

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SUMMARY OF OIG ACTIVITIES ON
MEDICAID**



JUNE 1993

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program, and management problems, and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

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The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

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JUNE 1993 OEI-12-92-00550

EXECUTIVE SUMMARY

PURPOSE

This report consolidates information obtained during the course of Office of Inspector General (OIG) reviews of the Medicaid program and offers solutions to long standing problems. This is not an assessment of the Health Care Financing Administration's (HCFA) effectiveness in managing Medicaid. We focus on problems that have not been resolved. As policymakers consider ways to reform the health care system, lessons drawn from the Medicaid program can be instructive.

BACKGROUND

The Medicaid program is the major vehicle through which the Federal and State governments provide health care to low income persons and long term care to the disabled and low income elderly.

In Fiscal Year (FY) 1991, 28.2 million Medicaid beneficiaries were eligible for services. Thirteen million of those were children; another 6.8 million were their parents. While the nonelderly poor comprise the great majority of Medicaid beneficiaries, they use proportionately far fewer of Medicaid's dollars than the 3.4 million elderly beneficiaries or the 4.1 million blind or disabled beneficiaries. In reality, a few beneficiaries requiring intensive services consume most of the dollars spent by the Medicaid program. Elderly persons receiving long term care represent 6 percent of beneficiaries, using 30 percent of program spending. Nonelderly disabled persons represent 15 percent of Medicaid beneficiaries, using 38 percent of program spending. Of \$76.9 billion in vendor payments made in fiscal year 1991, 28 percent went to hospitals for inpatient services, 27 percent went to nursing facilities, and 10 percent went for intermediate care services for the mentally retarded.

ISSUES

The Medicaid program must successfully implement major new legislation expanding eligibility for services and implementing cost containment measures, such as service expansions for pregnant women and children.

The Medicaid program must aggressively identify policies which are outdated and waste precious resources, such as overly generous payments to institutions for mentally retarded persons and enhanced Federal matching for family planning services.

The Medicaid program must identify new strategies to maximize its health care dollars, such as managed care and cost sharing.

States must ensure that payments made to providers are fair while reducing administrative burdens, through operational changes to ensure claims are accurate and overpayments

are recovered, scrutiny of payment rates which might be too generous to some providers and too skimpy to others, aggressive pursuit of third party liability, review of claims to ensure services are medically necessary, and more extensive use of electronic claims, review and payment.

The Medicaid program must ensure that long term care expenditures, which account for a large proportion of Medicaid outlays, are managed wisely, through tighter limits on transfers of assets and tougher asset recovery laws.

The Medicaid program must ensure that quality of care is being delivered to beneficiaries, including effective implementation of new rules for nursing homes, development of an effective system of quality assurance for Medicaid managed care settings, and implementation of new rules for review of drug use.

The Medicaid program must effectively protect itself from fraud and abuse, taking full advantage of Medicaid Fraud Control Units, identifying questionable patterns of care and billings, and designing strategies to prevent fraud.

Finally, Federal and State relations must be improved, thus avoiding unconstructive attempts by the Federal government to save money or accomplish its objectives at the expense of States and unproductive attempts by the States to increase the amount of Federal funds they receive without instituting real changes in their own programs.

RECOMMENDATIONS

As discussed in this report, the problems and challenges facing the Medicaid program are substantial. We are aware, of course, that many policymakers are arguing for a fundamental restructuring or elimination of the Medicaid program. During the course of our audits, inspections, and investigations in the Medicaid program, we have made numerous specific recommendations for change. Many of these recommendations have been accepted by the Health Care Financing Administration and some have not. Some require legislative changes; others require action by the States.

All significant unimplemented OIG recommendations are included in one of two documents. The Office of Inspector General Cost-Saver Handbook (the Red Book) is a compendium of OIG recommendations to reduce unnecessary spending by the Department through administrative or regulatory change, or by the Congress and Administration through legislative change. The Office of Inspector General Program and Management Improvement Handbook (Orange Book) contains recommendations for strengthening program and management efficiency and effectiveness. For our readers' convenience, we have reproduced our listing of recommendations to improve the Medicaid program in the appendices to this report.

We are pleased to see that the Administration supports our recommendations for extending the ban on self-referral, for lifting the ban on drug formularies, and for tightening loopholes on transfers of assets and strengthening asset recovery laws.

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INTRODUCTION

PURPOSE

This report consolidates information obtained during the course of Office of Inspector General (OIG) reviews of the Medicaid program and offers solutions to long standing problems. This is not an assessment of the Health Care Financing Administration's (HCFA) effectiveness in managing Medicaid. We focus on problems that have not been resolved. As policymakers consider ways to reform the health care system, lessons drawn from the Medicaid program can be instructive.

BACKGROUND

The Medicaid program is the major vehicle through which the Federal and State governments provide health care to low income persons and long term care to the disabled and low income elderly. Persons receiving grants from the Aid to Families with Dependent Children (AFDC) program, and the aged, blind or disabled receiving cash assistance through Supplemental Security Income (SSI), are "categorically" eligible for Medicaid. Asset and income tests are also applied. States can, at their option, expand eligibility under Medicaid to the "medically needy," those who are categorically eligible but don't meet the income and asset tests.

In Fiscal Year (FY) 1991, 28.2 million Medicaid beneficiaries were eligible for services. Thirteen million of those were children; another 6.8 million were their parents. While the nonelderly poor comprise the great majority of Medicaid beneficiaries, they use proportionately far fewer of Medicaid's dollars than the 3.4 million elderly beneficiaries or the 4.1 million blind or disabled beneficiaries. In reality, a few beneficiaries requiring intensive services consume most of the dollars spent by the Medicaid program. Elderly persons receiving long term care represent 6 percent of beneficiaries, using 30 percent of program spending. Nonelderly disabled persons represent 15 percent of Medicaid beneficiaries, using 38 percent of program spending. Of \$76.9 billion in vendor payments made in fiscal year 1991, 28 percent went to hospitals for inpatient services, 27 percent went to nursing facilities, and 10 percent went for intermediate care services for the mentally retarded.

