Department of Health and Human Services

Office of Inspector General

Semiannual Report

October 1, 1996 - March 31, 1997

June Gibbs Brown
Inspector General

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

A MESSAGE FROM THE SECRETARY

I would like to take this opportunity to acknowledge the vital role played by the Office of Inspector General (OIG) in the Department's efforts to safeguard the Nation's human services and health care systems. Ridding Medicare and Medicaid of fraud and abuse is one of the greatest challenges facing Federal and State authorities responsible for the integrity of these two national programs.

The Administration has set a policy of zero tolerance for health care fraud and abuse and has made the Department's efforts in this area a top priority. We will continue this crackdown through implementation of the Medicare integrity and antifraud and abuse programs authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Crucial to this intensified effort are the numerous antifraud initiatives launched by OIG in cooperation with other Federal agencies, State and local officials, health care professionals and consumers themselves. I am gratified to note the remarkable success of one of those undertakings, Operation Restore Trust, a project on which OIG worked jointly with the Health Care Financing Administration and the Administration on Aging. This interagency and interdisciplinary approach to law enforcement is a model that exemplifies the kind of coordinated planning program required by HIPAA to control health care fraud and abuse. I am pleased to note that HIPAA will provide a reliable funding stream for future years, allowing OIG to commit to increases in staffing and to expand its presence nationally.

The Inspector General and her staff can be proud of their record of accomplishment, and I am confident that their continued dedication and commitment will enable us to make further inroads in our efforts to enhance the quality of the Nation's human services and health care systems.

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, 1997. Since 1976, OIG's primary mission has been to protect the integrity of HHS programs and the health and welfare of the beneficiaries of those programs. Given the Department's size and scope, this is a broad mandate. To maximize our effectiveness in this effort, we have devised innovative ways of working and initiated collaborative projects with others in areas of common interest.

We have found that the partnerships forged over the past three years have greatly enhanced our ability to accomplish our mission. Among these initiatives were the establishment of the Executive Level Health Care Fraud Policy Group, through which we and the Department of Justice have jointly managed development of our investigative cases; the State Medicaid Audit Partnerships, which have allowed for more effective use of scarce audit resources by both Federal and State audit sectors; Operation Restore Trust, a 2-year demonstration project ending in March 1997, which has targeted abuses in home health agencies, nursing homes and durable medical equipment suppliers; and a 3-year investigative initiative conducted in coordination with other Federal and State law enforcement agencies to target abusive marketing and billing practices by the Nation's largest independent clinical laboratories.

To enlist the public's involvement in the antifraud campaign, our office has established a fraud and abuse hotline (1-800-HHS-TIPS) which, since its inception, has received more than 12,000 complaints that warranted follow-up action. Further, we are encouraging the health care industry to voluntarily strengthen internal controls by implementing Medicare and Medicaid compliance programs based on OIG-developed model compliance programs. We are also establishing protocols by which providers can arrange for third party review of certain billing practices.

Our accomplishments clearly reflect the success of our efforts. Moreover, through passage of the Health Insurance Portability and Accountability Act of 1996, that success has been acknowledged. The Health Insurance Act significantly increases OIG's resources and authorities to combat health care fraud. Currently, an intensified crackdown is being pursued, with the full support of the Administration. We have bolstered our investigative and audit staffs, formulated new antifraud strategies and strengthened our collaboration with the Health Care Financing Administration, the Administration on Aging, the Department of Justice and other Federal, State and local law enforcement offices. The number of OIG investigators and auditors will increase by about 20 percent this year, and we are opening new field offices in six States. By tne end of the year 2002, we expect to have nearly twice as many investigators and auditors as we had in Fiscal Year 1996.

Over the years, OIG has proven its value to the American public and the Nation's decision-makers. I am confident that our renewed resources will permit us to continue to do so.

June Gibbs Brown
Inspector General

HIGHLIGHTS

Introduction

During the 6-month period ending March 31, 1997, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) carried out a number of initiatives in furtherance of its mission to protect HHS programs, and the health and welfare of the beneficiaries served by them. Highlights of OIG's accomplishments for this reporting period follow. In large part, these accomplishments resulted from OIG's efforts to identify innovative means of maximizing its resources and supplementing those resources through collaboration with other Federal, State and local agencies in areas of mutual interest.

Health Care Fraud and Abuse Control Program

The recently enacted Health Insurance Portability and Accountability Act of 1996 contains far-reaching reforms to Federal laws to combat health care fraud and abuse. The Act establishes and funds a comprehensive new Health Care Fraud and Abuse Control Program, to be jointly administered by the HHS Secretary (acting through the Department's Inspector General), and the Attorney General. The program features a coordinated effort to fight fraud and abuse committed against all health plans. This focus on collaboration among Federal, State and local health care enforcement programs provides clear congressional recognition of the highly successful results of Operation Restore Trust, discussed below. With the Health Insurance Act, the Congress has enabled continued coordination among enforcement officials charged with combatting fraud and abuse in Medicare and Medicaid, and has expanded the program to include all health programs, both public and private. Moreover, the Congress has provided funding to OIG and its partners to ensure continuity of their important antifraud activities.

In addition to coordinating Federal, State and local health care law enforcement programs, the statutory goals of the program are: to facilitate enforcement of all applicable remedies for such fraud; to provide industry guidance relating to fraudulent practices; to establish a national Adverse Action Data Bank; and to conduct investigations, audits and other reviews relating to the provision of and payment for health care in this country.

The ambitious reforms contained in the Act have had, and will continue to have, a dramatic effect on OIG operations. The OIG is directing its current resources toward rapid, effective implementation of the Health Care Fraud and Abuse Control Program. The OIG is also hiring new staff to assume these expanded responsibilities. For more information concerning the Health Care Fraud and Abuse Control Program, see page 4.

Operation Restore Trust

As noted above, in implementing the Health Care Fraud and Abuse Control Program, OIG will build upon and extend the proven effective policies and practices of Operation Restore Trust, a 2-year project which has targeted fraud and abuse in three high-growth areas of the health care industry: nursing homes (including hospices), home health agencies and durable medical equipment (DME) suppliers. Using the expanded team concept, OIG has worked jointly on this project with the Health Care Financing Administration (HCFA) and the Administration on Aging (AoA). As the project's coordinator, OIG assembled multidisciplinary teams that included investigators from its Office of Investigations and the States' Medicaid fraud control units; auditors and evaluators from OIG and HCFA; quality assurance specialists from the State surveyors and DME regional carriers; State long-term care ombudsmen through AoA; and prosecutors from the Department of Justice (DOJ) and the State Attorneys General.

