



Department of Health
and Human Services

Office of Inspector General

Semiannual Report

October 1, 1997 - March 31, 1998



June Gibbs Brown
Inspector General

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 98-502	Single Audit Act of 1984
P.L. 99-499	Superfund Amendments and Reauthorization Act of 1986
P.L. 101-576	Chief Financial Officers Act of 1990
P.L. 102-486	Energy Policy Act of 1992
P.L. 103-62	Government Performance and Results Act of 1993
P.L. 103-355	Federal Acquisition Streamlining Act of 1994
P.L. 103-356	Government Management Reform Act of 1994
P.L. 104-191	Health Insurance Portability and Accountability Act of 1996
P.L. 104-193	Personal Responsibility and Work Opportunity Act of 1996
P.L. 104-208	Federal Financial Management Improvement Act of 1996

Office of Management and Budget Circulars:

A- 21	Cost Principles for Educational Institutions
A- 25	User Charges
A- 50	Audit Follow-up
A- 76	Performance of Commercial Activities
A- 87	Cost Principles for State, Local and Indian Tribal Governments
A-102	Grants and Cooperative Agreements with State and Local Governments
A-110	Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations
A-122	Cost Principles for Nonprofit Organizations
A-123	Management Accountability and Control
A-127	Financial Management Systems
A-129	Policies for Federal Credit Programs and Non-Tax Receivables
A-133	Audits of States, Local Governments and Non-Profit Organizations

General Accounting Office Government Auditing Standards

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

- Title 31, United States Code, section 3729 et seq., the False Claims Act and 3801 et seq., the Program Fraud Civil Remedies Act
- Title 42, United States Code, sections 1320a-7, 1320a-7a, 1320b-10, 1320c-5, 1395l, 1395m, 1395u, 1395dd and 1396b



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

A MESSAGE FROM THE SECRETARY

One of the Department of Health and Human Services' (HHS') foremost priorities is the continuing fight against fraud and abuse in the Nation's health care programs. This Administration has focused unprecedented attention on these areas and we are proud of the significant strides already made.

The intensified crackdown on fraud and abuse by the HHS Office of Inspector General (OIG) and its partners within and outside the Department has yielded a new, more detailed picture of the nature and scope of the fraudulent activities aimed at the Medicare and Medicaid systems. New audits and surveys have helped investigators pinpoint areas of vulnerability and ongoing patterns of abuse, which in turn have led to changes in program policy and law enforcement techniques.

In January 1998, the President sent to the Congress the first annual report of the Health Care Fraud and Abuse Control Program created by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This joint report by HHS and the Department of Justice reflects the remarkable progress made in rooting out health care fraud and abuse in the first full year of HIPAA funding. Nearly \$1 billion was returned to the Medicare Trust Funds in Fiscal Year 1997, the largest amount ever. Also, the Department excluded more than 2,700 individuals and entities from doing business with Medicare, Medicaid and other Federal and State health care programs for engaging in fraud or other professional misconduct.

We have also seen significant advances in the area of child support enforcement, another top Administration priority. Along with the Office of Child Support Enforcement and its other partners in government, OIG has developed procedures designed to expedite the detection and prosecution of absent parents who are delinquent in their child support.

While we can all be proud of these outstanding results, much remains to be accomplished. Vital to the Department's ongoing efforts to enhance the effectiveness of these and other HHS programs is the excellent work being done by the Inspector General and her staff. This report reflects not only accomplishments already realized, but a shared commitment for the future.

A handwritten signature in black ink, appearing to read "D. E. Shalala".

Donna E. Shalala

FOREWORD

This semiannual report highlights the activities and accomplishments of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) for the 6-month period ending March 31, 1998. Once again, we have seen marked progress in our efforts to promote efficiency and effectiveness in the Department's programs and operations, and to reduce their vulnerability to fraud, waste and abuse.

In recent years, OIG's heightened emphasis on interdisciplinary teamwork within its own organization and greater collaboration with other Federal and State agencies have resulted in a more forceful response to the growing problems of fraud and abuse. This coordinative approach, employed so successfully in Operation Restore Trust, has greatly enhanced our ability to protect the Federal dollars allotted to the Department's programs. Moreover, we are gratified that many of the policy changes advocated by OIG in response to the findings and recommendations arising from Operation Restore Trust activities have been adopted by the Administration and the Congress.

The additional resources and authorities provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 have enabled us to further intensify and extend our antifraud efforts. As anticipated by HIPAA, we have continued to expand into additional geographical areas. Currently, there are OIG investigative offices in 31 States and the District of Columbia; by the year 2003, we plan to have an OIG presence in virtually all States.

Pursuant to HIPAA, the Attorney General and the Secretary, acting through the Inspector General, established a national Health Care Fraud and Abuse Control (HCFAC) program in Fiscal Year (FY) 1997 to coordinate Federal, State and local law enforcement activities with respect to health care fraud and abuse. In January 1998, the Secretary and the Attorney General published a joint report on the program's first year accomplishments, noting that almost \$1 billion was recovered as a result of the restitutions, fines, judgments, settlements, administrative impositions, collections and offsets brought about through HCFAC activities.

While much has been accomplished, OIG recognizes that the Federal Government alone cannot solve the problems of fraud and abuse. Accordingly, we have continued to invite the health care community to fully cooperate, support and join in our antifraud efforts. In one such initiative, OIG has worked with its partners in government and the health care industry to develop guidance on compliance programs which providers may implement voluntarily. Such guidance is intended to help companies self-regulate and self-report. The OIG released its first guidance for clinical laboratories in February 1997. During the current

semiannual period, OIG issued compliance guidance for hospitals. Outlining the seven fundamental elements of an effective compliance program, OIG also identified specific areas of hospital operations that have proven to be particularly vulnerable to fraud and abuse. We will continue to work in collaboration with provider groups to develop similar guidance in other areas.

With the cooperation of our partners and the ongoing support of the Administration and the Congress, we are confident that our efforts will continue to have a positive impact in strengthening and protecting HHS programs and operations.

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

June Gibbs Brown
Inspector General

HIGHLIGHTS

Introduction

During the 6-month period ending March 31, 1998, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) continued to maximize its impact through a heightened emphasis on interdisciplinary teamwork within its own organization, and greater collaboration with other Federal and State agencies. The effectiveness of this partnership approach is amply demonstrated by the results of many of the initiatives described in this semiannual report. Highlights of OIG's accomplishments for this period follow.

Health Care Fraud and Abuse Control Program

The OIG has long been committed to aggressive efforts to prevent and detect health care fraud. Those efforts to combat such fraud were consolidated and strengthened by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA directed the Attorney General and the Secretary of HHS, acting through the Inspector General, to establish a national Health Care Fraud and Abuse Control Program to accomplish a number of purposes, chief among them to coordinate Federal, State and local law enforcement activities with respect to health care fraud and abuse. Other important statutory goals are to facilitate enforcement of all applicable remedies for health care fraud; to provide industry guidance relating to fraudulent practices; to establish a national adverse actions data bank; and to conduct investigations, audits and other reviews relating to the provision of and payment for health care in this country.

The HIPAA, strengthened by the Balanced Budget Act of 1997, brought much needed authorities and resources to oversight of health care services. With these additional resources, OIG has intensified and expanded its activities in the health care field and is now able to coordinate a more effective effort to curb those who exploit the Nation's health care systems, particularly Medicare. The accomplishments during the first year of expanded antifraud efforts brought about by HIPAA were reported in the first Annual Report of the Departments of HHS and Justice submitted to the Congress in January 1998. As required by the Act, the report identifies program funds expended on health care antifraud activities during Fiscal Year (FY) 1997, and the dollars returned to the Medicare Trust Funds during that year. These monetary results reflect the most successful year ever in the Nation's efforts to detect and punish fraud and abuse against health care programs. For example, during FY 1997, a total of \$1.087 billion in criminal fines, civil judgments or settlements, and administrative impositions was collected or otherwise recovered for all Federal health care programs. Of this, nearly \$1 billion was restored or transferred to the Medicare Trust Funds.

With the enhanced resources provided by HIPAA, OIG continues to expand its investigative, audit and evaluation staffs, and to extend coverage to geographical areas that were

underserved in recent years. Such growth will further bolster OIG's ability to fulfill its responsibilities under HIPAA. In addition, OIG made major strides in the area of preventing health care fraud and abuse through provision of industry guidance. The OIG reached consensus with the health care industry on companion regulations to a new exception (set forth in HIPAA) to the anti-kickback statute for certain managed care arrangements. Use of the negotiated rulemaking process to develop the regulations was mandated by the Congress when it created the exception.

For further information on these and other accomplishments under the Health Care Fraud and Abuse Control Program, see page 2.

Compliance Program Guidance for Hospitals

In February 1998, OIG released compliance program guidance for hospitals to assist in developing measures to combat fraud and abuse in the hospital industry. The guidelines are part of OIG's continuing efforts to work with health care providers to promote voluntary compliance with the applicable statutes, regulations and program requirements pertaining to Federal and other health care programs. The guidance sets out the seven fundamental elements of an effective compliance program, and identifies specific areas of hospital operations that, based on prior Government enforcement efforts, have proven to be vulnerable to fraud and abuse. (See page 17)

Prescription Drugs

In a study entitled "Excessive Medicare Payments for Prescription Drugs," OIG found more evidence that Medicare was consistently paying too much for prescription drugs. For more than one-third of the 22 drugs reviewed in this study, Medicare paid more than double the actual average wholesale price to physicians and suppliers. The Congress used the draft of this report, as well as previous related studies, to reduce Medicare payment rates for drugs by 5 percent in the 1997 Balanced Budget Act. The change in pricing methodology will save the Medicare program \$370 million over the next 5 years. Moreover, OIG found that Medicare's current Epogen reimbursement rate of \$10 per 1,000 units administered exceeds the current cost of purchasing the drug by about \$1. Reducing the rate to \$9 per 1,000 units administered would result in annual savings of approximately \$94 million to the Medicare program and \$24 million to its beneficiaries.

In addition, a series of evaluations was conducted on the subject of prescription drug use in nursing homes. Medication problems and concerns raised collectively by these three coordinated reports demonstrate the need for stronger monitoring and more positive enforcement of existing regulations and required reviews of medication usage in nursing homes. (See page 30)

Laboratory Fraud and Abuse

In a nationwide audit, OIG determined that Medicare carriers reimbursed independent and physician laboratories for claims involving unbundled and/or duplicate chemistry, hematology and urinalysis tests that should have been grouped together (bundled) and paid

at a lesser amount, and for additional indices that were not ordered, received or needed by a physician. As a result, OIG estimated that carriers overpaid these providers more than \$50 million between July 1, 1993 and June 30, 1995. During the same 2-year period, an additional \$31 million could have been saved if policies had been adopted to preclude payment for additional automated hematology indices. (See page 23)

Also during this reporting period, OIG successfully completed several criminal and civil cases related to billing for these unbundled tests on the part of independent laboratories and physicians. Convictions and settlements were also obtained for other types of fraudulent or abusive activities involving these health care providers. Among the most reprehensible of these cases were those involving kickbacks and fraudulent billing for tests on nursing home patients that either were not performed or were not necessary. (See pages 18 and 23)

Durable Medical Equipment Fraud

Over the years, the durable medical equipment (DME) industry has been the source of a variety of fraud and abuse problems. More than 3 years ago, the Health Care Financing Administration (HCFA) published new regulations addressing some of the recurring DME reimbursement problems, especially those created by telemarketing and carrier shopping. As fraud cases involving these problems appear to be diminishing, however, others continue to grow. During the present reporting period, DME fraud convictions accounted for 23 of OIG's 96 health care criminal convictions. Monetary returns from DME companies, owners and other participants totaled more than \$40.5 million for the period.

In the New York area alone, 12 convictions were obtained. Many of the convictions for DME fraud were for kickbacks and for billing for equipment not provided or of lesser cost than that claimed. (See page 27)

Hospice Care

During this reporting period, several initiatives focused on hospice care, a treatment approach which recognizes that an individual's impending death warrants a change from curative to palliative care, such as pain control and symptom management. The OIG's investigations and audits uncovered abusive billings by selected providers, and evaluation studies and audits revealed systemic vulnerabilities for hospice services provided in a nursing home setting.

The OIG's consolidated report discussed 12 hospice studies in which auditors, in partnership with physicians from Medicare peer review organizations, reviewed long-term patients' medical files. Although some of these hospices are still being evaluated, OIG estimates that Medicare paid a total of \$83 million for beneficiaries whose diagnoses did not justify enrollment in the hospice program. A hospice in Illinois, for instance, received over \$10 million in Medicare overpayments for ineligible beneficiaries.

Taking a different perspective, another review questioned whether Medicare reimbursement for hospice care provided to nursing home patients may be excessive. This reimbursement

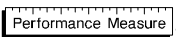
level is the same as that for hospice care provided to patients in their homes, even though nursing home hospice patients receive almost 46 percent fewer services. Finally, OIG examined the contractual relationships between hospices and nursing homes. This report noted that financial incentives -- rather than clinical needs -- could influence decisions about patient care.

The Balanced Budget Act of 1997 addressed some of the problems noted above. For example, the Act requires more frequent recertifications of eligibility and allows patients whose conditions improve to be discharged from hospices without loss of future benefits. In addition, in response to OIG's recommendations, HCFA is taking a number of actions to reduce ineligible hospice enrollments and to prevent other abusive activities. (See page 21 - 22)

Child Support Enforcement

The OIG, the Department of Justice and the Federal Bureau of Investigation have developed procedures for expediting detection and prosecution of parents in one State who refuse to pay past due support for a child in another State. A single agent has been designated as contact in each judicial district for responsibility for these cases. The success of this effort is largely due to cooperative efforts with the Office of Child Support Enforcement, which has been key in obtaining the involvement of State and local officials. As a result, OIG has initiated more than 250 cases nationwide. Some 23 convictions and court-ordered restitutions of more than \$640,00 were obtained during this period. Especially active has been the Federal Eastern District of Virginia, whose operation "Long Arm" has served as a model for other judicial districts. (See page 44)

OIG Work in Performance Measurement

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

Internet Address

This semiannual report and other OIG materials may be accessed on the Internet at the following address: <http://www.dhhs.gov/progorg/oig>

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**Health Care
Financing
Administration**

Chapter I

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

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

The Medicaid program provides grants to States for medical care for low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for cash assistance programs. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average.

The 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 medical equipment and of services provided by home health agencies; analyzed various State licensure and discipline issues; reviewed several

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

The OIG also audits HCFA's financial statements, which account for more than 83 percent of Department of Health and Human Services (HHS) outlays. In addition to issuing an opinion on the statements, OIG has assessed compliance with Medicare laws and regulations and the adequacy of internal controls.

Fraud and Abuse Control Program

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

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

During this semiannual period, the Government reported on the accomplishments achieved during the first full year of operation under the Health Care Fraud and Abuse Program, including a summary of the expenditures and recoveries under the program. These monetary results document the most successful year ever in the Nation's efforts to curb abuses against health care programs. For example, during FY 1997, a total of \$1.087 billion in criminal fines, civil judgments or settlements, and administrative impositions was collected or otherwise recovered for all Federal health care programs. Of this, nearly \$1

billion was restored or transferred to the Medicare Trust Funds. Also, more than 2,700 individuals and entities were excluded from federally sponsored health care programs, a 93 percent increase over 1996.

Although the additional authorities and resources provided by HIPAA have increased the effectiveness of the Government's antifraud efforts, the Government, alone, cannot solve the problem of fraud and abuse. Accordingly, OIG has redoubled its efforts at enlisting the help of the provider and beneficiary communities to prevent impropriety. Foremost among these preventive efforts during the reporting period were reaching consensus on negotiated rulemaking involving potential kickbacks in shared risk arrangements; issuing program compliance guidelines for hospitals; and participating in a broad beneficiary outreach program.

Section 216 of HIPAA created an exception to the anti-kickback statute for certain managed care arrangements, including remuneration between Medicare eligible health maintenance organizations (HMOs) and competitive medical plans, and individuals or entities providing items or services. In addition, the statute excepted remuneration between any organization and an individual or entity that has a risk-sharing arrangement, if a written agreement places the individual or entity at "substantial financial risk" for cost or utilization of the items or services provided. Section 216 further directed the Department to use a negotiated rulemaking process to establish companion regulations. The negotiated rulemaking committee was comprised of 21 industry representatives, a representative each from OIG and the Department of Justice. In January 1998, the committee reached consensus on a final proposal which will be the basis for an interim final rule to be published in the spring. The consensus proposal provides for two new safe harbors. The first will protect managed care plans and their providers where the Federal health care programs, including Medicare HMOs, most Medicare + Choice plans, Medicaid managed care plans and TriCare, pay such plans on a capitated basis. The second will protect employer sponsored group health plans where the providers under such plans are placed at substantial financial risk for the cost or utilization of Medicare items or services.

The OIG also released compliance program guidelines to assist in developing measures to combat fraud and abuse in the hospital industry. The guidelines are part of OIG's continuing efforts to work with health care providers to promote voluntary compliance with applicable statutes, regulations, and program requirements governing Federal and other health care programs. The guidelines are discussed further on page 17.

In addition, OIG has pursued other measures designed to promote fraud prevention, among them, issuance of fraud alerts, advisory opinions and other guidance as part of an ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry. The OIG continued to work in conjunction with the Administration on Aging, HCFA and various advocacy groups to develop an outreach campaign to educate beneficiaries and

others who work directly with the elderly to recognize Medicare and Medicaid fraud, waste and abuse when they encounter it, and to know how and where to refer it.

The OIG continues to provide direction, technical assistance and advice regarding the creation of the final adverse action data bank mandated by HIPAA, now named the Healthcare Integrity and Protection Data Bank (HIPDB). The Health Resources and Services Administration continues its work on the implementation on behalf of OIG. The OIG chairs the Executive Steering Council, which includes representatives from DOJ, HCFA and HHS's Assistant Secretary for Management and Budget (ASMB). These representatives participate in the oversight of HIPDB. The OIG also acts as liaison to involve other Federal and State law enforcement agencies in both reporting to and querying HIPDB.

The OIG has added additional staff to accomplish its responsibilities under the expanded antifraud and abuse program. Implementation of HIPAA has been a cooperative effort. The OIG has and will continue to work closely with other components of HHS, chiefly HCFA and ASMB.

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

Beneficiary Awareness of Medicare Fraud

Performance Measure

In 1996, OIG launched an initiative called "Outreach" whose primary goal is to combat Medicare fraud, waste and abuse. The initiative involves three activities: creation of a more user-friendly hotline; establishment of partnerships with HCFA, the Administration on Aging and the American Association of Retired Persons; and inauguration of a nationwide outreach campaign to educate beneficiaries and other citizens on Medicare fraud. As part of that campaign, OIG conducted a telephone survey to assess current beneficiary knowledge and awareness of Medicare fraud.