Administration of the Program

States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining income and other resource criteria for eligibility, covered benefits, and provider payment mechanisms. As a result, Medicaid programs vary considerably from State to State.

Within the Federal government, the Health Care Financing Administration is responsible for reviewing State plans for their Medicaid programs and approving

waivers from Federal rules. The Medicaid Bureau was established in order to give proper attention to the role of the Federal government in overseeing States' implementation of Federal requirements.

Program Costs

The Medicaid program is financed jointly with State and Federal funds. Federal contributions vary from State to State and currently range from 50 percent to 83 percent of program medical expenditures. Administrative costs are financed at other rates.

Medicaid is a major source of budget pressures for both the Federal and State governments. Expenditures have grown dramatically in recent years. Total Medicaid expenditures were \$88 billion in 1991, compared to \$38 billion in 1988. For States, this means that Medicaid threatens to break the bank. It is the second largest or largest State budgetary item in most States, surpassed only by education. Some States have responded by cutting services or limiting eligibility. The pressures that are placed on the Federal government are also serious. If current trends continue, Federal expenditures for Medicaid will match Federal expenditures for Medicare sometime around 1997. The Congressional Budget Office projects that Medicaid will represent seven percent of all Federal spending in 1996, compared to three percent in 1990.

Recent Initiatives

In recent years, two competing pressures have been placed upon the Medicaid program. First, the program has been called upon to provide more services or provide existing services to more beneficiaries. New Federal mandates were placed upon States to expand coverage for pregnant women and children. At the same time, the Federal government has called upon States to reduce their costs.

Because of their frustration with the program's rising costs, administrative requirements, and new mandates, States have taken action. Some States have attempted to implement new and innovative ways of providing health care for their low-income and disabled populations, but face losing Federal financial support if existing Medicaid rules aren't waived. Many States have instituted measures, such as provider taxes, to increase the amount of the Federal match. Other States weigh reducing services or limiting eligibility to portions of their Medicaid populations.

Role of the Office of Inspector General

The OIG's mandate is to protect the integrity of the United States Department of Health and Human Services' (DHHS) programs and the beneficiaries of those programs by reducing fraud, waste and abuse and by promoting the effectiveness and efficiency of the department's programs.

The OIG accomplishes its mission through a series of audits, evaluations (inspections) of program operations, and investigations of possible civil or criminal violations. The OIG also reviews all regulatory and legislative proposals developed by the Department to assess their effect on fraud, waste and abuse.

Methodology

The issues presented in this report are based on the inspection, audit and investigative work of the OIG.

Rather than present findings, as we normally do, this report describes the challenges facing the Medicaid program. We describe how program managers must implement new requirements successfully, identify outdated and wasteful policies, identify new strategies to maximize its health care dollars, ensure that providers are paid fairly while reducing administrative burdens, ensure that long term care dollars are managed wisely, ensure that services provided are of high quality, protect the program from fraud and abuse, and ensure a constructive relationship between the Federal and State governments.

ISSUES

IMPLEMENTING MAJOR NEW LEGISLATION

The Medicaid program must successfully implement major new legislation expanding eligibility for services and implementing cost containment measures.

- ▶ *HCFA and the States must successfully implement program expansions for pregnant women and children.*

Eligibility levels for the Medicaid program have recently been extended beyond the traditional "welfare" populations previously served by Medicaid. Medicaid programs must now cover all pregnancy related services for pregnant women, and medical services for children under age six, whose income exceeds the States' AFDC income level but is less than 133 percent of the Federal poverty level. At their option, States can receive Federal matching for such services provided for pregnant women and children up to 185 percent of the Federal poverty level. By 2001, all children under age 19 in families living under the Federal poverty level must be covered by Medicaid.

Our 1992 report on the Medicaid expansions for pregnant women found that many States have endorsed the optional eligibility expansions, with some States innovatively implementing the expansions. However, significant problems still prevent newly eligible women from receiving prenatal care. These problems include inadequate client outreach, cumbersome application processes, insufficient prenatal providers, difficulties with presumptive eligibility, staffing shortages, lack of timeliness in providing information and training for States to implement the expansions, and inadequate data collection systems and evaluation processes to measure progress and outcomes.¹ The OIG plans periodic reports on States' efforts in these areas.

- ▶ *HCFA and the States must successfully implement program expansions for EPSDT mandated in OBRA 1989.*

OBRA 1989 enacted major changes to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, which is the mandatory program to provide comprehensive health services to those under 21. Children must be screened periodically for health and developmental problems. If potential problems are found, the child must be referred for further services or treatment.

OBRA 1989 instituted new major changes to the EPSDT program. Among other things, it required HHS to establish goals for States to meet and mandated coverage of any service found to be necessary as a result of screenings.

The HHS set a yearly participation goal for each State, by the end of FY 1995, to screen at least 80 percent of EPSDT-eligible children and to provide at least 80 percent of screenings recommended for children. States report on their performance

to the Federal government. An OIG inspection completed in August 1992 examined State reports from the period April 1, 1990 to September 1, 1990. We found that the screening and participation ratios used to measure States' performance in the EPSDT program are essentially inaccurate. According to their own reporting, some States screen more than 100 percent of eligible children. At the same time we conducted our study, HCFA had formed a task group to evaluate the EPSDT reporting system. We recommended that HCFA modify the methods by which it measures screening and participation rates so that they are meaningful and accurate reflections of performance.² The HCFA agreed with our recommendations. We are awaiting final action to implement the necessary changes. Once these changes are place, it will be both possible and important to monitor State performance, understand why some States may be performing better than others, and take necessary corrective action so that all States may reach the goals set by OBRA.

A second major change under OBRA 1989 is that States must now pay for any service that is necessary to treat a condition a screening identifies, whether or not the State Medicaid plan covers the service (as long as the service is one for which Federal matching payments would be allowed). In a future study, the OIG plans to evaluate what kinds of treatments are being provided and how referrals for treatment are being made under the EPSDT program.

