20th Anniversary

Office of Inspector General

Semiannual Report

April 1, 1996 - September 30, 1996

June Gibbs Brown
Inspector General

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

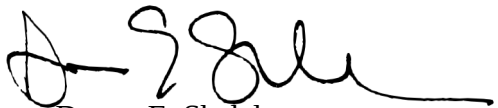
A MESSAGE FROM THE SECRETARY

Fiscal Year 1996 was one of the most challenging periods in the history of the Department of Health and Human Services (HHS). The uncertainty of resource levels and the significant disruptions hampered our ability to meet out obligations to the public. Nevertheless, we pulled together and strove to carry out our mission. One of the partners in that team effort was the HHS Office of Inspector General (OIG).

As the Government works to balance the Federal budget, it is critical that every Federal dollar spent on HHS programs goes to meet the needs of the beneficiaries we serve. In that regard, we are committed to doing all we can to eliminate fraud, waste and abuse in departmental programs and operations. I am again gratified at the significant contributions made by OIG toward that end, working in cooperation with our Operating Division.

The OIG's accomplishments and history of facilitating savings to the Federal Government underscore its record as a solid investment for the American taxpayer. I am pleased to note that passage of the Health Insurance Portability and Accountability Act of 1996 will allow OIG to expand its presence and extend its efforts to safeguard the health and welfare of HHS program beneficiaries.

I continue to be impressed by the level of commitment and proficiency exhibited by the Inspector General and her staff. Together we are making a positive difference in the lives of all Americans.



Donna E. Shalala

FOREWORD

In presenting this semiannual report on the accomplishments of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) for the 6-month period ending September 30, 1996, I am pleased to note that this date marks our 20-year anniversary. Created by Public Law 94-505 under what was then the Department of Health, Education and Welfare, this was the first statutory civilian Inspector General (IG) to be established in the Federal Government.

Over the years, HHS OIG has come to be regarded by decision-makers as a valuable source of independent, objective, timely and relevant information and products. While it became increasingly difficult in recent years to keep pace with our growing responsibilities, many mandated by statute, OIG worked to maintain productivity by streamlining its organization, refining its operations and targeting the most significant programs and issues within the Department.

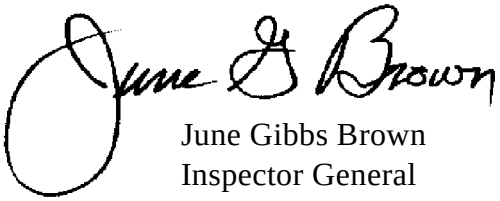
Since beginning my tenure as the Department's third Inspector General in November 1993, I have aggressively sought new and innovative ways to maximize our impact. In these few years, we have forged new and stronger links amongst ourselves and with others in the Federal and State communities who are working toward similar goals. These multidisciplinary approaches have greatly enhanced our ability to carry out OIG's mission of protecting the health and welfare of the Department's beneficiaries and its vital resources.

Among these initiatives are: the establishment of the Executive Level Health Care Fraud Policy Group, through which we and the Department of Justice (DOJ) have jointly managed development of our investigative cases; our partnership with State auditors and evaluators, as well as the Health Care Financing Administration, to identify opportunities for curbing Medicaid costs and produce savings at both the Federal and State levels; and Operation Restore Trust, a highly targeted and proactive campaign against fraud in the health care industry, which is paying handsome dividends for the Department's beneficiaries and the American taxpayer.

Although the continuing resolutions and furloughs caused serious disruption to OIG's operations in Fiscal Year (FY) 1996, we are very proud of our achievements during this time. Some of our most significant accomplishments during the 6-month period are outlined in the Highlights section of this semiannual report.

Moreover, we are greatly encouraged that coming years will allow us to extend our reach. The recently enacted Health Insurance Portability and Accountability Act of 1996 constitutes a major step forward in the effort to eliminate health care fraud and abuse, providing a multi-year source of funding for the coordinated antifraud activities of HHS OIG and DOJ.

With the skill and dedication of OIG's staff and the willingness of our partners in the Department and elsewhere to work with us in accomplishing our mutual objectives, I look confidently to the future.



June Gibbs Brown
Inspector General

HIGHLIGHTS

Introduction

The Office of Inspector General (OIG) at the Department of Health and Human Services (HHS) is proud of its achievements during this difficult period. Moreover, OIG is greatly pleased that the more stable funding ensured under the recently enacted Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) recognizes OIG's past accomplishments and provides OIG the means to continue to build upon its successes.

Many of those successes have resulted from the innovative approaches employed by OIG in order to extend its reach at a time of fiscal constraint. To respond most effectively to the growing problems of fraud and abuse in the Department's programs, OIG has heightened its emphasis on interdisciplinary teamwork within its own organization and on greater collaboration and sharing of resources in its relationships with other Federal and State agencies. The synergistic effect of these partnerships has greatly enhanced OIG's ability to protect the Federal dollars allotted to HHS programs. The beneficial effects of these innovations are demonstrated in some of OIG's most significant accomplishments for this semiannual period.

Federal/State Partnership: Medicaid Program

Continuing its 2 year old partnership with State auditors in reviewing the Medicaid program, OIG issued reports on the drug rebate program in Montana and Washington during this semiannual period. To date, active partnerships have been developed with 15 State auditors, 11 State Medicaid agencies and 2 State internal audit groups. Twenty State auditor partnership reports have been issued with financial impact of over $100 million affecting both Federal and State Government funds. (See page 29)

Operation Restore Trust

Using the expanded team concept, OIG has been working jointly with the Health Care Financing Administration (HCFA) and the Administration on Aging (AoA) on Operation Restore Trust, a 2-year project targeting fraud and abuse in three high-growth areas of the health care industry: home health agencies, nursing homes and durable medical equipment (DME) suppliers. As the project's coordinator, OIG assembled teams that include investigators from its Office of Investigations and the States' Medicaid Fraud Control Units; auditors and evaluators from OIG and HCFA; quality assurance specialists from the State surveyors and DME regional coordinators; State long-term care ombudsmen through AoA; and prosecutors from the Department of Justice and the State Attorneys General.

Now in its second year, this cooperative venture has yielded remarkable results. Operation Restore Trust is discussed in detail in Chapter I of the semiannual report. Within the text of

the report, summaries of audits, evaluations and investigations related to Operation Restore Trust which were finalized during this 6-month period are labeled with the symbol  for ready identification. The labeled summaries are listed in Appendix G.

☐ Nursing Homes

As part of its focus under Operation Restore Trust, OIG released several reports that highlighted the wide variety of Medicare abuse in the areas of enteral nutrition, durable medical equipment and mental health services in nursing homes. In this series of evaluations, OIG determined that the Medicare Part B reimbursement program in nursing homes is particularly vulnerable to fraud, waste and abuse because payment rules and safeguards largely ignore the special character of the nursing home environment and the varied services and supplies which can be provided.

One study concluded that what Medicare pays for enteral nutrients far exceeds the price commonly available through volume purchasing and recommended reducing the reimbursement rate to stem unnecessary expenses. Another study found that Medicare paid for medically unnecessary psychiatric services in 32 percent of the records reviewed -- a projected $17 million in unnecessary expenses. The Health Care Financing Administration initiated action to implement OIG's recommendations in these areas. (See page 20)

☐ Home Health Care

Also under the Operation Restore Trust initiative, OIG issued three reports during the period identifying $3.7 million in unallowable costs claimed for home health care. Unallowable costs included reimbursements for services that did not meet Medicare guidelines, services deemed not reasonable or necessary, and services not authorized by a physician as well as reimbursement for services not performed. These reviews pointed up the need for HCFA to monitor fiscal intermediaries and home health agencies for compliance with Medicare regulations and HCFA guidelines. (See page 18)

☐ Durable Medical Equipment

As an industry which has suffered waves of fraudulent Medicare and Medicaid schemes, DME was selected as one of the focus areas for Operation Restore Trust. During this reporting period, the most common DME fraud cases concluded involved physicians' signing certificates of medical necessity for patients not seen, or the forging of physician signatures, and overbilling or billing for equipment not provided. (See page 24)

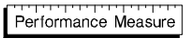
Some durable medical equipment is used to deliver prescription drugs, including an inhalation therapy drug called albuterol sulfate. The OIG found that Medicare allowances for this drug substantially exceeded supplier's actual acquisition costs. As a result, HCFA is exploring new strategies to improve drug reimbursement and take advantage of some cost-cutting techniques. (See page 26)

Head Start Grantees

At the request of the Administration for Children and Families (ACF), OIG is providing contracted audit services under a cost competitive procurement mechanism developed with the Assistant Secretary for Management and Budget. The purpose of the audits is to assist ACF in its efforts to strengthen the financial management and program compliance capabilities of Head Start grantees to ensure the fiscal integrity of the Head Start program and proper stewardship over Federal funds.

Reports on three of the five audits contracted for under this agreement were issued during this semiannual period. These reviews found deficiencies and violations of procurement standards, bidding processes, prior approval requirements, budget provisions, grant award proposals, and other fiscal and programmatic requirements. Total questioned costs exceeded $1.1 million. The ACF expressed its intention to act immediately on these findings, including suspending or terminating grantees. (See page 43)

OIG Work in Performance Measurement

In order to identify work done in the area of performance measurement, OIG has labeled some items throughout this report as "performance measures" with the symbol 

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

Statistical Accomplishments

Among its accomplishments, OIG takes pride in its role in generating savings for the Federal Government through its recommendations to put funds to better use; the disallowance of costs questioned because of a violation of law, regulation or grant; and the fines, restitutions, settlements and recoveries which accrue from judicial and administrative processes that result from OIG investigations.

However, OIG is but one partner in the process. It is through the cooperation and support of departmental managers and the Congress that OIG's recommendations are translated into action. In the 20-year period since OIG's inception, this fruitful collaboration has resulted in savings of more than $80 billion to the Federal Government. Moreover, as detailed in its Cost Saver Handbook (the Red Book), OIG has identified billions of dollars in potential savings through analyses and recommendations which can be considered for implementation.

Due, in part, to the serious disruptions caused by the many continuing resolutions and furloughs of this fiscal year, as well as the separation of the Social Security Administration

and the consequent transfer of many HHS OIG employees to the new agency, OIG's statistical accomplishments are well below the Fiscal Year (FY) 1995 levels. Nevertheless, savings are significant. The OIG reported savings of $4.7 billion for FY 1996, comprised of $4,184.9 million in implemented recommendations to put funds to better use, $274.6 million in disallowances from questioned costs and $237.4 million in investigative receivables. (See Appendix A, and the sections entitled "Resolving Office of Inspector General Recommendations, A. Questioned Costs" and "Investigative Prosecutions and Receivables" in the General Oversight chapters of OIG's FY 1996 semiannual reports for details.)

During this fiscal year, OIG also reported 151 convictions of individuals or entities that engaged in crimes against departmental programs and 1,937 administrative sanctions against health care providers and suppliers or their employees that engaged in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries.

As noted above, OIG is confident that future funding levels will heighten its ability to vigorously pursue its mission of protecting the integrity of HHS programs and operations and the health and welfare of those programs' beneficiaries.

Internet Address

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

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Operation Restore Trust

Chapter I

OPERATION RESTORE TRUST

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

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

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

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

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

All OIG ongoing and new investigations, audits and inspections related to fraud and abuse in the targeted areas of the five States were gathered into the project, that they might benefit from its focused attention, expertise and energies. At the present time, there are 270 pending cases. Sixty-four of the 270 cases are joint investigations with other law enforcement agencies, including the Federal Bureau of Investigation, the United States Postal Service, the Railroad Retirement Board OIG, the Defense Criminal Investigation Service and State Attorneys General offices.

Since the special hotline was established in June 1995, it has received 12,533 complaints related to Department programs. Since its inception, resolving these complaints has resulted in recovering approximately $1.3 million of overpayments.

Thus far, 49 criminal convictions, 44 civil actions and 38 indictments have been obtained under Operation Restore Trust. In addition, 132 providers have been excluded. Also, OIG has identified a total of more than $70 million in fines, recoveries, settlements and civil monetary penalties owed to the Federal Government.

To date, 28 audit and inspection reports related to Operation Restore Trust have been issued. At the present time, another 56 audits and evaluations are underway. In addition, HCFA and OIG are jointly performing reviews at 16 skilled nursing facilities. Further, OIG's Operation Restore Trust activities have either resulted in proposals or supported existing proposals to change policy in order to correct systemic weaknesses.

Within the text of the semiannual report, summaries of audits, evaluations and investigations related to Operation Restore Trust which were finalized during this 6-month period have been labeled with the symbol  for ready identification. The labeled summaries are listed in Appendix G. Operation Restore Trust is but another example of how OIG is working to ensure the integrity and efficiency of the Medicare and Medicaid programs and to protect the beneficiaries of those programs.

Health Care Financing Administration

Chapter II

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

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

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

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

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

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

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

The OIG also audits HCFA's financial statements under the Chief Financial Officers Act and the Government Management Reform Act. The HCFA has been designated as a separate reporting entity because it represents more than 82 percent of Department of Health and Human Services outlays.

Health Maintenance Organization Customer Satisfaction Surveys

Performance Measure

At HCFA's request, OIG conducted a survey to determine how Medicare health maintenance organizations (HMOs) measure customer satisfaction and how they utilize the resulting data. The OIG found that while virtually all HMOs conduct customer satisfaction surveys, most do not target their Medicare members. As a result of their limited focus, their lack of uniformity and technical weaknesses, the usefulness of these surveys to HCFA is substantially reduced. Accordingly, OIG proposed that HCFA consider alternative approaches to measuring Medicare client satisfaction with managed care, such as conducting its own surveys or requiring HMOs to periodically survey their Medicare members with standardized instruments and comparable procedures.

The HCFA indicated that the OIG study will be a major factor in influencing its decision to develop an independent beneficiary satisfaction survey capability. (OEI-02-94-00360)

Health Care Financing Administration's Combined Financial Statements

Performance Measure

The OIG conducted an audit of the HCFA's combined financial statements for Fiscal Year (FY) 1995. Because internal controls were not adequate, OIG was unable to determine whether the reported Medicare accounts receivable balance of $3.2 billion at September 30, 1995 was fairly presented. Nor was the necessary documentation supporting the actuarial determination of the Medicare accounts payable balance of $22 billion made available for review. Further, because HCFA recorded the Medicaid program on a modified cash accounting basis, it did not record the Federal share of Medicaid accounts receivable and payable recorded by States. Because of the significance of these matters, OIG was unable to express an opinion on HCFA's combined financial statements for FY 1995.

In its response to the OIG report, HCFA generally concurred with OIG's recommendations. The HCFA believes that the methodology used by its Office of Actuary (OACT), which OIG was not able to review in detail with OACT, supports the liability recorded for Medicare

accounts payable. The OIG will review the methodology in its audit of the FY 1996 financial statements. (CIN: A-17-95-00051)

Major Hospital Initiatives

The OIG has launched two national projects and one State project involving civil actions at hospitals that were falsely billing the Medicare program. All three grew from OIG hospital audits that identified irregularities in Medicare billing practices.

A. Physicians at Teaching Hospitals

A nationwide initiative to review compliance with rules governing physicians at teaching hospitals (PATH) and other Medicare payment rules grew out of earlier extensive work performed by OIG at a major east coast university. The focus of the review was compliance with the Medicare rule affecting payment for physician services provided by residents. The OIG found that not only was the institution not complying with this rule but also teaching physicians were improperly upcoding the level of service provided in order to maximize Medicare reimbursement. This review resulted in the Government's recovery of more than $30 million, including damages under the Federal Civil False Claims Act. As part of the negotiated settlement, the responsible parties also avoided program exclusion under OIG authorities.

The OIG initiated the PATH project to determine whether, and to what extent, similar problems were present at other teaching institutions throughout the country. The nationwide PATH reviews focus on compliance with the Medicare rule and the appropriateness of service codes. In addition, OIG encourages physician group practices affiliated with teaching hospitals to examine their own practices under these requirements. Group practices that choose to participate actively in such a process, under a protocol established by OIG, may potentially reduce their legal exposure, if any, under OIG exclusion authorities.

Active participation includes arrangement, at the hospital's or group's expense, for an independent review conducted by a third party, using OIG's review protocol. A hospital must be an institution that receives graduate medical education payments under Medicare Part A, and a group must be affiliated with such an institution. To receive the benefits of active participation in a PATH review, they must adhere to principles set out in the review protocol.

During this period, the first hospital/physician practice plan entered into a voluntary settlement under PATH, agreeing to pay $11.9 million to settle its civil false claims liability. The hospital had received approximately $5.9 million in overpayments related to improper billing for services provided by residents and for errors in the level of supervision billed. In addition to the settlement, which represents double damages, the hospital is implementing a corporate compliance program.

B. Diagnosis Related Group 72 Hour 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 hospital's inpatient payment under the prospective payment system (PPS). Hospitals that submit claims for the outpatient service in addition to the inpatient admission are, in effect, submitting duplicate claims for the outpatient services. A prevalent pattern of abuse was identified through repeated OIG audits of hospital claims for inpatient services under PPS. Prior to the inception of this project, OIG had issued four reports to HCFA identifying approximately $115.1 million in Medicare overpayments to hospitals caused by these improper billings.

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

The project is being coordinated by the U. S. Attorney's Office - Middle District of Pennsylvania. As of the end of the reporting period, settlements have been executed with over 925 hospitals resulting in recoveries in excess of $22 million. The total anticipated recovery under this nationwide project is approximately $90 million to $110 million over the next 2 years from an estimated 4,446 hospitals.

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

C. Ohio Outpatient Laboratory Unbundling Project

The OIG, DOJ and the State of Ohio have joined forces to combat Medicare and Medicaid fraud in hospital outpatient laboratory billing practices. The Ohio Outpatient Laboratory Unbundling Project seeks to recover overpayments related to erroneous or excessive claims submitted for automated blood chemistry tests by hospital outpatient laboratories. These abusive practices stem from the unbundling of lab tests, which is believed to be a widely practiced abuse.

Laboratory services are particularly vulnerable to this practice because of the number of tests ordered at one time, and the capability of equipment to run several tests from one sample. Medicare and Medicaid have implemented billing guidelines and physicians'

current procedural terminology codes to accommodate laboratory panels, and the reimbursement for the panel is less than if each test were run separately.