The OIG found that more than half of beneficiaries believe that Medicare fraud is common, and they overwhelmingly agree that it is their personal responsibility to report suspected cases of Medicare fraud. Further, beneficiaries appear to be well-positioned to identify potential Medicare fraud with three out of four saying that they "always" read their Explanation of Medicare Benefit statements. However, beneficiaries believe that recognizing fraud is difficult and most have never received information on Medicare fraud. They are not aware of agencies working to stop Medicare fraud nor of the toll-free number to report Medicare fraud. Finally, most beneficiaries agree that they would be more likely to report Medicare fraud if they knew more about it.

The survey findings not only confirm the need for a campaign to educate beneficiaries, but also provide OIG with baseline data on Medicare beneficiaries' current awareness of Medicare fraud. The survey will be repeated in 1 to 2 years to assess the effectiveness of the outreach campaign. (OEI-12-97-00440)

Major Hospital Initiatives

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

A. Physicians at Teaching Hospitals

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

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

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

The PATH audits also include a review of Part B claims information and medical records to determine if the teaching physician claimed the appropriate reimbursement for the level of service provided. The Medicare billing system's vulnerability to upcoding is a longstanding concern at OIG. The PATH reviews are designed to detect patterns or practices of upcoding, resulting in unwarranted loss to the Medicare Trust Fund.

The PATH initiative has been undertaken as a result of OIG's extensive audit and investigative work in this area. To date, four institutions have entered into settlements with

the Federal Government to resolve their False Claims Act liability for overpayments related to improper claims submitted in the teaching setting. These settlements have resulted in the Government's recovery of approximately \$67 million. As a condition of settlement, these institutions have also implemented corporate integrity programs to prevent and detect future improper claims. An audit completed at two other institutions disclosed no major problems with either billings in the teaching setting or upcoding, demonstrating that providers can and do bill the Medicare program correctly.

To determine whether, and to what extent, problems similar to those noted above were present at other teaching institutions throughout the country, the PATH project was expanded into a national initiative, but limited to those institutions that received guidance from the Medicare Part B carriers communicating the applicable HCFA reimbursement standards. In addition to conducting focused audits of these providers' medical billing records, the providers are given the opportunity to conduct a self-audit with Government oversight and to report their findings to OIG.

B. Diagnosis Related Group Payment Window Project

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

This national project identified 4,660 hospitals that submitted improper billings for outpatient services. These hospitals receive notification from the local U.S. Attorney's Office concerning OIG's identification of erroneous claims and the facility's potential exposure under the False Claims Act. The hospitals are given the opportunity to enter into a settlement with the Government under which the financial exposure of the institution is substantially less than if litigated under the Act. Compliance measures to prevent and detect erroneous billing are also required under the terms of the settlement. The project is primarily coordinated by the U.S. Attorney's Office - Middle District of Pennsylvania. As of the end of the reporting period, settlements had been executed with approximately 2,300 hospitals and about \$57 million had been recovered.

One of the most important parts of this project is the stipulation in each settlement agreement that each hospital will assure compliance with proper billing for

inpatient/outpatient services. It is hoped that the deterrent effect of possible civil actions, along with promised compliance, will remove this source of improper claims.

C. Operation Bad Bundle

The OIG, DOJ and multiple States have joined forces to combat Medicare and Medicaid fraud in hospital outpatient laboratory billing practices. A project begun in Ohio by OIG, DOJ, the State of Ohio and the Medicare fiscal intermediary proved so successful, it was expanded to other States as Operation Bad Bundle. This project seeks to recover multiple damages for improper and excessive claims submitted for hematology and automated blood chemistry tests by hospital outpatient laboratories. These abusive practices stem from the improper unbundling and double billing of laboratory tests and in certain cases the billing for certain medically unnecessary tests, which have been found to be widely practiced abuses.

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

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

Operation Bad Bundle targets hospital outpatient laboratories using a computer-based audit of claims submitted for outpatient laboratory services along with a preliminary investigation. Where the initial audit and preliminary investigation uncover suspected fraudulent practices, the United States Attorney's Office will send a letter to each hospital identifying the abusive practice at that facility and its potential exposure under the False Claims Act. In many jurisdictions, the hospitals are invited to participate in a self-audit program, the results of which are separately verified by the United States Attorney's Office. In recognition of their participation in this self-audit process, the hospitals generally receive the benefit of double, rather than triple, damages for settlement purposes. In certain jurisdictions, the hospitals may not be asked to do a self-audit, in which case up to treble damages have been sought. In these cases, however, the hospital may request the opportunity to do a self-audit in exchange for the benefit of paying only double damages. The settlement amount is determined on a hospital-specific basis. The terms of all of the settlements require implementation of compliance measures to prevent future similar misconduct within the hospitals' clinical laboratories.

In a related lawsuit, a Federal court in Ohio granted the Secretary's motion to dismiss a lawsuit filed by the Ohio Hospital Association and the American Hospital Association. The hospital associations' suit had challenged the Department of Justice's use (on behalf of the Secretary) of the False Claims Act in connection with laboratory billing issues. The action was brought against the Secretary to halt the Ohio Hospital Project, which has since evolved into Operation Bad Bundle. Thus far, 114 hospitals have entered settlements in Operation Bad Bundle, with settlements totaling more than \$26.3 million. More hospitals are expected to settle in the near future.

D. Patient Transfers

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

Since 1986, however, OIG has found that many transferring hospitals inappropriately claim full diagnosis-related payment rather than the per diem payment. The HCFA has already acted on OIG's first report, which identified \$227 million in recoveries and savings. The OIG's second report, issued in November 1996, and a more recent computer analysis of claims disclosed additional overpayments of approximately \$165 million. Currently, OIG is working with the U.S. Attorney's offices nationwide to address this continuing problem.

E. Bacterial Pneumonia Project

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

The OIG is currently investigating the coding for bacterial pneumonia at over 100 hospitals. To date, one hospital has entered into a settlement with the Government based on its Medicare inpatient coding of bacterial pneumonia cases. The settlement included payment of over \$600,000 and an agreement by the hospital to implement compliance measures to prevent future Medicare billing or coding problems.

Other Hospital Investigations

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

- A Mississippi medical center and its former employee agreed to settle their liabilities for submitting claims for services which were not rendered, not medically necessary or insufficiently documented during June 1994 through August 1995. The employee, the hospital's psychiatrist, had caused the filing of the claims. Their agreements, including penalties, totaled \$647,000 of which \$347,000 went to Medicaid, \$289,065 to Medicare and \$10,935 to the Civilian Health and Medical Plan of the Uniformed Services (CHAMPUS).
- A New York hospital agreed to an out-of-court settlement of more than \$43,170, of which \$14,840 is reimbursement for investigative costs, for billing improper codes. The hospital was paid for an uncommon eye procedure (ophthalmic ultrasound) but the examining physician declared she had never performed the procedure. Further investigation showed that the hospital's billing company was using a faulty computer program which improperly converted to Medicare billing codes. As a result, 270 of these claims were paid between 1993 and 1997. The OIG also identified six other procedures improperly converted, including 810 chest x-rays paid for by Medicare. Settlement with another hospital affected by the faulty computer program is pending.
- After a Florida cancer center requested assistance in determining whether it had processed radiation oncology billing errors, a review showed it had been overpaid \$655,570 by Medicare and \$173,350 by Medicaid. The center improperly billed the technical components for radiation oncology services to hospital inpatients which had already been billed by the hospital. Investigation showed that the billings were errors and not fraudulent. The center agreed to pay \$831,500 to the Medicare trust fund.

Resolution of Patient Transfers

In a prior review, OIG reported on improperly paid patient transfers under the Medicare prospective payment system and recommended that HCFA take action to resolve the improper payments. This follow-up review demonstrated that as a result of HCFA's efforts, the large majority of the original 13,771 unresolved transfers have been successfully resolved and the Medicare Part A Trust Fund has recovered more than \$8.4 million. Therefore, OIG recommended that HCFA consider its actions on the transfers as completed. (CIN: A-06-97-00007)

Medicare Hospital Discharge Planning

In this inspection, OIG determined that hospital ownership of nursing homes seemed to have little influence on which nursing homes patients were referred, although it did influence the length of stay in both the hospital and the nursing home. The OIG found shorter hospital stays combined with longer nursing home stays for patients who went to hospital-owned nursing homes. In contrast, hospital ownership of home health agencies did seem to have an influence on which home health agencies patients were referred. Ownership also influenced the duration of home health agency services, but the impact on hospital stays was not clear. Beneficiaries who went to hospital-owned services reported better continuity of care for both home health agency and nursing home services. Hospital ownership did not impact beneficiaries' level of satisfaction. The recently enacted Balanced Budget Act of 1997 partially addressed OIG concerns about shifting patients prematurely from hospitals to other facilities of theirs. It also required disclosure of ownership and dissemination of information about all available nursing homes and home health agencies to patients being discharged from the hospital, as OIG recommended. (OEI-02-94-00320)

Hospital Closure: 1996

This final report on hospital closures in 1996 is the latest in a series of annual reports on this subject since 1987. Thirty-seven hospitals closed in 1996 -- 0.7 percent of all hospitals. This is the same number that closed in 1995. At the same time, five hospitals opened. Most of the hospitals that closed were small and had low occupancy rates. The average daily patient load in the year prior to closure was 5 in rural hospitals and 38 in urban hospitals. Although residents of a few communities had to travel greater distances for hospital care, most had emergency and inpatient medical care available within 10 miles of a closed hospital. (OEI-04-97-00110)

Partial Hospitalization Services and Costs Claimed by a Florida Community Mental Health Center

Medicare covers partial hospitalization services -- specialized outpatient mental health services -- if they are reasonable and necessary for diagnosing and treating a beneficiary's mental condition. Community mental health centers that provide these services receive

interim Medicare payments during the year and a year-end settlement based on their Medicare cost report.

In Florida, one community mental health center claimed reimbursement totaling \$4.5 million for services provided to 305 beneficiaries in FY 1995. The OIG's review of services provided to 43 of these beneficiaries disclosed that 74 percent did not meet Medicare eligibility criteria or were considered unallowable by medical review personnel because they were not adequately documented, not reasonable and necessary, or not ordered. The fiscal intermediary agreed with OIG's recommendation to recover a \$1.2 million overpayment and to place the four providers owned by the center under focused medical review with special emphasis on beneficiary eligibility. (CIN: A-04-96-02118)

Co-issued with the above report was another pointing out that the same center's FY 1994 cost report, which claimed costs totaling \$2.3 million, included \$1.4 million that was not related to patient care, not reasonable and necessary, or not supported with sufficient documentation. As a result, the fiscal intermediary began to recover the unallowed costs, and HCFA suspended payments pending full recovery. The OIG recommended that the fiscal intermediary review subsequent cost reports for similar unallowable costs, and the intermediary agreed. (CIN: A-04-96-02124)

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 1,831 sanctions, in the form of exclusions or civil actions, on individuals and entities for engaging in fraud or abuse of Federal and State health care programs and/or their beneficiaries. More than half the exclusions were based on conviction of program-related crimes, conviction for the illegal manufacture or distribution of controlled substances, conviction related to patient abuse or 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 program participation. 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, crimes related to patient abuse, felony convictions for defrauding other health care programs and felony convictions for the illegal manufacture or distribution of controlled substances. A number of OIG exclusions involve failure to repay HEALs, as discussed in the chapter on Public Health Service Operating Divisions.

The Balanced Budget Act of 1997 was designed to ensure further protection of the integrity of Medicare and other Federal and State health care programs for current and future beneficiaries, and to combat fraudulent and abusive program activities. As a result of the Act, the scope of an OIG exclusion now extends beyond Medicare and the State health care programs to any Federal health care program. The OIG will directly impose exclusions from all Federal health care programs. The Act also provides for a mandatory exclusion of not less than 10 years for individuals who have been convicted on one previous occasion of one or more offenses under a Federal health care program, and a permanent exclusion if the individual has been convicted of two or more previous occasions of one or more offenses under a Federal health care program (including program-related crimes, patient abuse, health care fraud and convictions relating to controlled substances).

During this reporting period, OIG imposed exclusions on close to 1,400 individuals and entities in all. The following are examples of some of the exclusions that were imposed during this reporting period:

- An Arkansas medical transportation driver was excluded for 20 years for filing false claims under the Medicaid program. As part of the scheme, he purchased completed transportation forms from Medicaid recipients, when no corresponding Medicaid services had been provided. He also submitted multiple transportation forms for payment for transportation services and inflated the total number of miles driven. The driver was sentenced to 10 years incarceration and ordered to make restitution of \$220,550.
- A physician in New York was excluded for 25 years for Medicaid fraud. Damages to the program in the case were \$1.6 million, with a direct benefit to the physician of \$157,000. He was ordered to make restitution of this amount, and sentenced to incarceration for 30 months. The physician billed and was paid by Medicaid for treatment, procedures and tests that were either not rendered or not medically necessary. He created bogus charts indicating various medical conditions for which the procedures and tests were ordered.
- A husband and wife team who were emergency medical technicians in West Virginia were convicted of mail fraud and sentenced to 18 months incarceration followed by 3 years probation, and restitution of \$10,000. The conviction involved claims for ambulance services which were medically unnecessary because they involved fully ambulatory patients, trips to regularly scheduled doctor appointments, and non-emergency trips to dentists, pharmacists and other health providers. Medicaid recipients were called and asked about trips to doctors, and the technicians completed forms

corresponding to those visits despite not using an ambulance. Both husband and wife were excluded for 10 years.

- A Mississippi certified nurse's aide was convicted of hitting a nursing home resident multiple times with a closed fist, violently grabbing the resident's arm and pushing her against the wall. The aide received a 1-year jail term and was excluded for 10 years.
- A New York physician was convicted of sexual abuse for sodomizing a patient who was incapable of consent by reason of being physically helpless. The physician was sentenced to incarceration for up to 10 years and was excluded from Medicare participation for at least 15 years.
- In the first exclusion involving a felony conviction related to prescription and distribution of controlled substances, a director of nursing in Missouri was excluded for the minimum mandatory period of 5 years. She phoned a pharmacy and ordered controlled substances and other medications for nursing home residents when they had not been prescribed by a physician. She then diverted the drugs for her own use. The pharmacy in turn billed and was reimbursed by the Medicaid program.
- A dentist in Michigan was excluded for 10 years after his conviction for submitting fraudulent claims to insurance companies in order to obtain money to which he was not entitled. The dentist inappropriately submitted bills to more than one insurance carrier for the same services, billed for alleged medical services which were, in fact, dental services, billed for services not rendered, and failed to return to the insurance companies the excess compensation he received as a result of his fraudulent billings. As a result of his conviction, he was sentenced to 24 months incarceration. The financial loss approximated \$93,000.
- A conviction in a scheme to defraud the State compensation insurance fund in California resulted in a 15-year exclusion for a private citizen. As part of the scheme, the individual grossly under-reported monies paid to temporary employees, falsely stated that temporary employees had performed clerical or sales work, used fictitious names on reports sent to the State fund, sent clients forged certificates of workers compensation insurance, used cash to impede the State funds detection of the scheme, and destroyed incriminating documents and erased computer data tying him to the scheme. The individual was sentenced to 30 months incarceration and restitution of \$1,817,186.

- An osteopath in Pennsylvania was convicted on 25 counts of dispensing and distributing a controlled substance. He received 40 months incarceration, followed by 3 years probation, and 500 hours of community service. He was excluded for 10 years.
- A physician was indefinitely excluded after being forced to surrender his license to practice in New Jersey. The surrender was the result of sexual misconduct related to his maintaining a sexual relation with an individual while treating her as a psychiatric patient. He also committed insurance fraud.
- A New York physician was indefinitely excluded because his license was revoked. The revocation was based on his conviction for making false business entries relating to CT scans, and on the intent to commit insurance fraud.
- After the State of Illinois revoked the license of a physician when his medical charts documented a poor quality of care, he was excluded from the Medicaid program. The physician failed to provide adequate physical examinations, improperly prescribed medications containing the narcotic codeine, did not respond appropriately to abnormal lab test results, inappropriately prescribed excessive antibiotics and improperly prescribed medication without obtaining essential information. The physician has been excluded until the State reinstates his eligibility.

B. Civil Penalties for Patient Dumping

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

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

The OIG collected \$710,000 in CMPs from 21 providers during this reporting period. The following are examples of CMP cases resolved by OIG:

- A hospital in Maryland paid \$150,000 in penalties to resolve allegations of dumping patients because of insurance status. Patients presented to the emergency room for evaluation and treatment and before receiving a medical screening examination, their HMO was routinely contacted for authorization to pay for services rendered at the emergency room. When such prior authorization was denied, the individuals did not receive a screening examination or treatment.
- A Florida hospital paid \$42,500 in penalties for allegedly failing to provide an appropriate medical screening to a woman who was brought to the hospital parking lot after suffering a stroke in her truck. The emergency staff refused requests for assistance from her husband and the police because the woman had not been brought into the building. Hospital staff told the husband to call an ambulance for help.
- An Arkansas hospital paid \$30,000 for allegedly failing to provide an appropriate medical screening, treatment or transfer of a pregnant woman who presented with contractions. A nurse paged the on-call physician who ordered the nurse to transfer the patient to another hospital because she was covered by Medicaid. The patient was discharged and had to independently transport herself to the other hospital.
- A New York hospital paid \$35,000 in penalties for allegedly discharging an AIDS patient with an unstable emergency medical condition. The patient died approximately 6 hours after being discharged and later taken to another hospital.
- An Illinois hospital allegedly did not provide an appropriate medical screening, treatment or transfer of a pregnant woman in labor. The on-call physician never came in to examine her and instead gave instructions that she be transferred. The woman was sent by private automobile to a hospital approximately 15 minutes away where she gave birth 20 minutes after

arrival. The hospital was subject to a maximum CMP of \$25,000 because it had fewer than 100 beds and paid \$20,000 in penalties.

C. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law allows recoupment of monies lost through illegitimate claims as well as the imposition of additional penalties, 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 False Claims Act. Many providers elect to settle their cases prior to litigation. As part of resolving these cases, OIG frequently imposes corporate integrity programs on entities as a condition for being allowed to remain as a provider in the Medicare program. These integrity 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 more than \$84.4 million through both CMP and False Claims Act civil settlements related to the Medicare and Medicaid programs during this reporting period. Some examples of these cases include:

- A chain of four nursing homes in Philadelphia agreed to settle liability for grossly deficient diabetes monitoring, decubitus ulcer care and other nursing care which received widespread publicity in the area. The HCFA sent survey teams and found violations that led to a notice of termination. The OIG investigated and found treatment poor enough to justify a False Claims Act suit. Faced with these actions, the chain agreed to pay \$500,000 over 5 years and up to \$150,000 a year for the cost of a monitor selected by the Government, to abide by specific standards of care and to develop a compliance program.
- In Utah, two doctors along with another man and their now-defunct portable x-ray company agreed to pay more than \$214,200 to settle civil liabilities for false Medicare and Medicaid claims. They charged \$65 each for multiple trips to a nursing home when they only made one trip and took x-rays of multiple patients.
- A Mississippi cardiologist and his office manager agreed to resolve their liability for false Medicare claims, paying \$100,000 for penalties and actual damages of \$35,792. The office manager submitted claims on behalf of the cardiologist indicating that myocardial perfusion imaging had been performed, when the cardiologist did not even have the necessary equipment. The office manager, who is not a physician and has no Medicare number, claimed he was told by the carrier to bill this code to recover for pharmacological services rendered in conjunction with EKGs.