- ▶ *HCFA and the States must successfully implement new programs designed to limit Medicaid costs mandated in OBRA 1990.*

OBRA 1990 included provisions for two new programs designed to control Medicaid costs: a rebate program for prescription drugs, and a buy-in provision for private insurance by Medicaid for some beneficiaries.

Drug Rebate Program: Though an optional service (not required to be provided by Federal rules), nearly all States cover prescription drugs. Due to concerns that costs of prescription drugs for Medicaid were rising faster than both the non-medical and medical inflation rate, and that Medicaid programs were paying more than other purchasers for such drugs, the Congress enacted legislation in OBRA 1990 requiring drug manufacturers to give rebates to Medicaid programs as a condition for participation in Medicaid payments for their drugs.

Section 4401 of OBRA 1990 established a detailed process for the payment of rebates under Medicaid by drug manufacturers to the States and HCFA. As a condition for payment by the Medicaid program to pharmacies for a manufacturer's drugs, the drug manufacturer must enter into a contractual arrangement with HHS (acting for the States), whereby the manufacturer will offer rebates to the States in exchange for the States agreeing to cover all of the manufacturer's drugs under Medicaid (the law nearly eliminated the use of drug formularies).

The rebates are calculated using formulas based on manufacturer pricing data. The law requires manufacturers to report quarterly to the Secretary on their average

manufacturer price (AMP) and their "best price" for each covered drug (the lowest price offered to any buyer). The HCFA provides this information to the States. States use claims data to determine the total number of doses of each drug dispensed in the previous quarter and the pricing data provided by the manufacturers through HCFA to arrive at a bill that is submitted to the manufacturer. This bill represents the difference between the AMP and the best price, multiplied by the number of doses paid for by the State Medicaid program.

Since the law's inception in January 1991, the OIG has been actively involved in monitoring the implementation of the drug rebate program. Certain significant problems have been identified, including:

- ▶ Drug manufacturers are increasing the "best price" of Medicaid covered drugs.³
- ▶ States had no procedures to monitor the correct identification of either the drug product or number of units dispensed, as reported by pharmacists.⁴
- ▶ Drug manufacturers vary in the methods they use to determine AMP and the length of time records should be retained.⁵
- ▶ HCFA supplied inaccurate unit rebate data to the States for all new drugs that entered the market during the first quarter of 1991.⁶
- ▶ HCFA supplied pricing data to the States that included errors in AMP, base AMP, and best price, resulting in unit rebate amounts being overstated.⁷
- ▶ HCFA has not ensured that States establish adequate accountability and control over the drug rebate program. Of \$475 million in rebates billed in 1991, \$111 million remains uncollected.⁸

In addition to concerns regarding the implementation of the drug rebate program, we are also concerned that the law may have "given away with the left hand what it took with the right" when it effectively eliminated formularies.

In 1990, we studied the difference between Canada's reimbursement for drugs and costs of the Medicaid program. We estimated that the Medicaid program paid \$474 million more for name brand drugs than would have been paid by Canadian prescription drug programs. Canada's lower prices were attributable to negotiated price reductions between the drug manufacturers and provincial government. Centrally, the Federal government (Ottawa) sets prices through a price control board. Importantly, provinces can include or exclude drugs in their formularies (lists of covered drugs), and thus can decide that a given drug is too expensive and other options are available.⁹

We recommended that HCFA address rising drug costs by pursuing strategies to limit payments for drugs. We suggested three options: drug formularies (which were

eliminated by OBRA 1990), drug price limits, and negotiation with manufacturers. Relying solely on a rebate program as a form of negotiation, without the option of deciding what you'll pay for, reduces the amount of cost savings available. In the course of our work on the drug rebate program, we attributed part of over \$500 million in increased drug costs by the Medicaid program to OBRA 1990's requirement that States open drug formularies.¹⁰

Use of Employer Group Health Insurance: Section 4402 of OBRA 1990 requires States to purchase (buy in) group health insurance for Medicaid clients when such purchases would be cost effective. The first step in implementing this mandate is for States to establish methodologies and systems for determining cost effectiveness. Currently only about 18 States have established some sort of program. Methodologies for measuring cost effectiveness (as a basis for deciding whether to buy into the private insurance plan) include diagnosis or disease based systems, demographically determined systems, or systems which include both approaches. We are currently gathering details on these systems and the savings they have generated for States, if any.

IDENTIFYING OUTDATED POLICIES

The Medicaid program must aggressively identify policies which are outdated and waste precious resources.

Over time, the Medicaid program has instituted policies designed to provide financial incentives for certain types of care, to increase the quality of care, or to maintain or improve access to care. In light of the scarce resources that are available to the Medicaid program, the continued justification for such policies must be reviewed once new information suggests a better course of action or the original objectives are met. In this regard, we would point to two examples: reimbursement policies for State-operated intermediate care facilities for the mentally retarded (ICF/MRs); and enhanced Federal financial participation (FFP) for family planning services.

Reimbursement for State ICF/MRs: At one time, the quality of care provided to most persons suffering from mental retardation ranged from poor to worse. In response, public financing and direct provision of care to the mentally retarded, often in the form of large State-run institutions, became quite popular. In 1971, the Medicaid program was amended to provide Federal reimbursement to States for caring for people with developmental disabilities living in institutions. As a result of public support for these institutions, the quality of care provided to persons who are mentally retarded improved quite dramatically.

Today, however, the situation is different. The preferred setting for treating persons with developmental disabilities has shifted from the institutional to community based care. A number of studies have shown that clients with developmental disabilities make better progress toward independent functioning in community rather than institutional settings. Still, Medicaid policies favor institutions (the amount spent on services in the community can't exceed the amount spent in the institutions) and

reimbursement rules for large State institutions are quite generous. Despite the policy shift toward community-based treatment, most Federal Medicaid funds for the developmentally disabled continue to be spent on large ICF/MRs.