The Ohio Project targets hospital outpatient labs through an ongoing computer-based evaluation of claims submitted for outpatient laboratory services. A demand letter is then sent to each hospital identifying the scope of the abusive practice at that facility and its potential exposure under the Civil False Claims Act. The hospitals are invited to participate in a self-audit program, the results of which are separately verified by the State of Ohio Auditor's Office. In recognition of their participation, the hospitals generally receive the benefit of double damages for settlement purposes. The terms of the settlement require implementation of compliance measures to correct the identified misconduct, and a separate payment to the Ohio State Auditor's Office for its independent review and verification of the audit reports submitted by the facility.

To date, settlements with five hospitals have recovered $2.3 million. It is anticipated that approximately 150 hospitals from the Northern and Southern Districts of Ohio will participate, representing 90 percent of the hospital population in the State of Ohio. The projected recovery under this project is approximately $15 million. See page 29 for other State partnership work.

Rural Health Clinics: Growth, Access and Payment

The Rural Health Clinic (RHC) program, created in 1977, is intended to increase access to health care for rural medically underserved areas and expand the use of midlevel practitioners (nurse practitioners, physician assistants and certified nurse midwives) in rural communities. The HCFA is responsible for certification and oversight of RHCs.

The OIG found that the number of rural health clinics has grown seven-fold since 1990, and associated Medicare and Medicaid expenditures have more than doubled since 1992. However, OIG determined that the centers may not be increasing access to care in some areas. Further, OIG identified vulnerabilities stemming from the program's cost reimbursement system.

The OIG recommended that HCFA, along with the Health Resources and Services Administration, modify the certification process of the clinics; expedite the issuance of pending regulations; and improve the oversight and functioning of the current cost reimbursement system. (OEI-05-94-00040)

Hospice Eligibility

The OIG is conducting reviews to assess the accuracy of beneficiary eligibility determination and resultant reimbursements at selected hospices. During this semiannual period the following hospice reviews were completed:

A. Puerto Rico

In prior audits at two hospices in Puerto Rico, OIG had determined that a significant percentage of beneficiaries whose eligibility was questioned were ineligible for hospice coverage, resulting in approximately $2.6 million of improper Medicare payments between April 1992 and July 1994.

In an expansion of those audits, OIG obtained listings from 38 hospices in Puerto Rico and identified a number of beneficiaries who appeared to be ineligible for the hospice program. Of the 100 suspect cases selected for a random sample, OIG found that 67 of the beneficiaries were in fact ineligible for hospice benefits and that $1.2 million was improperly paid on their behalf. Based on those results, OIG estimated that, in the period September 1991 through July 1994, approximately $19.7 million was improperly paid to 37 hospice providers in Puerto Rico on behalf of ineligible beneficiaries.

The OIG recommended that HCFA instruct the regional home health intermediary for Puerto Rico to recover the outstanding balance of $874,000 in improper payments identified in OIG's sample; initiate medical record reviews of the balance of identified potential ineligible beneficiaries not included in OIG's sample and recover any additional unrecovered improper payments; improve its claims processing controls by instituting a front end diagnosis-based edit; and conduct medical record reviews of the suspect claims identified through this edit. The HCFA concurred with OIG's findings and recommendations. (CIN: A-02-94-01035)

B. Florida

The OIG found that Medicare paid a Florida hospice provider $8.9 million for care to 176 ineligible beneficiaries and another $5.9 million for 118 beneficiaries of questionable eligibility. The OIG review, which included a medical evaluation of the hospice's eligibility determinations, covered 364 beneficiaries who had been in hospice care for more than 210 days. Of the 364 cases, 237 were active in hospice at the time of the review and represented 26 percent of the total active Medicare hospice beneficiaries as of April 30, 1995.

The OIG believes that these problems occurred because hospice physicians inaccurately made prognoses of life expectancy based on the medical evidence in the patients' files or because the evidence was insufficient to determine whether the beneficiaries were terminally ill.

In addition to financial adjustments, OIG recommended that the Medicare intermediary coordinate with HCFA in providing training to hospice providers and physicians on eligibility requirements for beneficiaries, and conduct periodic reviews of hospice claims to ensure the hospice is obtaining sufficient medical information to make valid eligibility determinations. The intermediary generally agreed with the recommendations and stated it is committed to working closely with HCFA to strengthen program procedures and controls to ensure proper payment of hospice claims. (CIN: A-04-95-02111)

Medicare Administrative Costs

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

A. Parts A and B: Blue Cross and Blue Shield of Michigan

The OIG recommended a financial adjustment of $15.6 million for unallowable administrative costs claimed by Blue Cross and Blue Shield of Michigan (BCBSM) for FYs 1990 through 1993. The unallowable costs included: $8.1 million spent over authorized budget; $2.4 million for strategic planning costs that did not directly benefit the Medicare program; and $2.1 million in credits due the Medicare program from BCBSM's Medicare secondary payer activities. The BCBSM generally did not concur with the recommended adjustment. (CIN: A-05-94-00064)

B. Parts A and B and Railroad Retirement Board Provisions of the Medicare Program: Travelers Insurance Company

The OIG recommended a net financial adjustment of $2.8 million as a result of unallowable costs claimed by Travelers Insurance Company for FYs 1990 through 1993. The findings included $1.2 million for unallowable facility and occupancy costs, and $2.5 million for unallowable corporate cost centers (including $1.8 million identified in a previous audit). The recommended adjustment takes into account underclaimed amounts of approximately $900,000. Travelers disagreed with the bulk of the recommended adjustments for facility and occupancy costs and the corporate center costs identified in the prior audit. Travelers agreed with the remaining audit adjustments. (CIN: A-01-96-00508)

C. Associated Insurance Companies, Inc.

The OIG recommended a net financial adjustment of almost $4 million as a result of unallowable costs claimed by Associated Insurance Companies, Inc. The major finding of $2.4 million was for unallowable corporate cost centers. Other significant findings were for excessive executive salary increases and unallowable pension costs. The company disagreed with only $500,000 of the recommended adjustment. (CIN: A-05-94-00080)

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 1,151 sanctions, in the form of exclusions or civil recoveries, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. About three-fourths of the exclusions were based on conviction of program-related crimes, conviction of controlled substance manufacture or distribution, conviction related to patient abuse or loss of license to practice health care. Monetary penalties can be assessed under several civil monetary penalty (CMP) authorities which have been delegated to OIG.

A. Program Exclusions

Title XI of the Social Security Act provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, distribution of a controlled substance, revocation or surrender of a health care license, or failure to repay health education assistance loans (HEALs). Exclusion is mandatory for those convicted of program-related crimes or crimes relating to patient abuse. A significant number of OIG exclusions involve failure to repay HEALs, as discussed in more detail in the chapter on the Public Health Service. During this reporting period, OIG imposed exclusions on 793 individuals and entities in all.

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

- Exclusions ranging from 5 to 20 years were imposed on the two owners of a Louisiana medical transportation company and seven others who were convicted of a scheme in which the Medicaid program was defrauded of over $2 million. In addition, the transportation company was excluded for 20 years. The company provided Medicaid recipients with nonemergency transportation to medical service providers and defrauded the program by preparing fraudulent documentation in support of their billings, billing for miles not actually traveled and altering documentation of multiple passenger trips. The length of each individual's exclusion was determined based on factors such as the length of time he/she participated in the scheme, program damages, and whether his/her sentence included incarceration.

- Two officers of durable medical equipment companies in Florida were each excluded for 20 years after being convicted of participating in a scheme to defraud the Medicare program. The companies provided liquid nutritional supplements to Medicare beneficiaries who didn't need them. In order to get paid by the Medicare program, the companies paid fees to several doctors to sign the certificates of medical necessity (CMNs) authorizing the supplements even though these doctors never examined the beneficiaries. Once the companies had the CMNs, they billed Medicare about $400 a month for nutritional supplements and $250 a month for tubal feedings. Exclusions were previously imposed against others involved in this scheme, based on their convictions.

- A certified medication aide in a Texas nursing home was excluded for 12 years after being convicted of theft of a nursing home resident's money. The aide had set up a credit card in the resident's name and used it for her own personal needs.

- After being convicted of submitting bills to Medicare for equipment which was not needed, a Texas durable medical equipment company was excluded for 10 years.

- A licensed practical nurse in Maine was excluded for 15 years after being convicted of endangering the welfare of an incompetent person. Over a period of 3 days, the practical nurse had increased the morphine drip dosage to a patient without legal authorization. An autopsy proved that the patient ultimately died from a morphine overdose.

- Two nurses aides in Texas were convicted based on their separate assaults on nursing home patients. They were each excluded for a minimum of 5 years.

- A systems analyst in New York was excluded for 5 years after being convicted of grand larceny involving a municipal health organization.

- A Pennsylvania pharmacist was excluded for 10 years after being convicted of two counts involving the illegal distribution of controlled substances.

- The Illinois licensing board suspended the license of a physician who failed to appropriately diagnose and treat a patient in cardiac distress. As a result, the physician was excluded for an indefinite period of time.

- A registered nurse in Iowa was excluded after her license was revoked. The licensing board acted after its review of complaints involving medication errors, one of which was life threatening.

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

Department of Health and Human Services' OIG specifically be queried to determine if any of the HMO's health professionals have been excluded from program participation.

As more and more HMOs have sought accreditation and the practice of credentialing has grown in the health care arena, the number of queries to OIG for exclusion information has increased substantially. During this 6-month period, OIG responded to credentialing requests from HMOs, hospitals, medical societies, licensing boards, etc., to certify the exclusion status of over 10,000 individuals.

B. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law allows recoupment of monies lost through illegitimate claims, and it also protects health care providers by affording them due process rights. The OIG also assists DOJ in bringing cases against wrongdoers under the Federal Civil False Claims Act. Many providers elect to settle their cases prior to litigation. As part of resolving these cases, OIG frequently imposes corporate compliance programs on entities as a condition for being allowed to remain as a provider in the Medicare program. These compliance programs are designed to prevent a recurrence of the fraudulent activities which gave rise to the case at issue. The Government, with the assistance of OIG, recouped over $94 million through both CMP and False Claims Act civil settlements related to health care during this reporting period. Some examples of these cases include:

- In Massachusetts, a laboratory agreed to pay $6.67 million to settle civil allegations that it overcharged the Medicare program. An investigation showed that between 1989 and 1992 the laboratory routinely billed Medicare for a serum iron test whenever a physician requested a standard panel of tests. Physicians did not knowingly request the serum iron tests; rather, they assumed they were part of the standard panel. A computer analysis program developed by OIG showed that the laboratory improperly collected more than $3.35 million from Medicare for the serum iron tests. The computer program is readily adaptable to similar cases throughout the country.

- Also in Massachusetts, 87 hospitals agreed to pay more than $3.5 million to settle allegations that they violated the Federal Civil False Claims Act. The hospitals submitted duplicate claims for outpatient services for Medicare patients performed within 3 days of admission to the hospital. These services had already been reimbursed as part of the hospital stays. The hospitals also agreed to implement procedures to ensure future compliance with Medicare billing rules.

- A Kansas medical center agreed to pay more than $1.2 million to settle its false claims liability resulting from a kickback scheme. A medical group involving five hospitals located in Kansas and Missouri, which provided on-site care to nursing home patients through its physicians, paid a "fee" or inducement to the medical center for the referral of patients to its "geriatric center." The resulting Medicare overpayment to the medical center amounted to $500,000. The settlement represents greater than double damages, including a $100,000 penalty. The center also has agreed to cooperate in the investigation of the medical group.

- A California urologist pled guilty to defrauding Medicare and agreed to pay a civil penalty of $440,000, plus accept a 10-year exclusion from the Medicare program. The urologist submitted claims for invasive medical procedures which were not medically necessary or which he did not perform. He billed between $200,000 and $350,000 over a 23-month period for tests. They included cystourethropscopies, which allow visual examination of the urethra and bladder, and cystometrograms, which assess the bladder's neuromuscular function. He is to be sentenced for the criminal part of this global settlement. He also surrendered his medical license.

- Three Pennsylvania osteopaths, one of their business partners and a pharmacist signed an agreement to pay the Government a total of $175,000 in settlement of civil charges. In exchange for payments for space in two buildings they owned, they signed certificates of medical necessity for a DME company to use in Medicare and private insurer claims. The company and its owner were sentenced earlier.

C. Compliance Activities

The question of whether or not an organization has established compliance standards and procedures is an important factor in Federal sentencing guidelines. As a result, there has been a growing effort by the private sector to establish methods to reduce violations under the Federal Civil False Claims and CMP Acts. The OIG has begun a significant outreach effort with the private sector to discuss these endeavors.

To provide further assistance to the private sector in this area, OIG is developing model compliance plans for the various parts of the health care industry. It is also monitoring and verifying the completion of compliance plan obligations that have been and are being established as a result of settlement negotiations following an OIG investigation or audit.

Currently, OIG is monitoring 40 Government-imposed compliance plans. These plans cover the range of providers from small physician offices to large laboratory corporations. Most compliance plans are for 5 years and require a major effort by the provider to ensure that the

company is operating within HCFA regulations and the parameters established by the compliance plan. Failure to adhere to the compliance agreement within the agreed time limit could result in the exclusion of the provider.

Medicare Providers and Electronic Claims Processing

Performance Measure

The OIG reported that excellent progress is being made at the provider level in converting Medicare claims processing to a total electronic environment. However, OIG believes that additional provider guidance would be beneficial for defining needed internal controls and the responsibilities of each provider in the claims process. Providers still submitting hard copy claims need further encouragement to convert to an electronic media claims (EMC) processing environment.

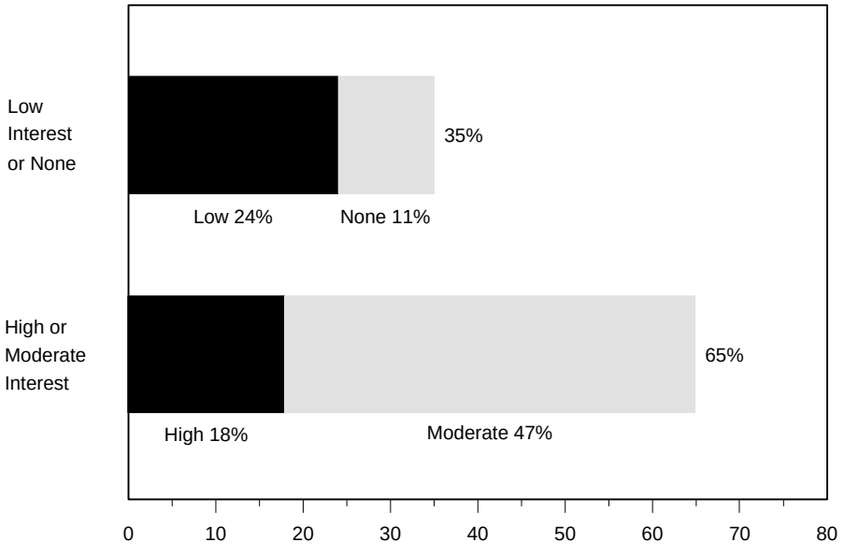
The OIG recommended that HCFA consider: developing additional guidance and instruction on internal controls; providing free training and cost-benefit information on EMC to providers still submitting hard copy claims; and phasing in requirements that Medicare providers with significant paper claims volume convert to EMC. The HCFA concurred with the recommendations and noted several steps already taken to implement them. (CIN: A-05-94-00039)

Encouraging Physicians to Use Paperless Claims

Performance Measure

In an OIG survey of physicians who still submit paper claims for Medicare reimbursement, a majority of respondents indicated a high or moderate level of interest in using paperless claims.

PHYSICIAN LEVEL OF INTEREST IN PAPERLESS CLAIMS



Eighty-three percent of physicians using paper claims cited three or more concerns about the use of paperless claims, including: technical complexity, costs and perceptions about the administrative rules and regulations that govern the use of paperless claims for Medicare.

The OIG recommended that HCFA lead a targeted outreach effort to encourage voluntary conversion to paperless Medicare claims filing for those physicians interested in making the switch. As part of that effort, HCFA could: send informational brochures with cards for requesting additional information; establish an 800 number; target mailings to Medicare participating physicians; and/or furnish information with every new provider number or address change. Further, OIG urged that HCFA begin to plan now for the policy changes that will become necessary to achieve an almost completely paperless environment for processing Medicare claims. The HCFA concurred with the recommendations. (OEI-01-94-00230)

Criminal Fraud

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

- The California Medicare Part B carrier was sentenced after pleading guilty to conspiracy and obstruction of a Federal audit. The carrier was fined the maximum of $1.5 million and assessed $600. The OIG investigators found that company employees misled HCFA auditors in their contract performance review. The carrier relinquished its Medicare carrier contract. A civil case is underway.

- A Boston area psychiatrist was sentenced to 46 months imprisonment and fined $1 million for Medicare and private insurer fraud, obstruction of justice and intimidation of a witness. The psychiatrist filed hundreds of claims, some for more sessions than patients attended and others for patients he never saw. When he became aware of the investigation, he called former patients and attempted to get them to lie on his behalf. He also called a potential witness and threatened to make public the medical records of a family member if she cooperated with the Government. The witness refused to be intimidated. The psychiatrist used an insanity defense, claiming he suffered from a psychotic delusion that caused him to overbill. He is being prosecuted civilly for Medicare fraud and criminally in State court for Medicaid fraud.

- The former executive vice president and chief financial officer for a medical center in New Jersey was sentenced for conspiracy, bribery, embezzlement,

money laundering and tax evasion. The scheme cost the hospital well over $3.8 million, including monies received from Medicare, of which the former officer received nearly $1.17 million. He also received more than $546,000 in bribes for steering hospital transactions to a co-conspirator's company. He laundered much of the illegal money though a Maryland bank account with a fictitious company name. He was sentenced to 55 months incarceration and ordered to pay $21,000 in restitution, which the court found was all he was able to repay. He received a downward departure from sentencing guidelines because of past and continued cooperation in the investigation. Several other participants in schemes to defraud the hospital are to be sentenced in the near future.

- A dermatologist was sentenced in Massachusetts for defrauding Medicare and private insurers of more than $500,000. He was sentenced to 30 months imprisonment and 3 years probation, fined $32,500 and ordered to pay private insurers $182,720 in restitution. He billed and overcharged Medicare for the destruction of numerous skin lesions when patients were provided either weight loss or minor dermatological services. Medicare restitution is to be determined through civil proceedings.