Funding for the 2-year demonstration project was completed in March 1997. During the funding period, Operation Restore Trust yielded remarkable results. The success of this cooperative venture is illustrated by OIG's accomplishments in working to eliminate inappropriate payments for incontinence supplies. Medicare Part B covers certain urinary incontinence supplies. An evaluation of reimbursements for these supplies found that Medicare allowances for such incontinence supplies had more than doubled in 3 years, from $88 million in 1990 to $230 million in 1993. In a December 1994 study, OIG found that questionable billing practices may have accounted for almost half of incontinence allowances in 1993. Outlays continued to rise to $260 million in Fiscal Year (FY) 1994, when the evaluation report was released. During this semiannual period, it became apparent that OIG's exposure of these billing abuses, coupled with a coordinated nationwide investigation involving more than 20 separate cases, and a concerted effort by HCFA's DME carriers, had turned the escalating reimbursements significantly downward. By the end of FY 1995, the abusive practices OIG identified had all but disappeared, eliminating more than $100 million a year in questionable payments. (See page 37)

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

Laboratory Initiatives

In coordination with HCFA, DOJ and other law enforcement agencies, OIG is concluding a 3-year initiative targeted at abusive marketing and billing practices by the Nation's largest independent clinical laboratories. During this reporting period, three of these laboratories signed agreements to pay a total of $642 million to settle civil and/or criminal liability for these practices. One result of this initiative was a series of lawsuits initiated by private citizens as well as OIG audits and investigations against smaller laboratories. Yet another was an interagency project focusing on billings by hospital-based outpatient clinical laboratories. During this period, nine hospitals signed agreements to settle possible charges of unbundling laboratory test panels to obtain higher Medicare reimbursement. As with the independent clinical laboratories, all the agreements contained corporate integrity requirements to ensure compliance with Medicare-regulated billing practices. (See pages 7 and 31)

Child Support Enforcement

Recently OIG expanded its participation in child support cases under deputation from DOJ. Several successful prosecutions and orders for restitution have already been obtained. In addition, OIG and the Internal Revenue Service (IRS) conducted a joint review that found that a simple coordinated approach between the Office of Child Support Enforcement and IRS could help identify noncustodial parents who misrepresent children's living arrangements on their tax returns. This approach would have resulted in additional tax liabilities of $212 million in 1993. Moreover, this study and other information developed independently by IRS indicate that total annual tax losses of $1.4 billion or more could result from noncustodial parents inappropriately claiming custody of children on Federal income tax returns. (See pages 52, 53)

Health Education Assistance Loan Program

The OIG has been very successful in enforcing program rules and returning tax dollars through its involvement in the Health Education Assistance Loan (HEAL) program under which the Department provides money to students seeking an education in a health-related field. Unfortunately, some loan recipients ignore their indebtedness. At this point, OIG excludes them from participating in the Medicare, Medicaid and other Federal programs. Upon being notified of their exclusion, some of these health professionals immediately repay their entire HEAL debt. Others enter into settlement agreements whereby the exclusion is stayed while the individuals pay monthly amounts to satisfy their debts; if they default on these agreements, they are then excluded until their entire debt is repaid.

As of the conclusion of this reporting period, 707 individuals had entered into settlement agreements or completely repaid their HEALs. The amount of money already repaid and being repaid through settlements totals over $43 million. (See page 47)

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 Measure . Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program which is measured by the number of inoculations provided per dollar of cost. In OIG's opinion, the 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.sbaonline.sba.gov/ignet/internal/hhs/hhs.html

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Operation Restore Trust

Chapter I

OPERATION RESTORE TRUST

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

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

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

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

All OIG ongoing and new investigations, audits and inspections related to fraud and abuse in the targeted areas of the five States were included into the project, so that they might benefit from its focused attention, expertise and energies. At the present time, there are 210 pending cases. One hundred fifty-five of the 210 cases are joint investigations with other law enforcement agencies, including the Federal Bureau of Investigation, the United States Postal Service, the Railroad Retirement Board OIG, the Defense Criminal Investigative Service and State Attorneys General offices.

Since the special hotline was established in June 1995, it has received 13,794 complaints related to Department programs. Resolving these complaints has resulted in recovering approximately $5.2 million of overpayments.

Thus far, 74 criminal convictions, 58 civil actions and 54 current indictments are attributable to Operation Restore Trust. In addition, 219 providers have been excluded. Also, OIG has identified a total of more than $167 million in fines, recoveries, settlements and civil monetary penalties owed to the Federal Government.

To date, 47 audit and inspection reports related to Operation Restore Trust have been issued. At the present time, another 31 audits and evaluations are underway. In addition, HCFA has completed reviews at 168 home health agencies and nursing homes. Further, OIG's Operation Restore Trust activities have either resulted in proposals or supported existing proposals to change policy in order to correct systemic weaknesses.

The funding for the 2-year Operation Restore Trust initiative terminated at the end of March 1997. However, the team approach using the talents of multiple agencies will continue to be used in OIG's future work.

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

Health Care Financing Administration

Chapter II

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

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

The Medicaid program provides grants to States for medical care for 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 certain services and medical equipment; analyzed various State licensure and discipline issues; reviewed several aspects of medical necessity and quality of care under PPS, including the risk of early discharge; and evaluated the care rendered by itinerant surgeons and the treatment provided by physicians performing in-office surgery.

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

Fraud and Abuse Control Program

During this reporting period, OIG took steps toward implementing its significant new responsibilities under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191). The Act establishes a comprehensive program to combat fraud committed against all health plans, both public and private. This legislation required the Departments of Justice (DOJ) and Health and Human Services (HHS) to establish a Fraud and Abuse Control Program, no later than 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, the Act directs that an amount equalling 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 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."

In the first year of operation under the new fraud control program (Fiscal Year 1997), the Secretary and the Attorney General certified $104 million for appropriation to the account. Of these funds, "not less than $60 million and not more than $70 million" are to be available for OIG for Medicare and Medicaid work.

In addition to establishing the Fraud and Abuse Control Program, the Act directs the Attorney General and the Secretary to issue guidelines to carry out the program, including guidelines on the collection of information from health plans, and the confidentiality of such information. In fulfillment of this mandate, OIG and DOJ drafted implementing guidelines that were approved by the Attorney General and the Secretary in December 1996. The OIG has begun the important job of hiring additional auditors, investigators, evaluators and attorneys to accomplish the office's responsibilities under the expanded antifraud and abuse program. Regulations mandated by the Act are under development, and those pertaining to OIG's process for securing formal advisory opinions were issued (see page 60). The OIG is providing technical assistance to the Department in establishing the Adverse Action Data Bank. The OIG has also begun the important process of tracking expenditures and recoveries in health care cases so as to be able to accurately assess the effectiveness of the Fraud and Abuse Control Program.

Implementation of the Act has been a cooperative effort. The OIG has and will continue to work closely with other components of HHS, chiefly HCFA and the Office of the Assistant Secretary for Management and Budget.