Although Federal rules since 1980 require that reimbursement to State-run ICF/MRs reflect the reasonable costs of an efficiently and economically operated facility, these terms are not defined in regulation. Each State has considerable discretion in defining these terms and setting ICF/MR payment methodology.

A 1993 inspection conducted by the OIG examined payments to large, State-run ICF/MRs. We found that Medicaid reimbursement rates for large ICF/MRs are more than five times greater in some states than in others. Average Medicaid reimbursement in 1991 for large ICF/MRs ranged among States from \$27,000 to \$158,000 per resident. This variation was unrelated to the patients' severity of illness, quality of service, facility characteristics, or resident demographics.¹¹

We have recommended that HCFA take action to reduce excessive spending of Medicaid funds for ICF/MRs through administrative action, legislation to control ICF/MR reimbursement, or comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and Home and Community Based (HCB) waiver services for people with developmental disabilities. In addition to saving wasted dollars (we estimate that \$683 million in Federal and State Medicaid funds could have been saved in 1991 if costs were capped in ICF/MRs), such new policies would provide incentives for community-based care rather than institutional care.

Enhanced FFP for Family Planning Services: States have been reimbursed at the enhanced matching rate of 90 percent for family planning services since 1972. While the higher FFP rate was originally needed to "jump start" the program, family planning services are now a well established part of the States' Medicaid programs and it is time for this incentive to be eliminated. A 1992 OIG audit found that the 90 percent rate is costly, unjustified, and may act as a disincentive to the States' design and maintenance of internal controls.¹²

In addition to examining program costs funded at special rates, we are also looking at administrative costs for the AFDC, Medicaid and Food Stamp programs. We are exploring the impact of a single block grant for these three programs' administrative costs on the States and Federal government. Reducing special matching rates is one option that we are examining.

IDENTIFYING NEW STRATEGIES

The Medicaid program must identify new strategies to maximize its health care dollars.

Like every other third party insurer, the Medicaid program must search for ways it can make the best use of its health care dollars. In the course of our work on the Medicaid program, two important strategies present themselves: increased use of

managed care or gatekeepers as a way to reduce the inappropriate use of services and provide continuity of care; and cost-sharing by beneficiaries as a way to collect funds that can be used to maintain services.

Managed Care: Many health care policy analysts have suggested the use of managed care, whether in formal staff health maintenance organizations (HMOs) or in looser confederations of primary care case managers, as a way to reduce the inappropriate use of services by beneficiaries and provide better access to and continuity of care. While significant expansions in the use of managed care by Medicaid recipients will undoubtedly present new problems and challenges (such as the difficulty of recruiting case managers, as is now being faced by the Maryland Medicaid program), our work on nonurgent use of emergency rooms (ERs) suggests that managed care can indeed be an important strategy.

The use of emergency departments for non-urgent care by Medicaid recipients has long been recognized by State and Federal policymakers as a problem. In 1983, the OIG reported that Medicaid recipients use ERs for non-urgent care largely because other sources of care are either unavailable or inaccessible to them. We estimated that at least half of Medicaid ER visits were non-urgent and could have been more appropriately treated in community care settings.

Our 1992 study on use of ERs by Medicaid recipients found that non-urgent use of emergency rooms has remained a problem, for some of the same reasons we cited in 1983. We estimate that over one-half to two-thirds of Medicaid emergency room visits in our nine sample states are non-urgent.

We identified a number of ways that States are using to reduce non-urgent use of emergency rooms. These approaches include managed care, pre-paid plans, 24 hour telephone line to a nurse, tiered pricing, triage fees, emergency room claims review, co-payments, and lock-ins. The approach most frequently considered successful (by the states' own self evaluations) addresses access to care through managed care or prepaid programs. One of the primary functions of managed care/pre-paid plans is to provide recipients with an ongoing source of primary care and referral to other services. By having an individual or group act as a "gate keeper," and directing care to the most appropriate setting, the number of non-urgent visits to the emergency room may be reduced.

The success of state initiatives to control non-urgent use of ERs is difficult to document, but our sample states offered some evidence to indicate these controls have had a salutary effect. In Missouri, for example, ER visits by individuals enrolled in a managed care/pre-paid program have declined despite an increase in enrollment. In Wisconsin and Pennsylvania, the percent of non-urgent visits for Medicaid recipients enrolled in managed care is lower than that of Medicaid recipients in the traditional fee-for-service Medicaid program. For the years 1987 through 1989, seven states have reported savings of approximately \$182 million from managed care and pre-paid programs which included controls placed on non-urgent use of ERs. Three of the

programs have reported savings of approximately \$13.6 million that are directly attributable to ER controls.¹³

Cost Sharing: Section 1902(a)(14) of the Social Security Act provides that Medicaid may impose "enrollment fees, premiums, or similar charges, and deductions, costs sharing or similar charges." Children, HMO enrollees, pregnancy services, emergency services, hospice services, and services provided to residents of nursing facilities or medical institutions are exempt from cost sharing.

A 1993 study by the OIG found that 27 States use cost-sharing in their Medicaid programs. Copayments range from 50 cents to \$3.00, with the exception of inpatient hospital copayments which range up to \$50 per admission. Four States also use a 2 or 5 percent coinsurance for certain services, and one State recently implemented a inpatient hospital deductible of \$100. The cost of administering a cost-sharing program is minimal, since the charges are simply deducted from provider reimbursement, effectively requiring the provider to collect the copayment or accept a reduced fee.

States without cost sharing could save between \$167 and \$355 million annually by applying cost sharing to just four services--inpatient hospital services, outpatient hospital services, physician visits, and prescription drugs.