- A New Jersey physician agreed to pay \$30,000 to settle his civil liability for filing improper Medicare claims. He had EKGs and other diagnostic testing equipment installed in his office by a laboratory that provided ultrasound and nuclear imaging diagnostic tests. He performed the diagnostic tests but contracted with another physician to interpret the test results. He then billed Medicare for the interpretations of the tests. The loss to Medicare over a 2-year period was more than \$19,000. The laboratory remains under investigation.
- A Pennsylvania urologist agreed to pay \$25,000 and enter a compliance program to resolve civil liability for false Medicare claims. Between 1992 and 1995, the urologist billed Medicare for unnecessary services, falsified documentation, waived beneficiary co-payments and engaged in other violations. The \$25,000 is twice the amount he was overpaid.
- In New Jersey, a CMP action was settled against a podiatrist for submitting false Medicare claims. The podiatrist agreed to pay \$20,000 -- \$2,000 at the time he signed the agreement, plus a 10 percent interest rate per year until the balance is paid. In February 1994, the podiatrist was excluded from participating in the Medicare program for 2 months after he defaulted on a Health Education Assistance Loan. However, during the time of his exclusion, he submitted 110 false Medicare claims for podiatry services he provided to beneficiaries. Although the Medicare carrier paid only \$1,600, the CMP damages could have totaled \$706,000.
- A New Hampshire nephrologist agreed to pay \$20,000 to settle liability for filing false Medicare claims. He had expressed to the Government concerns regarding his Medicare billings and claims. An OIG auditor analyzed the claims and found some false and misleading. He received a monthly "capitation fee" for patients under his care who had end stage renal disease. Nonetheless, he submitted claims for "office visits" and "unrelated services" for these patients, when reimbursement for these services was included in the monthly capitation fee.

D. Compliance Activities

One of the important factors in Federal sentencing guidelines is whether or not an organization has established compliance standards. This has increased the efforts by the private sector to develop methods to reduce violations under the False Claims and CMP Acts. The OIG has begun a significant outreach effort with the private sector to discuss these endeavors.

To further assist the private sector in this area, OIG is developing compliance program guidance for the various parts of the health care industry which providers may adopt voluntarily. To this end, OIG developed a model corporate compliance plan for laboratories, which was released in February 1997.

During this reporting period, OIG issued compliance program guidance for hospitals. This guidance, like that provided to clinical laboratories, is premised on OIG's belief that a health care provider can use internal controls to more efficiently monitor adherence to applicable statutes, regulations and program requirements. The seven fundamental elements of an effective compliance program are: written policies, procedures and standards of conduct; designation of a compliance officer and compliance committee; conducting effective training and education; developing effective lines of communication; enforcing standards through well-publicized disciplinary guidelines; conducting internal monitoring and auditing; and responding promptly to detected offenses and developing corrective action initiatives. Using these seven building blocks, OIG identified specific areas of hospital operations that, based on prior Government enforcement efforts, have proven to be vulnerable to fraud and abuse. The guidelines were further enhanced by the input of hospital trade associations and others with expertise in the hospital industry.

In addition to developing model corporate compliance plans, OIG also monitors and verifies the completion of corporate integrity obligations that have been and are being established as a result of settlement negotiations following an OIG investigation or audit. Currently, OIG is monitoring 230 Government-imposed corporate integrity plans. These plans cover the range of providers from small physician offices to large laboratory corporations. Most corporate integrity 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 corporate integrity plan. Failure to adhere to the corporate integrity agreement could result in exclusion of the provider.

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 settlements and sentencings for this crime:

- As a result of the ongoing investigation of a Florida impotence clinic company, the owner of a mobile diagnostic laboratory agreed to pay the Medicare Trust Fund \$1.77 million and the Internal Revenue Service (IRS) \$230,000. The laboratory owner paid kickbacks not only to impotence clinic owners but also to numerous physicians in the area for Medicare patient referrals. During the investigation, \$2.3 million of his assets were frozen.
- Another subject of the Florida impotence clinic case, the owner of a diagnostics service in Florida was sentenced for paying kickbacks for Medicare patient referrals by clinic owners. The kickbacks were disguised as rental or marketing fees paid to the clinics. He was sentenced to 4 months house arrest and 5 years probation, and ordered to make restitution of \$106,000 to Medicare.
- The office manager of a Florida multi-physician practice was sentenced to 21 months in prison and 3 years of supervised release for conspiracy to defraud Medicare. He was also ordered to pay \$50,420 in restitution. Between August 1993 and August 1994, he accepted about \$23,000 from a clinical laboratory owner in return for referrals. Upon learning of the OIG investigation, he and the laboratory owner drew up a bogus, backdated consulting contract to give the appearance of its being part of a valid agreement. Despite the contract, the office manager was convicted at trial of all 15 counts of conspiracy and kickbacks.

Criminal Fraud

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

- The owner of two home health agencies (HHAs) was sentenced in Texas for making false statements in a Medicare cost report. Her family wrote off personal expenses in the cost reports. She then funneled the proceeds through the two HHAs and eventually into the family's personal bank account. She was sentenced to 42 months in prison and 3 years probation, ordered to make restitution totaling more than \$2.26 million and fined \$111,540. She was further ordered to make immediate payment of more than \$66,370, which was the profit from sale of her residence, and to forfeit two parcels of property, estimated as worth \$300,000, to be paid to the Department. The HHAs were placed on 5 years probation. Charges against her husband and son were dropped.
- A psychiatrist was sentenced in Georgia after being convicted of Medicare/Medicaid fraud. He was sentenced to 87 months incarceration, 36 months of supervised release and 400 hours of post-release community service. His medical group's former business manager was sentenced to 33 months incarceration and 36 months supervised release. The defendants conspired to defraud Medicare, Medicaid and CHAMPUS by filing claims for services not rendered as claimed or not covered by the programs. Between 1992 and 1996, the Government paid the group more than \$5.2 million.
- In Florida, two brothers were sentenced after pleading guilty to conspiracy to defraud Medicare. After operating a furniture store in Miami for 20 years, the brothers decided to open a clinic. Within a few months, they found they were not making enough money and elected, along with three doctor employees, to bill for more expensive tests on all patients. More than 4,100 false claims were submitted to Medicare, and the brothers received over \$1 million. One brother was sentenced to 21 months in prison and 3 years supervised release, and ordered to pay \$5,000 in restitution. The second brother was sentenced to 10 months in prison and 2 years supervised release. Earlier he, his wife and the clinic agreed to pay \$1 million to settle civil liability.
- Three persons were sentenced to prison in New York for their participation in a scheme to defraud Medicare, the Social Security Administration (SSA), the Department of Labor (DOL) and various private insurance companies. One person was ordered to serve 27 months in prison and to pay restitution of \$49,400 to insurance companies. She had falsified nursing receipts submitted to the companies for reimbursement. A second person was ordered to serve 24 months and to pay \$66,900 to SSA and an insurance company for falsifying her own disability claims to receive reimbursement.

A third person, a psychologist, was sentenced to 87 months in prison and ordered to pay restitution of \$590,600, of which \$515,900 goes to Medicare and the remainder to DOL and various insurance companies. The psychologist diagnosed people, brought to her by an individual who pled guilty earlier, with post-traumatic stress disorder as a result of auto accidents that never happened. She then billed Medicare, DOL and various insurance companies for services not performed. Some beneficiaries received money for their part in the scheme.

- A Florida podiatrist was sentenced for mail fraud, making a false statement and fraud in relation to false Medicare claims after he had been excluded from the program. In 1991, the podiatrist pled guilty and was sentenced in Pennsylvania for defrauding the Medicaid program, and as a result was excluded from Medicare and State health care programs for 8 years. Later, while still on probation, he moved to Florida and applied for and received a Medicare provider number after making false statements on his application. He then billed Medicare, through the practices with which he was associated, for services to beneficiaries in nursing homes, adult living facilities and outpatient surgery centers as well as at the medical office. He was sentenced to 18 months imprisonment, followed by 3 years supervised release, and ordered to make restitution of \$29,739.
- As a result of an OIG investigation requested by the Iowa Medicare carrier and a county prosecutor, a carrier employee pled guilty to armed robbery and forgery related to Medicare and other insurance fraud. The employee was terminated in May 1997 for failing to come to work for 3 days, after which his theft of two checks from the agency was discovered. One of the checks was payment for Medicare crossover claims. He was also a suspect in numerous crimes in the area. Interviewed in jail, he admitted stealing the checks because he needed to recoup large gambling debts. He was sentenced to 15 years in prison for forgery of the Medicare checks, 10 years for armed robbery and 15 years on each of three remaining counts. All sentences are to be served consecutively, for a total of 70 years.

Hospice Eligibility

In the two reports summarized below, OIG reviewed the eligibility of beneficiaries for the Medicare hospice program.

A. Consolidated Hospice Report

This report consolidated the results of several earlier audits of the Medicare hospice program. Previously, OIG issued 5 individual hospice reports to HCFA recommending that the regional home health intermediaries recover \$17.2 million for payments to ineligible

beneficiaries; another 7 hospices accounting for ineligible payments totaling \$65.8 million are pending further OIG action.

The OIG determined that some hospices failed to adhere to the 6-month prognosis requirement, especially for various noncancer patients; the complexity of the hospice regulations applicable to nursing home patients gave rise to abusive practices; a nationwide chain of hospices engaged in several practices which led to the enrollment of hospice patients who were not terminally ill; and internal controls were weak with respect to physician certifications of terminal illness, claims processing and other areas.

In the consolidated report, OIG made broad recommendations to prevent the various problems and abusive practices identified in its reviews. The HCFA generally concurred with the recommendations in the draft report. The Balanced Budget Act of 1997, enacted after publication of OIG's draft report, resulted in numerous modifications to Medicare's hospice benefit, one of which addressed an OIG recommendation. (CIN: A-05-96-00023)

B. Beneficiary Eligibility at Illinois Hospice Provider

At a hospice provider in Illinois, OIG evaluated the medical records of 224 individuals who had been in hospice care for more than 210 days, the point (at the time of the review) when a beneficiary enters the final authorization period for benefits. The evaluation found that 213 of these beneficiaries were not eligible and that, as a result, Medicare overpaid more than \$10 million.

Because the findings in this report are included in pending criminal and civil cases against the hospice's previous owner, OIG did not recommend that HCFA independently recoup the overpayments. The OIG did, however, reemphasize recommendations made in the roll-up report discussed above, particularly those calling for improved controls over the "cap" (or maximum amount) reporting system used in the reimbursement process. (CIN: A-05-96-00024)

Hospice Patients in Nursing Homes

Performance Measure

Since 1986, patients can receive hospice care either in their homes or in medical facilities, including nursing homes. In an inspection reviewing hospice care provided to nursing home patients, OIG found that hospices receive the same daily reimbursement from Medicare for nursing home patients as they would for patients living at home, even though they provide fewer services in the nursing home setting. Further, OIG identified incentives which might financially reward hospices for premature elections by patients of the hospice benefit. The Balanced Budget Act of 1997 began to address some of these problems by requiring periodic recertification of eligibility. The OIG recommended that HCFA seek legislation to modify Medicare or Medicaid payments for hospice patients living in nursing homes in order to make the program more effective. (OEI-05-95-00250)

In a related report examining the contractual relationships between hospices and nursing homes, OIG expressed concern that some decisions about patient care might be influenced by financial rather than clinical factors. The OIG recommended that HCFA work with the hospice associations to educate the hospice and nursing home communities on avoiding potentially fraudulent and abusive activities that might influence decisions on patient benefit choices and care, and work with the States to develop regulations defining what is included in their nursing home room and board payment. The HCFA concurred with both recommendations. (OEI-05-95-00251)

Clinical Laboratory Tests Performed by Independent Laboratories and Physicians

The objective of this nationwide audit was to determine the adequacy of procedures and controls used by Medicare carriers to process payments for clinical laboratory tests performed by independent and physician laboratories. Specifically, the OIG review was designed to determine whether certain chemistry, hematology and urinalysis tests were appropriately grouped together (bundled into a panel or profile) and not duplicated for Medicare payment purposes and whether certain additional automated hematology indices paid by the Medicare program were ordered by physicians.

The OIG estimated that, nationwide, Medicare carriers overpaid independent and physician laboratories about \$50.2 million for these three types of tests during the period July 1, 1993 through June 30, 1995. For the same period, an additional \$30.8 million could have been saved if policies had been adopted to preclude payment for additional automated hematology indices.

The OIG recommended that HCFA direct Medicare carriers to implement procedures and controls to ensure that clinical laboratory tests are appropriately grouped together, not duplicated for payment purposes and actually ordered by physicians. Also, OIG proposed that HCFA consider eliminating separate reimbursement for additional indices and that the identified potential overpayments be recovered through coordination with applicable investigative agencies. The HCFA generally concurred with the recommendations and agreed to take corrective action. (CIN: A-01-96-00509)

Laboratory Fraud

During Fiscal Year (FY) 1997, OIG, in coordination with DOJ and other law enforcement agencies, concluded a 3-year initiative targeted at abusive marketing and billing practices by the Nation's largest independent clinical laboratories. The initiative grew out of an audit and a criminal investigation of one of the Nation's largest laboratories and its fraudulent schemes involving the "unbundling" of clinical laboratory tests.

During the course of this initiative, OIG found numerous problems in the ways that most independent clinical laboratories were charging Medicare for clinical tests. In turn, industry awareness of the initiative spawned a series of qui tam lawsuits against laboratories. Under the qui tam provisions of the False Claims Act, a private party may sue on behalf of the Government to recover damages and penalties flowing from the submission of false claims to the Government. The Act requires the party to file the action under seal and to disclose all material evidence to DOJ, which conducts an investigation to determine whether the Government should intervene. In its investigation, DOJ works closely with the Federal agency allegedly victimized. The private party initiating the suit is awarded a portion of any damages or penalties assessed. These qui tam cases, as well as audits and investigations of smaller laboratories, are significant not only because of the recovery of Medicare funds but also because they highlight vulnerabilities that continue to put Medicare at risk.

Several successful laboratory cases were completed during this period, of which the following are examples:

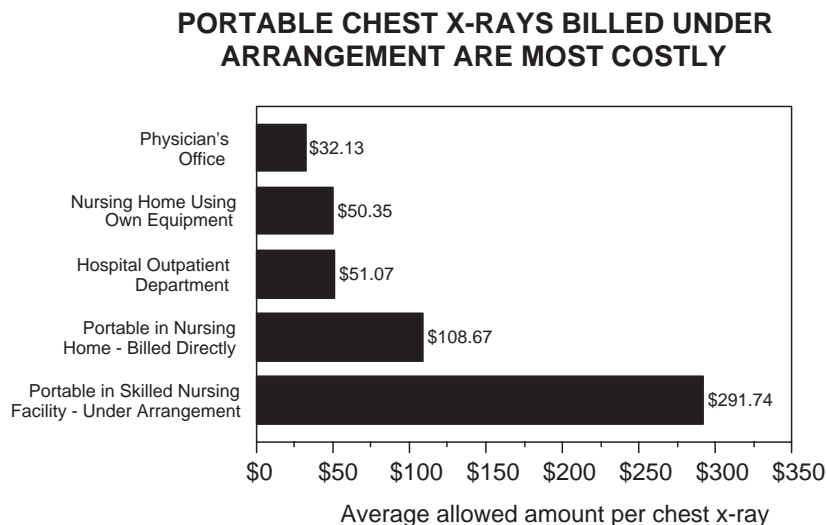
- A nationally known provider of ultrasound and imaging diagnostic tests agreed to pay \$4.2 million to settle allegations it entered an illegal arrangement with doctors throughout the United States. The laboratory marketed its services to doctors who were not trained to interpret test results, telling them they could bill for the professional component of the tests. When a doctor ordered an imaging test from the laboratory, it billed Medicare for the technical component. It then sent the test to a specialist for interpretation, who did not bill Medicare but charged the referring doctor a low flat rate. The doctor then billed Medicare for the professional component and got the difference between the specialist's fee and the Medicare-allowed amount. As a result, the laboratory received a total of \$2.1 million in Medicare payments to which it was not entitled.
- In Illinois, another laboratory and its owner agreed to settle civil allegations that they submitted false claims totaling more than \$1.6 million for transtelephonic EKGs. The services were supposedly provided to nursing home patients in Illinois, Indiana, Michigan, Tennessee, Kentucky, and North and South Carolina. The services were either medically unnecessary or never rendered. The owner had dissipated a large part of his assets, and therefore the amount of settlement was only \$200,000, including \$12,000 in EKG equipment. The owner agreed to a lifetime program exclusion.
- In New Jersey, the physician owner of a laboratory entered a civil settlement agreement to pay the Government \$500,000 for submitting false Medicare claims. The physician performed various non-invasive tests on large groups of Medicare beneficiaries living in senior citizen apartment complexes. He

billed Medicare for tests that were medically unnecessary and were not ordered by the patients' attending physicians.

Portable Imaging Services

Nursing homes arrange for ancillary services, such as x-rays, for patients who require them. Portable x-ray and EKG services provided to nursing home patients may be billed either by a skilled nursing facility to the Part A fiscal intermediary (billing under arrangement) or by the portable supplier to the Part B carrier (direct billing).

In this inspection, OIG found that portable chest x-rays cost far more than non-portable chest x-rays. The following chart illustrates the stark differences in cost of nursing home resident chest x-rays taken in 1994.



The OIG found that more than 60 percent of chest x-rays rendered to nursing home patients were performed by portable x-ray suppliers in 1994.

Based on these and other findings, OIG's draft report to HCFA included recommendations for changes that would have saved an estimated \$66 million in 1 year. Subsequent to release of the draft report, the Balanced Budget Act of 1997 was enacted. While the Act contains provisions which address the intent of OIG's recommendations, including establishment of a prospective payment system for beneficiaries in Part A covered stays in skilled nursing facilities, OIG is concerned that the cost of ancillary services has been inflated by the practices described in its report. Accordingly, OIG recommends that, in implementing the Balanced Budget Act, HCFA take into account the inflated charges for services billed under arrangement and transportation charges that were excessive or prorated incorrectly. (OEI-09-95-00090)

In a related report examining nursing home perspectives, OIG concluded that patients in nursing homes routinely receive portable services because portable services are less costly and more convenient for nursing homes and they believe that portable services are easier and more convenient for the patient. Respondents were unable to shed much light on the reasons for billing under arrangement. The OIG also noted that records of patients receiving portable services are not secure.