- A former heart surgeon and his corporation were convicted and sentenced in Colorado for Medicare and Medicaid fraud. They were ordered to pay Medicare $30,000 in restitution, fines and damages. The former surgeon billed for more heart bypasses than he performed. He was sentenced to 30 days incarceration, 3 years probation and 200 hours of community service. Earlier, he agreed to settle a civil lawsuit out of court with 17 former patients and their families.

- One of Oregon's highest Medicare-billing ophthalmologists pled guilty and was sentenced for submitting false claims for medically unnecessary cataract surgeries. In several instances, the patients had near-perfect vision prior to surgery. The ophthalmologist gave the hospital false information about patients' true visual acuities, to justify the surgery. He was sentenced to 2 years probation and ordered to pay partial restitution of $10,370. He surrendered his medical license and declared bankruptcy.

Kickbacks

Many businesses engage in referrals to meet the needs of customers or clients for expertise, services or items which are not part of their own regular operations or products. The medical profession relies heavily upon referrals because of the myriad specialties and technologies associated with health care. If referrals of Medicare or Medicaid patients are

made in exchange for anything of value, however, both the giver and receiver may violate the Medicare/Medicaid anti-kickback statute.

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

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

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

Violators are subject to criminal penalties, or exclusion from participation in the Medicare and Medicaid programs, or both. The following cases are some of the examples of the sentencings for this crime:

- In Pennsylvania, the last of five individuals was sentenced in a scheme in which Medicare and Medicaid were defrauded of an estimated $1.7 million. A physician was sentenced to 121 months in prison for accepting kickbacks from a DME company for signing fictitious certificates of medical necessity. The DME company owner and two employees were sentenced earlier for fabricating test results and forging physician signatures as well. The physician's pharmacist brother was also sentenced for routinely billing Medicaid for brand name drugs while supplying generic brands.

- The faculty practice plan of a Massachusetts hospital agreed to pay $177,000 in settlement of civil monetary liabilities for kickback arrangements by two of the hospital's divisions. Since cardiologists could not bill Medicare for interpretations of coronary angiograms and ventriculograms, but radiologists could, arrangements were made for the radiologists to bill for these interpretations. In return, the radiology group paid kickbacks to the cardiology group. This case is the first civil monetary penalties case to have been based solely on violations of the anti-kickback law.

- The president of a Florida DME company and one of her employees were sentenced for conspiracy to violate the anti-kickback law and for fraudulent billing of Medicare. The company president was ordered to make restitution of $98,750. The employee, an unlicensed doctor who recruited

licensed doctors to sign orders for DME, was ordered to repay $42,350. Both were sentenced to 3 months confinement and 3 years probation.

- Two Maryland doctors each agreed to pay $24,000 in settlement of allegations that they accepted kickbacks for referring patients to an area cardiologist. The cardiologist and another doctor were convicted and sentenced to prison earlier.

Home Health Care Costs

In the following reviews of home health care costs, OIG recommended that HCFA require the fiscal intermediary (FI) to instruct the home health agencies on their responsibility to properly monitor their subcontractors for compliance with the Medicare regulations and HCFA guidelines, monitor the FIs and the home health agencies to ensure that corrective actions are effectively implemented, and recover all overpayments. Further, OIG recommended that HCFA direct the FIs to investigate all cases of possible fraud and refer them as necessary to OIG. The HCFA agreed with the recommendations.

A. Florida - Miami Lakes

The OIG reviewed 100 claims (representing 1,445 home health services) for Medicare reimbursement by a home health agency during the fiscal year ended December 31, 1993. In 24 percent of the claims, services did not meet Medicare guidelines: 11 percent were for 145 services that were not reasonable or necessary, 4 percent were for 24 services not provided, and 9 percent were for 177 services which physicians either denied authorizing or authorized improperly. During this fiscal year period, the agency claimed $8.5 million in 9,391 claims representing 126,386 services. The OIG estimates that at least $1.2 million did not meet the reimbursement guidelines. (CIN: A-04-95-01104)

B. Florida - Miami

In a review of 100 claims (representing 2,068 home health services) submitted for Medicare reimbursement during the fiscal year ending December 31, 1993, OIG found that 40 claims contained 846 services that did not meet Medicare guidelines. These included 25 percent of the claims for 466 services made to individuals who were not homebound; 8 percent of the claims for 200 services which were not reasonable or necessary; 5 percent of the claims for 127 services not provided; and 2 percent of the claims for 53 services which physicians denied authorizing.

During the fiscal year ending December 31, 1993, the home health agency claimed $3.6 million on 2,922 claims representing 54,545 services. Based on its review, OIG estimates that $1.2 million did not meet the reimbursement guidelines. (CIN: A-04-95-01106)

C. Florida - Dade County

The OIG reviewed 100 claims (representing 1,856 home health services) submitted by a home health agency for the fiscal year ended December 31, 1993. Of these, OIG found that 32 claims contained 403 services that did not meet Medicare guidelines: 9 percent of the claims for 129 services were provided to beneficiaries who were not homebound; 16 percent were for 208 services which were not reasonable or necessary; 4 percent were for 18 services not provided; and 3 percent were for 48 services which physicians either denied authorizing or authorized improperly. The OIG estimated that 1.3 million did not meet the reimbursement guidelines. (CIN: A-04-95-01103)

Home Health Agency Fraud

The owner of a home health agency (HHA) was sentenced in Georgia to 7 1/2 years in prison and fined $10 million for defrauding Medicare. The sentence was 18 months less than the maximum under Federal sentencing guidelines for 28 counts of conspiracy, witness tampering and making false statements, but the fine was far beyond the guidelines maximum of $150,000. The owner's wife and business partner was sentenced to 2 years and 8 months in Federal prison for conviction on two counts of making false statements to the Government. The corporation's transportation director, who pled guilty and cooperated in the case, was sentenced to 6 months incarceration and fined $20,000. The corporation itself was ordered to pay $9.9 million in restitution and fines, making the case one of the richest Medicare fraud prosecutions on record.

The owners and the company were given 120 days to pay all penalties. They had been charged with falsely billing at least $1.1 million. Among other charges, they were accused of seeking Medicare reimbursement for employee campaign contributions, recreational plane flights for the owners, secret buy-out agreements with rival providers and billing Medicare for payments to lobbyists. After the convictions, OIG used its administrative authority and excluded the owner of the company from participation in Medicare and any State health care program for a minimum of 15 years. His wife was excluded for a minimum of 10 years. At its height, the corporation employed more than 15,000 people and made 30,000 visits per day to homebound, elderly patients. It was the largest privately owned home health care provider in the Nation, billing Medicare more than $440 million in 1994.

In a related case, the former owner of a Michigan HHA was sentenced to 5 months house arrest and ordered to pay $18,000 for his participating in a Medicare fraud scheme. He sold his HHA on December 1, 1994 to the Georgia HHA corporation, but all documents relating to the sale and employees were backdated to November 12, 1994. The backdating allowed the corporation to bill Medicare for all care provided by the former owner's HHA, thereby covering nearly all the corporation's acquisition costs. In addition, the former owner received a salary from the corporation of $5,000 a month from December 1994 to June 1995, although he performed no service to justify it, and the salary was billed to Medicare.

His light sentence was the result of his cooperation in the investigation of the corporation and its Michigan satellite office.

Medicare Part B Services in Nursing Homes

Medicare Part B covers a wide range of medical services and supplies for the program's beneficiaries, including those in nursing homes. These include physician services and outpatient hospital services, diagnostic laboratory services, imaging, ambulance services, and a host of medical equipment and supplies.

In the following reviews of Part B services in nursing homes, OIG used information on expenditures from a 1992 nationally projectable sample of nursing home residents in 10 States and 150 nursing homes.

A. Overview

In 1992, Medicare payments of $2.7 billion were made for Part B services provided to nursing home residents. The most money was spent on physician evaluation services ($894 million), followed by medical equipment, supplies, prosthetics and orthotics ($772 million). The Part B average daily charge varied significantly among States and among nursing homes. Differences in nursing home average daily charges were sometimes, but not always, explained by differences in the acuity level of the residents treated in the facility.

The OIG determined that the Part B program in nursing homes is particularly vulnerable to fraud, waste and abuse because payment rules and safeguards largely ignore the special character of the nursing home environment and the varied services and supplies which can be provided. Program vulnerabilities identified included the potential for duplicate payments by Medicare and Medicaid, lack of oversight by Medicare contractors, and questionable supplier or physician practices already documented in earlier studies.

This review suggested the need for further work in many areas. In addition, to support the development of fraud detection methods, OIG is gathering further information on the nature and magnitude of abusive provider practices or program vulnerabilities involving nursing home residents. (OEI-06-92-00865)

B. Enteral Nutrient Payments

Based on its medical records review, as well as survey information obtained from nursing homes and hospitals, OIG determined that Medicare Part B payments for enteral nutrition substantially exceeded purchase prices commonly available through volume purchasing and other contractual relationships. In addition, approximately 75 percent of charges are for Category I nutrients, the simplest and most readily available type considered by the Food and Drug Administration to be food.

The OIG concluded that Medicare reimbursement policies fail to recognize the ability of nursing homes to purchase nutrients and supplies at reduced costs and to provide incentives for nursing homes to exert their buying power to save the taxpayer money. Further, OIG noted that, if enteral nutrients were recognized as food, payment could be made as a part of the facility payment rather than separately billed to Medicare Part B.

The OIG recommended that enteral nutrients be excluded from Part B reimbursement when patients reside in nursing homes or that Part B reimbursement be continued at lower levels when provided to nursing home residents. The HCFA concurred with OIG's findings and supported the first option. (OEI-06-92-00861)

C. Durable Medical Equipment Payments

In 1992, Medicare carriers allowed as much as $35 million for DME during nursing home stays. Of this, $27 million was paid by Medicare and $8 million by beneficiaries.

Based on its review, OIG determined that no effective mechanism currently exists to ensure the appropriate payment of DME under Medicare Part B for beneficiaries in nursing homes. To be covered by Medicare Part B, DME must be furnished for use in the beneficiary's home. A hospital or skilled nursing facility (SNF) is specifically excluded as a resident's home. A SNF is defined as a facility primarily engaged in providing skilled nursing care. To ensure correct payments, clarification is needed to determine which nursing homes are primarily engaged in providing skilled care.

The OIG recommended that HCFA develop and implement a workable and fair definition of what constitutes a SNF for the purposes of payment of DME under Medicare Part B. Such a definition should reflect the principle that SNFs are responsible for the provision of a basic range of services to the residents under their care, and a SNF cannot be considered a home for the purposes of DME coverage under Medicare Part B. The HCFA concurred. (OEI-06-92-00862)

D. Mental Health Services in Nursing Facilities

This OIG study draws an overall picture of the kinds of mental health services being provided in nursing facilities and identifies potential vulnerabilities for the Medicare program. In a review of nursing home records for the five Medicare codes most commonly reimbursed to psychiatrists, clinical psychologists and clinical social workers in 1993, OIG found that Medicare paid for medically unnecessary services in 32 percent of the records reviewed. This projects to $17 million, or 24 percent of all 1993 Medicare payments for mental health services for nursing home residents. In 16 percent of the records, OIG found that Medicare paid for highly questionable services. This projects to $10 million in Medicare payments. At the same time, OIG concluded that some beneficiaries are not getting the care they need.

The OIG recommended several approaches that HCFA, together with the carriers, might take to ensure the integrity of Medicare payments while promoting the delivery of needed care. The HCFA concurred with OIG's recommendation and detailed the actions underway to carry it out. (OEI-02-91-00860)

In a companion report covering the five Operation Restore Trust States, OIG noted that, as a whole, these States were as likely as others to have unnecessary or questionable services. However, New York and Florida did appear to have a greater than average percentage of unnecessary services. This report offers detailed information on the five States for HCFA, the carriers and relevant State agencies to consider in targeting the problems peculiar to each. (OEI-02-91-00861)

Nursing Home Fraud

Nursing facilities and their residents have become common targets for fraudulent schemes. The OIG has become aware of a number of fraudulent arrangements by which health care providers, medical professionals, and nursing facility management and staff inappropriately bill Medicare and Medicaid for the provision of unnecessary services and services which are not provided to residents. The following cases are some of the examples of fraudulent schemes related to health care services to residents of nursing facilities:

- In California, a former nursing home owner was ordered to pay more than $10.5 million for submitting over 7,000 false claims relating to a multimillion dollar Medicare fraud scheme. He billed Medicare for nonexistent medical supplies for his nursing homes and filed cost reports with false expenses. He attempted to conceal the scheme by supporting the cost reports with falsified medical records and fabricated invoices. He was sentenced earlier on the criminal aspect of the case to 11 years and 3 months imprisonment and ordered to pay $3.5 million in restitution. The amount of damages ordered to settle civil liabilities was treble the amount of restitution ordered. Medicare payments to the nursing homes were suspended.

- Also in California, a former psychiatrist was sentenced to 18 months in prison for defrauding Medicare. He billed Medicare more than $100,000 for fictitious psychotherapy services to nursing home patients. Earlier he confessed to OIG agents that he made the false claims in order to purchase drugs. On the basis of the confession, the State prosecuted him separately on drug charges and his license was revoked. The psychiatrist is to perform community service in lieu of restitution following his incarceration.

- In Ohio, a for-profit hospital agreed to pay the Federal Government $1.45 million in settlement of charges of defrauding the Medicare and Medicaid

programs. While operating an outpatient clinic for nursing home patients, the hospital submitted false claims for geriatric psychiatric services that were nontherapeutic or unnecessary. Many of the patients suffered organic brain disorders and would not have benefitted from psychiatric treatments. As a result, the hospital was overpaid more than $600,000 by Medicare and Medicaid. In addition to the settlement, the hospital agreed to initiate an approved compliance plan before reinstituting similar programs in the future and to continue to cooperate in the investigation.

- As a result of a joint investigation by OIG and the Federal Bureau of Investigation (FBI), a DME corporation agreed to a $3.6 million settlement. The corporation, a shell company with a Pennsylvania address, was established by a New York DME supplier solely to bill Pennsylvania's Medicare carrier for prosthetic and orthotic supplies provided to nursing home beneficiaries in New York. As a result of this billing arrangement, the corporation was overpaid $1.1 million over a 3-year period. As part of the agreement, the supplier will implement a corporate compliance plan.

- The former owner of an ambulance company in Illinois agreed to pay the Government $367,000 in a global settlement for submitting false claims to Medicare and Medicaid. The company was charged with billing Medicare and Medicaid for transporting nursing home patients as bed-confined or for other higher levels of service than that performed. As part of the settlement, the owner entered a plea of guilty to criminal charges, was ordered to make restitution of $15,800 and was fined $12,750. He and the company agreed to an exclusion of 5 years.

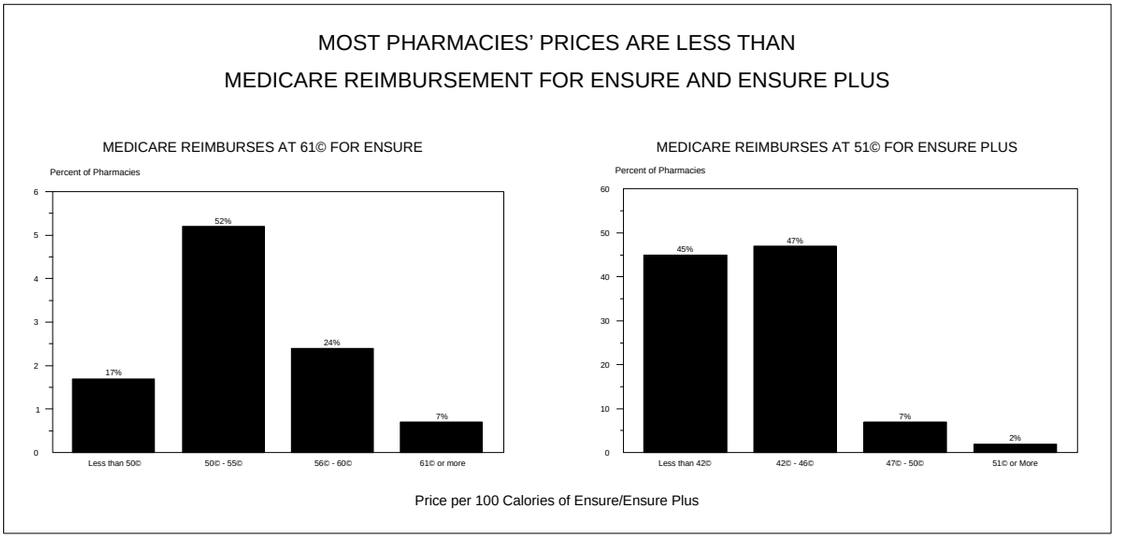
In view of the magnitude of the schemes uncovered, OIG issued a special fraud alert during this reporting period that focused on the provision of medical and other health care services to residents of nursing facilities and identified some of the illegal practices.

Payments for Enteral Nutrition: Medicare and Other Payers

At HCFA's request, OIG reviewed Medicare's reimbursement methodology for enteral nutrition products. These products are usually liquid formulas that provide nourishment directly to the digestive tract of patients who are unable to ingest an appropriate amount of calories. For purposes of comparing pricing information, OIG surveyed other payers as well as retail pharmacies.

The OIG found that for three enteral nutrition products -- Ensure, Osmolite, Glucerna -- payers using competitive acquisition strategies reimbursed less than Medicare fee-for-service. Three traditional fee-for-service payers fared no better than Medicare in obtaining the best prices available.

As illustrated below, almost all of the retail pharmacies surveyed charged less than Medicare fee-for-service allowances for Ensure and Ensure Plus.



The OIG recommended that HCFA reduce payments for enteral nutrition, either across the board or for certain product categories, or use enteral nutrition as one of the first product types to acquire under new competitive acquisition strategies. The HCFA concurred with OIG's recommendation. (OEI-03-94-00021)

Fraud Involving Durable Medical Equipment Suppliers

The DME industry has consistently suffered from waves of fraudulent schemes in which Medicare or Medicaid is billed for equipment never delivered, higher-cost equipment than that actually delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State from that billed in order to obtain higher reimbursement. More than 2 years ago, HCFA published new regulations addressing reimbursement problems that have recurred over the years, especially those created by telemarketing and carrier shopping. It is hoped that consolidation of claims processing into four regional jurisdictions, as specified in the regulations, will resolve many of these problems. In the meantime, OIG continues to obtain settlements and convictions of unscrupulous suppliers for other schemes, as shown in the following examples:

- A New York physician was sentenced to 12 months imprisonment for conspiracy to defraud the Medicare program. He was one of 19 persons who participated in a fraud scheme involving a medical supply company.