Major Hospital Initiatives

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

A. Physicians at Teaching Hospitals

The OIG has undertaken a nationwide initiative to review compliance with the rules governing reimbursements to physicians at teaching hospitals (PATH) and other Medicare payment rules. 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 to ensure that the claims accurately reflect the level of service provided to the patient.

The PATH initiative has been undertaken as a result of OIG's extensive audit and investigative work in this area. To date, two institutions have entered into settlement with the Federal Government to resolve their civil False Claims Act liability for overpayments related to improper claims submitted in the teaching setting and to upcoding, i.e., charging a higher level of service than was actually delivered. These settlements have resulted in the Government's recovery of more than $41 million in overpayments and penalties. As a condition of settlement, these institutions have also implemented corporate integrity programs in order to prevent and detect future erroneous claims.

In addition to conducting focused audits of these providers' medical billing records, OIG is trying a new approach -- giving the institution the opportunity to conduct a self-audit with Government oversight and to report its findings to OIG.

Medicare pays the costs of training residents and interns through the Graduate Medical Education (GME) program. Medicare also pays an additional amount per diagnosis-related group in recognition of the additional costs associated with training residents and interns. These reimbursements can total over $100,000 per resident per year. Medicare paid approximately $8 billion to teaching hospitals in 1996 for the costs of training residents. The Medicare payments described above include payments to teaching physicians for their role in supervising residents and interns.

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. The project addresses two issues: whether teaching physicians are performing the services themselves or in the presence of the residents and whether the levels of services are being billed accurately. The Medicare billing system's vulnerability to upcoding is a longstanding concern at OIG. That concern is focused on identifying patterns of abuse, not isolated, inadvertent mistakes.

At the initiation of each PATH review, OIG gathers the guidance available to the hospital from the local Medicare contractor, as well as the hospital's internal policies on documenting and billing physician services. These guidelines and instructions are an important component in the PATH review and are used to establish the standard by which the institution's Medicare billings are evaluated.

Over 20 hospitals have already elected the self-audit approach. In addition, there are currently two OIG-conducted audits underway.

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

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

The project is being coordinated by the U. S. Attorney's Office - Middle District of Pennsylvania. As of the end of the reporting period, settlements have been executed with 804 hospitals. The total anticipated recovery under this nationwide project is approximately $90 million to $110 million over the next 2 years from an estimated total of more than 4,400 hospitals.

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

C. Ohio Outpatient Laboratory Unbundling Project

The OIG, DOJ and the State of Ohio have joined forces to combat Medicare and Medicaid fraud in hospital outpatient laboratory billing practices. The Ohio Outpatient Laboratory Unbundling Project seeks to recover overpayments related to erroneous or excessive claims submitted for urinalysis, organ panel, hematology and automated blood chemistry tests by hospital outpatient laboratories. These abusive practices stem from the unbundling of laboratory tests, which has been found to be a widely practiced abuse (see page 31).

Laboratory services are particularly vulnerable to this practice because of the number of tests ordered at one time and the capability of equipment to run several tests from one sample. The reimbursement for tests bundled into a panel is less than that for each test run separately.

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

To date, OIG has recorded settlements with nine hospitals that have recovered more than $6 million. At least another 16 settlements are expected, for an estimated project total of close to $10 million. The OIG and DOJ are working together on a national project to obtain recoveries in unbundled laboratory claims in hospital outpatient laboratories, and to provide data to the United States Attorneys Offices interested in pursuing this recovery initiative in their districts. The OIG is also collaborating with DOJ to produce a model settlement agreement, including compliance measures.

See page 41 for other State partnership work.

Hospital Fraud

Besides the major national projects related to hospitals' overbilling of Medicare, several other cases involving hospital fraud reached closure during this period.

- A former controller and vice president of finance at a New Jersey medical center was sentenced to 25 months in prison for tax evasion, embezzlement and fraud. He was ordered to make restitution of more than $1 million to the hospital and $24,870 to Medicare Part A. He was also fined $20,000. The official became a cooperating witness shortly after subpoenas were issued in this case, which involved kickbacks and false billing schemes that cost the hospital nearly $3.8 million. His early cooperation significantly advanced the investigation of the executive vice president of finance at the hospital and other defendants. The executive vice president was sentenced earlier to 55 months in prison and ordered to repay $21,000 -- which was all he was able to pay. Three others who also pled guilty have yet to be sentenced.

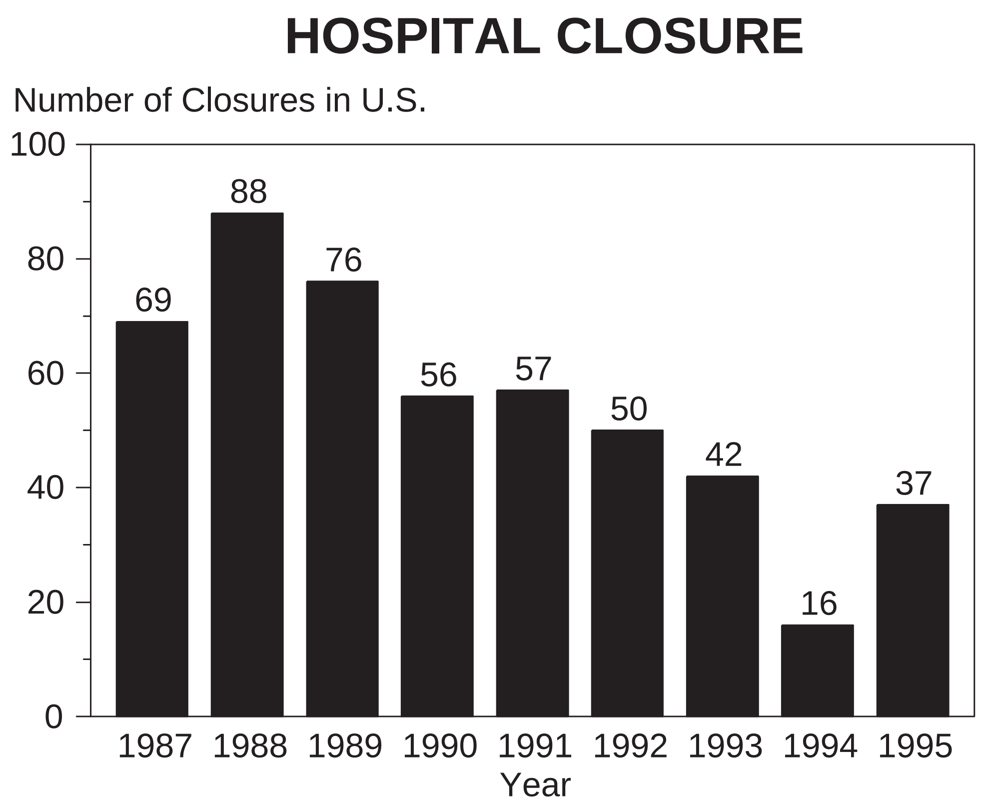
- Also in New Jersey, a corporation operating four hospitals agreed to pay the Government $875,000 to resolve civil liabilities under the False Claims Act and the civil monetary penalties (CMP) law. Between 1986 and 1995, the corporation billed Medicare twice for the same service or billed both Medicare and the patient's private insurance. Rather then refunding the outstanding credit balances to Medicare, the corporation kept more than $350,000 and transferred the money to its operating account. As part of the settlement, the corporation agreed to enter into a comprehensive corporate compliance program to prevent recurrence of the problem.