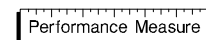
The OIG recommended that HCFA enforce the current requirement that physicians justify the need for portable services, which could save as much as \$63.7 million in 1 year, and remind nursing homes that suppliers should not have access to patient records. (OEI-09-95-00091)

Medical Equipment Suppliers: Assuring Legitimacy

In this inspection, OIG set out to determine whether persons who obtain DME billing numbers are operating bona fide businesses. Of the 420 enrolled suppliers and 35 new applicants reviewed, OIG found that 1 of every 14 suppliers and 1 of 9 new applicants did not have a physical address. Moreover, 41 percent of the suppliers and 40 percent of new applicants failed to meet at least one Medicare standard, such as the one related to warranties. The OIG noted that oversight of suppliers who work out of their homes is difficult since they are typically away during normal business hours. Further, the ease and low cost of obtaining a DME number may encourage abusers to get into the program.

To help ensure ethical DME suppliers, OIG recommended that HCFA charge an application fee, require a surety bond, conduct on-site visits, require training for new suppliers, increase the review of inactive numbers, seek authority to require applicants' Social Security numbers and impose a 6-month wait for denied applicants to reapply. The HCFA concurred with the recommendations and various actions have since been taken. For example, the Balanced Budget Act of 1997 authorized Medicare to collect Social Security numbers and required suppliers to have a surety bond. (OEI-04-96-00240)

Medicare Orthotics



An orthosis is a device applied to the outside of the body that supports a body part. In a review of billing for Medicare orthotics, OIG found that at least 19 percent of those provided were medically unnecessary, representing \$6.4 million in Medicare payments. Another 5 percent of orthotic devices were medically questionable, representing \$1.5 million.

The Medicare orthotics industry is fairly evenly divided between two types of suppliers: orthotists and DME companies. According to the billing review, 68 percent of questionable cases were supplied by DME companies, in contrast to 35 percent of orthotist cases. Moreover, OIG determined that the billing controls of the DME regional carriers (DMERCs)

were limited. The OIG also found that 68 percent of the cases in nursing facilities were questionable.

Among its recommendations, OIG proposed that HCFA and the DMERCs develop guidelines that better define orthotic devices; develop policies for orthotic billing codes; develop screens for billing many orthotic devices on the same day or within a short time frame; and pay special attention to billing for orthotics in nursing homes. The HCFA concurred with the recommendations. (OEI-02-95-00380)

Fraud Involving Durable Medical Equipment Suppliers

The DME industry has consistently suffered from waves of fraudulent schemes in which Medicare or Medicaid is billed for equipment never delivered, higher-cost equipment than that actually delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State from that billed in order to obtain higher reimbursement. A few years ago, HCFA published new regulations addressing reimbursement problems that have recurred over the years, especially those created by telemarketing and carrier shopping. Consolidation of claims processing into four regional jurisdictions, as specified in the regulations, may resolve many of these problems. In the meantime, OIG continues to obtain settlements and convictions of unscrupulous suppliers for other schemes. Conspicuous success was especially evident in several DME cases in New York.

- In New York, 3 more persons were sentenced in a case involving a medical supply company and its subsidiaries, bringing to 14 the number sentenced of the 19 originally indicted. A physician was sentenced to 46 months in prison, and ordered to pay \$1.23 million in restitution for signing certificates of medical necessity (CMNs) for patients he never saw. A woman was sentenced to 1 year probation for her part in laundering money from two company subsidiaries. Conspirators at the company arranged to have about \$100,000 paid to a company the woman worked for, and she gave the checks to her boss, since deceased, who put them in his account for subsequent payoffs. The woman returned to the Government some \$57,000 intended for payoffs. Also, an accountant was sentenced to 4 years probation and fined \$30,000 for aiding and assisting in filing false tax returns. The accountant arranged for large sums of monies to be laundered through the bank accounts of the company's subsidiaries. He was granted a downward departure from sentencing guidelines because of his cooperation in the investigation of several participants. Two subjects remain for legal action in this case, one of whom is a fugitive.
- In New York, the former owner of a DME company was sentenced to 33 months imprisonment and 3 years probation, and ordered to pay \$2.5 million in restitution for his part in a multi-million-dollar Medicare fraud

scheme. The owner supplied air conditioners, televisions and microwaves to beneficiaries in exchange for their Medicare numbers, then billed Medicare \$12 million for DME not medically necessary. Two company sales personnel and the physician who signed the CMNs have also pled guilty. The owners' co-conspirator is believed to have fled to Russia.

- Another DME company owner was also sentenced in New York, after a trial conviction for filing false Medicare claims, paying kickbacks and money laundering. He paid physicians kickbacks in return for patient referrals and CMNs for equipment such as lymphedema pumps. The owner not only made cash payments to doctors but also purchased items such as computers, jewelry, and Rolex watches to conceal his kickbacks. In one instance, he even fabricated the purchase of a medical practice. The fake purchases earned him the money-laundering conviction. He was sentenced to 70 months in prison and 3 years supervised release, ordered to pay \$100 in special assessments, and made to forfeit \$335,000 in cash and 3 vehicles.
- Investigations in two other cases resulted in convictions and same-day sentencing of two owners of DME companies. The owner of one company must serve 6 months home detention and 5 years probation. He had paid a physician informant \$3,380 in kickbacks for signing fraudulent CMNs, for which Medicare paid him \$25,370 -- which he must repay. The co-owner of another DME company paid the same physician informant \$5,760 in kickbacks for CMNs, for which Medicare paid \$123,600. Both were videotaped paying the kickbacks. The co-owner of the second company was scheduled for jail, but the judge ordered 5 years probation, and no restitution, on the basis of personal problems.
- Yet another owner/operator of a New York DME company was sentenced to 5 years probation and ordered to pay \$20,000 in restitution for conspiracy to pay kickbacks. He supplied air conditioners, microwaves, seat lift chairs and angora underwear to Medicare beneficiaries in exchange for their accepting back supports, then billed Medicare for DME not supplied. He received a downward departure from sentencing guidelines because of his cooperation in investigations of several DME companies.

Successful DME cases elsewhere are shown in the following examples:

- In Florida, two sisters and the two companies they owned agreed to pay a total of close to \$1.6 million to resolve liability for billing Medicare for DME that was either not provided as claimed or medically unnecessary. One sister and her company agreed to pay more than \$1.5 million, while the

second and her company agreed to pay \$44,690. The sisters deposited the Medicare reimbursements in their joint personal account and used the money to buy real estate. They both agreed to permanent exclusion from Medicare and State health care programs.

- A North Carolina man was sentenced to a term of 87 months incarceration and 2 years supervised release for defrauding the Medicare program. He also was ordered to pay a special assessment of \$300 and more than \$1.86 million in restitution. The man established numerous fictitious medical supply companies supposedly doing business in the Charlotte, North Carolina area. He and other persons used the firms to bill Medicare for over \$13 million for nonexistent supplies, of which more than \$2 million was approved. The carrier, however, placed about one half of the funds in an escrow account pending resolution of the investigation. When Medicare denied payment, the culprits shifted the scheme to private insurance. During the investigation, the Government seized three residences, one franchise business, seven automobiles, 35 bank and investment accounts, cash, travelers checks and jewelry. Sentencing is pending on three additional defendants, and two others have fled the country.
- The owner of an orthotics and prosthetics center was sentenced in Texas to 25 months imprisonment and 5 months home confinement for Medicare fraud. He was also ordered to pay \$172,930 in restitution. He had furnished prostheses to beneficiaries and then billed Medicare for additional parts not supplied.
- A sales representative for a now-defunct Alabama DME company was sentenced to 18 months in prison for filing \$900,000 in fraudulent Medicare claims. The woman went from door to door in California, soliciting beneficiaries' Medicare numbers for \$100 to \$200. She got a physician to sign blank CMNs, photocopied the blank CMNs and filled them in as she got Medicare numbers from beneficiaries. Over a 3-month period, she received \$82,000 in commissions for submitting false claims for lymphedema pumps and alternating pressure pads.
- A Pennsylvania DME manufacturer agreed to pay \$50,000 to resolve liability for involvement in violation of Medicare point-of-sale rules. Independent dealers of the company's equipment -- with the owner's knowledge and assistance -- billed carriers in other regions rather than the region in which the equipment was sold, to obtain higher reimbursement. Separate criminal and civil proceedings were brought against the dealers which resulted in recoveries of \$3.4 million.

Excessive Medicare Payments for Prescription Drugs

Performance Measure

The OIG compared Medicare allowances for drugs with drug acquisition prices available to the physician and supplier communities. The OIG found that Medicare payments for 22 drugs exceeded actual wholesale prices by \$447 million in 1996. For the 22 drugs reviewed, Medicare payments based on manufacturers' published average wholesale prices were 41 percent higher than the actual wholesale prices available. For more than one-third of the 22 drugs reviewed, Medicare paid more than double the actual average wholesale price available to physicians and suppliers. The OIG also found that there is no consistency among carriers in establishing and updating Medicare drug reimbursement amounts.

The information in this report provides further support for a recommendation made in an earlier report, "Medicare Payments for Nebulizer Drugs," in which OIG proposed that HCFA reexamine its Medicare drug reimbursement methodologies with a goal of reducing payments as appropriate. The HCFA concurred with the recommendation. In this report, OIG also recommended that HCFA require all carriers to reimburse a uniform allowed amount for each common procedural coding system drug code. (OEI-03-97-00290)

Prescription Drug Use in Nursing Homes

Performance Measure

The use of inappropriate or contraindicated drugs may be a contributing factor to the high health care costs in the elderly population as well as a quality of care concern. The OIG undertook an inspection, using three different approaches, to provide insight into several issues relating to prescription drug use in nursing homes.

The first report describes prescription drug use in Texas nursing facilities. The second report presents the results of a national survey of consultant pharmacists who perform federally-mandated monthly drug regimen reviews in nursing homes. The third report discusses the results of a pharmaceutical review of 254 sampled Texas nursing home patients and includes OIG's specific recommendations.

Medication problems and concerns raised collectively by these three coordinated reports demonstrate the need for stronger monitoring and more positive enforcement of existing regulations and required reviews of medication usage in nursing homes. Accordingly, OIG recommended that HCFA continue to monitor and encourage reductions in the use of potentially inappropriate prescription drugs in the elderly nursing home population; work with other Federal and State agencies to identify and analyze reasons for the rapid escalation in costs and claims for certain types of drugs used in nursing homes; strengthen the effectiveness and impact of medication reviews conducted by consultant pharmacists in nursing homes; require nursing homes to ensure that the curriculum for required ongoing, in-service training for personal care staff includes information on how to recognize and report signs of possible contraindications, adverse reactions or inappropriate responses to medications; strengthen and enforce coordination and communication among the involved

health care team members in nursing homes; and more vigorously pursue enforcement of resident health outcomes. The HCFA concurred with the recommendations. (OEI-06-96-00080; OEI-06-96-00081; OEI-06-96-00082)

Review of Epogen Reimbursement

The OIG found that the current Epogen (EPO) Medicare reimbursement rate of \$10 per 1,000 units administered exceeds the current cost of purchasing EPO by approximately \$1. The Social Security Act provides that the Secretary may set an appropriate reimbursement level for EPO beginning January 1, 1995. Accordingly, OIG recommended that the Secretary consider reducing Medicare reimbursement to \$9 per 1,000 units administered, resulting in savings to Medicare of approximately \$94 million and to its beneficiaries of approximately \$24 million per year beginning in 1998. In response to the draft report, HCFA concurred and agreed to pursue this change. In fact, the President's FY 1999 budget calls for a 10 percent reduction in the EPO reimbursement rate. (CIN: A-01-97-00509)

Medicare Ambulance Payments

The OIG determined that policy on Medicare payments for ambulance services lacked common sense. In 26 States, Medicare paid more for routine, nonemergency basic life support (BLS) transportation than it did for advanced life support (ALS) emergency transportation. Moreover, ambulance payment policies were vulnerable to fraud and abuse. The complexity of the then current system enabled transportation suppliers to bill for ALS services when BLS services were provided, misrepresent the patient's true medical condition and avoid carrier program safeguards. Carriers reported widespread abusive situations involving unnecessary transports, oxygen, EKGs and other services. Over the past 5 years, OIG had more than 100 convictions involving ambulance suppliers.

The OIG concluded that these problems were the result of extremely complex payment methods and inconsistent policies, and recommended that HCFA seek legislative authority to develop a fee schedule for ambulance transportation. Actual savings from simplification and more uniform policies would depend on how base rate and mileage were defined and the fee schedule allowances for them, but, if implemented as suggested, OIG projected that Medicare could save at least \$242 million annually. Since issuance of OIG's draft report, the Balanced Budget Act of 1997 was enacted, requiring that HCFA establish a fee schedule for Medicare ambulance payments. (OEI-05-95-00300)

State Ambulance Policies and Services

Medicare ambulance costs and services skyrocketed to almost \$2 billion in 1995. In this study, OIG found that all States regulate ambulance services; however, less than half mandate levels of service and only one -- Hawaii -- requires advanced life support services. Only two States use Metropolitan Statistical Areas and non-Metropolitan Statistical Areas to designate ambulance service areas. Previous OIG studies have recommended that HCFA

base reimbursement on the patient's condition rather than the type of vehicle and personnel used. The OIG continues to support this recommendation. In addition, OIG recommended that HCFA reevaluate its proposal to use the Metropolitan Statistical Area/non-Metropolitan Statistical Area designation as the basis for granting waivers when determining a waiver policy in its final rule on ambulance coverage. The HCFA concurred with the recommendations. (OEI-09-95-00410)

Transportation Fraud

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

- In New York, the owner of an ambulance company was sentenced after pleading guilty to filing a Medicare claim for ambulance transport when an ambulette was actually used. The company was paid more than \$14 million for similar false claims and for transporting ambulatory patients to free-standing dialysis centers. Investigators took videotapes of patients watering their plants and sitting outside waiting for the ambulance. The owner was sentenced to 9 months home confinement and 3 years probation, and ordered to pay \$64,000 in restitution, the cost of electric monitoring and a \$20,000 fine. The judge wanted to impose a jail sentence but agreed to the more lenient sentence after a cardiologist testified to the owner's failing health.
- The owner of a Maryland ambulance company was sentenced to 5 years supervised probation and ordered to pay \$33,990 in restitution for submitting false Medicare claims. He submitted claims for transporting patients to free-standing dialysis centers, which is not covered by Medicare. He also transported multiple patients in the same ambulance at the same time, and then billed Medicare as if each had taken a separate trip.

Medicare Contractor Administrative Costs

Under agreements with HCFA and Blue Cross and Blue Shield, Associated Insurance Companies, Inc. (AIC) reviews, audits and pays Medicare Parts A, B and durable medical equipment claims. The AIC (now known as Anthem) is entitled to reimbursement for reasonable administrative costs subject to limitations specified in the agreements.

The OIG's review of \$87 million in administrative costs claimed by AIC in FY 1994 and 1995 showed that over \$2.5 million was inappropriately claimed. The overclaim resulted

primarily because AIC understated complementary insurance credits, claimed executive salary increases which exceeded average increases for comparable positions, claimed non-Medicare related costs, claimed costs that exceeded actual costs and overstated return on investment. In addition to recommending procedural corrections and improvements to internal controls, OIG recommended a \$2.5 million financial adjustment. In response to the draft report, AIC concurred with \$83,272 of the recommended financial adjustment. (CIN: A-05-97-00005)

Federal and State Partnership: Joint Audits of Medicaid

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

To date, partnerships have been developed with 19 State auditors, 11 State Medicaid agencies and 2 State internal audit groups. Extensive sharing of audit ideas, approaches and objectives has taken place between Federal and State auditors. Completed reports have resulted in recovered and/or identified overpayments and potential program savings of \$140 million in Federal and State Government funds.

Medicaid Reimbursement to Ohio Nursing Facilities

In a prior report, OIG estimated, based on a statistical sample, that Medicaid overpayments to hospitals and long-term care (LTC) facilities in Ohio totaled about \$29.3 million from January 1989 through December 1992. These overpayments occurred because the State paid LTC providers the full daily per diem rate rather than the 50 percent rate that applies when hospital leave days are used by beneficiaries; paid the normal Medicaid per diem rate to LTC providers for dates of service for which beneficiaries were covered by Medicare; and made duplicate payments to LTC facilities for the same service. The OIG recommended that Ohio identify and recover the actual amount of overpayments made to the providers.

In response, the State engaged a consulting group to review overpayments and to initiate a retroactive recovery process. The consulting group identified over \$34 million in overpayments from January 1, 1989, through May 31, 1996 (a longer period than that covered by the OIG audit). The OIG's follow-up determined that the methodology used by the consulting group to identify Medicaid overpayments was reasonable. The OIG recommended that the State recover the \$34 million overpayment, and Ohio officials concurred with the findings and recommendations in the draft report. (CIN: A-05-97-00028)

Medicaid Payments for Pathology and Laboratory Services in Virginia

To help physicians diagnose and treat ailments, patients often undergo pathology and clinical laboratory tests. Medicaid reimbursement for these tests is limited to the amount paid by the Medicare program. However, a prior OIG review noted that the Virginia Medicaid agency had paid more than Medicare for many laboratory claims in Calendar Years (CYs) 1993 and 1994. This follow-up review found a similar situation for CYs 1995 and 1996, when the agency's payments exceeded the Medicare limits by \$3.2 million (\$1.6 million Federal share). The OIG recommended that the State agency revise its fee schedules and procedures to limit Medicaid reimbursement to those amounts recognized by the Medicare program and adjust its quarterly expenditure report to HCFA for the \$1.6 million overpayment. (CIN: A-03-97-00200)

Reimbursement Method for Indiana Hospital

In an earlier review, OIG determined that a hospital in Indiana had received Medicaid overpayments based on a reimbursement system patterned after the Medicare Tax Equity and Financial Responsibility Act of 1982. Final settlement of reimbursement levels under this system depended on the number of discharges made during a fiscal year. The OIG found that the payment system was unsuitable for the hospital because it served long-term patients and had few discharges. Despite that, the hospital received numerous interim payments from Medicaid and was paid approximately \$800,000 over actual costs in 1991. The OIG recommended that Indiana confer with HCFA to negotiate a settlement with the hospital on all outstanding overpayments.

In this follow-up, OIG reviewed Indiana's proposed settlement of \$3.1 million (estimated Federal share \$2 million) to resolve all overpayment issues for 1988 through 1995. The OIG found the amount to be reasonable and recommended that Indiana go forward with the settlement. (CIN: A-05-97-00029)

Medicaid Fraud

At present, 47 States have Medicaid fraud control units (MFCUs) 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 1997, OIG administered approximately \$80.5 million in grants to the MFCUs to facilitate their mission. The MFCUs reported __ convictions and \$__ million in fines, restitutions and overpayments collected for the period July 1, 1997 through December 31, 1997.