The scheme cost Medicare more than $13 million over an 18-month period. The physician signed medical necessity forms without seeing the patients, then falsified the medical charts to indicate he had treated them. He was also ordered to pay $87,000 in restitution. The other participants in the scheme have already been sentenced or await trial.

- A Pennsylvania DME company, its two former owners/operators and their spouses agreed to pay the Federal Government a total of $4 million in settlement of civil charges of Medicare fraud. They submitted fraudulent claims for medical devices used to treat lymphedema, altered signed certificates of medical necessity (CMNs), forged physicians' signatures on CMNs, misrepresented services to beneficiaries and falsely billed Medicare for new equipment when they provided used equipment. They also agreed to lifetime exclusions from participating in Medicare and State health care programs. In addition, the company and its parent company agreed to institute a 3-year program to assure compliance with all Medicare and Medicaid regulations.

- In New York, one of the three owners of a now-defunct DME company was ordered to pay the Government $2 million in settlement of false Medicare claims. The company had submitted false billings for transcutaneous electrical nerve stimulator units and accessory kits. Settlements with the other two owners are pending. All three were previously prosecuted criminally, and the other two were given lengthy jail sentences.

- In Florida, six persons were sentenced for their parts in conspiring to create 18 separate fictitious companies which they used to defraud Medicare of more than $6.2 million. They submitted false claims for parenteral nutrition. A total of more than $1.8 million was ordered in restitution and special assessments. One man was sentenced to 25 months in prison, and the remainder received 3 years probation.

- After pleading guilty to Medicaid fraud, the owner of a Colorado DME supply company was sentenced to 3 months in jail, 45 days of home detention and 18 months probation. He was also ordered to repay Medicaid $100,000. For several years, he billed Medicaid and Medicare (in crossover claims) for wheelchairs he did not provide. The State chose to prosecute on the Medicaid claims only.

- A Pennsylvania man was sentenced for his part in a scheme to defraud Medicare by violating point of service regulations. Earlier, his corporation

paid $2.1 million to settle civil damages associated with the fraud. He was sentenced to 2 years probation, and fined $14,740.

Other DME cases appear in the sections on kickbacks and nursing home fraud.

Appropriateness of Medicare Prescription Drug Allowances

While Medicare Part B does not pay for over-the-counter or many prescription drugs that are self-administered, the program does pay for some categories of drugs used by Medicare beneficiaries. In 1994, Medicare expenditures for prescription drugs totaled at least $1.4 billion.

The OIG found that, under a drug rebate program similar to Medicaid's, Medicare would have saved $122 million for 17 prescription drugs in 1994. Moreover, Medicare could have saved $144 million in 1994 had the program employed a discounted average wholesale price drug reimbursement formula as do many Medicaid States. Because the Medicare program pays for drugs billed by HCFA's Common Procedure Coding System codes, it reimburses based on a drug category; information on the specific drug supplied would be necessary for the implementation of any rebate or discounting program by Medicare.

The OIG's conclusions in this inspection supported its earlier proposal in a report on drugs used with nebulizers (a type of durable medical equipment). The OIG recommended that HCFA reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. The HCFA agreed with the recommendation and is examining available options in an effort to make appropriate drug payment reductions. (OEI-03-95-00420)

Medicare Payments for Albuterol Sulfate

Albuterol sulfate is a prescription drug commonly used for inhalation therapy with nebulizers. Between January 1994 and February 1995, Medicare allowed $182 million for this drug, 68 percent of the $269 million in total Medicare allowances for all nebulizer drugs.

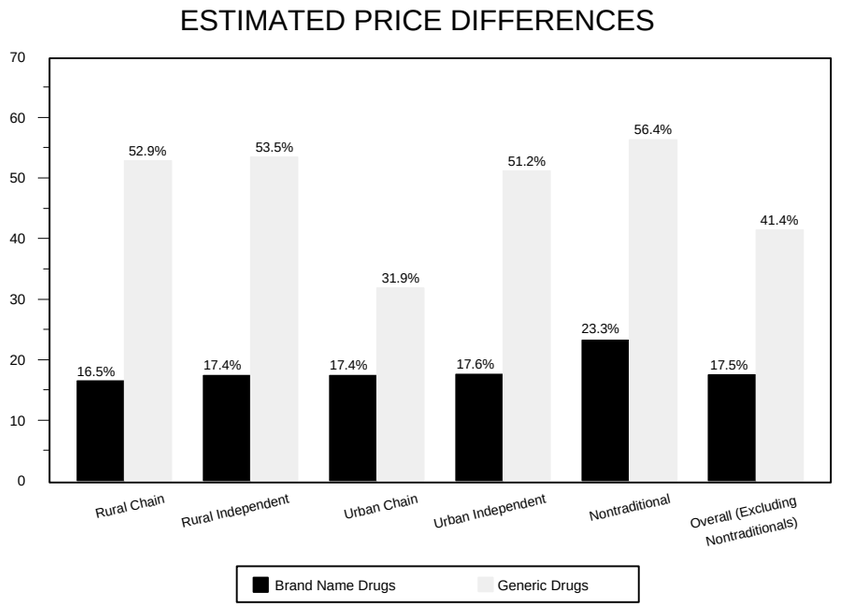
The OIG reported that Medicare's allowances for albuterol sulfate substantially exceeded suppliers' actual acquisition costs for the drug and that many pharmacies, pharmaceutical buying groups and mail-order pharmacies charged customers less for generic albuterol sulfate than Medicare's allowed reimbursement. The HCFA agreed to explore new strategies to improve drug reimbursement. (OEI-03-94-00392; OEI-03-94-00393)

Pharmacy Acquisition Costs for Drugs Reimbursed under Medicaid

These reviews were conducted as part of a nationwide audit of pharmacy prescription drug acquisition costs undertaken at HCFA's request. Most States reimburse pharmacies for Medicaid prescription drug costs using a formula which generally discounts the average wholesale price (AWP) by 10.5 percent. The OIG reviews focused on developing an estimate of the difference between AWP and the actual acquisition cost of drugs by pharmacies for both brand names and generic drugs. The OIG estimates exclude results from nontraditional pharmacies, such as nursing home or hospital pharmacies, which would have inappropriately inflated percentages.

A. California

One of 11 States randomly selected as part of the nationwide review, California reported drug expenditures of $1.3 billion in Calendar Year (CY) 1994. As shown in the chart below, OIG estimated that AWP exceeded invoice prices for brand name drugs by 17.5 percent and for generic drugs by 41.4 percent in California.



The OIG recommended that the State consider these results as a factor in any future changes to pharmacy reimbursement for Medicaid drugs. The State replied that the audit results substantiated their position that current drug ingredient cost reimbursement does not reflect actual purchasing activity of California pharmacies. It intends to use the report data to support a provision in the Governor's budget proposal to decrease drug ingredient reimbursement. (CIN: A-06-95-00062)

B. Montana

Montana reported drug expenditures of $26 million in CY 1994. The OIG estimated that, in Montana, AWP exceeded invoice prices for brand name drugs by 16.2 percent and for generic drugs by 48.5 percent. The OIG recommended that the State consider these results as a factor in any future changes to pharmacy reimbursement for Medicaid drugs. In response, the State noted that any evaluation of Medicaid pharmacy pricing should consider additional factors and expressed concern that further discounting of AWP in pricing formulas would result in a corresponding inflation in AWP. The OIG acknowledges the State's concerns, but believes that information on prices actually paid by pharmacies is useful in setting future reimbursement rates. (CIN: A-06-95-00068)

C. Florida

Florida reported drug expenditures of $486.7 million in CY 1994. The OIG estimated that AWP exceeded invoice prices for brand name drugs by 20.2 percent and for generic drugs by 41.5 percent. The OIG recommended that the State consider the results of this review as a factor in any further changes to pharmacy reimbursement for Medicaid drugs. The State responded that it compared the data from OIG's review to its current reimbursement policy and believes no change is warranted at this time. (CIN: A-06-95-00065)

D. North Carolina

North Carolina reported drug expenditures of $222.5 million in CY 1994. The OIG estimated that AWP exceeded invoice prices for brand name drugs by 16.9 percent and for generic drugs by 45.2 percent. The State agreed with OIG's recommendation that it consider the results of our review in any future changes to pharmacy reimbursement for Medicaid drugs. (CIN: A-06-95-00071)

Medicaid Reimbursement for Clinical Laboratory Services

As part of its nationwide review of States' procedures and controls over Medicaid payments for clinical laboratory services, OIG determined that Connecticut, Maryland, Georgia, Wisconsin, Arkansas, Missouri, California and Washington were reimbursing providers for services that were not properly grouped together (bundled into a panel) or were duplicated for payment purposes. The OIG determined that resultant overpayments were due to the States not having adequate edits in place to ensure that payments for clinical laboratory services did not exceed amounts recognized by Medicare for the same services.

Based on its audits, OIG estimated the following recoveries for CYs 1993 and 1994: Connecticut, $427,000 (Federal share $213,000); Maryland, $255,000 (Federal share $127,000); Georgia, $3.4 million (Federal share $2.1 million); Wisconsin, $569,000 (Federal share $343,000); Arkansas, $167,000; Missouri, $1.1 million (Federal share $653,000); California, $8 million (Federal share $4 million); and Washington, $716,000 (Federal share $213,000).

The OIG recommended that the States install edits to preclude payments for clinical laboratory services that exceed amounts recognized by Medicare for the same services; recover overpayments for clinical laboratory services identified in the review; and make adjustments for the Federal share of the amounts recovered by the States in their quarterly reports of expenditures to HCFA.

Connecticut, Georgia, Arkansas and Washington concurred with the recommendations. Maryland and Missouri both agreed with the installation of edits but did not agree with the recovery of overpayments and adjustment for Federal share recovered. California generally disagreed with the recommendations but did agree to research points raised in the report to identify opportunities for future savings. Wisconsin disagreed with the recommendations. (CIN: A-01-95-00006; CIN: A-03-96-00200; CIN: A-04-95-01109; CIN: A-05-95-00035; CIN: A-06-96-00002; CIN: A-07-95-01138; CIN: A-09-95-00072; CIN: A-10-95-00002)

Federal and State Partnership: Joint Audits of Medicaid

Two years ago, OIG began an initiative to work more closely with State auditors in reviewing the Medicaid program. The Partnership Plan was created as an effort to provide broader coverage of the Medicaid program by partnering with State auditors to conduct joint reviews. The OIG believed that this partnership approach would be a more effective use of scarce audit resources by both the Federal and State audit sectors.

Active partnerships have been developed with 15 State auditors, 11 State Medicaid agencies and 2 State internal audit groups. Twenty State auditor partnership reports have been issued with a financial impact of over $100 million affecting both Federal and State Government funds. The following Partnership reports were issued during this semiannual period and several more reports are in process:

A. Washington: Medicaid Drug Rebate Program

The Washington State Auditor reviewed certain compliance requirements related to the drug rebate program as part of the 1995 single audit of the State. The Auditor found that Washington did not have policies or procedures established to ensure that rebate billings which have been disputed by manufacturers were resolved within prescribed timeframes. Moreover, the State Auditor found that although over half the manufacturers included in the audit remitted their rebate payments past the due date, none paid interest as required. Appropriate recommendations were made. This information was included in a letter to management dated March 4, 1996. The single audit report was issued on April 5, 1996. (No CIN assigned)

B. Montana: Medicaid Drug Rebate Program

The Montana Legislative Auditor found that the State did not actively pursue the collection of outstanding drug rebate amounts. Only one employee was assigned to collect the rebates

and resolve the disputes. As of October 15, 1995, uncollected rebates in dispute status totaled $1.2 million. Manufacturers are required to apply interest to late rebate payments on amounts not paid by the prescribed due date. As of October 15, 1995, interest totaling approximately $116,000 should have been charged on unpaid amounts.

Recommendations called for the State to resolve disputed drug rebate amounts in a timely manner and establish procedures to charge interest on past due drug rebates. This information was included in the single audit report dated January 1996. (No CIN assigned)

C. Montana: Durable Medical Equipment

The Montana Legislative Auditor reviewed the State's Medicaid expenditures for DME and identified potential cost savings in the processing of DME claims and the acquisition of medical equipment and supplies. The report recommended that the State evaluate competitive bidding for term contracts for oxygen concentrators to reduce costs; require a written description and/or prior authorization of all Medicaid items paid from invoices billed under miscellaneous equipment codes; determine whether the current State term contract for diapers could be modified to achieve savings; and define allowable incontinence supplies and document the medical necessity of these supplies. (CIN: 06-96-00042)

Children's Dental Services under Medicaid: Access and Utilization

Performance Measure

Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive health program that provides initial and periodic examinations and medically necessary follow-up care. Federal law requires that States provide EPSDT services to eligible children from birth through age 20. States must ensure that health care providers are available and accessible, and teach Medicaid families how to use available resources effectively. In recent years, State and Federal officials have expressed concern about the number of dentists who are willing to see EPSDT enrollees.

The OIG's inspection confirmed what HCFA data show -- that few children receive EPSDT dental services and the extent of the problem varies significantly from State to State. Data from HCFA indicate that only 1 in 5 (4.2 million of 21.2 million) eligible Medicaid children received preventive dental services in 1993, a slight decrease from 1992.

The OIG determined that children do not receive preventive dental services for three basic reasons: few dentists are willing to accept Medicaid patients; Medicaid families give dental services a low priority; and the youngest children are the most difficult to serve and frequently are not screened at all. In the past few years, State, local and private agencies have begun initiatives to improve the participation of dentists in Medicaid and to encourage children and families to use dental services. While some States are planning to evaluate their projects, most do not yet have data to show whether they are effective.

The OIG recommended that the Department convene a work group to develop an integrated approach to improving dental access and utilization for EPSDT eligible children, and proposed several issues for consideration. Several departmental agencies concurred and the Assistant Secretary for Health and the National Institutes of Health suggested that the existing Public Health Service Oral Health Coordinating Committee Work Group, with expanded membership, could address OIG's recommendation. (OEI-09-93-00240)

Medicaid Fraud

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

During FY 1995, OIG administered approximately $110 million in grants to the MFCUs. The MFCUs reported 291 convictions and $19.5 million in fines, restitutions and overpayments collected for the period January 1, 1996 through June 30, 1996.

Although most Medicaid fraud cases are investigated by the MFCUs, OIG occasionally works with them and/or other law enforcement agencies on such cases. The following instances of successful prosecutions in these cases bear noting:

- A North Dakota State social worker signed an agreement to repay $110,500 she had defrauded in false Medicaid claims in Minnesota and South Dakota from 1988 through 1992. She also agreed to a 5-year exclusion from Medicare and Medicaid. The social worker billed for the services of a physician psychiatrist which were actually performed by social workers. She conspired with a psychiatrist who signed the claims in exchange for a part of the reimbursements, for services he never performed. Earlier the psychiatrist agreed to pay $80,000 for his part in the scheme.

- In Tennessee, two men were sentenced to 7 months incarceration, 7 months home confinement and 2 years supervised release for defrauding Medicaid. The father of one of the men was sentenced to 1 day incarceration and 18 months supervised release. The three submitted fraudulent crossover claims to Medicaid, including false expenses on cost reports and failure to report related parties. The father was incarcerated earlier in a related case involving his brother and several nursing homes.

- In 1992, OIG joined the FBI in a Medicaid fraud project in Illinois involving drugs. During this reporting period, one man was sentenced to 6 months in prison for purchasing and reselling illegally obtained drug samples and prescription drugs from Medicaid recipients. Investigation revealed that the recipients would visit several doctors on the same day and obtain prescriptions. After they filled the prescriptions they sold the drugs to a "non-con" (an individual who does not deal in controlled substances and is usually not concerned about refrigeration or sanitary storage of drugs). The non-con resold the drugs to pharmacies, causing Medicaid to pay for the same drugs multiple times. Similarly, an Illinois pharmacist was sentenced for buying drugs collected from Medicaid patients by a non-con. Their convictions made a total of 15 resulting thus far from the project. The FBI has expanded the project nationally.

Public Health Service Operating Divisions

Chapter III

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Overview of Program Area and Office of Inspector General Activities

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

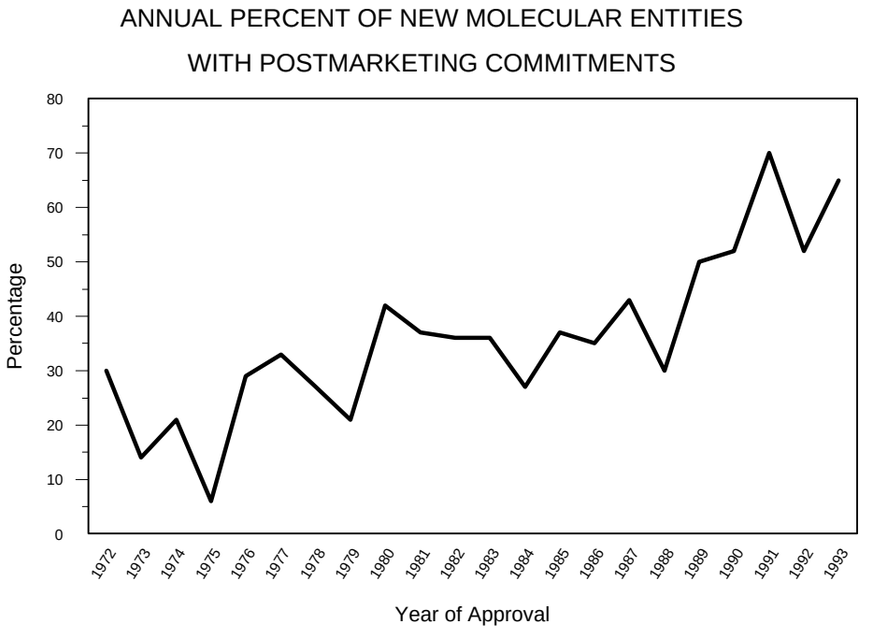
In the past 5 years, the Office of Inspector General (OIG) has significantly increased its oversight of public health programs and activities. The OIG has concentrated on a variety of issues such as biomedical research funding, substance abuse, Indian health services, drug approval processes and community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

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

Postmarketing Studies of Prescription Drugs

Performance Measure

Postmarketing studies -- drug studies conducted after FDA marketing approval -- can provide important information on new uses and dosing information for special patient populations, such as the elderly. A company's agreement to conduct an FDA-requested postmarketing study is called a postmarketing or Phase IV commitment. As illustrated in the following chart, FDA is requesting postmarketing studies for an increasing number of drugs.