Hospital Closure: 1995

Performance Measure

In past years, the closure of general, acute care hospitals generated public and congressional concern. In response, OIG issued a report in May 1989 which described the nationwide phenomenon of hospital closure in 1987. Since that time, OIG has issued annual reports on the extent, characteristics and impact of hospital closure. Overall, OIG determined that the hospitals that closed were small and had low occupancy rates. Most patients were able to get medical care nearby.

The OIG's inspection of hospital closure in 1995 produced similar findings. As indicated in the following chart, 37 general, acute care hospitals closed in that year. While this was 21 more than in 1994, it was still less than in any other year since OIG began its series of reports.



Although residents in 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. At the time of OIG's inspection, 17 of the 37 closed hospital facilities were being used for health-related services and plans were being made to use 3 additional vacant hospitals for health-related services. (OEI-04-96-00060)

Hospital Patient Transfers Incorrectly Paid as Discharges

Under Medicare regulations, PPS payments are available at the full prospectively set diagnosis related group (DRG) rate for patients who are discharged from the hospital; payments for transfers between PPS hospitals are determined through the calculation of per diem amounts and the actual length-of-stay at the transferring hospital. Previously, OIG identified incorrectly reported transfers under Medicare's PPS through November 1991, resulting in approximately $227 million of recoveries and savings. In accordance with

OIG's recommendation, HCFA agreed to develop an edit to detect these types of coding errors and alert the intermediary to take corrective action.

In a follow-up review, OIG found that intermediaries continued to make payments for incorrectly reported transfers, and identified another 43,000 incorrectly reported transfers and approximately $127.3 million of potential overpayments for the 3-year period ended December 31, 1994. The OIG determined that the PPS transfer edit does detect incorrectly reported PPS transfers, but that fiscal intermediaries may not be processing them according to HCFA's instructions. The OIG recommended that HCFA advise all intermediaries that the PPS transfer instructions must be followed when processing future transactions, assist OIG in identifying the cause of the problem, and cooperate with Department of Justice efforts to recoup past overpayments and penalties. In response to the draft report, HCFA agreed with OIG's recommendations. (CIN: A-06-95-00083)

Medicare Beneficiary Interest in Health Maintenance Organizations in 1995

Performance Measure

Based on a 1995 national survey of randomly selected Medicare beneficiaries, this study found that general awareness of health maintenance organizations (HMOs) had increased since 1994. Seventy percent of beneficiaries had heard of HMOs, and about 44 percent knew whether or not they lived in locations where they could join an HMO. Of the respondents, 35 percent expressed an interest in joining an HMO. Of those who were not interested, about 33 percent said the main reason was they could not select their own physicians. Only 7 percent of the beneficiaries expressed concern about quality of care in an HMO. At the same time, only 17 percent of the beneficiaries were aware that they would have appeal rights if they joined an HMO.

While HCFA has done much to enhance beneficiaries' choices in medical care, OIG believes that further steps might be taken to educate Medicare beneficiaries about Medicare HMOs, and explore ways that allow beneficiaries greater freedom to choose their own physicians in managed care settings. (OEI-04-93-00151)

Medicare Health Maintenance Organization Appeal and Grievance Processes

Performance Measure

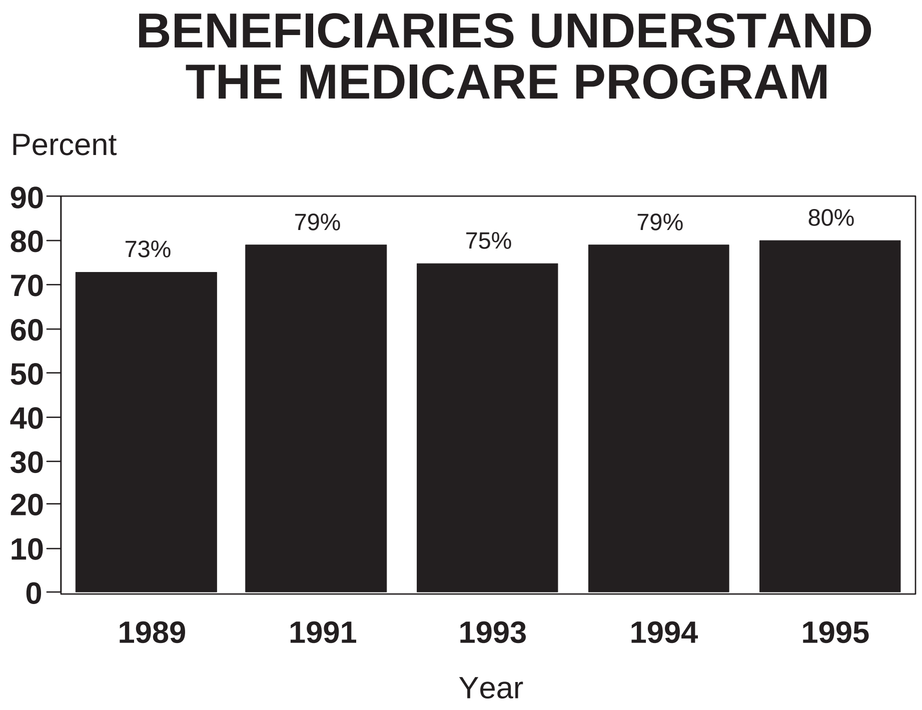
An inspection on the Medicare HMO appeal and grievance process resulted in a series of four final reports on various aspects of the subject. The OIG found that most beneficiaries were aware of their general right to complain about HMO services and payments. However, they were less aware of the particular circumstances under which they could exercise this right. The OIG also found some problems regarding communication between HMOs and patients about denial of payments or services. Other weaknesses included: HMOs not fully complying with HCFA's directives for processing appeals and grievances; marketing and enrollment materials and operating procedures containing incorrect or incomplete information on appeal and grievance rights; and HMOs not maintaining statistical information needed for the ongoing evaluation of appeal and grievance practices.