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 results in these cases bear noting:

- An Ohio man and his corporation, which operated four group homes for the mentally retarded, were sentenced after being convicted on 44 counts related to Medicaid fraud, including theft of Government funds, mail fraud, Medicaid false claims and money laundering. Between 1990 and 1994, the man and the corporation filed Medicaid cost reports containing falsified expenses for the homes, including personal expenses, invoices for fictitious services or supplies, and inflated expenses. He had actually spent the money to hire a go-go dancer as a consultant, to install a sound system for a go-go nightclub and for various other personal pleasures. The man was sentenced to 4 years incarceration, and he and his corporation were ordered to pay \$423,260 in restitution. The loss to Medicaid over a 2-year period was more than \$490,000. The corporation owner, who has a doctorate and is a former college professor, pled guilty in 1989 to drug trafficking and theft.
- A Washington, D.C. taxi driver was sentenced to 14 months in prison for Medicaid fraud. From December 1993 through March 1995, he obtained blank taxicab vouchers from sources inside several health care facilities. He filled out the vouchers, using inter-State destinations to obtain a high reimbursement rate. He submitted the vouchers for Medicaid reimbursement, thereby defrauding the program of \$31,890. The taxi driver had been investigated by the OIG earlier and prosecuted for working the same scheme.
- An Illinois hospital agreed to pay \$75,000 to settle its civil liability for submitting false claims to Medicaid. Through one of its physician employees, the hospital billed Medicaid for acupuncture services related to its drug and alcohol program. The hospital knew or should have known that Medicaid does not cover acupuncture. The hospital refused to enter a corporate integrity agreement, and the Department reserved its right to pursue permissive exclusion. The settlement amount is approximately 3.5 times the overpayment.
- A State Medicaid agency returned more than \$1.7 million it overpaid for ventilator-dependent clients. It paid a capitation rate for acute care in addition to the capitation rate for ventilator-dependency in 1994, 1995 and 1996. The overpayment was discovered in the course of another investigation of the agency. Since the system used by the agency for this

period was closed out at the end of 1996, the overpayment probably would not have been discovered otherwise.

**Public Health Service
Operating Divisions**

Chapter II

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Overview of Program Area and Office of Inspector General Activities

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

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

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

Results-Based Systems for Public Health Programs

Performance Measure

The Department has been considering performance partnership grants for some of its public health programs for several years. At the request of the Assistant Secretary for Planning and Evaluation, OIG reviewed results-based initiatives in the preventive health, maternal and child health, substance abuse and mental health programs of several States. The results-based accountability initiatives examined were generally of two types: broad efforts at Statewide strategic planning and priority setting, and systems focused on target populations and specific program interventions. The OIG found that the 11 States reviewed had several characteristics in common: public pressures for better government, top-level commitment and extensive stakeholder involvement. While State officials saw many benefits from development and implementation of results-based systems and were using data in various ways, they noted that it would be inappropriate to base programmatic, budgetary or contracting decisions solely on such data. The OIG identified several issues confronted by the States in developing their accountability systems (formulation of the measures themselves; the availability, reliability and timeliness of the data; the use of the results; and system capacities) and outlined many of the challenges facing the Department as it considers future directions for its performance partnership grant initiative. (OEI-05-96-00260; OEI-05-96-00261)

Contract/Grant Fraud

Resolution of charges of misusing grant funds from NIH occurred in two cases involving universities:

- A civil lawsuit was settled against an Illinois university and a former professor of obstetrics, gynecology and pathology there, for misapplying approximately \$550,000 in grant funds from NIH. The university had received a grant totaling \$1.9 million over 7 years to design and implement a computer-based system to help cytopathology laboratories diagnose cervical cancer and precursor lesions. In about the sixth year, the university notified NIH that the professor was suspected of misapplying grant funds. The OIG found he used some of the funds for salaries, computer maintenance, telephones and equipment in connection with other, private business. The university is to pay \$250,000 and the professor \$400,000 to settle the suit.
- In California, a U.S. Attorney's office received a check for \$135,999 from a university, completing the terms of a civil agreement for a researcher's falsification of research data submitted to NIH. The university also paid

\$30,000 to the relator's counsel. A former university staff member had entered a qui tam alleging the false data was submitted for the purpose of obtaining a grant for immunology research. The relator received \$10,125.

Internal Controls over Purchase Card Activities

During this reporting period, OIG made two reviews of internal controls over purchase card activities. These cards provide a cost-saving method of making small purchases.

A. National Institutes of Health

In a review of NIH's internal controls over and use of purchase cards, OIG determined that NIH had generally designed and implemented adequate management controls. However, OIG made recommendations to improve those controls in such areas as separation of duties, payment of sales taxes and recording of sensitive property procurements. The NIH generally concurred with the recommendations. (CIN: A-15-96-80003)

B. Food and Drug Administration

In a similar review at FDA headquarters, OIG found the agency to be in compliance with guidelines issued by the General Services Administration. However, because certain basic internal controls, such as separation of duties, are inherently missing in FDA's purchase card system, OIG recommended that FDA evaluate the effectiveness of its compensating controls. The FDA concurred with the recommendation. (CIN: A-15-97-80002)

State AIDS Drug Assistance Programs

Performance Measure

Recent amendments to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act require States to use a portion of CARE Act funds for AIDS drug assistance programs. If they elect to do so, these programs may participate in the 340B program, which provides discount prices for drugs purchased directly from manufacturers or wholesalers.

In analyzing 1996 expenditures for five large State AIDS drug assistance programs that chose not to participate in the 340B drug pricing program, OIG found that the programs could have purchased an additional \$4.4 million (8 percent) in drug therapies had they participated. Since participation in the 340B drug pricing program holds significant potential for providing additional drug therapies and improving the quality and length of life for individuals with AIDS, OIG recommended that HRSA take several actions to encourage such participation. In response to the draft report, HRSA agreed with most of these recommendations. (CIN: A-01-97-01501)

Exclusions for Health Education Assistance Loan Defaults

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

After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Once the individual has been declared in default, the Social Security Act permits, and in some instances mandates, exclusion from Medicare and State health care programs for nonpayment of these loans. During this 6-month period, 193 individuals were excluded as a result of PSC referral of their cases to OIG.

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

At the conclusion of this reporting period, 900 individuals had taken advantage of the opportunity and entered into settlement agreements or completely repaid their HEALs. The amount of money being repaid, through settlement agreements or through complete repayment, totals over \$55.7 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 debt, an Ohio osteopath entered into a settlement agreement to repay almost \$176,000.
- Two Illinois physicians signed settlement agreements to repay their HEAL debts after being excluded for defaulting on their obligations. One agreed to repay over \$161,000, and the other over \$306,600.
- A settlement agreement was signed by a New York podiatrist to repay his HEAL debt of over \$203,000.
- A Connecticut dentist entered into a settlement agreement to repay a HEAL debt in excess of \$172,000.

- Shortly after being notified of his exclusion for defaulting on his HEAL debt, a Florida physician entered into a settlement agreement to repay over \$238,000.

Superfund Financial Activities at the Agency for Toxic Substances and Disease Registry

The Hazardous Substance Response Fund, commonly known as the Superfund, is used to respond to emergency environmental hazards and to pay for removing toxic substances. Through agreements with the Environmental Protection Agency, certain HHS agencies receive Superfund money to carry out health-related activities mandated by law.

During FY 1996, ATSDR obligated about \$58.7 million in Superfund monies and disbursed approximately \$59 million obligated during and prior to that year. The OIG concluded that the agency generally administered the Superfund monies in accordance with applicable laws and regulations. However, OIG determined that ATSDR should ensure that all grantees obtain and submit required independent audit reports; maintain adequate supporting documentation related to its interagency agreement for administrative and support services with CDC; and submit the Minority Contractor Utilization Report to EPA in a timely manner. In response to the draft report, ATSDR concurred with OIG's recommendations. (CIN: A-04-97-04599)

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

Chapter III

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. The major programs 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 Personal Responsibility and Work Opportunity Act of 1996 eliminated the AFDC, EA and JOBS programs as of FY 1997 and created the Temporary Assistance for Needy Families (TANF) block grant, which was designed to reduce dependency on welfare programs. The block grant eliminated individual entitlement to assistance, established time limits on benefits and set strong work participation requirements. However, the Act gave States and tribal governments greater flexibility to establish and operate programs structured to their needs. While the Federal role in TANF has changed, OIG will continue to ensure program integrity, identify opportunities for program improvement, and provide Federal and State management with useful information regarding the goal of moving individuals and families from welfare dependency to self-sufficiency.

In addition, OIG reviews the Department's programs that serve children, and has issued 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.

Child Support Enforcement

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

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. More recently, OIG has expanded its participation in child support cases under a deputation from DOJ to include all violations of the Child Support Recovery Act.

The OIG has made the investigation of these matters a high priority. It is a member of the DOJ task force established by the President to develop "best practice" approaches to the enforcement of the Child Support Recovery Act. The OIG is a major participant in several pilot programs designed to develop these investigative practices.

To date, OIG has initiated over 250 child support cases nationwide. These cases have resulted in approximately 77 arrests, 50 convictions, and court-ordered restitution of close to \$5.7 million. Prosecutions in this area are unique in that sentences ordered by a judge take into account the need for the defendant to continue to be able to pay. Therefore, alternative sentencing options -- such as work release, home detention and probation where nonpayment is a violation -- are ordered.

In several Federal districts, the U.S. Attorney's office has been aggressive in pursuing child support enforcement cases. One of the first to be most active was the Eastern District of Virginia, which dubbed its operation "Long Arm" and vigorously prosecutes nonpaying parents OIG turns up. The following examples illustrate some of the circumstances involved in the Virginia cases:

- The man who had been at the top of Virginia's 10 most wanted "deadbeat dads" list since 1991 was sentenced to 8 nights in jail and 5 years probation. The judge told him that if he "survives jail" he will have to pay the \$54,290 he owes in child support and \$5,960 in unpaid medical bills for his

11-year-old son living in Virginia. The man fled to Florida in 1988 and avoided detection by working under false social security numbers and not filing income tax returns. He also has three children in Pennsylvania by his first wife and two more in Kentucky by another wife. Until recently, he never supported any of his children, despite his earning more than \$40,000 a year. His son went to the sentencing with his mother because he wanted "to see what his father looked like."

- Another man was sentenced to 60 days in jail for failure to pay child support. The man, who lives in Florida, had been ordered to pay \$629 a month in the support of his two children, but he had made no payments since April 1995 despite being employed and owning more than \$28,000 in common stock. As part of his sentence he was ordered to pay the \$27,000 he owed in past-due child support.
- A man who had not made a payment since October 1992 pled guilty and was sentenced to 5 years probation, directed to spend 5 weekends in jail and ordered to pay more than \$24,660.
- Another man who also pled guilty was sentenced to 5 years probation and ordered to pay \$15,540 in restitution.

In all, 11 individuals were successfully prosecuted in the Eastern District of Virginia during this period for failing to pay court-ordered child support. The following cases are examples of some of these cases successfully prosecuted elsewhere:

- A man who now resides in North Carolina where he operates a commercial and residential roofing business pled guilty in a Maryland Federal court to violating the Child Support Recovery Act. When the man and his wife divorced, a Maryland county court awarded her custody of their child and ordered him to pay \$288 a month in child support. He was indicted in August 1997, owing \$10,000. At the time of his arrest he turned over \$7,700 as a term of release, and when he pled guilty he paid \$3,200 -- the rest of the arrearage plus the payment for September. The man was sentenced to 5 years probation and is specifically required to continue the \$288 monthly payments.
- After pleading guilty and paying his arrearage, a man was sentenced in Texas to 5 years probation and a \$10 special assessment for failing to pay \$14,970 in child support for his 10-year-old son who lived in California with his former wife. The father was employed as a computer specialist with an investment company and earned \$73,540 in 1996.

- In Oklahoma, a man was sentenced to 6 months probation and ordered to pay the \$51,500 in arrears in child support. In 1978, he had been ordered to pay \$75 per month for each of his three children who lived with their mother in Oklahoma. He left Oklahoma for Montana, where he has been living with his current spouse since 1992. Between the two, they have an income of over \$50,000.

States' Child Care Certificate Systems: An Early Assessment of Vulnerabilities and Barriers

Performance Measure

In this review of States' child care certificate systems under the Child Care and Development Fund, administered under the Child Care and Development Block Grant, OIG found that parental choice may be restricted by low provider payment rates and high copayment rates. Further, OIG noted that child care consumer education appears limited, and State efforts may not be sufficient to ensure that health and safety standards are met. The OIG recommended that ACF set forth the goal that States monitor all providers through professional inspections and know the backgrounds of all providers through background checks; help States establish background registries and a toll-free number to report problems and concerns; disseminate information about effective ways to enhance consumer education; and help States devise outcome measures of quality consumer education. The ACF concurred with OIG's recommendations. (OEI-05-97-00320)

Foster Care

During this reporting period, OIG conducted two reviews to determine whether Federal funds available under the title IV-E foster care program were appropriately used in State foster care programs.

A. Retroactive Claims Submitted by Indiana

In 1990, Indiana contracted with a consultant to enhance Federal reimbursement by identifying additional eligible foster care claims. Under the contract, the consultant was to receive a 15 percent contingency fee based on the incremental increase in retroactive claims submitted to ACF as prior-quarter adjustments. The OIG initiated an audit of these claims because a previous ACF/OIG review had found that \$6.4 million in retroactive claims developed by the same consultant covered ineligible children or duplicated other claims.

The OIG's recent audit determined that documentation was not available to support \$8.5 million in retroactive claims submitted by Indiana. These claims represent prior-quarter adjustments, applicable to calendar year 1993, which were developed by the consultant and submitted to ACF during 1995. In response to OIG's recommendation, the State adjusted its next quarterly claim for the \$8.5 million in unsupported costs. (CIN: A-05-97-00026)

B. Rate-Setting Methodology for Foster Family Agencies in California

In California, county welfare departments contract with foster family agencies to provide services to or on behalf of foster children. With few exceptions, the children placed by these agencies have emotional or behavioral problems requiring treatment services. To compensate the agencies for children in the treatment program, State payment rates cover several cost components, including administrative costs (which are federally reimbursed at 50 percent) and social work costs (which are not eligible for Federal reimbursement).

The OIG's review found that the rates established for the administrative component were too high and that administrative payments claimed as costs to the title IV-E program were significantly greater than the costs reported as incurred by the foster family agencies. The review also noted that the rates established for the social work component, while not federally reimbursable, provided payments to the agencies that were significantly lower than the costs reported. The OIG recommended that the State review the rate methodology and make revisions to ensure that only costs necessary for the proper and efficient administration of the title IV-E foster care program are claimed for Federal reimbursement. (CIN: A-09-96-00082)

Discretionary Grants Awarded to Alleviate Poverty

The ACF's Office of Community Services (OCS) makes discretionary awards under its Block Grant program to help alleviate the causes of poverty in distressed communities. As discussed below, two OIG reviews focused on the accountability of grantees that receive such awards and the achievement of grant objectives.

A. Risk of Awarding Equity Investment Grants

Certain OCS awards permit grantees to acquire equity investments (stock purchases) in other organizations which, in turn, are expected to create new jobs for low-income individuals. The OIG's review determined that this type of grant severely limits the Government's ability to examine the use of grant funds redistributed to subsidiary organizations. The achievement of grant objectives is difficult to monitor, and the accountability of responsible parties for the funds and the disposition of assets is impaired. As a result, OIG recommended that ACF prohibit these grant arrangements or include the necessary terms and conditions that would protect Federal interests. The ACF agreed and indicated that steps were being taken to protect Federal interests. (CIN: A-12-97-00007)

B. Grants Awarded in Mississippi

Performance Measure

From 1991 through 1995, a private corporation in Mississippi received four grants totaling \$1.43 million to create permanent full-time jobs for low-income residents of the local community. The OIG found that the corporation did not create permanent full-time jobs; used Federal funds for a wide range of purposes unrelated to the grant objectives; did not provide the private cash and in-kind services it had proposed to ensure the success of the

grants; and submitted reports to OCS that were often untimely and inaccurate. As a result, the \$1.43 million intended to assist families in climbing from poverty provided little or no benefit. In addition to recommending that these funds be repaid to the Federal Government, OIG proposed that the corporation strengthen its management controls and demonstrate the capability to properly manage and expend any future Federal grants. Corporation officials agreed that their grants management controls needed strengthening but did not agree to refund the grant funds. (CIN: A-04-96-00105)

Community Services Block Grants in Puerto Rico

Performance Measure

To reduce the causes of poverty, grantees in Puerto Rico received \$32.9 million through the Community Services Block Grant Program from October 1, 1994 to September 30, 1996. The OIG found that Puerto Rico did not follow established policies and procedures in evaluating the merit of proposed projects and did not effectively monitor grantees after funds were awarded. As a result, there was no assurance that the Block Grant funds were used in the most beneficial manner.

The OIG recommended that the Commonwealth develop a system that will provide funding only to those grantees that design programs with the most potential for reducing the causes of poverty; adhere to established policies and procedures for monitoring and documenting grantee performance; and evaluate current programs to determine grantee effectiveness in accomplishing goals and objectives. In commenting on the draft report, Puerto Rico officials generally agreed with OIG's findings and recommendations. (CIN: A-02-96-02004)

Protection and Advocacy for the Disabled

During FY 1996, a private nonprofit corporation in Pennsylvania received \$2 million in Federal funds to provide protection and advocacy services to people with disabilities as defined in Federal statute. The funds were furnished by the Department's Administration on Developmental Disabilities and Center for Mental Health Services, as well as the Department of Education's Rehabilitation Services Administration.

The OIG found that the corporation's financial management practices were generally sufficient to ensure that expenditures charged to Federal grants were allowable and reasonable. However, OIG noted that program income earned by subcontractors was not reported to the corporation for reuse in the program, certain unallowable costs were charged to the Federal grants, and financial status reports could not be reconciled to financial statements and general ledgers. The corporation generally agreed with OIG's recommendations, which focused on improving accountability for program income amounting to over \$400,000 a year. (CIN: A-03-97-00516)

Maryland's Ombudsman for the Elderly

Performance Measure

Ombudsman programs play an important role in helping to ensure that the elderly are properly cared for and are protected from abuse in long-term-care facilities, such as nursing homes. Ombudsmen are responsible for overseeing these facilities and for identifying, investigating and resolving complaints of abuse, neglect and exploitation.

The OIG's review in Maryland found that the local ombudsmen did not always follow State procedures for reporting and investigating incidences of abuse. Also, the State ombudsman had not made annual monitoring reviews of over half of the local ombudsmen programs, and the Geriatric Nurse Aide Registry, which is required to flag nurse aides who have abused the elderly, did not always do so. As a result, nursing facilities that consult the registry to determine an aide's fitness for employment would not be aware of his or her history of abuse. The OIG recommended several improvements, and Maryland's Office on Aging said it would work diligently to implement them. (CIN: A-12-96-00016)

General Oversight

Chapter IV

GENERAL OVERSIGHT

Introduction

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

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

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from 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 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. Also, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG is responsible for auditing the Department's financial statements beginning with the FY 1996 statements.