The OIG found that there are no formal standards and procedures for monitoring or for establishing whether a postmarketing commitment has been met. The OIG recommended that FDA establish standards, procedures or guidelines for carrying out monitoring and tracking objectives, and establish accountability for monitoring, tracking and bringing commitments to closure. Included in OIG's report were several ideas for FDA's consideration in streamlining data management. The FDA agreed with OIG's findings and recommendations and has drafted a directive that establishes procedures and provides guidance. (OEI-03-94-00760)

Processes to Review Medical Devices

Performance Measure

The OIG conducted a follow-up review to assess corrective actions taken by FDA to improve its premarket approval (PMA) and investigational device exemption (IDE) application review processes. The OIG found that FDA's Center for Device and Radiological Health (CDHR) had taken actions that should enhance the review processes.

However, OIG concluded that CDHR could further strengthen the integrity of these decision-making processes by fully implementing a program for conducting independent internal quality control reviews of the PMAs, similar to reviews conducted of IDEs. The FDA concurred with OIG's recommendation. (CIN: A-15-95-50001)

Food and Drug Administration's Urgent Notices

Performance Measure

At FDA's request, OIG conducted an inspection to assess the effectiveness of an Urgent Notice on recalled blood glucose test strips which was released on October 11, 1995. The OIG surveyed pharmacies nationwide through telephone interviews and site visits. Approximately two-thirds of the pharmacists contacted acknowledged receiving the notice. About one-half indicated that the notice was the means by which they first learned of the problem of the defective test strips. The majority of pharmacists who acknowledged receiving this notice reported that they did, in fact, check and remove stock as recommended in the notice. However, OIG found recalled test strips in one pharmacy. Further, few pharmacists posted the public notice which FDA provided to them.

The inspection results did not explain why one-third of the pharmacists interviewed were not aware of the Urgent Notice. Clearly more research is needed on this. The OIG strongly encouraged FDA to continue its efforts to improve ways to notify the health care community on important safety issues regarding medical devices. The FDA should also consider restructuring and rephrasing future Urgent Notices to clearly convey to recipients what actions they are expected to take. (OEI-07-94-00631)

Processing of 17 Error and Accident Reports Involving Blood

Performance Measure

When an error or accident occurs that may affect the safety, purity or potency of blood, licensed blood establishments are required to report the incident to FDA's Center for Biologics Evaluation and Research (CBER). In an earlier review, OIG determined that CBER generally processed the error and accident reports in accordance with established procedures, but noted that it would continue to review 17 of the 163 report sample that had been identified by CBER as warranting further evaluation for a recall classification.

The OIG's current review finds that FDA correctly processed 12 of the 17 error and accident reports it had identified as warranting further evaluation. For the five reports not processed in accordance with established procedures, FDA said that the reports should have been classified as blood recalls and published as such in the FDA Enforcement Report, a document distributed within FDA and to other Federal Government agencies, the press and consumers.

Although these processing errors are causing delays in publication, OIG does not believe the public was placed at additional risk in these cases. Classification and publication of a blood

recall generally take place long after the error or accident occurs and is reported by the blood establishment. In the five error and accident reports that OIG identified as processed incorrectly, the blood establishments acted quickly after detecting the error or accident.

The OIG recommended that FDA improve its tracking system to ensure that all error and accident reports warranting further evaluation for blood recall classification are tracked until final resolution. Further, OIG proposed that FDA complete the recall classification and publication of the five error and accident reports not processed in accordance with established procedures. The FDA agreed with the recommendations. (CIN: A-03-95-00350)

Educational Resource Centers

Performance Measure

The CDC provides grant funds to 14 university-affiliated centers that provide training on occupational safety and health. These Educational Resource Centers (ERCs) were instituted in response to the Occupational Safety and Health Act of 1970 which mandated that the Secretary ensure an adequate supply of trained professionals for the field.

As illustrated in the following chart, OIG found that most CDC-supported graduates did pursue occupational safety and health careers.

CDC-SUPPORTED GRADUATES PURSUING OCCUPATIONAL SAFETY AND HEALTH CAREERS ANNUALLY

	1989-1990	1990-1991	1991-1992	1993-1994	1993-1994	Total 5-Years
Number of graduates	202	220	193	225	222	1,062
Number of graduates pursuing careers in occupational safety and health	170	195	176	195	192	928
Percent of graduates pursuing careers in occupational safety and health	84%	89%	91%	87%	86%	87%

Approximately 52 percent of the CDC-supported graduates pursued occupational safety and health careers in private organizations, and approximately 45 percent pursued careers in government or academia. Seventy percent of the responding graduates rated the quality of ERC training as excellent. Ninety-four percent said that ERC training adequately prepared

them for occupational safety and health careers. The OIG report included a number of suggestions from graduates for improving the curriculum. The CDC concurred with OIG's findings. (OEI-04-92-00900)

Administration of Flood Grants for the Midwestern Flood of 1993

The OIG conducted a review to determine whether grants totaling $8.2 million provided relief to flood victims in accordance with guidelines established by the Midwest Flood Health and Medical Task Force. The OIG determined that awards totaling $4.2 million were not granted for purposes consistent with Task Force guidelines. Two grantees whose clinics were undamaged by the flood received funds for new construction and acquisition of clinical facilities that would not be operational until years after the disaster. One grantee received funds to provide primary health care services, but no services were provided for nearly 1 year after the grant award was made.

The OIG recommended that HRSA review the justification used to fund the three questionable awards and replace the emergency funds with other appropriate funding if the awards were not consistent with Task Force guidelines or the intent of the law. In addition, OIG proposed that HRSA develop procedures for objectively evaluating applications against established criteria. Subsequent review by HRSA found adequate justification existed for awarding emergency flood funds to the three identified grantees consistent with Task Force Guidelines. (CIN: A-07-94-00821)

Providing Medical Malpractice Coverage to Community and Migrant Health Centers

The OIG analyzed the costs to the Federal Government for providing medical malpractice liability insurance to community and migrant health centers (C/MHCs). The Federal Tort Claims Act (FTCA) currently provides unlimited dollar coverage for each medical malpractice claim because there are no Federal restrictions on the amount of money that can be paid on each claim under FTCA.

The OIG concluded that unlimited dollar coverage could result in significant additional malpractice claims costs under FTCA. The OIG estimated that the Federal Government would incur $30.6 million more over a 3-year period to provide unlimited dollar coverage, compared to providing coverage with a $1 million per claim limit. The OIG recommended that HRSA consider seeking a legislative change to limit malpractice settlement or judgments involving C/MHCs to $1 million. The HRSA concurred. (CIN: A-04-95-05018)

Access to Community Health Centers by Homeless Persons

This inspection was conducted at the request of the Assistant Secretary for Planning and Evaluation. The OIG found that nearly two-thirds of community health centers conduct

outreach by sending staff or contacting homeless shelters to provide information on services available, and that the centers provide a wide range of treatment to homeless clients. However, the centers also report that homeless persons experience barriers in obtaining needed medical services from them, and some shelters do not refer clients to the centers for services.

The findings suggest a great potential for community health centers (CHCs) to help homeless people. The HRSA can build on current initiatives to do this. Collaboration between the health centers and nearby shelters is particularly important. The report contains no recommendations but does identify some opportunities for improving the relationship between the homeless and CHCs. (OEI-07-95-00061)

Exclusions for Health Education Assistance Loan Defaults

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

The Social Security Act permits and, in some instances, mandates exclusion from Medicare and State health care programs for nonpayment of these loans. During this 6-month semiannual period, 204 individuals were excluded as a result of PSC referral of their cases to OIG.

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

At the conclusion of this reporting period, 583 individuals had taken advantage of the opportunity and entered into settlement agreements or completely repaid their HEALs. The amount of money being repaid, through settlement agreements or through complete repayment, totals almost $36 million. The following are examples of some of these settlements:

- After being notified that she was excluded as a result of her failure to repay her HEAL, an Illinois physician entered into a settlement agreement to repay over $145,000.

- Two Ohio podiatrists signed settlement agreements to repay their HEAL debts after being excluded for defaulting on their obligation. One agreed to repay over $130,000 and the other agreed to repay over $113,000.

- A settlement agreement was signed by a Tennessee dentist to repay his HEAL debt of over $211,000.

- Shortly after being notified of his exclusion for defaulting on his HEAL, a California physician entered into a settlement agreement to repay over $183,000.

Tribal Contracting for Indian Health Services

At IHS's request, OIG evaluated efforts by IHS and Indian tribes to implement the Indian Self-Determination and Education Assistance Act, Public Law 93-638. Through contracts, tribes can receive the money that IHS would have used to provide direct health services for tribal members. Tribes can use these funds to provide directly, or through another entity, a broad range of health services. This option is commonly referred to as "638" contracting. Tribes contract for nearly 32 percent of the total IHS budget of approximately $1.7 billion.

The OIG found that, because tribes view 638 contracting as an opportunity to customize and improve health care for their communities, almost 75 percent of them want to increase the number and scope of their contracts. However, many of the smaller noncontracting tribes face barriers to increasing their level of contracting and many tribes remain poorly informed about the 638 contracting process. Well-informed tribes rely on Indian health boards, consulting firms, other tribes and attorneys for 638 contracting information, technical assistance, training and contract monitoring.

The OIG recommended that IHS continue and expand its efforts to increase tribal awareness and foster self-determination. Specific suggestions included: providing 638 contracting orientations to tribes that need them; simplifying communications and increasing personal contact; distributing individual tribal budget information annually; and informing tribes of their option to use existing community health services. The IHS agreed with OIG's recommendation. (OEI-09-93-00350)

Public Health Service's Service and Supply Fund: Fiscal Year 1995

Performance Measure

The purpose of PHS' Service and Supply Fund is to provide consolidated financing and accounting for business-type operations involving the provision of common services to customers in PHS and other governmental agencies.

The independent accounting firm engaged to audit the Fund's statements determined that except for the omission of a statement of cash flows and a statement of budget and actual expenses (both of which were waived by the Office of Management and Budget as a departmental requirement), the Fund's financial statements presented fairly, in all material respects, the financial position of the Fund as of September 30, 1995 and 1994.

The auditors also noted internal control weaknesses in certain accounting operations and noted the need to improve security over access to computer systems data. The Fund's managers made appropriate adjustments in the accounting records and concurred with the procedural recommendations. (CIN: A-17-95-00053)

Administration for Children and Families, and Administration on Aging

Chapter IV

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

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

The recently enacted Personal Responsibility and Work Opportunity Act of 1996 eliminates the AFDC, EA and JOBS programs as of Fiscal Year (FY) 1997 and creates the Temporary Assistance for Needy Families (TANF) block grant, and is designed to reduce dependency on welfare programs. The block grant eliminates individual entitlement to assistance, establishes time limits on benefits and sets strong work participation requirements. However, the Act gives States and tribal governments greater flexibility to establish and operate programs structured to their needs. While the Federal role in TANF is reduced, OIG will continue to ensure program integrity, identify opportunities for program improvement, and provide Federal and State management with useful information regarding the goal of moving individuals and families from welfare dependency to self-sufficiency.

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

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

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

Fingerprinting Demonstration Project

Performance Measure

At ACF's request, OIG reviewed the ongoing Automated Fingerprint Image Reporting and Match System (AFIRM) demonstration project underway in Los Angeles County, California. The 3-year project, which addresses problems involving multiple-case fraud in the AFDC program, is funded at $20.6 million, half of which is to be provided by the Federal Government. The project defines multiple-case fraud as a situation in which an individual receives concurrent benefits for the same child(ren) on two or more AFDC cases. The principal purposes of the project are to demonstrate that AFIRM will prevent, detect and deter AFDC multiple-case fraud; is cost-effective; and will assist the provision of timely, fair and equitable service to eligible families.

The OIG found that the AFIRM project meets the cost neutrality provision, and has achieved savings and positive results in the area of welfare fraud. Net savings over the project period are estimated by Los Angeles County at $66 million. Although the AFIRM project was designed to combat multiple-case fraud, the results also show an impact on other types of welfare fraud. The OIG report provides ACF with information which should prove useful in making future decisions involving use of automated fingerprinting technology in the TANF block grant program. (CIN: A-09-95-00054)

Privatization of Florida's Overpayment Recovery Function

Performance Measure

At ACF's request, OIG conducted a limited review of Florida's proposed privatization of its overpaid welfare benefit recovery function. Specifically ACF asked OIG to review the State's Request for Proposal (RFP) to determine whether it addressed deficiencies noted in past OIG and ACF reports. As of June 1995, Florida had about $105 million in accounts receivable for overpaid welfare benefits and a backlog of about 347,000 referrals of potential overpayment cases.

The OIG found no significant problem with the RFP but concluded that the State's privatization efforts would only partially address problems previously reported by OIG and ACF. Moreover, most would likely remain uncorrected by welfare reform legislation. The OIG recommended that ACF require the State to prepare and implement a corrective action plan based on the deficiencies previously reported, and follow closely the State's implementation of privatization and other corrective action. After a reasonable trial period of privatization, ACF should reevaluate the State's entire overpayment and recovery process to determine the effectiveness of actions taken. The ACF agreed with OIG's findings and recommendations. (CIN: A-04-96-00096)

Facility Purchases by the Head Start Program

At ACF's request, OIG evaluated the procedures for reviewing, approving and accounting for purchases of facilities by Head Start grantees. During the review period FYs 1993 through 1994, ACF approved the purchase of 95 facilities valued at $24.1 million with renovation costs estimated at an additional $4.4 million.

The OIG recommended that ACF: continue efforts to develop expertise for providing technical assistance to grantees acquiring or planning to acquire facilities; require that property inspection reports submitted by grantees include the results of tests for environmental hazards; and require grantees to disclose any restrictions on the use of the facilities imposed by organizations providing supplemental funding; continue efforts to develop and implement a system to account for Head Start funds utilized for each facility purchased; and provide guidelines to calculate the Federal interest in properties which are acquired with the assistance of funds provided from other programs and when a portion of the facility is used for other purposes. In response to the draft report, ACF concurred with the recommendations. (CIN: A-09-94-00085)

Head Start Grantees

In response to the Head Start Bureau's concerns with several grantees, OIG provided contracted audit services under a streamlined cost competitive procurement mechanism it developed with the Assistant Secretary for Management and Budget. These agreed-upon-procedure reviews serve to assist ACF's efforts to strengthen the financial management and program compliance capabilities of these grantees, which in turn help ensure the fiscal integrity of the Head Start program and proper stewardship over Federal funds.

A. Oakland, California

A review was performed concerning the operations of a Head Start grantee, and more specifically, the grantee's agreement with a construction company for the leasehold improvement renovations for a property it leases. The review found that for FYs 1995 and 1996, the grantee violated not only the Department of Health and Human Services procurement standards, but also Federal regulations which require changes in the budget and construction to be preapproved by the granting agency. These violations resulted in questioned costs of $352,000 for the renovations at the facility construction site, and the auditors questioned an additional $25,000 paid as rent for the facility as a related cost to the renovations. In addition, the auditors found possible unrecorded liabilities in the amount of $217,000 relating to the aforementioned renovation project during a review of the construction company's billing records. (CIN: A-12-96-00017)

B. Levelland, Texas

The review disclosed that for FYs 1994 and 1995, a Levelland, Texas Head Start grantee violated departmental regulations and Head Start grant conditions and budgets. These violations resulted in questioned costs of $639,400 for lack of compliance with budget provisions and deviations from grant award proposals related to the misuse of funds designated for specific purposes, payments for unapproved salaries and less-than-arms-length transactions. In addition, the grantee had not procured adequate audit services from a qualified independent audit firm. (CIN: A-06-96-00062)

C. Victoria, Texas

The review disclosed that for FYs 1994 and 1995, a Texas Head Start grantee did not comply with Head Start grant conditions and budgets. These instances of noncompliance resulted in questioned costs of $104,463 for lack of compliance with budget provisions and deviations from grant award proposals, including the misuse of $65,000 budgeted to cover unfunded employee pension plan contributions. In addition, the grantee was in violation of its policies concerning the organization's management structure and violated proper bidding procedures. (CIN: A-06-96-00063)

Child Support Enforcement

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

The DOJ has been working since 1993 with the Federal Bureau of Investigation (FBI) and the Department of Health and Human Services' (HHS) Office of Child Support Enforcement to develop an avenue for child support cases administered by State offices (partially federally funded) to go directly to the appropriate U.S. Attorneys' offices for adjudication. The OIG became part of this effort in 1995, initially concentrating only on cases involving AFDC payments necessitated by parental failure to provide ordered support.

In the fall of 1995, a more effective process for investigation and prosecution for all child support enforcement cases was developed and adopted. The DOJ granted deputation to OIG agents to work all Federal child support violations, regardless of whether Department funds are involved. The deputation authority is contingent on working jointly with any other agency having interests in the case, such as the Internal Revenue Service.

The FBI fugitive squads continue to place a high priority on child support enforcement cases, and OIG works constantly to coordinate efforts. Since the cases can be pursued in

either the place where the nonpaying parent or the custodial parent resides, the agencies involved have agreed that venue will be decided on a case-by-case basis.

During this reporting period, the first conviction was handed down in a case in which OIG was involved, when a former professional wrestler was sentenced in Virginia for failing to pay child support for two children in North Carolina.

Interstate Compact on Adoption and Medical Assistance

The OIG determined that Interstate Compact on Adoption and Medical Assistance membership provides States with significant administrative advantages in maintaining medical assistance for title IV-E adoptive children with special needs. Member States benefit from active involvement, an accessible contact person, standard forms, the ability to issue timely Medicaid cards, good coordination and an active secretariat. As a result, virtually all 30 member States are satisfied with the compact. Despite these advantages, however, OIG found that more than half the nonmember States saw no need to join.