The OIG recommended that HCFA: more actively monitor HMOs; standardize marketing and enrollment materials; ensure that HMOs properly distinguish and process appeals and grievances; require HMOs to report minimum statistical information; establish minimum requirements for case file documentation; and modify the HMO/Competitive Medical Plan Manual. In its comments, HCFA agreed that improvements are needed in the appeal and grievance processes and summarized its initiatives in this area. (OEI-07-94-00280; OEI-7-94-00281; OEI-07-94-00282; OEI-07-94-00283)

Medicare Beneficiary Satisfaction: 1995

Performance Measure

In OIG's fifth survey to determine beneficiary experience and satisfaction with Medicare services, 80 percent of respondents said the program is understandable. As illustrated in the following chart, these results were similar to those of earlier years.



The OIG found that beneficiary understanding of and satisfaction with certain Medicare services had improved; for example, claims were processed with greater speed and fewer problems. However, several other areas continued to need improvement. The OIG recommended that HCFA develop a plan for improving beneficiary satisfaction and understanding in the problem areas noted in the report. (OEI-04-93-00150)

Medicare Beneficiary Satisfaction with 1996 Medicare Handbook

Performance Measure

More than 500 beneficiaries responded to OIG's survey of satisfaction with the new 1996 Medicare Handbook. Most Medicare beneficiaries who received the new handbook thought it provided them with enough information to understand Medicare benefits. Most preferred the condensed 1996 version to the more detailed earlier versions of the handbook. Twenty-seven percent of respondents, however, said they had not received the 1996 handbook. Beneficiary opinions were mixed on how often they would like to receive the handbook. The HCFA plans to examine its distribution strategies to determine ways to improve the dissemination of the handbooks. (OEI-04-96-00280)

Medicare Beneficiary Satisfaction with Supplemental Health Insurance

Performance Measure

In the 1995 survey of Medicare beneficiary satisfaction, 942 beneficiaries were asked about their satisfaction with insurance that supplements Medicare coverage. The survey indicated that 84 percent of beneficiaries have medical coverage in addition to Medicare, and they are satisfied with their supplemental policies. Most said they would call the insurance company that issued the supplemental policy if they had problems with their supplemental policies. (OEI-04-93-00154)

"Know Your Number" Brochure for Dialysis Patients

Performance Measure

An inspection of the HCFA "Know Your Number" Brochure for end stage renal disease patients found that the brochure shows promise as a tool for improving the health and well-being of dialysis patients. That is especially true when the dialysis facility actively promotes the use of the urea reduction ratio (URR) or urea kinetic model (KT/V) numbers. The OIG found that the brochure was somewhat successful in increasing patient awareness of URR or KT/V tests used by dialysis facilities to measure adequacy of dialysis. However, there were problems with dissemination of the brochure. The majority of patients did not receive it, and most of those who did were not familiar with the tests used by their dialysis facilities to measure adequacy of dialysis and the associated target numbers. Furthermore, the inspection found that some facilities do not calculate patients' URR or KT/V numbers on a monthly basis.

The OIG made a number of recommendations to deal with these shortcomings, and HCFA concurred with them. However, a new concern arose after the drafts were issued. The HCFA informed OIG that it had no requirement for facilities to measure adequacy of dialysis at prescribed intervals but that its revised End Stage Renal Disease Conditions for Coverage will soon require facilities to calculate adequacy of dialysis quarterly. In contrast, the upcoming National Kidney Foundation's Dialysis Outcome Quality Initiative guidelines will recommend a monthly calculation. The OIG is concerned that facilities will interpret HCFA's Conditions for Coverage as the acceptable standard and conduct adequacy testing only quarterly. The OIG is convinced that facilities should be required to calculate adequacy numbers monthly and urges HCFA to reconsider to amend the Conditions for Coverage accordingly. (OEI-06-95-00320; OEI-06-95-00321)

Medicare Administrative Costs

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

A. Arkansas Blue Cross Blue Shield: Parts A and B

The OIG recommended a financial adjustment of $1.4 million for unallowable administrative costs claimed by Arkansas Blue Cross Blue Shield for fiscal years (FYs) 1989 through 1994. The unallowable costs included: over $800,000 in understated complementary credits from its private insurance business; more than $118,000 for its share of interest earned on an HMO reserve balance for employee health insurance; nearly $68,000 used to fund a general contingency reserve for a preferred provider organization as part of its employee health insurance plan; over $228,000 in excess executive compensation costs allocated during FYs 1991 through 1994; and nearly $59,000 in miscellaneous expenses. The company agreed with $1.2 of the questioned costs and disagreed with the findings on employee health insurance and executive compensation costs. (CIN: A-06-96-00008)

B. Blue Cross Blue Shield of Colorado: Part B

This OIG review of the administrative costs claimed by Blue Cross Blue Shield of Colorado resulted in a recommended financial adjustment of $4.2 million due to costs claimed in excess of approved budget amounts. Almost $260,000 of the $4.2 million was also unallowable for other reasons. This amount consisted of excessive executive compensation of $141,000 and unallowable cafeteria costs of $116,000. The contractor disagreed with OIG's findings and recommendations. The HCFA will resolve this matter. (CIN: A-07-96-02001)

Costs Claimed by Blue Cross and Blue Shield of Michigan

Blue Cross and Blue Shield of Michigan administered Medicare Parts A and B operations under cost reimbursement contracts until the contractual relationship was terminated in 1994.

A. Post Retirement Costs

At HCFA's request, OIG reviewed the company's $9 million claim for post retirement costs estimated to be incurred after termination of the Medicare contracts. The OIG determined that the claim represented a retroactive change in the basis of accounting and a request for reimbursement of unfunded costs, which are not permitted under the Federal Acquisition

Regulations. Accordingly, OIG recommended that the claim for $9 million be denied. The company disagreed, arguing that the costs would have been allowable if the contract had continued until the costs were funded. However, HCFA concurred with OIG's analysis and recommendation. (CIN: A-07-96-01177)

B. Pension Plan

The OIG determined that as of January 1995, the company had excess Medicare pension assets of almost $12 million. Regulations and the Medicare contracts provide that pension gains which occur when the Medicare contract terminates should be credited to the Medicare program. Accordingly, OIG recommended that the company remit almost $12 million in excess pension assets to the Medicare program. While the company disagreed, asserting that the calculations should have considered future benefits and a lower retirement age, HCFA concurred with OIG's analysis and recommendation. (CIN: A-07-96-01176)

C. Administrative Costs

The OIG's audit of the company's final claim for Medicare Parts A and B administrative costs identified unallowable costs of $1.7 million. These costs included: over $500,000 in unallowable severance pay for terminated employees and over $800,000 in professional consultant fees, post-retirement benefit costs, data entry costs, executive incentive awards and other costs which were unreasonable, unallowable and improperly allocated. The company generally disagreed with OIG's findings and recommendations; however, HCFA was supportive of OIG's position. (CIN: A-05-95-00059)

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:

- One of the Nation's largest DME suppliers agreed to pay $1.6 million to settle allegations that it submitted false Medicare claims for patients referred through kickback arrangements with providers in Georgia, Florida and New Mexico. A group of four physicians in Georgia agreed to pay almost $350,000 for accepting the kickbacks, under the guise of a sham consulting contract, for referring patients for oxygen supplies. The supplier agreed to enter a corporate integrity agreement to undertake measures to ensure compliance with applicable laws and Medicare rules and regulations.