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

Nonfederal Audits

The OMB Circular A-133 establishes the audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, these entities are required to have an annual organizationwide audit which includes all Federal money they receive.

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the first half of FY 1998, OIG's National External Audit Review Center (located in Kansas City) reviewed over 1,700 reports that covered over \$452 billion in audited costs. Federal dollars covered by these audits totaled \$106 billion, about \$46 billion of which was HHS money.

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

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

A. Office of Inspector General's Proactive Role

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

- Through evaluation of reported data, OIG is able to provide basic audit coverage and analyze reports to identify entities for high-risk monitoring and trends that could indicate problems within HHS programs. These problems are brought to the attention of departmental management to improve program administration. In addition, OIG profiles nonfederal audit findings of a particular program or activity over a period of time to identify systemic problems.
- To ensure audit quality, OIG maintains a quality control program (discussed below) and has taken steps to ensure that adequate guidance is available to the nonfederal auditor. The OIG actively assists the National Association of State Auditors, Controllers and Treasurers in performing peer reviews of State auditors.

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number (800-732-0679) and through training. In addition, formal training was provided to certified public accountant societies and State auditor staff on issues related to Circular A-133.
- The OIG is also very much involved with OMB and the American Institute of Certified Public Accountants in developing authoritative guidance for nonfederal auditors.

B. Quality Control

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

Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 1,747 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,556
Reports issued with major changes	10
Reports with significant inadequacies	<u>181</u>
Total audit reports processed	1,747

The 1,747 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling \$13.2 million as well as 2,561 recommendations for improving management operations. In addition, these audit reports provided information for 47 special memoranda which identified concerns for increased monitoring by departmental management.

Resolving Office of Inspector General Recommendations

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

A. Questioned Costs

The following chart summarizes the Department's responses to OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs which are challenged because of a violation of law, regulation, grant, etc. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and the Inspector General Act Amendments of 1988. These costs are separate from the amount ordered or returned as a result of OIG investigations (see page 59).

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

	<u>Number</u>	<u>Dollar Value</u>	
		<u>Questioned</u>	<u>Unsupported</u>
A. For which no management decision had been made by the commencement of the reporting period ¹	416	\$424,330,000	\$25,251,000
B. Which were issued during the reporting period	<u>101</u>	<u>\$126,201,000</u>	<u>\$28,615,000</u>
Subtotals (A + B)	517	\$550,531,000	\$53,866,000
Less:			
C. For which a management decision was made during the reporting period ² :	141	\$200,056,000	\$3,968,000
(i) dollar value of disallowed costs		\$77,699,000	\$3,814,000
(ii) dollar value of costs not disallowed		\$122,357,000	\$154,000
D. For which no management decision had been made by the end of the reporting period	376	\$350,475,000	\$49,898,000
E. For which no management decision was made within 6 months of issuance ³	271	\$223,027,000	\$44,605,000

See Appendix D for footnotes.

B. Funds Put to Better Use

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

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

	<u>Number</u>	<u>Dollar Value</u>
A. For which no management decision had been made by the commencement of the reporting period ¹	36	\$55,252,000
B. Which were issued during the reporting period	<u>9</u>	<u>\$859,322,000</u>
Subtotals (A + B)	45	\$914,574,000
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	8	\$148,091,000
(b) based on proposed legislative action		
Subtotals (a+b)	8	\$148,091,000
(ii) dollar value of recommendations that were not agreed to by management	<u>3</u>	<u>\$733,326,000</u>
Subtotals (i + ii)	11	\$881,417,000
D. For which no management decision had been made by the end of the reporting period ²	34	\$33,157,000

See Appendix D for footnotes.

Legislative and Regulatory Review and Regulatory Development

A. Review Functions

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigations and other activities highlighted in this and previous semiannual reports. Recommendations made by OIG for legislative and regulatory change can be found throughout this semiannual report.

B. Regulatory Development Functions

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

Among the regulatory initiatives promulgated during the reporting period were:

■ OIG Notice of Proposed Rulemaking: Revised Exclusion Authorities Resulting from Public Law 104-191

The OIG issued proposed rulemaking addressing revised OIG sanction authorities in conjunction with sections 211, 212 and 213 of the Health Insurance Portability and Accountability Act (HIPAA). The regulations are specifically designed to expand the protection of certain basic fraud authorities, and revise and strengthen the current legal authorities pertaining to exclusions from Medicare and all other Federal health care programs. The OIG is presently developing final regulations that will respond to the public comments received in response to the proposed rulemaking.

■ Additional Regulatory Activity

The OIG issued non-binding guidelines that are to be used by OIG in assessing whether to impose a permissive exclusion in accordance with section 1128(b)(7) of the Social Security Act. These guidelines identify specific factors with regard to whether an individual's or entity's continued participation in the Medicare, Medicaid and other Federal health care programs will pose a risk to the programs or program beneficiaries, and explain how these factors would be used by OIG to assess a permissive exclusion decision.

The OIG also issued a Federal Register notice setting forth compliance guidance for hospitals developed by OIG in cooperation with, and with input from, several provider groups and industry representatives. Development and issuance of this program guidance

for hospitals serves as a positive step towards promoting a higher level of ethical and lawful conduct throughout the health care industry.

Through the negotiated rulemaking committee process, OIG continued to develop interim final regulations addressing the shared risk exception to the Federal health care programs' anti-kickback provisions in accordance with section 216 of HIPAA.

The OIG also continued to develop proposed rulemakings addressing the HIPAA CMP provisions, expanded and revised exclusion and CMP sanction authorities resulting from Public Law 105-33 (the Balanced Budget Act) and the health care fraud and abuse data collection program for reporting final adverse actions, as well as revised final regulations on the OIG advisory opinion process.

C. Congressional Testimony and Hearings

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

Training and Administrative Costs Charged to Federal Programs

Based on OIG's work covering the period April 1, 1987 through March 31, 1995, the Department's Division of Cost Allocation (DCA) recovered \$31 million from New York State in December 1997. This amount included \$6 million more than OIG had recommended because DCA built on OIG's findings by including costs charged subsequent to the audit period. The OIG determined that the State had charged the Federal Government for certain training and administrative costs that should have been applied to State programs, which benefitted from the training. Specifically, the overcharges applied to the Aid to Families with Dependent Children, Foster Care and Medicaid programs. (CIN: A-02-96-02000)

Governmental Accounting

Each year, State and local government entities receive over \$200 billion for administration of Federal grants and associated activities. As part of its Governmentwide cognizance responsibilities, as defined in OMB Circular A-87, OIG assesses whether charges to Federal programs are in accordance with the appropriate Statewide cost allocation plans and

identifies cost containment areas and/or areas where costs are being inappropriately charged. During this reporting period, OIG made four reviews at the Department's request.

A. New York Certificates of Participation Expenses

New York State has entered into various arrangements for the refinancing and purchase of equipment and real property through the issuance of Certificates of Participation (COPs). These certificates (similar to bonds) are offered for sale by a trustee to the general public in \$5,000 increments. The State is responsible for making payments to the trustee that approximate the biannual interest and principal payments made by the trustee to certificate holders. In a previous audit, OIG found that New York State had charged unallowable interest to Federal programs for equipment purchased under COPS.

In this review, requested by the Department to fully resolve the interest issue, OIG determined that the State claimed over \$60 million in COPS expenses, consisting of \$49.7 million in principal payments and \$10.5 million (\$5.5 million Federal share) in interest payments, from April 1, 1993, through March 31, 1996. Because the interest portion of the claim is not allowable under OMB Circular A-87, OIG noted that the \$5.5 million should be recovered. The Department agreed with the findings and recommendation. (CIN: A-02-98-02000)

B. Georgia Telecommunications Fund Adjustments

The OIG evaluated the reasonableness of a refund offered by the Georgia Department of Administrative Services after the State made adjustments to its Telecommunications Fund. The refund represents the Federal share of overbillings to the fund for State fiscal years ending June 1994 and 1995. The fund was established to centralize the purchasing and maintenance of telephone and radio equipment and other telecommunications services.

The OIG determined that the State adjustments to the fund were reasonable and recommended acceptance of the State's offer to refund the Federal share of \$653,000. Additionally, OIG recommended that the Department ensure that Georgia make some procedural changes in the area of equipment and asset depreciation to improve the fund's future operations. (CIN: A-04-97-00114)

C. Georgia Self-Insurance Funds

Also in Georgia, OIG reviewed the reserve balances in three self-insurance funds: the Authorities Liability Fund, which provides coverage for the comprehensive general liability claims arising from the acts of State representatives; the Employees Liability Fund, which provides broad coverage to State and local government agencies; and the Tort Liability Fund, which provides liability coverage for torts committed by State employees.

As of June 30, 1996, these funds had excess reserve balances totaling \$62 million (\$5.3 million Federal share). The excess balances occurred because the funds' losses were lower

than expected, the State did not use valid actuarial methods for reserve estimates and the State chose a higher than expected claims level to set reserves. The OIG recommended that Georgia repay the excess \$5.3 million Federal share. The State generally agreed with the finding of excess reserves but disagreed with the dollar amounts. (CIN: A-04-97-00117)

D. Delaware Employees Pension Plan

The OIG reviewed the Delaware Public Employees' Retirement System to confirm the \$493 million surplus fund balance reported for FY 1995 and to compute the Federal share. This surplus fund balance contrasted with a \$17 million deficit fund balance reported for FY 1996. The OIG found that the significant difference in the fund balances between the 2 years resulted primarily from a change in reporting methodology arising from the newly issued Government Accounting Standards Board Statement Nos. 25 and 27. If the methodology used in FY 1995 had been used in FY 1996, a surplus fund balance of \$712 million would have been reported. Noting that the Federal share of this excess would be about \$112.5 million, OIG urged the Department to consider the surplus fund balance in any future negotiations involving the balance. (CIN: A-03-97-00453)

Reviews of Departmental Service Organizations

To support its mandated financial statement audits, OIG reviews several HHS service organizations which provide common accounting and administrative services to the individual operating agencies. During this reporting period, reviews of two of these organizations' internal controls were completed by an independent public accountant (IPA), as discussed below.

A. Division of Payment Management

The PSC's Division of Payment Management serves as the fiscal intermediary between HHS agencies (as well as other Federal departments) and their grant and contract recipients. The Division's Payment Management System processes about \$170 billion in payments to recipients each year. The IPA found that the control policies and procedures for this system were suitably designed and operating effectively. (CIN: A-17-97-00011)

B. Division of Computer Research and Technology

The NIH Division of Computer Research and Technology provides a variety of data processing services on a fee-for-service basis to NIH and other HHS agencies. The IPA concluded that the Division's control structure policies and procedures were suitably designed and operating effectively except for controls over computer room access privileges. (CIN: A-17-97-00013)

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 129 successful criminal actions. Also during this period, 230 cases were presented for criminal prosecution

to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 154 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over \$123.6 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.

APPENDIX A

Savings Achieved Through Policy and Procedural Changes Resulting from Office of Inspector General Audits, Investigations and Inspections October 1997 through March 1998

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

Legislative savings are annualized amounts based on Congressional Budget Office estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected or for multiple years, if applicable. Total savings from these sources amount to \$3,777.8 million for this period.

OIG Recommendation	Implementing Action	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Personal Care Services:		
Reinstate personal care services as a State optional service. (CIN: A-02-93-01022)	Section 13601 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 repeals the mandate for Medicaid coverage of personal care services and allows the States to cover personal care services furnished outside the home, effective October 1, 1994.	\$1,240
Medicare Home Health Payments:		
Restructure the payment system for home health care to eliminate inappropriate incentives which unnecessarily increase cost and utilization; prevent unscrupulous providers from gaining entry into the program; and improve program controls, such as eligibility determinations and approval of plans of care and services. (OEI-04-93-00260; OEI-09-96-00110; CIN: A-04-96-02121)	Subtitle G of Chapter I of the Balanced Budget Act of 1997, which pertains to home health benefits, addresses OIG's concerns regarding the need to restructure and control the payment system for these services. For example, it mandates that a prospective payment system be developed and that the total payments in FY 2000 be equal to the amount that would have been paid under the prior system if cost limits were reduced by 15 percent. It also eliminates periodic interim payments to home health agencies.	1,100
Reimbursement for Outpatient Facility Services:		
The Health Care Financing Administration (HCFA) should limit hospital outpatient department (OPD) facility fees to the applicable ambulatory surgical center (ASC) rate or reduce payments for OPD services to bring them in line with ASC payments. (OAI-85-IX-00046; CIN: A-14-89-00221)	Section 13522 of OBRA 1993 extended the 5.8 percent reduction in payment for OPDs through 1998.	593

OIG Recommendation	Implementing Action	Savings in Millions
<p>Medicare Home Health Care Services: The HCFA should revise Medicare regulations to require that the treating physician establish the plan of care and specifically prescribe the type and frequency of home health services needed. (CIN: A-04-94-02087)</p>	<p>Effective February 1995, Medicare regulations require that a beneficiary be under the care of a physician who establishes the plan of care and that the physician's orders for services in the plan of care specify the medical treatments to be furnished, the discipline to furnish the services and their frequency.</p>	\$199.2
<p>Medicaid Estate Recoveries: The HCFA should make stronger programmatic initiatives on estate recoveries and encourage statutory changes to enhance asset control and recovery activities, such as making liens (or some other form of encumbrance) a condition of eligibility. States should be required to recover Medicaid personal needs allowance funds from a deceased individual's estate to offset the cost of care. (OAI-09-86-00078; CIN: A-01-93-00002)</p>	<p>Section 13612 of OBRA 1993 required States to recover the costs of nursing facility and other long-term care services furnished to Medicaid beneficiaries from the estates of such beneficiaries, and establish hardship procedures for waiver of recovery in cases where undue hardship would result.</p>	128
<p>Medicare Secondary Payer Period for End Stage Renal Disease Beneficiaries: Extend the Medicare secondary payer (MSP) provision to the period of time that end stage renal disease (ESRD) beneficiaries have employer group health insurance. (CIN: A-10-86-62016)</p>	<p>Section 13561(c) of OBRA 1993 maintained the provision to extend the MSP period for ESRD beneficiaries from 12 to 18 months through Fiscal Year 1998.</p>	127
<p>Modifications to Medicaid Drug Rebate Program: Establish State-specific cost reduction targets based on the comparison of individual State drug prices with national and international drug price data; set specific drug price limits for brand name drugs similar to those in place for multi-source drugs; or negotiate directly with manufacturers for prescription drug discounts and rebates. The HCFA should support legislation to retain the current procedures for computing additional rebates. (CIN: A-06-93-00070; OEI-12-90-00800)</p>	<p>Section 13602 of OBRA 1993 permitted States to operate prescription drug formularies meeting certain requirements; removed current law prohibition on the imposition of prior authorization controls with respect to new drugs during the first 6 months following Food and Drug Administration approval; and repealed the weighted average manufacturer price inflation formula for calculating the additional rebate under current law.</p>	75
<p>Payment Rates for the Drug Epogen: The HCFA should reduce the reimbursement rate not to exceed \$10.10 per 1,000 units administered. (CIN: A-01-92-00506)</p>	<p>Section 13566 of OBRA 1993 reduced the reimbursement rate for Epogen to \$10 per thousand units.</p>	67
<p>Medicare Payments for Unnecessary and Poor Quality Endoscopies: The HCFA should reduce the incidence of payments for unnecessary and poor quality gastrointestinal endoscopies. (OEI-09-88-01006)</p>	<p>The OIG accepted the peer review organizations Fourth Scope of Work as an acceptable corrective action plan for HCFA to address OIG's recommendation and reduce payments for unnecessary and poor quality endoscopies.</p>	54.8

OIG Recommendation	Implementing Action	Savings in Millions
Intraocular Lenses in Ambulatory Surgical Centers and Hospitals:		
Reduce payments for intraocular lenses (IOLs) to current acquisition costs. (OEI-05-92-01030)	Section 13533 of OBRA 1993 reduced payments for IOLs in ASCs to \$150.	\$18
Short/Doyle Medicaid Payment Rates:		
The State of California should ensure that Short/Doyle payments are limited in accordance with the State's Medicaid plan and Federal requirements. (CIN: A-09-91-00076; CIN: A-09-92-00094)	The HCFA approved a California State plan amendment that modified and clarified the States's reimbursement policy for Short/Doyle Medicaid mental health services.	5.7
PUBLIC HEALTH SERVICE OPERATING DIVISIONS		
Graduate Student Compensation:		
The Assistant Secretary for Management and Budget (ASMB) should work with the Office of Management and Budget (OMB) to stipulate a reasonable standard for graduate student compensation charged to federally sponsored research. The standard should be based on assigned responsibilities and should not exceed compensation paid to other individuals for similar experience and work. (CIN: A-01-94-04002)	The National Institutes of Health (NIH) issued a notice in its Guide for Grants and Contracts (NIH Guide, volume 25, number 8, March 15, 1996). The guidelines provide that reasonable compensation for graduate students will not exceed the amount allowable for a first year postdoctoral level staff member, at the same institution, performing comparable work. In addition, ASMB has forwarded the OIG recommendation to OMB with an endorsement that this subject be addressed in the next revision of Circular A-21.	5.7
ADMINISTRATION FOR CHILDREN AND FAMILIES		
\$50 Child Support Disregard in the Child Support Enforcement Program:		
The \$50 disregard provision, which allowed the first \$50 collected from absent parents to be turned over to the family and not counted against Aid to Families with Dependent Children (AFDC) benefits, did not provide the AFDC family with any incentive to cooperate more fully with child support officials in locating the absent parent and should be eliminated. (CIN: A-02-86-72606)	Section 302 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 eliminated the authority which allowed the recipient to keep the first \$50 of child support collected in a month.	114

Other	Implementing Action	Savings in Millions
<p>Results of Investigations: In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the Operating Division.</p>	<p>The Operating Division takes action based on the results of the OIG investigation to suspend or terminate payments to the offending individual or entity.</p>	<p>\$50.4</p>

APPENDIX B

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

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

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Modify Formula for Costs Charged to the Medicaid Program:		
The Health Care Financing Administration (HCFA) should consult with the Congress on modification of the Federal Medical Assistance Percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per capita income relationships. (CIN: A-06-89-00041)	The HCFA did not agree with the recommendation, and no legislative proposal was included in the President's current budget.	\$4,100
Medicare Coverage of State and Local Government Employees:		
Require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (CIN: A-09-88-00072)	Although HCFA included a proposal to mandate Medicare coverage for all State and local government employees in the FY 1990 budget submission, no legislative proposal was included in the President's current budget. Also, HCFA did not agree with the recommendation to make Medicare the secondary payer.	1,559
Clinical Laboratory Tests:		
Develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CIN: A-09-89-00031; CIN: A-09-93-00056)	The HCFA agreed with the first recommendation but not the second. The Balanced Budget Act of 1997 reduces Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002.	1,130*