The OIG concluded that compact membership is advantageous to the States and families with IV-E children, and urged those States that are planning to join to do so expeditiously. Further, OIG suggested that ACF work with the compact's secretariat and adoption advocacy groups to disseminate information on these benefits. The ACF agreed and is doing so. (OEI-02-95-00040)

Title IV-E Foster Care Reimbursement Rates

The OIG's review of the reimbursement rates established for a nonprofit child care and placement agency in New York found that overpayments of over $945,000 were made during the audit period of July 1, 1992 through June 30, 1993. The nonprofit agency has four foster care programs subject to title IV-E reimbursement: foster family homes, group homes, persons-in-need-of-supervision and agency-operated homes. The four programs are reimbursed at different rates.

The OIG found that the maintenance reimbursement rates were overstated and included unallowable cost items, including improperly allocated general and administrative costs, improperly handled accounts payable write-offs, overstated rent adjustments and charges that should have been claimed under other programs. The OIG recommended financial adjustments to the Federal Government for $145,000 from the nonprofit agency and $800,000 from the State. (CIN: A-02-95-02001)

Grantee Fraud

A woman and her husband were sentenced in Georgia for defrauding Government grant funds. The woman was a clerk for a community service agency that received funds from

ACF for providing social, educational and nutritional services to disadvantaged children and their parents. Between 1992 and 1994, she altered payees' names, substituting her own name on agency checks and depositing them in her savings and various joint checking accounts, including her husband's business account. She pled guilty to conspiracy, embezzlement and misuse of Government funds. She was sentenced to 14 months imprisonment with 3 years released supervision, and ordered to pay restitution of $164,320. Her husband also pled guilty and was sentenced to 120 days home confinement with 5 years probation, and ordered to pay $63,960 in restitution.

Cost Sharing under the Older Americans Act

Through AoA, the Older Americans Act of 1965 authorizes financial assistance to States for services to older persons. Services provided under title III of the Act include, but are not limited to, nutrition, transportation, and in-home personal and medical services. In the past, States, area agencies on aging and service providers have been allowed to ask recipients of title III funded services for voluntary contributions to help cover the costs of the services. These charges have helped some States maintain or expand services to recipients. In the current reauthorization of the Act, AoA proposed amendments that would allow States, area agencies on aging and service providers to charge for some of the title III funded services. The AoA requested information on current cost sharing activities within the States.

The OIG found that all States collect voluntary contributions and 36 States make use of cost sharing programs. Their specific experiences with these practices will affect their readiness to implement title III cost sharing. While many of the States believe that cost sharing will enable them to expand the provision of services, some express concern that cost sharing might encourage some service providers to reach out to recipients better able to share costs, thereby undermining the targeting of efforts to the low-income elderly.

The OIG concluded that cost sharing with title III funds raises accountability and oversight questions for the States, area agencies on aging and service providers. If the Congress enacts legislation to permit cost sharing, AoA will need to carefully consider their direction, oversight and technical assistance to the States, area agencies on aging and service providers. The AoA stated that the report provided the necessary background information to assess cost sharing language in reauthorization bills in both the House and Senate. Further, it provided baseline information to develop program policy and technical assistance for State agencies administering programs under the Older Americans Act. (OEI-05-95-00170)

General Oversight

Chapter V

GENERAL OVERSIGHT

Introduction

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

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

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

Nonfederal Audits

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

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

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In FY 1996, OIG's National External Audit Review Center (located in Kansas City) reviewed over 4,000 reports that covered over $1.1 trillion in audited costs. Federal dollars covered by these audits totaled $261 billion, about $126 billion of which was HHS money.

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

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

A. Office of Inspector General's Proactive Role

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

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

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

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number (800-732-0679) and through training. During the past 6 months, 366

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

- The OIG is also very much involved with OMB and the American Institute of Certified Public Accountants in developing authoritative guidance for nonfederal auditors.

B. Quality Control

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

Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 1,944 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,640
Reports issued with major changes	19
Reports with significant inadequacies	285
Total audit reports processed	1,944

The 1,944 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling $13.6 million as well as 4,255 recommendations for improving management operations. In addition, these audit reports provided information for 80 special memoranda which identified concerns for increased monitoring by departmental management.

Resolving Office of Inspector General Recommendations

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

A. Questioned Costs

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

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]	334	$301,092,000	$25,282,000
B. Which were issued during the reporting period[2]	127	$53,341,000	$10,398,000
Subtotals (A + B)	461	$354,433,000	$35,680,000
Less:			
C. For which a management decision was made during the reporting period[3]:	197	$169,262,000	$2,481,000
(i) dollar value of disallowed costs		$164,515,000	$1,134,000
(ii) dollar value of costs not disallowed		$4,747,000	$1,347,000
D. For which no management decision had been made by the end of the reporting period	264	$185,171,000	$33,199,000
E. For which no management decision was made within 6 months of issuance[4]	152	$76,663,000	$23,491,000

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]	37	$3,323,021,000
B. Which were issued during the reporting period	17	$211,793,000
Subtotals (A + B)	54	$3,534,814,000
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	19	$1,817,439,000
(b) based on proposed legislative action[2]	7	$1,647,300,000
Subtotals (a+b)	26	$3,464,739,000
(ii) dollar value of recommendations that were not agreed to by management	4	$415,000
Subtotals (i + ii)	30	$3,465,154,000
D. For which no management decision had been made by the end of the reporting period[3]	24	$69,660,000

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. During this reporting period, OIG reviewed 51 of the Department's regulations under development and 12 departmental legislative proposals.

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

B. Legislative and Regulatory Development Functions

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

Among the regulatory initiatives promulgated during this year were revised final regulations on safe harbor protection for health plans under the Medicare and State health plans' anti-kickback statute. In addition, OIG jointly published with the Health Care Financing Administration final regulations setting forth requirements for physician incentive plans in prepaid health care organizations. Under this rulemaking, OIG may impose CMPs on Medicare and Medicaid managed care contractors who fail to conduct annual beneficiary surveys or otherwise violate the physician incentive rules.

Both final rules met with OIG goals set forth in accordance with the President's National Performance Review initiative to revise or eliminate burdensome or unnecessary regulations. The OIG is continuing work on regulatory initiatives involving CMP authorities, and safe harbors under the anti-kickback statute.

C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process. For example, OIG testified at five hearings during this 6-month period, principally on health care fraud and abuse issues. On several occasions, the testimony concerned OIG recommendations which, if implemented, could produce billions of dollars in annual savings to the Government. These recommendations are contained in the OIG Cost 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.

States' Allocations of Training Costs

The OIG's review of States' allocation of training costs charged to Federal programs covered procedures and practices used by five States in five regions -- New Jersey, Florida, Illinois, Missouri and California. In each State reviewed, OIG identified problems with the allocation of training costs. As a result of the problems identified, OIG is recommending financial adjustments totaling $22 million ($13 million Federal share) and setting aside $1 million ($577,239 Federal share) to be resolved by the Administration for Children and Families (ACF).

Among its specific findings, OIG determined that: costs were not allocated to all benefitting programs in three States, resulting in claims to the Federal Government being overstated by $12.7 million ($9.1 million Federal share); four States claimed costs for title IV-E foster parent recruitment and administrative costs at the enhanced rate of 75 percent rather than the allowable 50 percent rate, resulting in claims being overstated by $5.9 million ($1.5 million Federal share); and two States included unallowable and unsupported costs totaling $1.8 million ($1.4 million Federal share) plus another $1.3 million ($820,000 Federal share) of third party in-kind contributions that did not meet the definition of allowable costs under State and Federal criteria.

Separate reports were issued to ACF and each State agency. The ACF generally agreed with OIG's findings and recommendations. A roll-up report on OIG work to date will be issued shortly. (CIN: A-02-95-02003; CIN: A-04-95-00085; CIN: A-05-96-00013; CIN: A-07-95-01008; CIN: A-09-95-00056)

Employee Fraud and Misconduct

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

- A registered nurse with the Indian Health Service (IHS) entered into a pretrial diversion agreement in Arizona. Reconstruction of pharmacy issuance and emergency room dispensing records showed that the nurse misappropriated 14,795 millimeters (about 230 syringes) of controlled substances. She was given 12 months probation and ordered to continue in drug/alcohol counseling and to submit to random drug screening. The hospital did not terminate her employment, choosing instead to reassign her

to an area where she will not have to handle controlled medications. Restitution of $96 to IHS was ordered.

- A New York woman was sentenced to 3 years of supervised probation for pleading guilty to theft of Government funds. While employed by the Food and Drug Administration, the woman falsely underreported her annual income when she applied to New York City for a Housing and Urban Development loan. She was fined $25 and was ordered by the Court not to accrue any credit cards without probation department clearance. She received a light sentence because of extenuating personal circumstances.

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 79 successful criminal actions. Also during this period, 125 cases were presented for prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 72 individuals and entities.

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

In addition to terms of imprisonment and probation imposed in the judicial processes, nearly $129.2 million was ordered or returned as a result of OIG investigations during this semiannual period. Civil settlements from investigations resulting from audit findings are included in this figure.

Program Fraud Civil Remedies Act

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

During FY 1996, no settlements were made under PFCRA. While all cases are routinely analyzed for potential action under PFCRA, the availability of OIG's CMP authorities in health care matters often renders PFCRA unnecessary. Also, PFCRA cannot be applied to many of the grants administered by HHS, since these grants often exceed the financial limits of PFCRA.

Appendices

APPENDIX A

Implemented Office of Inspector General Recommendations to Put Funds to Better Use April 1996 through September 1996

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

Legislative savings are annualized amounts based on Congressional Budget Office estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures for the year in which the change is effected. Total savings from these sources amount to $2,225.6 million for this period.

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Medicare Laboratory Reimbursements: The Medicare fee schedule allowances for clinical laboratory tests should be brought in line with the prices physicians are paying for tests purchased from independent laboratories. (OAI-02-89-01910; CIN: A-09-89-00031)	Section 13551 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 reduced the national cap to 76 percent of the median of all fee schedules, and froze the annual update for 1994 and 1995.	$720
Disproportionate Share Hospitals: 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)	Section 13621 of OBRA 1993 prohibited designation of a hospital as a disproportionate share hospital (DSH) for purposes of Medicaid reimbursement unless the hospital has a Medicaid inpatient utilization rate of at least one percent. It also limited DSH payment adjustments to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid (other than DSH payment adjustments) and uninsured patients.	500
Capital-Related Costs of Inpatient Hospital Services: Extend congressionally mandated reductions in hospital costs. (CIN: A-09-91-00070)	Section 13501(a)(3) of OBRA 1993 mandated reduction of 7.4 percent for inpatient capital costs.	357
Capital-Related Costs of Outpatient Hospital Services: Extend congressionally mandated reductions in hospital costs. (CIN: A-09-91-00070)	Section 13521 of OBRA 1993 mandated reduction of 10 percent for outpatient hospital costs.	128

OIG Recommendation	Status	Savings in Millions
Medicaid Transfer of Assets: Strengthen the transfer of asset rules so that people cannot give away property to qualify for Medicaid. Assets and income from special need trusts should be counted for Medicaid qualifying purposes and be subject to third party liability recovery. (OAI-09-86-000078; CIN: A-09-93-00072)	Section 13611 of OBRA 1993 provided for a delay in Medicaid eligibility for institutionalized individuals or their spouses who dispose of assets for less than fair market value on or after a specified look-back date; set forth rules under which funds and other assets of an individual placed in trust by or on behalf of an individual or the spouse are treated, for purposes of Medicaid eligibility, as resources available to the individual, and under which payments from the trust are to be considered assets disposed of by the individual; and specified that, for purposes of applying transfer of asset prohibitions, the look-back period with respect to trusts is 60 months.	$125
Medicare Secondary Payer - Blue Cross and Blue Shield Association: The HCFA should negotiate a reasonable settlement to recover the sums improperly paid by HCFA contractors for which Medicare should have been the secondary payer. (CIN: A-02-93-01006)	The Blue Cross and Blue Shield Association agreed to a global settlement with the Department of Justice and HCFA to settle disputes over Medicare secondary payer (MSP) claims. As part of the settlement, the Association implemented a 3-year exchange agreement with HCFA which is expected to result in annual savings of $100 million.	100
Ambulance Services for Medicare End Stage Renal Disease Beneficiaries: The HCFA should ensure fairer payment for services rendered, and ensure that claims meet Medicare coverage guidelines. (OEI-03-90-02130; OEI-03-90-02131)	A set of proposed national codes for use by carriers was developed in January 1994, and a program memorandum was finalized and distributed a year later for January 1995 implementation.	55.4
Medicare Secondary Payer - Data Match: Extend MSP data match beyond the OBRA 1989's sunset date. (OEI-07-90-00760; CIN: A-09-89-00100)	Section 13561(a) of OBRA 1993 extended the MSP data match through 1998.	45
Ultrasound: The HCFA should prohibit payment for tests conducted with pocket dopplers, and advocate revisions in procedure codes and reimbursement rates to reflect the different levels of sophistication and quality of the diagnostic information provided. (OEI-03-88-01401; OEI-03-91-00460; OEI-03-9-00461)	The HCFA issued an instruction prohibiting separate payments for tests conducted with pocket dopplers and revised the Physician's Procedural Coding handbook to revise imaging codes for hand-held ultrasound devices.	5.8

OIG Recommendation	Status	Savings in Millions
Medicare Payments for Home Blood Glucose Monitors: The HCFA should ensure that Medicare payments for monitors are net of any available rebates. (CIN: A-09-92-00034)	The HCFA issued final regulations on the fee schedule for home blood glucose monitors. These regulations refer to the OIG report for support of fee schedule changes.	$5
Emergency Room X-Rays: The HCFA should pay for reinterpretation of x-rays only when attending physicians specifically request a second physician's interpretation in order to render appropriate medical care before the patient is discharged. (OEI-02-89-01490)	In December 1995, HCFA issued final rules in the 1996 Medicare Physician Fee Schedule implementing the change.	4.4
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Rising Costs in the Emergency Assistance Program: The Administration for Children and Families (ACF) should revise or rescind current policy allowing shifting of costs to Emergency Assistance (EA) programs, especially where such costs have been traditionally borne by the States. (CIN: A-01-95-02503)	In September 1995, ACF issued Action Transmittal ACF-AT-95-9 which discontinued Federal financial participation under the EA program for costs providing benefits and services to children involved in the juvenile justice system.	180

APPENDIX B

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

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

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Modify Formula for Costs Charged to the Medicaid Program: The Health Care Financing Administration (HCFA) should consult with the Congress on modification of the Federal Medical Assistance Percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per-capita income relationships. (CIN: A-06-89-00041)	No legislative proposal was included in the President's current budget.	$4,100
Medicare Coverage of State and Local Government Employees: Require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (CIN: A-09-88-00072)	Although a past budget of the President contained a proposal to include under Medicare all State and local government employees hired before April 1, 1986, no legislative proposal was included in the President's current budget.	1,559
Clinical Laboratory Tests: Require laboratories to identify and bill profiles (groups of related tests) at reduced rates whenever they are ordered, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CIN: A-09-89-00031; CIN: A-09-39-00056)	Although the President's past budget included a proposal to reinstitute coinsurance for clinical laboratory services, no legislative proposal was included in the President's current budget. The Omnibus Budget Reconciliation Act of 1993, however, will reduce Medicare fees for clinical laboratory tests to 76 percent of the national average in 1996. The HCFA is profiling physicians' ordering and referring patterns as part of focused medical review efforts.	1,130
Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)	The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.	1,100

OIG Recommendation	Status	Savings in Millions
Indirect Medical Education: Reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether any adjustment factor is warranted for all teaching hospitals. (CIN: A-07-88-00111)	The President's Fiscal Year (FY) 1997 budget reduces the IME adjustment factor to 6 percent in FY 1999 and thereafter.	$900
Reduce Hospital Capital Costs: Seek legislative authority to continue mandated reductions in capital payments beyond FY 1995. The HCFA should determine the extent of the capital reductions that are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070; CIN: A-14-93-00380)	The HCFA is seeking public comment on reducing prospective capital rates.	820
Medicaid Payments to Institutions for Mentally Retarded: The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)	The HCFA nonconcurred with OIG's recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA and OIG negotiated an agreement for HCFA to send the report to all State Medicaid directors. This action has been taken.	683
Medicare Secondary Payer - End Stage Renal Disease Time Limit: Extend the Medicare secondary payer (MSP) provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016)	The President's past budget contained a proposal to extend the MSP provision for individuals with ESRD to 24 months. Notwithstanding this proposal, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until such time as the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.	503

OIG Recommendation	Status	Savings in Millions
Home Health Agencies: The HCFA should intensify efforts to scrutinize claims submitted by high cost home health agencies, explore ways to prevent unscrupulous agencies from engaging in abusive practices and consider legislation to restructure the benefits to prevent fraud, waste and abuse. (CIN: A-04-95-01103; CIN: A-04-95-01104; CIN: A-04-95-01103; 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)	The HCFA concurred with the recommendations, and among other actions, has advanced a legislative proposal as part of the President's 1997 budget.	$500
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt policy. The OIG presented an analysis of four options for HCFA to consider including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system (PPS) hospitals which are profitable, and the inclusion of a bad debt factor in the diagnosis related group (DRG) rates. (CIN: A-14-90-00339)	This proposal was not included in the President's current budget.	487.7
Terminate Medicare Disproportionate Share Adjustments: Terminate disproportionate share adjustment payments without redistribution of the funds to PPS hospitals. Payments under PPS adequately compensate hospitals for services provided to Medicare patients, including low-income patients. (CIN: A-04-87-00111)	Although the President's past budgets contained a proposal to phase down Medicare disproportionate share payments, no legislative proposal was included in the President's current budget.	410
Flexible Benefit Plans: The value of flexible benefit plans, as defined by section 125 of the Internal Revenue Code, should be included in the hospital insurance portion of the Federal Insurance Contributions Act taxable wage base. (CIN: A-05-93-00066)	While HCFA agreed with the report findings related to revenue to the Hospital Insurance Trust Fund, a legislative proposal was not included in the President's FY 1996 budget.	420