Although we did not find evidence to suggest that expanded cost-sharing in the Medicaid program will significantly reduce inappropriate use of services, neither did we find that cost-sharing created a barrier to the appropriate use of needed services. Essentially cost-sharing is a way for the program to offset some of its costs without undue burden on providers or beneficiaries, and in our view is certainly preferable to reducing services or eligible beneficiaries. As a result, we have recommended that HCFA promote the development of effective cost-sharing programs in the States.¹⁴

ENSURING FAIR PAYMENTS AND REDUCING BURDENS

States must make operational changes to ensure that payments made to providers of service are fair and that payments are made only for services that are medically necessary, while reducing administrative burdens and streamlining claims processing.

In the course of our extensive work on the Medicare program, we have identified numerous instances in which the program has made excessive payments to providers. Three basic problems cause excessive payments: inaccurate claims (caused by imprecise coding systems, unbundling and upcoding), inappropriate payment rates, and other insurers not paying their share. The Federal government, in administering the Medicare program, has also faced challenges in determining whether services delivered are medically necessary. Finally, in order to reduce its own costs as well as the costs of providers, the Medicare program has attempted to streamline claims processing.

States administering the Medicaid program face similar problems, as discussed below.

Inaccurate Claims: Under the Medicare program's prospective payment system, inpatient hospital services are reimbursed a predetermined amount, depending on the illness and its classification under a diagnosis related group (DRG). Like Medicare, 21 States use a DRG type reimbursement system for inpatient hospital costs. An OIG computer match found that \$38.5 million in improper claims for outpatient physician services were made as a result of improper billing by hospitals.^{15 16} We've suggested that Medicaid programs using a DRG system may also be vulnerable to such improper claims.¹⁷ Likewise, we have documented unbundling by physicians billing Medicare and Medicaid,¹⁸ unbundling of laboratory tests,¹⁹ and unbundling of surgical procedures.²⁰ Even when the vast majority of providers try to bill the system accurately, imprecise coding systems--absence of a code to accurately reflect the services being provided, overlapping codes, inadequate definitions--can prevent providers from billing the system accurately.^{21 22 23 24} All third party payers who rely on providers to self-report the services they provide and pay for such services on a per claim basis face such problems.

When overpayments are made, it is important that the program seek to recover them. This does not always occur. We have conducted reviews of in hospitals and nursing homes which document significant credit balances. Credit balances occur when reimbursement for services provided to a Medicaid beneficiary exceeds the charges billed. We estimate that nationally hospitals have received and retained \$73.3 million in credit balances²⁵ and nursing homes have received and retained \$32 million in credit balances.²⁶

Inappropriate Payment Rates: Although for many types of providers, Medicaid payments rank low in comparison to Medicare and private payers, we have documented instances in which Medicaid payments may be too high.

For example, the Omnibus Budget Reconciliation Act (OBRA) of 1981 required State Medicaid agencies to establish hospital payment rates that took into account hospitals serving a disproportionate number of low-income individuals with special needs. The law did not define the criteria to be used to identify disproportionate share hospitals or low income individuals with special needs. Therefore, State Medicaid agencies were allowed to develop their own criteria and methodologies for qualifying and reimbursing hospitals. Subsequent legislation passed in 1986, 1987, 1990, and 1991 expanded the program, established minimum criteria, and placed some limited controls on the program. Even so, disproportionate share payments to hospitals are growing at an substantial rate: we estimate that for 34 States, payments will increase from \$763 million in FY 1990 to \$5.5 billion in FY 1993. Of most concern to us, however, are the results of our audit in South Carolina, where we found that such Medicaid payments contributed to total hospital profitability. When considering total hospital profits, the average South Carolina hospital receiving disproportionate share dollars earned profits of \$3.1 million. On the average, these hospitals received Medicaid disproportionate share payments of \$2.9 million. Current literature in the health care field indicates that hospitals in other States have increased their total profitability as a result of payments received under the disproportionate share program.²⁷ Eliminating

such payments in order to provide higher rates of payments to, for example, obstetricians, might be a better use of these funds.

Payments to HMOs are another area where we have concerns based on an audit of a major provider in Pennsylvania. Here again, we found substantial profits being enjoyed by a HMO servicing Medicaid patients, suggesting that the Medicaid payment rate is too generous. Rate setting for HMOs is an area we expect to focus on in the coming year.

Third Party Liability: Third party liability refers to the responsibility of other parties other than the Medicaid program or the beneficiary to pay the costs of care obtained by the beneficiary. The Medicaid program is the payer of last resort, meaning that any other responsible insurer must pay for services before Medicaid does. The OIG has performed third party liability reviews in several States. One survey of six agencies showed that five States do not have adequate systems to record and follow-up on outstanding billings to third parties.²⁸ In another State, our survey showed that although the State agency's system identified liable third parties, it did not bill all third parties.²⁹

Medical Necessity: OIG audits of Medicare home oxygen therapy claims and ambulance services found numerous instances in which claims were submitted and paid for services that were not medically necessary.^{30 31} We've suggested that State Medicaid programs, which also reimburse providers for oxygen and ambulance services, may also be vulnerable to such claims and have suggested joint audits with State agencies to examine the question.³²

Electronic Claims, Review and Payment: The increased use of electronic claims, point of service or point of sale technology, and electronic funds transfer holds promise for reducing administrative costs while at the same time improving relations with program providers.

Physicians contend that the "hassle factor"--administrative red tape associated with participating in Medicaid--discourages many doctors from treating patients who are covered by Medicaid. When providers refer to the administrative burden, they generally are referring to such problems as slow payments; rejection of claims because the billing form was completed incorrectly; difficulties in correcting claims that contain errors; inability to verify recipients' Medicaid eligibility, leading to claim denials; frequent changes in policies, covered procedures, and required documentation; and confusing provider manuals. Physicians often cite administrative burdens as one reason, in addition to low payment rates, that they don't participate in Medicaid.

In 1992, the OIG conducted a study to examine promising approaches being used by State Medicaid programs to be responsive to physician complaints about Medicaid's administrative burden. Particular complaints about claims processing center around frustration with the process of submitting and getting claims paid. For example, one physician told us, "Even the most intelligent neurosurgeon gets hung up on what needs

to be done." Another, expressing a common complaint, said, "Physicians aren't given an explanation for rejected claims. It is the doctor's responsibility to track the claim and find out why it was denied, which takes extra staff time and financial resources."