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

OIG Recommendation	Status	Savings in Millions
<p>Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)</p>	<p>The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.</p>	\$1,100
<p>Reduce Hospital Capital Costs: Determine the extent that capital reductions are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070; CIN: A-14-93-00380)</p>	<p>The HCFA did not agree with the recommendation. Although the Balanced Budget Act of 1997 reduces capital payments, it does not include the effect of excess bed capacity and other elements included in the base year historical costs.</p>	820
<p>Medicaid Payments to Institutions for Mentally Retarded: The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)</p>	<p>The HCFA nonconcurred with OIG's recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA and OIG negotiated an agreement for HCFA to send the report to all State Medicaid directors. This action has been taken. However, pursuant to section 4711 of the Balanced Budget Act of 1997, the Secretary shall conduct a study on the effect on access to, and the quality of services provided to beneficiaries of the rate-setting methods used by States.</p>	683
<p>Flexible Benefit Plans: The value of flexible benefit plans should be included in the definition of wages for the hospital insurance portion of the Federal Insurance Contributions Act. (CIN: A-05-93-00066)</p>	<p>While HCFA agreed with the recommendation and has submitted a legislative proposal to subject flexible benefit plans to the Hospital Insurance tax, the proposal was not included in the President's budget.</p>	291
<p>Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality. (CIN: A-05-89-00055; CIN: A-05-92-00006)</p>	<p>The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's current budget.</p>	210

OIG Recommendation	Status	Savings in Millions
<p>Graduate Medical Education: Revise the regulations to remove from a hospital's allowable graduate medical education (GME) base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020)</p>	<p>The HCFA did not concur with the recommendations. Although the Balanced Budget Act of 1997 contains provisions to slow the growth in Medicare spending on GME, OIG believes that its recommendations should be implemented and that further savings can be achieved.</p>	\$157.3
<p>Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 tests identified by the OIG audit. (CIN: A-01-93-00521)</p>	<p>The HCFA agreed with 8 of the 10 tests recommended for addition to the list and added 6 of these tests to its carrier manual. The HCFA will periodically review applicable tests and related equipment. Also, although a legislative proposal to add further tests was included in the President's FY 1997 budget, the Congress decided (through the Balanced Budget Act of 1997) to achieve savings through other means, including freezing laboratory payments through 2002 and reducing the national payment cap to 74 percent of the median of all fee schedules.</p>	130
<p>Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing and begin to plan now for the policy changes that will become necessary to achieve an almost completely paperless environment for processing Medicare claims. (CIN: A-05-94-00039; OEI-01-94-00230)</p>	<p>The HCFA concurred with OIG's recommendations and has developed a corrective action plan.</p>	126
<p>Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (CIN: A-06-94-00039)</p>	<p>The OIG is continuing to monitor the Medicaid drug rebate program. Audits will focus on enhancing the collection of rebates and providing potential savings to the rebate program.</p>	123
<p>Medicaid Cost Sharing: The HCFA should promote the development of effective cost sharing programs by: allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services; allowing for higher beneficiary cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800)</p>	<p>The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. It plans to solicit information from States implementing cost sharing and distribute it to States that do not impose it. Several States have submitted waiver applications to HCFA to develop demonstration projects which include experimental cost sharing provisions.</p>	122

OIG Recommendation	Status	Savings in Millions
<p>Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The HCFA should propose legislation to expand the diagnosis related group (DRG) payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)</p>	<p>The HCFA agreed to recover the improper Medicare billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and OIG. The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's current budget.</p>	\$83.5
<p>Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)</p>	<p>The HCFA considered a proposal recommending that the Medicare 190-day lifetime limit for psychiatric hospitals be extended to general hospitals; however, such a proposal was not included as part of the President's current budget.</p>	47.6
<p>Medicaid Payments for Employer Group Health Insurance: The HCFA should continue to strongly support States implementing Section 1906 of the Social Security Act, and should propose legislation that allows States to pay employer group health plan (EGHP) deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules. (OEI-04-91-01050)</p>	<p>The HCFA concurred with the first recommendation and has been working in partnership with regional offices and States to promote full implementation. The HCFA deferred comment on the second recommendation.</p>	32
<p>Reduce End Stage Renal Disease Payment Rates: The HCFA should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)</p>	<p>The HCFA agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing these rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatment. A March 1996 study by ProPAC recommended an increase to the current rates, but HCFA did not believe an across-the-board increase was warranted and intended to monitor facilities' costs and other factors to determine if a rate increase would be appropriate. Toward this end, the Balanced Budget Act of 1997 requires the Secretary to audit the cost reports of each renal dialysis provider at least once every 3 years.</p>	22*

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

OIG Recommendation	Status	Savings in Millions
<p>Collect Overpayments from Health Maintenance Organizations for Misclassified End Stage Renal Disease Beneficiaries:</p> <p>The HCFA should issue clear guidelines for the recovery of overpayments from health maintenance organizations (HMOs) and recover all overpayments occurring at least since 1992 that were made to HMOs on behalf of misclassified end-stage renal disease (ESRD) beneficiaries. (CIN: A-14-96-00203)</p>	<p>The HCFA agreed to clarify its policies for collecting overpayments from HMOs. However, it collected overpayments retroactively only to March 1995 for the majority of misclassified beneficiaries and retroactively to October 1993 for the remaining beneficiaries who were misclassified as having ESRD before enrollment in the HMO. Due to this limited recovery schedule, HCFA has not collected \$20.5 million in overpayments which occurred since 1992. The HCFA disagreed with the OIG recommendation to collect the overpayments retroactively to 1992.</p>	\$20.5
<p>Preclude Improper Medicaid Reimbursement for Clinical Laboratory Services:</p> <p>State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings that contain duplicate tests, recover overpayments and make adjustments for the Federal share of the amounts recovered. (CIN: A-01-95-00005; CIN: A-05-95-00035; CIN: A-01-96-00001; CIN: A-06-95-00078; CIN: A-06-95-00031; CIN: A-04-95-01108; CIN: A-04-95-01109; CIN: A-07-95-01139; CIN: A-07-95-01147; CIN: A-04-95-01113; CIN: A-07-95-01138; CIN: A-09-95-00072; CIN: A-05-96-00019; CIN: A-10-95-00002; CIN: A-01-95-00006; CIN: A-02-95-01009; CIN: A-03-96-00200; CIN: A-03-96-00202; CIN: A-03-96-00203; CIN: A-05-95-00062; CIN: A-06-96-00002; CIN: A-06-95-00100)</p>	<p>The HCFA is evaluating the OIG results.</p>	14
<p>Nonemergency Advanced Life Support Ambulance Services:</p> <p>The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513; CIN: A-01-94-00528)</p>	<p>This policy change was included in proposed regulations published by HCFA in June 1997. It will be finalized as part of a negotiated rulemaking process for development of an ambulance fee schedule (as mandated by the Balanced Budget Act of 1997).</p>	12.8

OIG Recommendation	Status	Savings in Millions
<p>Medicare Payments for Orthotic Body Jackets: The HCFA should require the durable medical equipment regional carriers (DMERCs) to closely monitor claims for body jackets, including: analysis of payment trends, provision of an early warning of abusive practices and monitoring of suppliers who have engaged in abusive practices. (OEI-04-92-01080)</p>	<p>The HCFA concurred and has instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices. However, payments continue at high levels. The OIG is currently updating this work.</p>	\$10.4
<p>Medicare Claims for Railroad Retirement Beneficiaries: Discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)</p>	<p>While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.</p>	9.1
<p>Medicare Orthotics: Develop guidelines that better define orthotic devices; develop policies for orthotic codes; develop screens for billing many orthotic devices on the same day or within a short time frame; pay special attention to billing for orthotics in nursing facilities; work with the American Orthotic and Prosthetic Association to develop a table of devices that should not be used together, and consider stricter standards to determine who is allowed to bill for orthotics. (OEI-02-95-00380)</p>	<p>The HCFA concurred with the recommendations. The HCFA continues to work with the DMERCs, the American Orthotic and Prosthetic Association to implement the recommendations.</p>	7.9
<p>Limit Reimbursement for Hospital Beds: The HCFA should develop a new approach for reimbursing suppliers of hospital beds used by Medicare beneficiaries at home. The new reimbursement methodology should reflect a hospital bed's useful life and the number of times a bed can customarily be rented over that period. (CIN: A-06-91-00080)</p>	<p>The HCFA awarded a demonstration project on this subject in 1996. The project is expected to run in at least three sites for two cycles of 2 years each which began in January 1997. The Balanced Budget Act of 1997 requires the Secretary to conduct a competition among individuals and entities supplying Part B items and services. Even though only oxygen and oxygen equipment were specifically mentioned in the statute for one of the five demonstration projects, HCFA is planning to include hospital beds in at least one of the sites.</p>	6.2

OIG Recommendation	Status	Savings in Millions
<p>Third Party Liability Settlements and Awards: The HCFA should develop legislative proposals to close the loopholes in the Omnibus Budget Reconciliation Act of 1993 that allow Medicaid beneficiaries, who receive settlements and awards from third parties as a result of accidents, to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. The HCFA should also develop guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties. (CIN: A-09-93-00033)</p>	<p>The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g., health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements. In June 1996, HCFA issued guidelines which set forth advice on ways in which States can better recover Medicaid expenditures from established third-party settlements, especially for the disabled population.</p>	\$3
<p>Institutional General and Administrative and Fringe Benefit Costs: Revise the Provider Reimbursement Manual (PRM) to provide explicit guidelines on the allowability of certain general and administrative and fringe benefit costs. (CIN: A-03-92-00017)</p>	<p>The HCFA has published changes to the PRM to clarify the allowability of several of the cost categories identified in OIG's report. In addition, the Balanced Budget Act of 1997 prohibits payments for such items as entertainment, gifts and donations. The HCFA should clarify the remaining cost categories noted in OIG's report, such as the relationship between employee benefits and perks; and the difference between advertising, marketing and public relations.</p>	to be determined
<p>Indirect Medical Education: Reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (CIN: A-07-88-00111)</p>	<p>The HCFA agreed with the recommendation, and the Balanced Budget Act of 1997 reduces the IME adjustment factor from the current 7.7 percent in Fiscal Year (FY) 1997 to 5.5 percent in 2001 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.</p>	to be determined

OIG Recommendation	Status	Savings in Millions
Medicare Secondary Payer - End Stage Renal Disease Time Limit:	The HCFA was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. The HCFA favored indefinitely extending the MSP provision for all other services and included this proposal in an earlier budget submission. Although the Balanced Budget Act of 1997 extends MSP policies for individuals with ESRD to 30 months, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.	to be determined
Home Health Agencies:	Although the Congress and the Administration included provisions to restructure home health benefits in the Balanced Budget Act of 1997, HCFA still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. While agreeing in principle, HCFA said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification.	to be determined
Modify Payment Policy for Medicare Bad Debts:	The HCFA agreed with the recommendation to include a bad debt factor in the DRG rates. The Balanced Budget Act of 1997 provides for some reduction of bad debt payments to providers, but additional legislative changes are needed to implement the modifications that OIG recommended.	to be determined
PUBLIC HEALTH SERVICE OPERATING DIVISIONS		
Institute and Collect User Fees for Food and Drug Administration Regulations:	In the absence of specific authorizing legislation, the Food and Drug Administration is precluded by statute from imposing user fees to cover additional functions.	\$44.3

OIG Recommendation	Status	Savings in Millions
<p>Medical Malpractice Coverage: The Health Resources and Services Administration (HRSA) should consider seeking a legislative proposal to limit to \$1 million malpractice settlements or judgments involving community and migrant health centers. (CIN: A-04-95-05018)</p>	<p>After conferring with the Department of Justice, the Department of Health and Human Services has decided not to seek a legislative change at this time.</p>	\$10
<p>Recharge Center Costs: The Assistant Secretary for Management and Budget should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (CIN: A-09-96-04003)</p>	<p>The Deputy Assistant Secretary for Grants and Acquisition Management concurred with the recommendations. In addition, the Council on Government Relations generally agreed and stated that the proposed criteria should be included in the Compliance Supplement to OMB Circular A-133, which provides guidance to independent auditors in conducting compliance audits of educational institutions.</p>	1
ADMINISTRATION FOR CHILDREN AND FAMILIES		
<p>Limit Federal Participation in States' Costs for Administering the Foster Care Program: Limit Federal participation in foster care administrative costs through one of the following actions: limit future increases in administrative costs to no more than 10 percent per year; fund administrative activities via a single block grant with future increases based on the consumer price index; limit administrative costs to a percentage of maintenance payments; or require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. (CIN: A-07-90-00274; OEI-05-91-01080)</p>	<p>This proposal was not included in the President's current budget. The Administration for Children and Families generally agreed with the recommendation, but recently noted that claims for administrative costs have leveled off in the past several years.</p>	247
GENERAL OVERSIGHT		
<p>Simplify Administrative/Indirect Cost Allocation Systems: The OMB should simplify the process for charging administrative/indirect costs to Federal programs through reform of the cost allocation plans. Options for reform include use of block grant awards, a flat percentage rate for administrative/indirect costs, and negotiation of a nonadjustable rate for a predetermined number of years. (CIN: A-12-92-00014)</p>	<p>Some of OIG's recommendations are cited in the National Performance Review report that calls for reform of the cost allocation process. The OMB's revision of Circular A-87 addressed those recommendations. However, further reform is needed to address the bulk of administrative/indirect costs charged to the Federal Government.</p>	660

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

OIG Recommendation

Status

HEALTH CARE FINANCING ADMINISTRATION

Improve the Health Care Financing Administration's Implementation of the Federal Managers' Financial Integrity Act Program:

The Health Care Financing Administration (HCFA) should extend its financial management review to the Office of the Actuary and to all functional areas of the Common Work File. The HCFA also needs to classify areas with pending material weaknesses as high risk, adequately implement its cost allocation system, and address significant Medicare secondary payer issues in its corrective action plan. (CIN: A-14-93-03026)

The HCFA agreed with the intent of most of the recommendations. Although HCFA does not agree with the need to expand financial management reviews to other systems, such as the Common Work File, Medicare contractors are now required to make internal control self-assessments. Also, since HCFA did not include the Office of the Actuary in its management control plan, it did not review the internal controls used in deriving the accounts payable balance. The HCFA believes that these controls are not directly applicable to the calculation of estimates for its financial reports.

Implement Proper Accountability over Billing and Collection of Medicaid Drug Rebates:

The HCFA should ensure that States implement accounting and internal control systems in accordance with applicable Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current and complete disclosure of drug rebate transactions and provide HCFA with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (CIN: A-06-92-00029)

The HCFA concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The HCFA issued interim regulations in Fiscal Year (FY) 1996.

OIG Recommendation	Status
<p>Medicare Trust Funds' Accounts Receivable Balances:</p> <p>The HCFA and its Medicare contractors need an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information. Also, HCFA should retain proper documentation to support the reported balances and should strengthen internal controls on segregation of duties. (CIN: A-01-92-00516; CIN: A-01-94-00520; CIN: A-17-94-03032; CIN: A-17-95-00051; CIN: A-17-95-00096)</p>	<p>The HCFA agreed with the recommendations and is pursuing methods to substantiate the Medicare contractors' accounts receivable balances. Although HCFA's long-range plan continues to focus on a contractor-based integrated accounting system, the short-term (FY 1998) plan focuses on using the contractors' existing subsidiary systems to improve the quality of data and to identify and document the audit trails necessary to support reported data. The HCFA requested the Medicare contractors to "snapshot" their systems at the end of each quarter to keep a complete audit trail, including transaction level ledgers. The HCFA also scheduled visits by technical teams to several contractors to review systems, reconcile financial data, ensure that appropriate audit trails are available, assess any short-term system improvements that may be needed and identify any changes needed to the HCFA 750/751 reports.</p>
<p>Improve Financial Management Systems to Enhance Financial Reporting:</p> <p>The HCFA should develop and implement financial management systems and related accounting and administrative controls to ensure that all Medicare accounts payable and liabilities are reported to the HCFA general ledger at fiscal year end. (CIN: A-14-92-03015; CIN: A-14-93-03027; CIN: A-17-94-03032; CIN: A-17-95-00051; CIN: A-17-95-00096)</p>	<p>A new payables methodology was developed for the FY 1997 financial statements, and it was accepted by OIG auditors. The HCFA is also asking the Medicare contractors to review their internal controls, particularly in the area of financial reporting. Data is currently being collected and analyzed.</p>
<p>Consider Recommended Safeguards over Medicaid Managed Care Programs:</p> <p>The HCFA should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)</p>	<p>The HCFA generally concurred with OIG's recommendations but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.</p>
<p>Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program:</p> <p>The HCFA should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The HCFA should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)</p>	<p>The HCFA did not concur stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP, but did not provide specific written methodology for computing AMP.</p>
<p>Physician Office Surgery:</p> <p>The peer review organizations (PROs) should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)</p>	<p>The HCFA 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.</p>

OIG Recommendation	Status
<p>Implementing the New Medicare Transaction System: The HCFA should take steps early to ensure that the new nationwide Medicare claims processing system, MTS, is designed to assure flexibility and adaptability to meeting future program requirements. (CIN: A-14-93-02543)</p>	<p>The HCFA concurred with OIG's recommendations. However, on August 15, 1997, HCFA terminated the contract with the design contractor for development of MTS. The HCFA is assessing its future actions.</p>
<p>Review Determinations of Graduate Medical Education Costs: The HCFA should take steps to ensure that fiscal intermediaries audit teaching hospitals' full-time equivalent resident counts for the base year used in determining graduate medical education (GME) payments. (CIN: A-06-94-00059)</p>	<p>The HCFA concurred with the recommendation but noted that currently Medicare GME payments are not tied to reported costs, which may affect the accuracy of such costs.</p>
<p>Properly Account for Medicare Secondary Payer Overpayments: Although agreement was reached to relieve Blue Cross and Blue Shield plans of past due Medicare secondary payer (MSP) overpayments, HCFA should continue to implement financial management systems to ensure that all overpayments (receivables) are accurately recorded. (CIN: A-09-89-00100)</p>	<p>The HCFA is currently pursuing the recommended administrative action through improved information systems to guard against making improper Medicare payments to the Blue Cross and Blue Shield plans.</p>
<p>Investigate Patient Dumping Complaints: The HCFA should improve its processes for investigating and resolving complaints involving potential violations of the Examination and Treatment for Emergency Medical Conditions and Workmen in Labor Act, commonly referred to as patient dumping. (CIN: A-06-93-00087)</p>	<p>The HCFA concurred with OIG's recommendations.</p>
<p>Medicare Beneficiary Satisfaction with Durable Medical Equipment Regional Carrier Services: The HCFA should evaluate ways to increase beneficiary satisfaction with the one durable medical equipment regional carrier with a low rating, and review effective ways to educate beneficiaries on what constitutes fraud and abuse. (OEI-02-96-00200)</p>	<p>The HCFA concurred. The HCFA conducts annual evaluations to identify ways to improve performance. The HCFA is also working to develop new outreach techniques to increase beneficiaries' knowledge on detecting fraud and abuse.</p>
<p>Pressure Reducing Support Services: The HCFA should establish the requirement for periodic review and renewal of the medical necessity for beneficiaries' use of group 2 support surface equipment. (OEI-02-95-00370)</p>	<p>The HCFA did not concur.</p>
<p>Excessive Medicare Payments for Prescription Drugs: The HCFA should examine its Medicare drug reimbursement methodologies. (OEI-03-97-00290)</p>	<p>The Balanced Budget Act of 1997 reduced Medicare payments by limiting them to 95 percent of the average wholesale price. Additional corrective action is warranted and called for in the President's 1999 budget and legislative program.</p>

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

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

A work group has been established to develop a substantive testing process which will produce a claims error rate. The HCFA's goal is to use substantive testing to gather data that is statistically valid to allow for projecting a national error rate and in a format that will benefit HCFA and its contractors in identifying areas for improvement.