OIG Recommendation	Status	Savings in Millions
Prospective Payment System's Capital Cost Rates: The HCFA should consider reducing payment rates by 7.5 percent to more accurately reflect costs of the base year used for the capital cost component of PPS, and continue to monitor the most current data and make any necessary further adjustments to the base rate. (CIN: A-07-95-01127)	The HCFA agreed with OIG's analysis that the Federal capital rate reflects a known over-estimation of base year costs. The HCFA also stated that comments from individual hospitals and hospital associations were uniformly opposed to making any of the possible rate reductions that were discussed in HCFA's proposed rule. The Prospective Payment Assessment Commission (ProPAC) acknowledged that there are legitimate issues regarding the appropriate level of the rates in light of the current data. The HCFA does not intend to adopt any of the possible approaches at this time, in anticipation of congressional action to realize savings in this area.	$249
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality. (CIN: A-05-89-00055; CIN: A-05-92-00006)	The OIG's follow-up report (CIN: A-05-92-00006) indicated that problems still exist with inappropriate admissions and that the volume of 1-day admissions on a national basis have increased approximately 150 percent over 1985 levels. The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's current budget.	210
Eliminate Separate Enteral Nutrient Payments in Nursing Homes The HCFA should eliminate separate payments for enteral nutrients for beneficiaries in nursing homes. (OEI-06-92-00861)	The HCFA concurred with the recommendation and is considering alternative payment mechanisms and enhanced control of utilization to contain costs while it examines a legislative remedy.	174
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 President's FY 1997 budget contains proposals to slow the growth in Medicare spending in GME.	157.3

OIG Recommendation	Status	Savings in Millions
Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 chemistry tests identified by the OIG audit. (CIN: A-01-93-00521)	The HCFA agreed with 8 of the 10 tests recommended for addition to the list. In November 1995, HCFA updated its carrier manual adding three of the tests recommended in the OIG report. A legislative proposal to add tests (including those identified in OIG's review) was included in the President's December 7, 1995 Medicare savings package.	$130
Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing and begin to plan now for the policy changes that will become necessary to achieve an almost completely paperless environment for processing Medicare claims. (CIN: A-05-94-00039; OEI-01-94-00230)	The HCFA concurred with OIG's recommendations. However, with respect to the policy options suggested, HCFA believes that mandating paperless claims is impractical.	126
Medicaid Drug Rebate Program: Best price calculation in the Medicaid drug rebate program should be indexed in a manner similar to the average wholesale price, which is indexed to the consumer price index-urban. (CIN: A-06-94-00039)	The OIG is continuing its review of the Medicaid drug rebate program.	123
Reduce Medicare Payments for Hospital Outpatient Department Services: Establish a legislative initiative to reduce the current payments for services in outpatient departments to bring them more in line with ambulatory service center (ASC) approval payments. Pay outpatient departments the ASC-approved rate or adjust hospital payments by a uniform percentage. (CIN: A-14-89-00221; OEI-09-88-01003)	The HCFA sent a report to the Congress on developing a PPS for outpatient departments. In addition, the President's FY 1997 budget contains a proposal to eliminate a formula-driven overpayment which allows Medicare to fully deduct beneficiary coinsurance payments received by the hospital before the program makes its payments, and establish a budget-neutral PPS for outpatient department services starting in 2002.	90
Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The fiscal intermediaries should recover improper payments made to hospitals for nonphysician outpatient services (such as diagnostic tests and laboratory tests) rendered within 72 hours of the day of an inpatient admission, and refund the beneficiaries' coinsurance and deductible related to these payments. The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)	The HCFA agreed to recover the improper billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and OIG. The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's current budget.	83.5

OIG Recommendation	Status	Savings in Millions
Preclude Improper End Stage Renal Disease Payments to Health Maintenance Organizations: The HCFA should advise all risk-based health maintenance organizations (HMOs) and comprehensive medical plans that ESRD capitation rates are only effective for beneficiaries who currently are diagnosed as having ESRD; identify and recover all payments to HMOs and comprehensive medical plans for beneficiaries misclassified as having ESRD; and make systemic and procedural changes to prevent future overpayments. (CIN: A-04-94-01090)	The HCFA agreed with OIG's findings and recommendations. The systems changes are scheduled to be implemented in August 1996 along with the recoupment of improper payments.	$50.7
Generic Drugs: The HCFA should identify and alert States to methods which would encourage the use of lower priced generic drug products in the Medicaid program. The HCFA should also take a more active role to encourage States to use generic drugs; provide stronger incentives for States to adopt policies that encourage use of generic drugs; monitor the States' efforts to encourage the use of lower priced drugs; and formally assess those activities. (CIN: A-06-93-00008)	The HCFA has provided a copy of the OIG report to States and encouraged them to use lower priced generic products. On February 2, 1996, States were requested to provide a description of any policies adopted that encourage use of equivalent generic drugs. This information will be included in the 1995 State Drug Utilization Review Annual Report due to regional offices by June 30, 1996.	49
Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)	The HCFA considered a proposal recommending that the 190-day lifetime limit for psychiatric hospitals be extended to general hospitals; however, such a proposal was not included as part of the President's current budget.	47.6
Nonemergency Advanced Life Support Ambulance Services: The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513; CIN: A-01-94-00528)	The HCFA prepared a draft regulation in late 1995 that would shift the policy focus away from the type of vehicle used and towards the medical condition of the beneficiary. No final regulation has been issued to date.	47
Medicaid Payments for Employer Group Health Insurance: The HCFA should continue to strongly support States implementing Section 1906 of the Social Security Act, and should propose legislation that allows States to pay employer group health plan (EGHP) deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules. (OEI-04-91-01050)	The HCFA concurred with the first recommendation and has been working in partnership with regional offices and States to promote full implementation. The HCFA deferred comment on the second recommendation.	32

OIG Recommendation	Status	Savings in Millions
Reduce End Stage Renal Disease 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 ESRD facilities have become more efficient in their operations and that the composite payment rate should reflect the costs of outpatient maintenance dialysis treatment in an efficiently operated facility. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing the ESRD composite rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatments. The study undertaken by ProPAC was presented to the Congress in March 1996 and recommended an increase to the current rates.	$22*
Medicaid Cost Sharing: The HCFA should promote the development of effective cost sharing programs by: allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services; and allowing for higher beneficiary cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800)	The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. It plans to solicit information from States implementing cost sharing and distribute it to States that do not impose it. Several States have submitted waiver applications to HCFA to develop demonstration projects which include experimental cost sharing provisions.	19.8
Minimize Incorrect Payments for Durable Medical Equipment Billed During Skilled Nursing Facility Stays The HCFA should minimize the opportunity for incorrect durable medical equipment (DME) payments by: improving the place of service coding system; improving the supplier knowledge of beneficiary location; reviewing the DME regional carriers' processes; and improving processes for identifying skilled nursing facilities for DME reimbursement purposes. (OEI-06-92-00860; OEI-06-92-00862; OEI-06-92-00865)	HCFA concurred with the recommendations and is currently developing a corrective action plan.	19
Reduce Medicare Part B Payment for Enteral Nutrition at Home Reduce payments through competitive acquisition strategies for patients receiving enteral nutrition at home. (OEI-03-94-00021)	A plan for a DME competitive bid demonstration that includes enteral nutrition is underway. Payment changes are likely to be implemented at the same time changes are made in Part B coverage for enteral nutrients for nursing home patients.	15

**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 which contain duplicate tests, recover overpayments and make adjustments for the Federal share of the amounts recovered. (CIN: A-01-95-00005; CIN: A-05-96-00031; CIN: A-01-96-00001; CIN: A-06-95-00078; CIN: A-04-95-01108; 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)	The HCFA is evaluating the OIG results.	$14
Medicare Payments for Orthotic Body Jackets: The HCFA should require the DME regional carriers (DMERCs) to closely monitor claims for body jackets, including: analysis of payment trends, provision of an early warning of abusive practices and monitoring of suppliers who have engaged in abusive practices. (OEI-04-92-01080)	The HCFA concurred and has instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices. However, payments continue at high levels. The OIG plans to revisit this issue as part of an ongoing study on orthotics.	10.4
Medicare Claims for Railroad Retirement Beneficiaries: Discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)	While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.	9.1
Limit Reimbursement for Hospital Beds: The HCFA should develop a new approach for reimbursing suppliers for hospital beds used by Medicare beneficiaries at home. A new reimbursement methodology should reflect a hospital bed's useful life and the number of times a bed can customarily be rented over that period. (CIN: A-06-91-00080)	Although a past budget of the President contained a proposal that authorized competitive bidding for DME, no legislative proposal was included in the President's current budget. The HCFA awarded a demonstration project on this subject in 1996. The project is expected to run in at least 3 sites for 2 cycles of 2 years each beginning in January 1997.	6.2
Third Party Liability Settlements and Awards: The HCFA should develop legislative proposals to close the loopholes in the Omnibus Budget Reconciliation Act of 1993 that allow Medicaid beneficiaries, who receive settlements and awards from third parties as a result of accidents, to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. The HCFA should also develop guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties. (CIN: A-09-93-00033)	The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g. health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements.	3

OIG Recommendation	Status	Savings in Millions
Hospital General Administrative and Fringe Benefit Costs:		
Revise the Provider Reimbursement Manual (PRM) to provide explicit guidelines on the allowability of certain general administrative and fringe benefit costs. (CIN: A-03-92-00017)	The HCFA has published changes to the PRM to clarify the allowability of several of the cost categories identified in OIG's report. The HCFA has not yet clarified the remaining cost categories noted in OIG's report.	to be determined
PUBLIC HEALTH SERVICE OPERATING DIVISIONS		
Institute and Collect User Fees for Food and Drug Administration Regulations:		
Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)	In the absence of specific authorizing legislation, the Food and Drug Administration is precluded by statute from imposing user fees to cover additional functions.	$44.4
Billings and Collections to Private Health Companies:		
The Indian Health Service (IHS) should establish the necessary internal controls, assign adequate resources to its business offices, and provide additional training to business offices to ensure that underbillings to private insurance companies are properly filed and collected. (CIN: A-06-93-00080)	The IHS fully concurred with OIG's recommendations. The IHS is in the process of, or has plans for: implementing an automated system to achieve the necessary internal controls; allocating resources to improve methods for billings and collections; meeting the training needs of business office staff; implementing fee schedules on a timely basis; ensuring adequate accounting and medical records are maintained for each patient; providing adequate resources to carry out claims follow-up; and improving policies and procedures for follow-up of unpaid claims.	28
Medical Malpractice Coverage:		
The Health Resources and Services Administration (HRSA) should consider seeking a legislative proposal to limit malpractice settlements or judgments involving Community and Migrant Health Centers to $1 million. (CIN: A-04-95-05018)	The HRSA agreed to consider a legislative proposal to amend the Federal Tort Claims Act to include the $1 million limitation.	10

OIG Recommendation	Status	Savings in Millions
Limit Graduate Student Compensation: The Assistant Secretary for Management and Budget (ASMB) should work with the Office of Management and Budget (OMB) to revise Circular A-21 to stipulate a reasonableness standard for graduate student compensation charged to federally sponsored research based on assigned responsibilities and not to exceed compensation paid to other individuals of similar experience for similar work. (CIN: A-01-94-04002)	The ASMB endorsed the OIG recommendation, concluding that a prudent person would not provide greater compensation to individuals who are less qualified by education and practical experience than others performing similar work. The National Institutes of Health (NIH) issued a notice in its Guide for Grants and Contracts on compensation of graduate students (NIH Guide, volume 25, number 8, March 15, 1996). The guidelines reiterate the requirements of OMB Circular A-21 that costs applicable to Federal agreements be allowable, allocable, reasonable, necessary and treated consistently, and provide guidance for assessing reasonableness.	$5.7
Recharge Center Costs: Universities should: improve their oversight of recharge centers; develop and implement policies and procedures for the operation of recharge centers that are consistent with OMB Circular A-21; establish and maintain adequate accounting and recordkeeping procedures for recharge centers; and analyze and adjust billing rates to eliminate deficit and surplus funds. (CIN: A-09-92-04020)	The ASMB concurred with the recommendations and has recommended to OMB that Circular A-21 be revised to provide more definitive guidance on the financial operations of recharge centers.	3.2
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Reduce Incentive Payments and Base Them on States' Performance: Base incentive payments on the States' demonstrated ability to meet Federal child support enforcement (CSE) requirements and performance objectives. Also, consider OIG recommended options to reduce financial incentives realized by States that would result in a more equitable cost sharing with the Federal Government. These options are: limiting incentives to a break-even point where a State's share of Aid to Families with Dependent Children collections, plus incentive, equal the State's share of CSE costs; eliminating incentives to poor performing States; and reducing the Federal share of administrative costs. (CIN: A-09-91-00147; CIN: A-09-91-00034)	This proposal was not included in the President's current budget.	277

OIG Recommendation	Status	Savings in Millions
Limit Federal Participation in States' Costs for Administering the Foster Care Program: Limit Federal participation in foster care administrative costs through one of the following actions: limit future increases in administrative costs to no more than 10 percent per year; fund administrative activities via a single block grant with future increases based on the consumer price index; limit administrative costs to a percentage of maintenance payments; or restrict, through legislation, the filing period for retroactive claims, namely require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. (CIN: A-07-90-00274; OEI-05-91-01080)	This proposal was not included in the President's current budget.	$247
GENERAL OVERSIGHT		
Simplify Administrative/Indirect Cost Allocation Systems: The OMB should simplify the process for charging administrative/indirect costs to Federal programs through reform of the cost allocation plans. Options for reform include: use of block grant awards, a flat percentage rate for administrative/indirect costs, and negotiation of a nonadjustable rate for predetermined numbers of years. (CIN: A-12-92-00014)	Some of OIG's recommendations are cited in the National Performance Review report that calls for reform of the cost allocation process. The OMB's revision of Circular A-87 addressed those recommendations. However, further reform is needed to address the bulk of administrative/indirect costs charged to the Federal Government.	660

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

OIG Recommendation	Status
HEALTH CARE FINANCING ADMINISTRATION	
Improve the Health Care Financing Administration's Federal Managers' Financial Integrity Act Program: The HCFA should enhance the testing used to evaluate the contractors' claims processing internal controls. (CIN: A-14-93-03026)	The HCFA agreed and has established a work group comprised of OIG and HCFA staff members to address Medicare contractors' controls. The work group is developing an internal control review protocol to review contractors' controls.
Implement Proper Accountability over Billing and Collection of Medicaid Drug Rebates: The HCFA should ensure that States implement accounting and internal control systems in accordance with applicable Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current and complete disclosure of drug rebate transactions and provide HCFA with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (CIN: A-06-92-00029)	The HCFA concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The HCFA hopes to have final regulations during Fiscal Year (FY) 1996.
Physical Therapy in Physicians' Offices: The HCFA should take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. Some options are: conduct focused medical review; provide physician education activities; apply existing physical therapy coverage guidelines for other settings to physicians' offices. (OEI-02-90-00590)	The HCFA concurred with options one and two, and have distributed copies of the report to the carriers to determine if the issues identified are problems in their service areas. The HCFA formed a work group that represents physicians who provide physical therapy services in their offices to focus on the clinical appropriateness of services provided, including monitoring of these services. The HCFA is currently drafting model guidelines for reviewing claims for patient and related services billed by the physicians under the physician "incident to" benefit.

OIG Recommendation	Status
Medicare Trust Funds' Accounts Receivable Balances: The HCFA needs to improve its internal controls and the controls of its fiscal intermediaries and carriers related to the recording and reporting of accounts receivables. Additionally, HCFA needs to properly estimate the allowance for uncollectible receivables and determine the amounts to be written off as uncollectible. In a review conducted in accordance with the Chief Financial Officers Act, OIG continued to find weaknesses in contractors' controls. (CIN: A-01-92-00516; CIN: A-14-93-03027)	The HCFA concurred with the intent of most of the recommendations and is taking corrective actions. However, HCFA has still been unable to resolve all the critical problems. The HCFA and OIG will continue to work together to develop corrective action plans to resolve these deficiencies. The HCFA has established a work group to review Medicare contractor operations and systems, analyze contractor controls and identify internal control weaknesses. The work group has contracted with a Medicare contractor and a certified public accounting firm to develop an approach to evaluate internal controls at Medicare contractors. The HCFA has also requested a clarification of the reporting of Medicaid financial information from the Federal Accounting Standards Advisory Board.
Medicare Trust Funds' Accounts Payable Balances: The HCFA should improve its internal controls and the controls of its fiscal intermediaries and carriers related to the recording and reporting of accounts payable. The HCFA should also perform Federal Managers' Financial Integrity Act (FMFIA) sections 2 and 4 reviews on all carrier accounts payable internal controls and financial management systems. (CIN: A-04-92-02054; CIN: A-05-92-00106)	The HCFA concurred with the recommendations. Regarding recommendations to perform FMFIA section 2 and 4 reviews at contractors, a work group is developing an internal control review protocol to review contractors' controls.
Improve Financial Management Systems to Enhance Financial Reporting: The HCFA should develop and implement financial management systems and related accounting and administrative internal controls to ensure that all Medicare liabilities are reported to the HCFA general ledger at fiscal year end. (CIN: A-14-92-03015)	The HCFA agreed that reasonable data should be included in the reporting of Medicare liabilities. However, HCFA asserts that the process for developing a reasonable estimate of a liability for provider reports would be too cumbersome. The HCFA is currently developing the Medicare Transaction System that will include an integrated accounting subsystem to estimate the amount of appealed cost reports.
Clarify the Allowability of General and Administrative Costs at Medicare Hospitals: The HCFA should revise the Provider Review Manual (PRM) to further clarify the allowability of specific types of general and administrative and fringe benefit costs. (CIN: A-03-92-00017)	The HCFA has published changes to the PRM to clarify the allowability of several of the cost categories identified in OIG's report. The HCFA has not yet clarified the remaining cost categories noted in OIG's report.
Consider Recommended Safeguards over Medicaid Managed Care Programs: The HCFA should consider safeguards available to reduce the risk of insolvency, and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)	The HCFA generally concurred with OIG's recommendations, but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.

