A-05-00-63666 Ho-Chunk Nation, February 2000, $7,851

CIN: A-03-91-02004 WVA B/C Admin. Cost FY 85/90 And Term. Cost, November 1992, $7,556

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

CIN: A-03-98-00045 Temple U./Physician Credit Balances/Medicare, July 1999, $7,280

CIN: A-01-97-49174 Brandeis U., August 1997, $7,068

CIN: A-01-00-61715 State of Vermont, October 1999, $6,766

CIN: A-06-96-40858 CADDO Community Action Agency Inc., February 1996, $6,557

CIN: A-09-00-58580 Tohono O Odham Nation, November 1999, $6,456

CIN: A-04-99-56945 Quitman County Development Organization Inc., March 1999, $6,142

CIN: A-07-95-01167 Pension Costs Claimed Nebraska BCBS, January 1996, $6,075

CIN: A-06-97-48062 SER-Jobs For Progress National Inc., May 1997, $5,924

CIN: A-05-00-58003 Community Unit School District No. 300, October 1999, $5,858

CIN: A-08-99-56446 Sisseton-Wahpeton Sioux Tribe, May 1999, $5,843

CIN: A-08-00-59899 South Dakota Urban Indian Health Inc., November 1999, $5,496

CIN: A-02-99-56463 Virgin Islands Advocacy Agency Inc., November 1998, $5,089

CIN: A-09-00-64725 Northland Crisis Nursery Inc., August 2000, $4,986

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

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

CIN: A-01-00-60299 Indian Township Tribal Government Passamaquoddy TR, January 2000, $4,597

CIN: A-06-00-65759 Seminole Nation of Oklahoma, August 2000, $4,584

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

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

CIN: A-04-00-65140 Four Square Community Action Inc., July 2000, $3,798

CIN: A-02-00-64365 NA- Municipality of Ponce Puerto Rico, May 2000, $3,788

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

CIN: A-04-99-59126 Sequatchie Valley Planning & Development Agency, September 1999, $3,360

CIN: A-01-98-00512 CFO of HCFA's FY 1997 Medicare Benefit Payments, June 1998, $3,264

CIN: A-06-00-65029 State of Louisiana, July 2000, $3,162

CIN: A-03-95-03318 Trans-Management Systems 105-92-1527 (CCO), May 1996, $3,016

CIN: A-07-00-62371 Omaha Tribe of Nebraska, March 2000, $3,005

CIN: A-07-98-02502 CT BCBS Pension Costs Claimed, March 1998, $2,725

CIN: A-03-98-51505 Alliedsignal Technical Services Corp., April 1998, $2,722

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

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

CIN: A-01-97-45487 ABT Associates Inc., January 1997, $2,596

CIN: A-08-00-61852 Native American Services Agency Inc., February 2000, $2,575

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

CIN: A-04-00-61462 Amputee Coalition of America, November 1999, $2,550

CIN: A-02-00-62577 Seneca Nation of Indians, January 2000, $2,545

CIN: A-06-00-58523 Osage Nation of Oklahoma, October 1999, $2,247

CIN: A-07-97-01221 PRO Closeout - DOSHI CPA - ARK Fdn for Med Care, March 1997, $2,096

CIN: A-09-98-53899 Stanford U., June 1998, $2,058

CIN: A-03-96-44076 St. Pauls College, August 1996, $2,029

CIN: A-10-96-38114 State of Washington, February 1996, $2,000

CIN: A-07-97-01232 PROWEST - DOSHI Alaska, June 1997, $1,473

B. Audit on which a management decision had not been made within 6 months due to possible litigation:

CIN: A-05-99-60620 Red Cliff Band of Lake Superior Chippewa Indians, July 1999, $1,459

Table II

[1] The opening balance was adjusted to reflect a downward revaluation of $126 million.

[2] Management decision has not been made within 6 months of issuance on 22 reports:

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

CIN: A-01-99-00507	Nationwide Ref Outpatient Psychiatric Services at Acute Care Hospitals, March 2000, $224,466,692
CIN: A-07-98-02534	Empire BCBS Pension Plan Termination, March 2000, $38,626,351
CIN: A-04-97-00109	Emergency Assistance Claims - NC, July 1998, $13,000,000
CIN: A-03-91-00557	Independent Living Program - National, March 1993, $10,161,742
CIN: A-07-96-01177	Medicare Post Retirement Claim BC Mich, November 1996, $8,978,998
CIN: A-01-97-02506	Review of the Avail of Medical Coverage/CSE Support, June 1998, $5,704,585
CIN: A-04-98-01188	Review Admin. Costs of Medicare Managed Risk Plan, August 1999, $2,559,357
CIN: A-09-95-00095	Health Services Advisory Group, Inc (HSAG), December 1995, $1,389,723
CIN: A-07-97-01230	OFMQ - DOSHI Oklahoma, June 1997, $203,510
CIN: A-07-97-01231	PROWEST - DOSHI Washington, June 1997, $163,552
CIN: A-02-96-02001	International Rescue Committee - Refugee Program, January 1998, $90,528
CIN: A-08-00-64113	Rural America Initiatives, April 2000, $87,468
CIN: A-07-97-01235	DOSHI - Texas, June 1997, $ 51,334
CIN: A-07-97-01232	PROWEST - DOSHI Alaska, June 1997, $21,218
CIN: A-09-00-60029	Cocopah Indian Tribe, December 1999, $20,830
CIN: A-05-96-00069	CPA Audit of Hooper Holmes HHA G&A - OI Case Open, February 1998, $17,555
CIN: A-07-95-01164	Medicare Admin. Costs - General American, December 1995, $16,632
CIN: A-01-97-00526	Psychiatric Outpatient Services, March 1998, $7,245
CIN: A-01-98-00506	Psychiatric Outpatient at Newton-Wellesley Hospital, March 1998, $1,120

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	71
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	72
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	69
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	70
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none

APPENDIX F

Performance Measure

Performance Measures

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

Page

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
P.L. 106-398	Government Information Security Reform Act
P.L. 106-554	Report on Federal Agencies' Monitoring of Personal Information Through "Cookies"
P.L. 106-554	Report on Water/Sewer Services Provided by the District or Columbia

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(l), 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, sections 3729-3733, (the False Claims Act) and 3801-3812 (the Program Fraud Civil Remedies Act)

Title 42, United States Code, sections 1320a-7, 1320a-7a (Civil Monetary Penalties Law), 1320b-10, 1320c-5, 1395l, 1395m, 1395u, 1395dd ("Patient Anti-Dumping" Act) and 1396b

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