Improve Medicare Electronic Data Processing Controls:

Electronic data processing (EDP) controls should be improved at the HCFA central office, selected Medicare contractor locations, Common Working File (CWF) host sites, the CWF maintainer and shared system maintainers. This review was limited to EDP general and application controls and did not include EDP management or operation controls used to administer, process and account for Medicare expenditures. (CIN: A-17-95-00096).

Most improvements relating to access and separation of duties have been completed. The HCFA is still considering system upgrades, is completing an update of the disaster recovery plan, and plans to improve controls making use of risk analysis and cost benefit analysis.

Medicaid Accounts Receivable and Accounts Payable:

The HCFA should improve its estimation model (State survey) for accounts receivable and accounts payable to ensure that clear and complete survey instructions are provided, procedures are implemented to address survey problems and trend data is appropriately developed. (CIN: A-17-95-00096)

Each State was given the opportunity to indicate, on the survey form, the best source and time to retrieve the information. The HCFA is currently establishing a process for monitoring the collection of data and is developing a methodology for trend data.

Financial Management Controls:

Improvements are needed in the HCFA contractors' controls to protect assets against theft, loss, misuse or unauthorized alteration and to reduce the opportunities for perpetuating and concealing errors or irregularities. In addition, contractors need to implement the controls necessary to ensure adequate financial reporting. (CIN: A-17-95-00096)

As a mid- to long-term strategy, HCFA has begun to analyze the shared systems to find a way to incorporate accounting and reporting processes into the intermediary, carrier and durable medical equipment regional carrier shared systems, as well as the CWF. The HCFA's ultimate goals are national standardization of the systems and automation of the claims, financial and reporting processes. In addition, HCFA has established audit coordinators, held seminars and contracted audits to review internal controls and financial reporting at intermediaries and carriers.

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Improve Blood Establishments' Error and Accident Reporting:

The FDA should ensure that timely error and accident reports are submitted by blood establishments currently required to submit such reports, and should take regulatory action to require that unlicensed blood establishments submit error and accident reports. (CIN: A-03-93-00352; CIN: A-03-95-00350)

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

OIG Recommendation**Status**

ADMINISTRATION FOR CHILDREN AND FAMILIES AND ADMINISTRATION ON AGING

Improve the Federal Foster Care Program:

The OIG provided options for the Administration for Children and Families (ACF) to consider in its efforts to improve its partnership with State and local governments in administering the Federal Foster Care program. The options included streamlining the process; determining whether legislative change is needed; and determining if certain program requirements could be changed to facilitate compliance. (CIN: A-12-93-00022)

The ACF concurred and has field-tested its redesigned titles IV-B and IV-E child welfare reviews. A draft notice of proposed rulemaking is currently in preliminary clearance. In addition, the child welfare waiver demonstrations are allowing several States to test alternative approaches to the title IV-E requirements.

Develop Effective Practices for Facility Purchases by Head Start Grantees:

The ACF should work to develop effective practices for handling facility purchases by Head Start program grantees, particularly in the areas of review and approval of purchase requests, and accounting for facility purchases. (CIN: A-09-94-00085)

The ACF agreed with OIG's recommendations.

GENERAL OVERSIGHT

Update Cost Principles for Federally Sponsored Research Activities:

The Department should act to modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (CIN: A-01-92-01528)

The Department 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 (PRB) costs arising from implementation of Financial Accounting Standards Board Opinion 106. It should also advise negotiators for the Department's Division of Cost Allocation to pay special attention to such costs when reviewing fringe benefit rates for schools and nonprofit organizations. (CIN: A-01-93-04000)

The OMB has revised Circular A-87 to limit PRB 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 that PRB costs claimed under Circulars A-21 and A-122 should be treated in the same manner as the proposed provisions of Circular A-87.

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 to develop guidelines related to the determination of administrative costs, including standards for using 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 \$58.1 million.

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

CIN: A-05-91-15510	ONEIDA Tribe of Indians of Wisconsin: After further review, it was determined that Federal funds were not charged for the previously disallowed indirect costs of \$179,667.
CIN: A-06-96-00027	VNA of Texas Hospice Eligibility Review: A more detailed review of documentation reduced the estimated Medicare overpayment by \$86,465.
CIN: A-05-95-32978	State of Ohio: Further review determined that Federal overpayments were underestimated by \$54,326.

Not detailed are revisions to previously disallowed management decisions totaling \$370,196.

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

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

CIN: A-09-96-00071	Audit of Foster Family Agency Rates in California, August 1997, \$15,849,210
CIN: A-05-94-00064	Michigan Blue Cross/Blue Shield, Audit of Administrative Costs, June 1996, \$15,609,718
CIN: A-09-97-44262	State of California, April 1997, \$7,419,900
CIN: A-09-96-00066	CA Dept of Social Services, September 1997, \$6,611,640
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-10-97-48849	State of Oregon, July 1997, \$6,379,395
CIN: A-07-92-00578	Blue Cross/Blue Shield of Texas Inc.-Unfunded Pension Costs, October 1992, \$6,244,637
CIN: A-05-96-00013	DCFS Training Costs, August 1996, \$5,812,360
CIN: A-04-96-04575	Audit ATSDRs Superfund Financial Accounting June 1997, \$5,360,000
CIN: A-07-97-01028	Review of Training Costs-Kansas, August 1997 \$5,136,647
CIN: A-04-97-04599	Audit of ATSDRs Superfund, September 1997, \$4,800,000
CIN: A-01-97-46859	State of Massachusetts, May 1997, \$4,798,706
CIN: A-07-96-02001	Medicare Part B Administrative Costs at Blue Cross/Blue Shield of Colorado, December 1996, \$4,483,104

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

CIN: A-09-95-00056 Review of Training Costs-CA Department of Social Services, August 1996, \$3,934,717

CIN: A-10-96-00004 Audit of Training Contracts, September 1997, \$3,840,343

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

CIN: A-05-93-00054 Illinois 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-07-92-00585 Pension Segmentation Blue Cross/Blue Shield of California, January 1994, \$2,973,504

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

CIN: A-06-97-43135 State of Texas, February 1997, \$2,987,053

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

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

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

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

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

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

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

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

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

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

CIN: A-03-90-00051 Maryland BC/BS Administrative Costs-Part A-FYs 85-88, August 1991, \$1,438,414

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

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

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

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

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

CIN: A-07-93-00070 Blue Cross/Blue Shield-Unfunded Pension Cost Audit, May 1994, \$1,290,740

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

CIN: A-10-97-47406 State of Idaho, April 1997, \$1,262,577

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

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

CIN: A-09-96-00061 Blue Shield of California Administrative Costs, December 1996, \$1,127,305

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

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

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

CIN: A-07-97-01220 Pro Closeout-McBride CPA, March 1997, \$1,006,560

CIN: A-07-97-01208 Community Mutual Pension, July 1997, \$991,972

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

CIN: A-09-96-00074 Blue Shield of California-Administrative Costs, December 1996, \$973,337

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

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

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

CIN: A-02-94-01022 Blue Cross/Blue Shield of New Jersey, Administrative Costs-Medicare, September 1997, \$864,851

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

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

CIN: A-07-96-01193 Pro Closeout-McBride CPA, August 1996, \$751,789

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

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

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

CIN: A-02-96-01015 Empire Administrative Costs Part A-Gardiner, Kamyra and Assoc., April 1997, \$652,492

CIN: A-06-96-00062 South Plains Community Action Association, July 1996, \$639,400

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

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

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

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

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

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

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

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

CIN: A-03-97-43787 State of Virginia, February 1997, \$455,520

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

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

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

CIN: A-03-95-00451 Escheated Warrants-District of Columbia, August 1995, \$420,607

CIN: A-07-96-01188 Pro Closeout-Doshi CPA, August 1996, \$432,698

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

CIN: A-01-97-48712 State of Rhode Island & Providence Plantations, August 1997, \$369,459

CIN: A-04-96-01134 HCFA Survey Team-Colonnade Medical, February 1997, \$358,338

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

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

CIN: A-17-95-00096 FY 1996 HCFA Financial Audit, July 1997, \$334,465

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

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

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

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

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

CIN: A-04-96-01129 HCFA Survey Team-American Trans. Care, February 1997, \$284,378

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

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

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

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

CIN: A-03-92-20033 State of Delaware, August 1992, \$247,609

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

CIN: A-03-97-48303 Management Systems Applications, July 1997, \$230,753

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

CIN: A-04-96-01135 HCFA Survey Washington Manor Nursing, February 1997, \$220,483

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

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

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

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

CIN: A-06-96-00070 Skilled Nursing Facilities at Methodist Hospital, January 1997, \$200,000

CIN: A-04-96-01149 Review of Presbyterian Hospital of Dallas, April 1997, \$198,663

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

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

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

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

CIN: A-04-96-01124 HCFA Survey of Stafford Ct., February 1997, \$161,774

CIN: A-07-97-01206 Washington/Alaska Unfunded Pension, March 1997, \$160,843

CIN: A-04-97-47239 State of Kentucky, June 1997, \$158,071

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

CIN: A-01-97-49353 State of Maine, September 1997, \$142,516

CIN: A-07-97-01222 Pro Close-out Doshi CPA, March 1997, \$140,332

CIN: A-04-96-01147 Parker Jewish Geriatric Center, Hyde Park New York, April 1997, \$140,188

CIN: A-05-92-00048 Wisconsin Physicians Services, Pension-Medicare vs. Erisa, October 1992, \$130,577

CIN: A-06-96-41681 Texas Migrant Council, Inc., March 1996, \$129,886

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

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

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

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

CIN: A-07-95-01159 Nebraska Blue Cross/Blue Shield Pension Segmentation, January 1996, \$96,955

CIN: A-07-96-01189 Washington/Alaska Blue Cross Pension, March 1997, \$96,740

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

CIN: A-09-97-48988 State of Nevada, July 1997, \$90,405

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

CIN: A-03-97-48850 Little Neighborhood Schools Inc., August 1997, \$86,478

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

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

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

CIN: A-03-97-43787 State of Virginia, February 1997, \$78,608

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

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

CIN: A-08-96-42696 Blackfeet Tribe of the Blackfeet Indian Reservation, July 1996, \$71,988

CIN: A-03-97-49045 State of Maryland, August 1997, \$69,693

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

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

CIN: A-08-97-44338 Three Affiliated Tribes, January 1997, \$68,468

CIN: A-09-96-43765 Arizona Affiliated Tribes Inc., September 1996, \$66,526

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

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

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

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

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

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

CIN: A-04-96-40781 State of Alabama, May 1996, \$56,573

CIN: A-03-97-49235 State of Pennsylvania, September 1997, \$55,704

CIN: A-04-96-01125 HCFA Survey- Rosemont, February 1997, \$55,306

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

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

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

CIN: A-09-95-00095 Health Services Advisory Group, December 1995, \$49,585

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-04-96-01122 HCFA Survey-AMI Town County Hospital, February 1997, \$47,147

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

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-01-97-49011 State of Washington, July 1997, \$41,772

CIN: A-05-97-45382 Child Care Resources Inc.-Ohio, November 1996, \$36,750

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

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

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

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

CIN: A-05-97-45225 University of Wisconsin, December 1996, \$32,011

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

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

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

CIN: A-06-92-00017 IHS Creek Contract, May 1992, \$28,387

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

CIN: A-03-97-48111 State of Virginia, May 1997, \$24,184

CIN: A-02-97-48759 Head Start Program Archdiocese of San Juan, August 1997, \$23,574

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

CIN: A-10-97-43797 State of Washington, January 1997, \$21,241

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

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

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

CIN: A-09-97-46954 Shasta County Head Start Action Agency, March 1997, \$20,085

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

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

CIN: A-06-96-42704 Eight Northern Indian Pueblos Council, July 1996, \$18,165

CIN: A-03-97-00007 NE Health Care Quality Foundation-Contract Close-Out, March 1997, \$17,045

CIN: A-01-97-45002 McLean Hospital Corp., March 1997, \$16,892

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

CIN: A-06-97-47306 Marie Detty Youth & Family Service Center Inc., April 1997, \$16,020

CIN: A-07-97-01205 Washington/Alaska Pension FACP, March 1997, \$15,688

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

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

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

CIN: A-06-97-42861 Tulsa Community Action Agency Inc., November 1996, \$14,157

CIN: A-09-98-49643 Hui No Ke Ola Pono Inc., October 1997, \$13,842

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

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

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

CIN: A-03-97-47731 State of Delaware, May 1997, \$11,880

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

CIN: A-01-97-47552 State of New Hampshire, May 1997, \$11,413

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

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

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

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

CIN: A-10-97-46803 Lutheran Social Services of Washington & Idaho, May 1997, \$9,962

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

CIN: A-06-97-48284 East Texas Family Services Inc., August 1997, \$9,130

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

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

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

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

CIN: A-06-97-48062 Cheyenne-Arapaho Tribes of Oklahoma, May 1997, \$8,321

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

CIN: A-07-97-01231 Prowest Doshi Washington, June 1997, \$8,027

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

CIN: A-03-91-02004 West Virginia Blue Cross Administrative Costs FYs 85-90 and Termination Costs, November 1992, \$7,556

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

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

CIN: A-04-96-01128 HCFA Survey Team-Ed White Transportation Care, February 1997, \$7,244

CIN: A-07-97-01227 Mt-WY Foundation for Medical Care, June 1997, \$7,168

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

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

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

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

CIN: A-04-97-48389 State of Florida, July 1997, \$6,337

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

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

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

CIN: A-03-97-46029 Monticello Area Community Action Agency, February 1997, \$6,000

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

CIN: A-02-96-39964 State of New Jersey, April 1996, \$5,497

CIN: A-09-97-48953 Chemehuevi Indian Tribe, July 1997, \$5,246

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

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

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

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

CIN: A-02-97-49051 Government of the Virgin Islands, August 1997, \$4,365

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

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

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

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

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-06-97-49060 East Texas Human Development Corp., August 1997, \$3,355

CIN: A-02-97-48714 St. Lawrence County Community Development Program, July 1997, \$3,352

CIN: A-03-95-03318 Trans-management Systems, May 1996, \$3,016

CIN: A-02-96-42965 Seneca Nation of Indians, June 1996, \$2,720

CIN: A-04-97049102 Henley-Roberts Civic Organization, August 1997, \$2,719

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

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

CIN: A-05-96-38861 Menominee Family Resources, February 1996, \$2,636

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

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

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

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

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

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

B. The following audits are open pending the resolution of the contractors termination audit, related termination agreements and pending lawsuits:

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

CIN: A-05-93-00013	Michigan Blue Cross/Blue Shield Medicare Contract Audit, April 1993, \$3,010,916
CIN: A-05-95-00059	Audit of Administrative Costs of Blue Cross of Michigan, January 1997, \$1,787,345
CIN: A-07-96-01178	Medicare Pension Costs Claimed by Blue Cross-Michigan, November 1996, \$631,248
CIN: A-07-96-01198	Rocky Mountain Unfunded Pension, February 1997, \$543,421
CIN: A-07-97-01199	Blue Cross Of New Mexico Unfunded Pension Costs, February 1997, \$31,372
C. Report recently closed by the US Attorney and will be resolved within the next month:	
CIN: A-09-9100155	Blackburn Care Home, November 1991, \$1,772,944 (Related recommendation of \$662,370 outstanding on Table II).
D. Report Resolved After the Close of the Period:	
CIN: A-03-94-26611	State of Delaware, December 1993, \$163,100
E. Report Awaiting Departmental Appeals Board Decision:	
CIN: A-03-92-16229	State of Pennsylvania, March 1992, \$468,217

Table II

¹ The opening balance was adjusted to reflect an upward adjustment of \$23.2 million.

² Management decisions have not been made within 6 months of issuance on 15 reports.

A. Discussions with management are ongoing and it is expected that the following reports will be resolved during the next semiannual reporting period:	
CIN: A-06-91-00089	Audit of CN B Accounts to Detect Status of IHS Cash on Hand, April 1992, \$445,890
CIN: A-09-96-00079	Health Care Management Skilled Nursing Facilities Medical Supplies, January 1997, \$400,000
CIN: A-02-97-47699	Community Action Organization of Erie County, June 1997, \$251,282
CIN: A-07-97-01231	Doshi Washington, June 1997, \$203,510
CIN: A-06-96-43154	Muskegan Oceana Community Action Against Poverty, June 1996, \$130,993
CIN: A-03-97-48996	North Central West Virginia Community Action, August 1997, \$128,919
CIN: A-02-95-34946	City of Caguas Puerto Rico, March 1995, \$64,206
CIN: A-03-97-49148	Lynchburg Community Action Group, September 1997, \$51,629
CIN: A-04-97-46151	Tallatoona Economic Opportunity Authority, February 1997, \$38,051
CIN: A-06-96-43307	Nueces County Community Action Agency, June 1996, \$22,667
CIN: A-07-97-01232	Doshi Alaska, June 1997, \$21,218
CIN: A-07-97-01230	Doshi Oklahoma, June 1997, \$13,461
CIN: A-03-97-48262	Northern Tier Community Action Corp., June 1997, \$9,500
CIN: A-06-97-45023	Caddo Community Action Agency Inc., November 1996, \$8,880

B. One report remains open pending the resolution of the contractor's termination audit, related termination agreements and pending lawsuits:

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

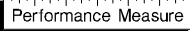
APPENDIX E

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

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

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	56
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	59
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	54
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	55
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none

Performance Measures

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

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Beneficiary Awareness of Medicare Fraud	4
Hospice Patients in Nursing Homes	22
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Excessive Medicare Payments for Prescription Drugs	30
Prescription Drug Use in Nursing Homes	30
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States’ Child Care Certificate Systems: An Early Assessment of Vulnerabilities and Barriers	46
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ACRONYMS

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

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