OIG Recommendation	Status
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.
Avoid Future Medicare Secondary Payer Overpayments: To identify Medicare secondary payer (MSP) situations, HCFA should continue to implement its corrective action plan to eliminate the designation of MSP as a high risk area, and seek legislation which would require employers to report other health insurance coverage on the W-2 and tax statement. (CIN: A-09-89-00100; OEI-07-90-00760; OEI-07-90-00763)	The HCFA is continuing implementation of the corrective action plan. The HCFA did not agree with the recommendation on use of the W-2, indicating that it preferred to evaluate the outcome of recent legislation which mandated a data exchange between the Internal Revenue Service, the Social Security Administration (SSA) and HCFA.
Recover Past Medicare Secondary Payer Overpayments: The HCFA should ensure that there is adequate funding available to contractors to pursue collection of MSP overpayments, and instruct contractors to recover the MSP overpayment backlog and notify insurance companies of improper payments within recovery regulation time frames. (CIN: A-09-91-00103; CIN: A-04-92-02037)	The HCFA is in the process of establishing funding needs for recoveries and agreed to make recovery of backlog cases a top priority.
Review Social Security Administration Procedures that Impact Medicare Trust Funds: The HCFA should review SSA's wage certification procedures to ensure that the transfer of Medicare Hospital Insurance trust funds is consistent and performed in accordance with the Social Security Act. (CIN: A-14-92-03013)	The SSA is pursuing a legislative solution to this problem.
Physician Office Surgery: The PROs should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)	The HCFA continues to work with the PROs to refine a methodology for review of quality of care for ambulatory services. The implementation plan is to expand the review of ambulatory services to additional States, first on a pilot basis, then on an implementation basis in other States.
Patient Advance Directives - Early Implementation Experience: The HCFA should develop and issue specific regulatory guidelines clarifying acceptable documentation methods to assist providers in meeting the requirements of the Federal statute. The statute requires providers to inform individuals of any rights they have under State law regarding self-determination. (OEI-06-91-01130)	The HCFA did not concur with the recommendation, but is willing to provide assistance to States by issuing interpretive guidelines for survey and certification containing examples of what would constitute acceptable documentation of whether a patient has an advance directive.

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

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

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

OIG Recommendation	Status
Improvements Needed in Monitoring Child Placing Agencies in the Texas Foster Care Program: The State should ensure that: foster children receive treatment in accordance with their treatment plan; State caseworkers make required visitations; foster homes are inspected for compliance with fire and health standards; and the National Crime Information Center system is used to conduct nationwide background checks. (CIN: A-06-94-00041)	The State concurred with all recommendations, but on a limited scale with the recommendation requiring the use of the nationwide system to conduct background checks.
Maintenance Payments Retained by Child Placing Agencies in the Texas Foster Care Program: The State should review periods subsequent to OIG's audit and make necessary adjustments for improper retention of title IV-E maintenance payments by child placing agencies. To ensure that children are receiving the full benefits of the maintenance payment, the State should perform periodic reviews of the child placing agencies and build into their contracts the requirement that these agencies pay the full maintenance payment to the foster home. Also, the State should develop edits in the payment system to preclude duplicate claims and claims for services not provided, review payments previously made and make appropriate adjustments. (CIN: A-06-95-00035)	The State did not concur with the recommendation to review subsequent periods and make necessary adjustments for the retention of title IV-E maintenance payments. The State did concur with the recommendations to perform periodic reviews and to build requirements into the contracts. The State only partially concurred with the recommendation to develop edits in the payment system.
Improve Oversight of Audits of Office of Community Service Grantees: The ACF should track Office of Community Services grantees' implementation of recommendations made as a result of single audits, and follow up with grantees to ensure actions taken were effective. (CIN: A-12-92-00043)	The ACF agreed and will take steps to implement the recommendations within the limitation of current staffing resources.
Colocating Intergenerational Programs: The Administration on Aging (AoA) and ACF should examine whether demonstrated successes in colocating programs and facilities in the private and public sector can be more broadly applied to departmental programs on a voluntary basis. (CIN: A-05-94-00009)	The AoA and ACF generally agreed with OIG's recommendations.
Improving Administration on Aging's Nutrition Program for the Elderly: The AoA and the Department of Agriculture (USDA) should remove barriers to increase States' use of commodities by fostering better communications and working relationships with State distribution agencies which handle USDA commodities; assuring a better variety of commodities; and improving dependability, quality and packaging of commodities. (CIN: A-01-93-02510)	The AoA and USDA generally agreed to address these issues through joint efforts.

OIG Recommendation	Status
Coordination of Specialized Transportation Services: The AoA needs to actively promote transportation consortiums, and provide the assistance needed by State agencies and local providers to promote improvements in coordinated transit systems. It should continue its work with other Department of Health and Human Services (HHS) agencies and Federal Departments to promote further development of coordinated transportation systems for the elderly, persons with disabilities and others in need of services. (CIN: A-05-95-00023)	The AoA concurred with the OIG recommended actions to increase implementation of coordinated transportation services nationwide. The AoA will work with the Joint Department of Transportation/HHS Coordinating Council to develop strategic plan for improving transportation services.
GENERAL OVERSIGHT	
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify HHS's disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to PHS, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040)	The OS and OASH have consolidated into one unit. The OASH had taken the lead in this area and has met with headquarters operating division emergency preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved.
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The OASH should issue guidelines to improve disaster planning. The plans of each operating and staff division should spell out lines of communication with each other, and should specify headquarters and regional lines of communication with the Federal Emergency Management Agency. (OEI-09-90-01040)	The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department. The OASH and OS have consolidated.
Ensure that New York Allocates Training Costs to Federal Programs for Actual Number of Attendees: The Department should be more aggressive when approving State plans to ensure that the State (among other actions): allocates future training contracts to programs based on the actual number of participants; maintains documentation which clearly details which programs benefit from future training and, where applicable, allocates training costs to all benefitting programs; and discontinues using third party contributions provided by private contractors to meet its share of training costs. (CIN: A-02-91-02002)	The Department's Division of Cost Allocation (charged with approval of State cost allocation plans) expressed agreement with the findings and recommendations.

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

APPENDIX D

Notes to Tables I and II

Table I

[1] The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of $50.1 million.

[2] Included in the reports issued during the period are management decisions to disallow $80,112 costs attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

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

CIN: A-09-92-00116	State of California: Federal programs continued to be assessed by the State for PERS contributions, after DCA's notification that the Federal Government should be reimbursed for its share. The Departmental Appeals Board upheld the DCA determination. $29,880,675
CIN: A-06-95-37037	State of Louisiana: HCFA recalculated the Federal share. $286,285
CIN: A-03-93-21786	District of Columbia Dept of Human Services: Grantee provided documentation to support expenditures. $141,898

Not detailed are revisions to previously disallowed management decisions totaling $665,000.

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

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

CIN: A-07-95-01009	Review of AFDC Emergency Assistance-Selected State, February 1996, $10,114,980
CIN: A-03-91-00552	Independent Living Program-National, March 1993, $6,529,545 (Related recommendation of $10,161,742 outstanding on Table II)
CIN: A-07-92-00578	BC/BS of Texas Inc-Unfunded Pension Costs, October 1992, $6,244,637
CIN: A-03-89-00046	Maryland BC/BS Administrative Cost-FY85-88, Part B, $5,996,278
CIN: A-07-95-01010	Review of MO Title IV-E Retro Claim, February 1996, $4,246,295
CIN: A-05-93-00054	IL-Associated Insurance Group-Contract Audit, October 1993, $3,355,560
CIN: A-07-93-00633	Pension Segmentation-AETNA Life Insurance Co., October 1993, $3,011,376
CIN: A-05-93-00013	MI-BC/BS Contract-Medicare, April 1993, $3,010,916
CIN: A-07-92-00585	Pension Segmentation BC/BS of California, January 1994, $2,973,504
CIN: A-01-95-00504	Medicare Parts A&B Admin Costs-AETNA, January 1996, $2,938,223
CIN: A-03-93-03308	GSX Services, Inc., February 1994, $2,806,577
CIN: A-06-95-00035	Fees Retained by Child Placing Agencies, February 1996, $2,796,650
CIN: A-07-92-00579	BC/BS of Michigan Inc.- Unfunded Pension Costs, October 1992, $2,535,698

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

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

CIN: A-03-90-02003 BC of Western PA Administrative Costs FY86-89, August 1993, $2,218,528

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

CIN: A-02-94-01030 Hospice Eligibility Review in Puerto Rico-Manati, June 1995, $1,598,837

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

CIN: A-03-90-00051 Maryland BC/BS Administrative Cost-Part A-FY85-88, August 1991, $1,438,414

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

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

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

CIN: A-05-95-00042 BCBS Administrative Costs-Contracted Audit, December 1995, $1,333,598

CIN: A-07-93-00070 BC/BS of Mass-Unfunded Pension Cost Audit, May 1994, $1,290,740

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

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

CIN: A-02-94-01029 Hospice Eligibility RVW in PR, June 1995, $1,070,814

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

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

CIN: A-05-94-00047 Nationwide Ins., Medicare Part B Admin. Costs, September 1995, $1,049,309

CIN: A-07-93-00634 Pension Segmentation-Travelers Insurance Co., October 1993, $1,026,460

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

CIN: A-05-92-00060 Contractor Audit-BC/BS-Administrative, February 1993, $879,609,

CIN: A-04-95-02096 Review of FY92 Unsupported G&A Costs-ACB, July 1995, $857,684

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

CIN: A-03-94-03304 Biocon Inc., February 1994, $747,865

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

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

CIN: A-06-94-00028 Review of Premium Payments for Risk-Based HMO, June 1995, $615,064

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

CIN: A-06-96-39974 Albuquerque-Bernalillo County Economic Opportunity, February 1996, $648,700

CIN: A-05-95-00034 BCBS of LA-Pensions-Contract Termination, February 1996, $647,127

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

CIN: A-04-93-01069	Monitoring Administrative Cost Audit Medicare Part A, BC/BS South Carolina, July 1994, $590,844
CIN: A-07-93-00679	AETNA-Unfunded Pension Cost Audit, May 1994, $590,207
CIN: A-02-91-03508	Audit of New Jersey Child Care and Supportive Services, June 1993, $506,710
CIN: A-09-94-00058	Transamerica Occidental Medicare Admin Costs, March 1995, $491,479
CIN: A-06-92-00017	IHS Creek Contract Closeout Report, May 1992, $468,217
CIN: A-06-93-00042	BC/BS of Texas Administrative Costs-Medicare Parts A&B, January 1993, $434,134
CIN: A-03-95-00451	Escheated Warrants-District Columbia, August 1995, $420,607
CIN: A-05-92-00126	Wisconsin Westcap Head Start, March 1993, $347,576
CIN: A-05-93-25697	West Central Wisconsin Community Action Agency Inc., August 1993, $324,759
CIN: A-09-94-30178	State of Arizona, June 1994, $267,021
CIN: A-07-95-01151	Oregon BCBS Unfunded Pension Costs, October 1995, $260,335
CIN: A-03-92-20033	State of Delaware, August 1992, $247,609
CIN: A-02-95-02005	Middlesex City EOC Review of Financial Management, September 1995, $237,963
CIN: A-07-93-00710	BC/BS of Connecticut-Unfunded Pension Cost Audit, March 1994, $237,392
CIN: A-09-95-34788	State Arizona, August 1995, $209,462
CIN: A-05-91-00064	Nationwide Administrative Costs Contract Audit, October,1991, $211,422
CIN: A-07-95-01141	BCBS of LA Pensions Contract Termination Part B, February 1996, $194,177
CIN: A-07-95-01150	Oregon BCBS Pension Segmentation, October 1995, $191,312
CIN: A-05-94-29229	West Central Wisconsin Community Action Agency Inc., March 1994, $167,977
CIN: A-03-94-26611	State of Delaware, December 1993, $163,100
CIN: A-09-92-06850	Santa Ysabel Band of Mission Indians, September 1992, $151,081
CIN: A-05-92-00048	Wisconsin Physicians Svcs., Pension-Medicare vs. ERISA, October 1992, $130,577 (Related recommendation of $2,068,964 outstanding on Table II)
CIN: A-09-96-40410	Community Services Agency, February 1996, $121,809
CIN: A-07-93-00709	BC/BS of Connecticut - Pension Segmentation Audit, April 1994, $119,472
CIN: A-04-93-20785	State of Florida, June 1993, $103,486
CIN: A-05-94-31408	Tri County Community Action Commission Inc., July 1994, $98,110
CIN: A-07-95-01159	Nebraska BCBS Pension Segmentation, January 1996, $96,955
CIN: A-07-95-01164	Medicare Admin Costs - General American, December 1995, $89,929 (Related recommendation of $16,632 outstanding on Table II)
CIN: A-03-94-27083	Pennsylvania State Univ., March 1994, $86,479
CIN: A-02-95-34278	Puerto Rico Dept. of Health, June 1995, $86,064
CIN: A-02-95-34279	Puerto Rico Dept. of Health, June 1995, $85,266

CIN: A-04-93-00059 Refugee Social Services and Targeted Assistance-Florida, September 1994, $84,676

CIN: A-07-95-01166 Unfunded Pension Costs Nebraska BC/BS, January 1996, $73,509

CIN: A-02-93-02518 Biederman Kelly & Shafer Contract, February 1994, $72,883

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

CIN: A-03-91-02002 Delaware Blue Cross Administrative Costs, October 1991, $66,858

CIN: A-01-94-00521 Audit of Non PPS A/G and Capital Costs N.E. Rehab., January 1995, $69,161

CIN: A-06-96-38417 Northwest Arkansas Head Start Human Services Inc., January 1996, $67,110

CIN: A-03-96-39611 City of Philadelphia, October 1995, $66,100

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

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

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

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

CIN: A-09-96-41388 Fresno County Economic Opportunities Commission, February 1996, $50,040

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

CIN: A-09-96-39877 Amity Inc., November 1995, $49,358

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

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

CIN: A-09-94-01022 Intelligenetics, October 1994, $44,590

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

CIN: A-09-96-39877 Amity Inc., November 1995, $42,725

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

CIN: A-09-96-38647 University of California, October 1995, $12,159

CIN: A-03-95-35319 Porter/Novelli, February 1995, $31,331

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

CIN: A-09-93-00106 Review of RSS and TAP Grants-CDSS, February 1995, $31,001

CIN: A-05-95-36811 Independent School District No 709-Duluth, Minn., April 1995, $63,666

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

CIN: A-05-95-36811 Independent School District-Duluth, Minn., April 1995, $30,000

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

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

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

CIN: A-04-96-38361 Mid-South Foundation for Medical Care Inc., November 1995, $22,208

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

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

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

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

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

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

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

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

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

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

CIN: A-01-95-36087 State of Maine, June 1995, $10,250

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

CIN: A-09-96-40115 Marianas Association for Retarded Citizens, November 1995, $8,870

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

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

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

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

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

CIN: A-09-96-41444 Immigrant Center, February 1996, $6,632

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

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

CIN: A-04-95-38272 State of Florida, August 1995, $6,101

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

CIN: A-09-96-38371 Education Training and Research Associates and Subsidies, February 1996, $5,673

CIN: A-01-96-38016 University of Maine System, January 1996, $5,500

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

CIN: A-09-96-40114 Marianas Association for Retarded Citizens, November 1995, $5,040

CIN: A-05-96-40217 NA-Washington Association of Black Social Workers, February 1996, $4,934

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

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

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

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

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

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

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

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

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

CIN: A-05-96-38861 Menominee Indian Tribe of Wisconsin, February 1996, $2,636

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

CIN: A-10-96-37604 Copper River Native Association, November 1995, $2,000

B. Reports in litigation:

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

CIN: A-09-91-00155 Blackburn Care Home, November 1992, $1,772,944 (Related recommendation of $662,370 outstanding on Table II)

CIN: A-03-91-02004 West VA B/C Administrative Cost and Termination Costs, November 1992, $7,556

C. Reports that have subsequently been resolved:

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

CIN: A-05-95-36138 Community Action Agency of Columbia County Inc., March 1995, $8,870

Table II

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[1] The opening balance was adjusted to reflect a downward adjustment of $1.779 billion.

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[2] The OIG has reported as "management decisions during the period" those line items in the President's Fiscal Year 1997 budget that relate directly to OIG recommendations contained in issued reports. Management does not report these decisions in its table.

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[3] Management decisions have not been made within 6 months of issuance on 4 reports. Discussions with management are ongoing and it is expected that the following reports will be resolved during the next semiannual reporting period:

CIN: A-04-93-00062 Refugee Social Services/Targeted Assistance Program, May 1995, $9,091,909

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

CIN: A-02-95 34946 City of Caguas Puerto Rico, March 1995, $9,976

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

APPENDIX E

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

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

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	52
Section 5(a)(1)	Significant problems, abuses and deficiencies	throughout
Section 5(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	throughout
Section 5(a)(3)	Prior significant recommendations on which corrective action has not been completed	appendices B and C
Section 5(a)(4)	Matters referred to prosecutive authorities	54
Section 5(a)(5)	Summary of instances where information was refused	none
Section 5(a)(6)	List of audit reports	under separate cover
Section 5(a)(7)	Summary of significant reports	throughout
Section 5(a)(8)	Statistical table I - reports with questioned costs	50
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	51
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none

APPENDIX F

Performance Measure

Performance Measures

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

APPENDIX G

Audits, Inspections and Investigations Related to Operation Restore Trust

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

ACRONYMS

ACF	Administration for Children and Families
AFDC	Aid to Families with Dependent Children
AHCPR	Agency for Health Care Policy and Research
AoA	Administration on Aging
ASC	ambulatory surgical center
ASMB	Assistant Secretary for Management and Budget
ATSDR	Agency for Toxic Substances and Disease Registry
AWP	average wholesale price
CDC	Centers for Disease Control and Prevention
CMN	certificate of medical necessity
CMP	civil monetary penalty
CSE	child support enforcement
CY	Calendar Year
DME	durable medical equipment
DOJ	Department of Justice
DRG	diagnosis-related group
EA	Emergency Assistance
EGHP	employer group health policy
EMC	electronic media claim
ESRD	end stage renal disease
FDA	Food and Drug Administration
FI	fiscal intermediary
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GME	graduate medical education
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHA	home health agency
HHS	Department of Health and Human Services
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IME	indirect medical education
JOBS	Job Opportunity and Basic Skills
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
OMB	Office of Management and Budget
PFCRA	Program Fraud Civil Remedies Act
PHS	Public Health Service
PPS	prospective payment system
PRM	provider review manual
PSC	Program Support Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SNF	skilled nursing facility
SSA	Social Security Administration
TANF	Temporary Assistance to Needy Families

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

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

Office of Management and Budget Circulars:

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

General Accounting Office "Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

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

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

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