- The owner of a New York DME company agreed to pay $80,000 to resolve civil liabilities for submitting false claims to the Medicare program. She paid kickbacks to a doctor for signing certificates of medical necessity (CMNs). She paid approximately $1,500 in exchange for the CMNs, which she then used to bill Medicare more than $40,000 for medical equipment. Earlier, in a related criminal action, the woman pled guilty to kickback violations after she was videotaped making seven payments to the doctor. The doctor, who became a confidential informant, agreed to cooperate in the investigation. The woman will be excluded from participation in Medicare and State health care programs for at least 5 years.

- The owner of a psychiatric hospital in Missouri entered for the hospital a plea of guilty to making a false claim to Civilian Health and Medical Plan of the Uniformed Services (CHAMPUS). The administrator of the hospital was indicted earlier for paying kickbacks to a physician for referring psychiatric patients to the hospital. The hospital was sentenced to 5 years probation and ordered to pay close to $63,160 in restitution. In lieu of a monetary fine, the hospital must produce a community service plan within 30 days. Both the owner and the hospital agreed to cooperate in the prosecution of the administrator and the physician for Medicare and CHAMPUS fraud. The two had worked together earlier at another hospital, at which the physician was convicted of accepting kickbacks.

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 1,353 sanctions, in the form of exclusions or civil recoveries, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. Over half of the exclusions were based on conviction of program-related crimes, conviction of controlled substance manufacture or distribution, conviction related to patient abuse or loss of license to practice health care. Monetary penalties can be assessed under several CMP authorities which have been delegated to OIG.

A. Program Exclusions

Title XI of the Social Security Act provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, distribution of a controlled substance, revocation or surrender of a health care license, or failure to repay health education assistance loans (HEALs). Exclusion is mandatory for those convicted of program-related crimes or crimes relating to patient abuse. A significant number of OIG exclusions involve failure to repay HEALs, as discussed in more detail in the chapter on the Public Health Service. During this reporting period, OIG imposed exclusions on 1,344 individuals and entities in all.

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

- A California psychiatrist and two unlicensed psychotherapists were each excluded for 10 years after being convicted of defrauding the California Medicaid program (Medi-Cal). They had devised a scheme where unlicensed individuals undertook psychiatric counseling sessions and their clinic billed Medi-Cal as if a psychiatrist had been present throughout the entire session. The loss to the Medi-Cal program as a result of this scheme was in excess of $500,000.

- An Oklahoma physician was required to make restitution to Medicare of $190,000 after being convicted for his part in a conspiracy to defraud Medicare in which he received remuneration for referring patients to a psychologist. After his conviction, he was excluded for 10 years.

- The owner of a clinic in California was convicted of defrauding Medi-Cal by submitting claims for the services of an unlicensed physician. The court ordered her to pay restitution of $100,000. After being convicted, the clinic owner was excluded for 10 years.

- A Florida DME company owner and the sales manager of the company were each excluded for 10 years. These exclusions were the result of their convictions for defrauding the Medicare program of over $108,000. They had submitted claims for DME and diagnostic x-ray tests which had not been ordered or determined to be medically necessary by a physician, and for equipment which had not been provided to beneficiaries. As a result of the owner's exclusion, the two companies that he owned were also excluded from program participation for 10 years.

- A Louisiana mental health rehabilitation provider and her company were each excluded for 10 years. Her exclusion was based on her conviction for defrauding the Medicaid program of $280,000 by billing for services which had to be ordered by a physician, or in some instances, performed under the supervision of a physician when no such order existed or no physician supervision was provided.

- An exclusion of 20 years was imposed on an Illinois physician. He had been convicted of aggravated criminal sexual assault of patients who were children as well as child pornography involving these patients.

- A Texas dentist was found guilty of involuntary manslaughter after giving a patient a fatal overdose of sedatives during gum surgery. After this conviction, the dentist was excluded for 15 years.

- The owner of a Pennsylvania medical center was convicted of defrauding insurance companies by submitting fraudulent medical bills and reports to them. He was ordered to pay over $106,000 in restitution to the insurance companies. As a result of this conviction, he was excluded for 10 years from program participation.

- A 10-year exclusion was imposed on the manager of a medical service for his part in a scheme to defraud health insurance companies. He had instructed company staff to fabricate fraudulent medical bills and reports describing medical treatment purportedly rendered to personal injury clients and to submit the claims to the insurance companies. He was ordered to pay restitution of $100,000 to the insurance companies.

- The Idaho Department of Health and Welfare sanctioned a Medicaid personal care services provider for intentionally submitting claims for services which were not provided. Based on this action, he was excluded from program participation for 10 years.

B. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law allows recoupment of monies lost through illegitimate claims 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 Federal Civil False Claims Act. Many providers elect to settle their cases prior to litigation. As part of resolving these cases, OIG frequently imposes corporate 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 almost $937 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 Pennsylvania-based ambulance company entered a global settlement of allegations that it billed the Government for nonallowable transportation services. The company agreed to forfeit $4.6 million in payments withheld by the Medicare carrier. Criminal investigation of several individuals is ongoing. Decisions on program exclusion have been postponed pending negotiation of a corporate integrity agreement with its new owner.

- A Wisconsin rehabilitation center entered a consent agreement to repay $326,000 to Medicare for submitting claims for nonallowable services. The company billed for individual occupational therapy when it was actually done in group sessions. It also claimed lease costs that were considerably higher than fair market price for the region. To escape making the repayment, the company attempted to file for bankruptcy and the owner attempted to sell the company. However, the judge ordered that neither action could be taken until the Medicare settlement was entered.

- A speech therapist, who practiced in Iowa and Minnesota, and his wife agreed to pay $300,000 to resolve civil liability for submitting false claims to Medicare. They set up several corporations to bill for speech therapy. Investigation showed that from 1988 till 1991 they billed for noncovered services disguised as covered services, billed for services performed by unlicensed aides and filed false cost reports. The loss to Medicare was approximately $835,000. A review of the speech therapist's financial statements showed funds were not available to make the Government whole. In 1993, he was sentenced to prison, ordered to pay $40,000 in restitution and excluded from Medicare and State health care programs for his part in the scheme.