In an attempt to address these types of complaints, at least 28 States have instituted electronic claims systems for physician services. The proportion of claims in each of these states that are submitted electronically ranges from 3 percent in North Dakota to 66 percent in Georgia.

Staff at several state Medicaid agencies we spoke with stressed their commitment to electronic claims submission. Advantages of using electronic claims submission include faster payment compared to submission of paper claims and reduced cost to the provider for clerical services, since paperwork is decreased and the physician's signature is not required on each claim. Despite the advantages of electronic claims processing, most physician claims are still submitted on paper. One reason is that many physician offices do not have available the computer hardware necessary for electronic submission of claims.

In Florida, the Medicaid agency had developed software that enables any provider to submit claims electronically. (The software, as well as claims submission, is free of charge to the provider.) Using the system, physicians can tailor the software to meet their particular needs when it is installed. For example, some information, such as the physician's name and address and the date of the claim, may be automatically inserted each time a claim is prepared, and diagnostic, procedure, or billing codes (for common illnesses that physicians may treat) can be inserted with a single keystroke.

Several states have also developed automated telephone inquiry systems to answer physician inquiries. These systems can be accessed with a touch-tone phone. Since most calls to Medicaid concern eligibility or claims status, these can be handled quickly and systematically, freeing staff to deal with the more difficult situations and questions. For example, Maryland's automated voice response system operates continuously, and permits providers to verify dates of program eligibility for services rendered up to one year previously.³³

Point of service systems have great potential for improving the administration of Medicaid programs across the country. They can perform eligibility verification, claims submission, claims adjudication, and utilization review on a real-time basis. New York's point of service system is saving millions a year by performing eligibility verification and utilization review. Massachusetts uses its point of service system for eligibility verification only. It is also saving millions of dollars annually. Even so, few States have developed or plan to develop point of service systems.³⁴

Likewise, our inspection on electronic funds transfer found that only eight States are using this electronic method to reimburse Medicaid providers. A number of factors are preventing additional States from using electronic funds transfer: concerns regarding loss of cash flow, potential fraud, and initial cost. We consider these

problems to be easily surmountable, although others (provider populations that change banks frequently, inadequate capabilities of local banks) may be more difficult to overcome. It is also true that electronic funds transfer will only save money if remittance advisories, the notifications sent to physicians regarding their payments, are also sent electronically. If remittance advisories are sent by paper, program administrators might as well include the check in the same envelope and forgo electronic funds transfer.³⁵

MANAGING LONG TERM CARE

The Medicaid program must ensure that long term care expenditures, which account for a large proportion of Medicaid outlays and are growing precipitously, are managed wisely.

As discussed earlier, the funds paid out for long term care under Medicaid represent a substantial portion of the program's total dollars. Yet, in many respects, here the Medicaid program acts more as an open checkbook than a payor of last resort for the needy.

In 1989, the OIG completed work on a case study of transfer of assets in the Washington State Medicaid program. We found that 58 percent of the elderly applying for assistance who were denied because they exceeded the resource eligibility threshold became eligible in a few months by transferring or sheltering their assets. In order to qualify for Medicaid, beneficiaries used various--and completely legal--means to appear as though they had access to no resources. For example:

- ▶ One beneficiary transferred \$153,500 to adult children using an irrevocable trust.
- ▶ One beneficiary used \$50,000 to pay off a note on the family home, which is exempt under Medicaid rules from asset tests.
- ▶ One beneficiary removed his name from bank accounts and certificates of deposits (totaling \$206,363) and from the family residence (\$40,000).
- ▶ One beneficiary transferred property with an assessed value of \$433,000 to the well spouse "to qualify the incompetent for medical assistance benefits," according to the court order.³⁶

Much of what we found in 1989 still holds true today. Elder law attorneys advising clients on how to hide their affluence by buying exempt assets, transferring money or assets to others, purchasing trusts and other means, appear to be a growing legal specialty. Although no one knows the extent of transfers of assets (both legal and illegal) to qualify for Medicaid, we found over \$4 million in assets of only 114 originally denied, but subsequently approved, Medicaid nursing home cases. Currently,

HCFA, the U.S. General Accounting Office, and the OIG are developing study plans in this area.

ENSURING QUALITY OF CARE

The Medicaid program must ensure quality of care of services that are delivered.

For the sake of the program's financial integrity and beneficiaries' protection, the Medicaid program had a responsibility to ensure that the care it pays for is necessary and appropriate. In this regard, three new initiatives are critical: successful implementation of new nursing home quality standards; development of a workable system to ensure quality in managed care settings; and implementation of drug use review.

Nursing Home Quality: The Omnibus Reconciliation Act of 1987 chartered a new direction in survey and certification of nursing homes. Rather than focus on process, the new surveys would focus on resident quality of life and outcomes. We are currently completing a study to assess how States are implementing the new survey and certification process.

One of the most significant requirements of OBRA 1987 was a new rule regarding the use of chemical and physical restraints. The OBRA 1987 established that nursing home residents have the right to be free from physical and chemical restraints not required to treat their medical symptoms. In 1992, we conducted a study to assess how average nursing homes were implementing this important provision. Our report described the lessons learned by nursing homes engaged in reducing the use of physical and chemical restraints. It presented the lessons in three areas that reflect the operational stages of restraint reduction: 1) establishing a commitment to restraint reduction; 2) reducing restraints; and 3) maintaining a restraint-free home.

Quality Assurance in Medicaid HMOs: As discussed above, States have turned to managed care as their best alternative to ensure access and continuity of care. It is especially important to have quality assurance (QA) systems in place because the capitated payment in managed care systems may create a financial incentive to undertreat, and because Medicaid beneficiaries may have difficulty negotiating a new and different system.