- An Iowa podiatrist agreed to pay $100,000 to resolve his civil liability for submitting improper Medicare claims. Between 1993 and 1995, the podiatrist billed for whirlpool treatments each time a patient visited his office. He also billed for removal of skin lesions when in fact he was performing noncovered routine foot care. The improper billing resulted in an overpayment of approximately $61,000.

Other major settlements are described under the sections on kickbacks, and laboratory and DME fraud.

C. Compliance Activities

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

To provide further assistance to the private sector in this area, OIG is developing model compliance plans for the various parts of the health care industry which providers may adopt voluntarily. On February 24, 1997, the Inspector General announced the release of the Model Compliance Plan for Clinical Laboratories. During the drafting of the plan, OIG consulted with the clinical laboratory industry, DOJ and HCFA, whose comments were considered and incorporated into the plan. The plan sets forth the fundamental components of an effective corporate compliance plan. The model offers advice and guidance to providers in the clinical laboratory industry who are initiating or maintaining voluntary compliance programs. Copies of the plan have been sent to numerous health care professional associations. The plan will also be published in the Federal Register and posted on the Internet. The OIG will release additional model plans specific to many types of health care providers.

The OIG is also monitoring and verifying the completion of corporate integrity plan obligations that have been and are being established as a result of settlement negotiations following an OIG investigation or audit. Currently, OIG is monitoring 70 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 within the agreed time limit could result in the exclusion of the provider.

Medicare Payments to Excluded and Unlicensed Health Care Providers

Performance Measure

In a review in Maryland, OIG determined that the Medicare program continues to reimburse individuals who have either been excluded by OIG from participation in the program or still practice even though their Maryland licenses were suspended or revoked.

Specifically, OIG found that 22 percent of the excluded individuals (6 of 27) and 15 percent of the unlicensed individuals (6 of 40) billed for and received Medicare reimbursement for services provided during the time of their exclusion or while unlicensed. Further, OIG found that individuals whose Maryland licenses were suspended or revoked relocated to other States where they continued to treat Medicare beneficiaries, and current databases containing exclusion and adverse licensure actions were incomplete and inaccessible.

The OIG recommended that HCFA: ensure that Medicare contractors establish controls to preclude payments to excluded and unlicensed providers; expand OIG's data match nationally to identify payments made to excluded providers; and recover the erroneous payments identified in the review and subsequent data matches. Moreover, OIG proposed that HCFA confirm that its contractors get licensing information from the appropriate State agencies and that Medicare payments are terminated to unlicensed individuals; institute edits to prevent inappropriate payments; continue to support proposals to create a comprehensive database to capture negative actions on all health care providers and be accessible to all parties; and work with the Public Health Service to implement section 1921 of the Social Security Act requiring States to provide information to the Secretary regarding specified adverse licensing actions taken by the State entity responsible for licensing of health care providers. The HCFA agreed with OIG's recommendations. (CIN: A-14-96-00202)

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:

- A Florida physician and acupuncturist were sentenced for conspiracy in fraudulently billing Medicare $1.9 million. The acupuncturist and her former husband, who co-owned six acupuncture clinics, hired the physician and other medical doctors to prescribe physical therapy when the couple had performed non-billable acupuncture. The physician also backdated physical examinations, and had others backdate them, to make them appear to have been done before the couple began treatments. The physician was sentenced to 30 months in prison and ordered to repay $144,390. The acupuncturist, who pled guilty and testified against him, was sentenced to 36 months probation and ordered to pay back $927,000, the actual amount Medicare overpaid. Her former husband is a fugitive and is believed to have fled to Hong Kong.

- The former chief executive officer of a vascular diagnostic testing laboratory was sentenced in Georgia to 51 months incarceration. Over a 3-year period, the officer used his position to cause submission of Medicare and Medicaid claims for services not performed. He was convicted on 100 counts of false claims, one count of attempting to induce a witness to give false testimony before a grand jury and one count of giving false testimony himself to the grand jury. He was fined $65,000 and ordered to pay $219,600 in restitution. At the time, he was on parole as a result of a 1985 conviction for Medicare/Medicaid fraud and related drug charges.

- A judgment was entered in Pennsylvania against the owner of several personal care boarding homes. He was ordered to pay $500,000, sell his personal care homes and turn over the proceeds to the Federal Government. The court also ordered that he be permanently enjoined from future ownership, management, operation or employment in a commercial boarding home or personal care home. Earlier, he was charged in a civil suit with posing as a medical doctor in order to defraud the Medicaid program through the residents of the homes, as well as stealing their Social Security and Supplemental Security Income checks, and providing inadequate care to the residents.

- A physician was sentenced in Ohio to 36 months incarceration and fined $195,000 for billing Medicare, Blue Cross Blue Shield and a private insurance company for physical therapy services that were not provided. The physician and his office manager also participated in a scheme involving insurance fraud. The office manager claimed injury from a no-contact auto accident, for which the physician submitted 159 false insurance claims. The physician also claimed payment for two sigmoidoscopies performed on the office manager, which she claimed she could not recall. The physician's conviction was the result of the testimony of the office manager, who was dismissed earlier as a defendant.

- A California urologist was sentenced to 24 months in prison for submitting false claims to Medicare. He had pled guilty to submitting claims for complex procedures he did not perform. Earlier he agreed to pay $440,000 in damages and penalties, which were paid before the sentencing. The urologist will be excluded from Medicare for 10 years because of aggravating circumstances: he performed invasive procedures such as cystourethroscopies (visual examinations of the bladder and urethra) and cystometrograms (assessments of the bladder's neuromuscular function) which he admitted were not medically necessary. He has surrendered his medical license.

- A consent judgment was entered in New York by which an optometrist will repay $120,000 in Medicare claims for post-cataract surgery eyeglasses which were not provided. The optometrist also billed Medicare for another optometrist's services in exchange for a portion of the proceeds. The judgment was based on his earlier criminal conviction, for which he served probation and made restitution of $24,000.

- The operator of a Mississippi laboratory was sentenced to 15 months incarceration for billing Medicare for doppler tests that were never done. The false billing resulted in an overpayment of $35,000. He was fined $1,000 and placed on 3 years supervised release following his prison term. A civil settlement of $85,000 has also been obtained from the owners of the laboratory.

- A Washington State chiropractor pled guilty to one count of submitting a false claim to an employee welfare benefit program. The chiropractor also billed Medicare and the Department of Labor for services for patients who missed or cancelled their appointments. The plea agreement called for him to pay a total of $102,110 in restitution, fines and civil monetary penalties. He was immediately sentenced to 3 years probation.