In 1992 we reported on HMO quality assurance standards required by Medicaid agencies. We found that all Medicaid agencies contacted the study use structural standards, such as requiring HMOs to have a written quality assurance plan. Most have carried over fee-for-service process standards to their HMO program, i.e., conducting episodic medical record reviews and requiring HMOs to verify provider credentials. Most rely on complaint standards more than patient satisfaction surveys and health outcome reviews to ensure quality.

Ensuring compliance with required standards varies significantly among Medicaid agencies. Compliance with some required standards is never verified by some, others rely heavily on HMO self-assessments of compliance. When Medicaid agencies do their own compliance audits they focus on HMO compliance with structural and process standards.³⁷

Drug Use Review: OBRA 1990 required States, by January 1, 1993, to develop a drug use review program consisting of prospective and retrospective review to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse effects.

Prospective drug review must provide for drug review before the prescription is filled, typically at the point of sale. Retrospective review must be performed through the mechanized drug claims system to identify fraud, abuse, or inappropriate care. The States must also establish a Drug Use Review Board. Each Board must report to the Secretary annually and the Secretary must use the reports to evaluate the effectiveness of the States' programs. The OIG plans a study to assess State implementation of drug use review programs in 1993.

Our report on ulcer treatment drugs demonstrates the program savings and quality of care issues that arise when reviewing prescription drug use. In a review of 1,600 Medicaid beneficiaries, we found that 38 percent of the recipients received dosages of ulcer treatment products that were in excess of manufacturers' recommendations. Limiting payment for the six ulcer treatment drugs under study to the dosages recommended by manufacturers would save the Medicaid program \$112 million annually as well as help prevent inappropriate prescription drug use.³⁸

GUARDING AGAINST FRAUD AND ABUSE

The Medicaid program must effectively protect itself from fraud and abuse.

- ▶ ***Medicaid Fraud Control Units stand as an essential force in the front lines combatting fraud and abuse in Medicaid.***

The Medicaid program must ensure that its system can identify and refer cases of fraud to appropriate authorities. In order to increase the quantity and quality of fraud referrals, the HCFA is encouraging close working relationships between Medicaid agency staff who review the use of services by beneficiaries and Medicaid Fraud Control Units (MFCU) staff, who investigate allegations of fraud in most States. We previously reported our concerns about the level of referrals from Medicaid agencies to the MFCUs and continue to support additional HCFA leadership in this area.

► ***Identification of questionable patterns of care can provide important information in identifying possible fraud.***

Several years ago, in response to concerns about the diversion and improper use of prescription drugs in Medicaid, the OIG developed software for use by Medicaid officials in identifying odd or unexpected patterns in the use, dispensing, or prescribing of prescription drugs. This program, called the Medicaid Abusable Drug Analysis System (MADAS), analyzes scripts for all drugs on Schedules 2 through 5 and targets potential diversion activity by Medicaid recipients and providers. It can be targeted to specific geographical areas, specific drugs, or an array of abusable drugs. Currently, 17 State Medicaid agencies or Medicaid Fraud Control Units are utilizing MADAS data to track prescriptions for controlled substances.

States utilizing MADAS have three basic objectives. They are (1) to restrict availability of prescription drugs to abusers through the use of lock-in programs, (2) the removal of physicians and pharmacies abusing the program and (3) the referral of physicians and pharmacies to law enforcement agencies for criminal prosecution.

While some States did not maintain detailed statistics on the results achieved using MADAS, we do know that MADAS has been directly responsible for three successful prosecutions in New Mexico and there are currently 20 ongoing investigations in Pennsylvania. We are also aware of numerous referrals to the State Bureau of Narcotics and the State Police in Minnesota, Missouri and Oklahoma.

► ***Strategies to prevent fraud on the front end are essential.***

While identification of providers and beneficiaries defrauding the system is crucial, it is also important to reduce opportunities for fraud. We recently completed a study in which we assessed the potential of Multiple Copy Prescription Programs (MCPPs) for the prevention of fraud and abuse of prescription drugs. We found that MCPPs reduce vulnerability to theft and forgery. While their effect on overall prescribing of scheduled drugs is difficult to assess from existing studies, MCPPs appear to have shown some effect on abuse of scheduled drugs and program officials associate MCPPs with better targeting of investigator resources and more successful prosecutions of offenders involved in drug diversion.³⁹

Legal prohibitions on behavior or activities which can lend themselves to fraudulent acts are also essential. For example, under the Medicare and Medicaid anti-kickback statute, section 1128(B)(b) of the Social Security Act, it is illegal to offer or pay a profit distribution to physicians to deliberately induce them to refer business payable under Medicare or any State health care program. Since 1987, we have received more than 1,300 allegations of violations of the anti-kickback statute and have opened over 850 cases.

IMPROVING FEDERAL-STATE RELATIONS

Federal and State relationships must be improved.

The Medicaid program is supported dually by the Federal and State governments. Rather than representing the best of both levels of governments, too frequently the interests of the State and Federal governments have been seen as opposing, rather than reinforcing, each other. The best, and most recent, example is the dispute over provider taxes and donations.

Prior to 1985, States were not permitted to use donated funds except for training State personnel to administer Medicaid. In 1985, a new regulation permitted States to use public and private donations for the State FFP with limitations (if the funds were transferred to the Medicaid agency and were under its administrative control and if the funds do not revert to the donor (unless donor was a nonprofit organization and the Medicaid agency decided independently to use the donor's facility)).

Following issuance of this rule, some States under fiscal stress began to use the provision to maximize funds from the Federal government. Contributions to States from Medicaid providers (mostly hospitals and nursing homes) were used as part of the State's share of spending for covered services and matched with Federal funds. Around the same time, some States imposed provider-specific taxes on health care providers.

These revenue sources quickly became controversial. From the Federal perspective, the Federal government should not reimburse States for the amounts collected from Medicaid-only providers. They contend that these are not costs incurred by the State, and therefore are not eligible for the Federal match. Reports by the OIG recommended that HCFA take action to control these provider tax and donation programs.⁴⁰ From the States' point of view, the Federal government should not care what sources of revenue the State uses to pay for its Medicaid program.

From 1988 to 1990, Congress enacted measures prohibiting HCFA from implementing regulations banning the use of funds from taxes and donations except in certain cases. Then in November 1991, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. Effective January 1, 1992, States are prohibited from using most voluntary contributions to claim FFP. The law prohibits use of Federal funds to match revenues derived from provider-specific taxes unless these taxes are broad-based and apply uniformly to all providers of a given type and all business of the providers within a class of services. These broad-based, uniform taxes are considered acceptable since they are not unlike imposing a new property tax to raise State revenues.

States budgets have also been strained by the introduction of unfunded Federal mandates, such as those introducing new requirements for services that must be provided to pregnant women and children. Administrative rules and requirements

placed on States (such as those requiring that States apply for waivers from Federal rules to implement a new program which has previously been approved for another State) have also caused unnecessary and unproductive tension between the States and Federal government. The poor Federal-State relationship has led to what some have termed "irresponsibility at all levels" and led to calls for repeal of the Medicaid program and its current Federal-State structure.

RECOMMENDATIONS

As discussed in this report, the problems and challenges facing the Medicaid program are substantial. We are aware, of course, that many policymakers are arguing for a fundamental restructuring or elimination of the Medicaid program. During the course of our audits, inspections, and investigations in the Medicaid program, we have made numerous specific recommendations for change. Many of these recommendations have been accepted by the Health Care Financing Administration and some have not. Some require legislative changes; others require action by the States.

All significant unimplemented OIG recommendations are included in one of two documents. The Office of Inspector General Cost-Saver Handbook (the Red Book) is a compendium of recent OIG recommendations to reduce unnecessary spending by the Department through administrative or regulatory change, or by the Congress and Administration through legislative change. The Office of Inspector General Program and Management Improvement Handbook (Orange Book) contains recent recommendations for strengthening program and management efficiency and effectiveness. For our readers' convenience, we have reproduced our listing of recommendations to improve the Medicaid program in the appendices to this report.

We are pleased to see that the Administration supports OIG recommendations made in various forums for extending the ban on self-referral, for lifting the ban on drug formularies, and for tightening loopholes on transfers of assets and strengthening asset recovery laws.

APPENDIX A

UNIMPLEMENTED OIG RECOMMENDATIONS: COST SAVERS

| | ANNUAL SAVINGS |
|---|----------------|
| Establish Mandatory Prepayment Edit Screens | \$12 million |
| Control Medicaid Payments to Institutions for Mentally Retarded People | \$683 million |
| Reduce Non-urgent Use of Emergency Rooms | \$39.5 million |
| Recover or Adjust Medicaid Credit Balances in Nursing Facility Accounts | \$32 million |
| Recover or Adjust Medicaid Credit Balances in Hospitals | \$73.3 million |

APPENDIX B

UNIMPLEMENTED OIG RECOMMENDATIONS: PROGRAM IMPROVEMENTS

Medicaid and Homeless Individuals

- ▶ The HCFA should work with SSA to develop a joint strategy to increase access to Medicaid for eligible homeless individuals.
- ▶ The HCFA should consult with PHS and SSA to develop models to help homeless individuals apply for Medicaid.
- ▶ The HCFA should provide technical assistance to States to promote the development of State strategies and linkages designed to use Medicaid more effectively to serve this population.
- ▶ The HCFA should use the Interagency Council on the Homeless to provide technical assistance to other Federal agencies and McKinney providers to make Medicaid more accessible to homeless individuals.

Medicaid Expansions for Prenatal Care--State and Local Implementation

- ▶ The HCFA should develop a comprehensive outreach strategy.
- ▶ The HCFA should simplify and streamline the application process.
- ▶ The HCFA should develop incentives to increase provider participation.
- ▶ The HCFA should clarify policy and monitor implementation of Medicaid expansions for prenatal care.
- ▶ The HCFA should develop data collection systems and evaluation processes to measure progress of the eligibility expansions and future program effects.

Point of Service Claims Management Systems for Medicaid

- ▶ The HCFA should collect information on point-of-service technology and regulatory distribute it to the States.

Electronic Funds Transfer for Medicaid Providers

- ▶ The HCFA should work with State Medicaid agencies to identify problems with electronic funds transfer (EFT) and share other States' solutions to these problems.

- ▶ The HCFA should assist States in developing billing agreements for providers who use electronic claims, remittance advisories, and fund transfers.
- ▶ The HCFA should develop guidelines for provider participation in EFT.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)--Performance Measurement

- ▶ The HCFA should modify the methods by which it measures rates to correctly reflect States' progress in meeting goals.

Controls over Prescription Drugs

- ▶ The HCFA should direct its oversight reviews to States that do not participate with the OIG in implementing its program to identify prescription drug abuse and diversion.
- ▶ The HCFA should incorporate into its review the OIG program to evaluate the effectiveness of the States' internal controls over prescription drug abuse and diversion.

Medicaid Disproportionate Share

- ▶ The HCFA should encourage South Carolina to explore alternative payment methodologies.
- ▶ The HCFA should gather more detailed data on disproportionate share payments that could be used to performed a nationwide review of the program.

Medicaid Drug Rebate Program

- ▶ The HCFA should require States to develop procedures to monitor the accuracy of reporting by pharmacists.
- ▶ The HCFA should require States to perform tests of the dosage units reports and establish computer edits to detect and correct obvious errors.
- ▶ The HCFA should contact the various national pharmacy associations and request their participation in alerting pharmacists to the program and its needs.
- ▶ The HCFA should alert Congress of the impact of eliminating the best price from the existing rebate formula.
- ▶ The HCFA should make a legislative proposal to redefine best prices based upon prices as they existed in October 1990 and adjust for increases in the Consumer Price Index.

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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SUMMARY OF OIG ACTIVITIES ON
MEDICARE**



JUNE 1993

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program, and management problems, and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.