- A California psychiatrist was sentenced for conspiracy and mail fraud related to submitting false Medicare and private insurer claims. The psychiatrist was sentenced to 15 months incarceration and 3 years probation, and ordered to pay $85,930 in restitution. He allowed his brother-in-law, who operated an optometry practice, to use his license to charge for tests that were either never performed or medically unnecessary. The brother-in-law was sentenced earlier to 5 months in jail and 5 months home detention, and ordered to pay restitution of $150,000.

- Three related ambulance companies in Connecticut agreed to pay $700,000 to resolve their civil liability for the submission of false claims to the Medicare program. Between 1991 and 1994, the companies submitted fraudulent claims for transporting mostly ambulatory patients from their residences or nonskilled nursing homes to renal dialysis clinics. The Medicare overpayment was approximately $541,000. As part of the settlement, the companies must enter a corporate compliance plan designed to prevent recurrence of improper billings.

- A Texas woman was sentenced to a year and a day in prison and ordered to make restitution of $41,500 she had stolen in Medicare and Medicaid checks. While employed by a doctor as an office manager, she submitted claims for a personal friend, although no services were performed. When the checks came in, the two split the proceeds, with the woman taking the larger amount. The friend was sentenced to a year of probation and fined $2,550.

- A former Internal Revenue Service (IRS) mail clerk was sentenced for impersonating a Federal officer, intimidating a witness and obstructing an official proceeding. He was sentenced to 5 months incarceration and 5 months home confinement with electronic monitoring, followed by 1 year supervised release. The man was employed by an ambulance company before becoming an IRS employee. During an investigation of the ambulance company for falsely billing Medicare and Medicaid, several employees said that the man claimed to be an IRS agent and threatened at least one of them with a tax audit if he cooperated in the investigation. The man was terminated from his IRS job after being convicted of charges.

- A former police officer was sentenced in Pennsylvania to 3 years probation and 300 hours of community service for Medicare and Medicaid fraud. As executive director of a drug and alcohol rehabilitation center in Philadelphia, he had billed for services not rendered, had billed for individual therapy sessions when group sessions had been provided and had altered clinical records to obstruct an audit by the State. The sentence reflected the man's cooperation in the investigation of the center's owners. The fraud identified amounted to $192,690, but the executive director was ordered to pay $9,000 because of his financial condition.

- A psychologist was sentenced in Pennsylvania for mail fraud in relation to Medicare fraud. She was sentenced to 6 months home detention, for which she must pay the cost, 12 months probation and 300 hours of community service. Over a 4-year period, she billed Medicare for more than 700 services she never provided. The estimated loss to Medicare was $113,000 for psychological testing and psychotherapy never performed. When the carrier questioned the charges, the psychologist created false clinical records. A civil prosecution is underway.

- Through its six owners, a company entered into an agreement in Louisiana to pay $85,000 to resolve Federal civil false claims liability. The company conducted diagnostic testing, primarily at nursing homes, and filed false Medicare claims for services that were either not performed or not medically necessary. The claims, which resulted in a $46,570 overpayment, were submitted by an employee, who pled guilty separately. The civil agreement with the owners is based on their "reckless disregard" of company and employee activities.

- In Colorado, the former business manager of three physical therapy clinics was sentenced to 1 year probation, ordered to perform 40 hours community service and fined $100 for Medicare fraud. One of several employees hired by the owner and operator of the clinics, she falsified working hours, wages, and personnel qualifications of unlicensed assistants and aides which the owner used to claim more therapy hours than were actually provided. The Medicare fiscal intermediary identified $4 million in overpayments and disallowances through cost reports filed by the owner's companies. She was sentenced earlier to 21 months in jail and excluded from Medicare and State health care programs. The business manager's light sentence was the result of her cooperation in the investigation and her testimony against the owner. A civil case is pending against the owner.

Home Health Care Costs

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

In the third report, OIG made no procedural recommendations because, at the time of the review, the HHA was in the process of being sold and would no longer participate in the Medicare program under its present ownership.

A. Florida

The OIG reviewed 100 claims (representing 1,784 home health services) submitted for Medicare reimbursement by a Florida HHA during the fiscal year ended December 31, 1993. Thirty-two percent of the sample contained 353 services that did not meet Medicare guidelines: 23 percent were for 262 services that were not reasonable or necessary; 5 percent were for 69 services provided to beneficiaries who were not homebound; 3 percent were for 17 services which physicians did not authorize; and 1 percent were for 5 services not provided. During this fiscal year period, the HHA claimed $12 million in 8,700 claims representing 151,015 services. Based on its review, OIG estimates that at least $1.7 million did not meet the reimbursement guidelines. (CIN: A-04-95-01105)

B. Florida

The OIG determined that 44 percent of the claims made by another Florida HHA for home health care services for the year ended December 31, 1993, did not meet Medicare reimbursement guidelines. Twenty-five percent of the claims were for services which, in the opinion of medical experts, were not reasonable or necessary; 14 percent were for services to beneficiaries who were not homebound; 3 percent were for services which physicians did not authorize; and 2 percent were for services not provided. Of the $6.7 million claimed by the HHA for the year, OIG estimated that at least $1.2 million did not meet the reimbursement guidelines. In its response to the draft report, HCFA concurred with the recommendations. (CIN: A-04-95-01107)

C. Pennsylvania

In a review of 100 claims (representing 1,731 services) submitted for Medicare reimbursement by a Pennsylvania HHA during the period January 1, 1995 through April 30, 1995, OIG determined that 28 percent contained 324 services that were ineligible for Medicare reimbursement. The OIG estimated that at least $2.5 million of $22.6 million claimed for this period did not meet reimbursement guidelines.

After conviction for Medicare-related offenses, the company and its subsidiaries filed for bankruptcy. While HCFA agreed with OIG's recommendation regarding recovery of the overpayments, it was unable to take administrative action because of the bankruptcy proceedings. In October 1996, the company entered into a civil settlement agreement providing for the payment of approximately $232 million to HCFA over several years; the settlement reflects the estimated overpayments to all subsidiaries over cost report years 1989 through 1996, including those identified in this report. (CIN: A-03-95-00011)

Low-Cost Home Health Agencies

As part of the ongoing Operation Restore Trust examination of home health, OIG examined the effects of home health agencies' operating practices on the wide variation in average number of visits per Medicare beneficiary. One report, based on a survey of 300 randomly selected home health agencies, examined operating practices and philosophies of the high- and low-cost agencies to ascertain whether there were differences which would account for the variation in the average number of visits per beneficiary.

The OIG found no differences in operating practices that could account for the variation. These findings reinforce OIG's conclusion that the explanation for these wide variations among home health agencies in average number of visits per beneficiary probably lies in the existence or lack of controls on the benefit. Unless increased oversight can be applied to the benefit, regulatory or legislative changes might be necessary. (OEI-04-93-00291; OEI-04-93-00263)

Home Health Agency Fraud

Home health agencies are one of the fastest growing segments of the health care industry because they allow many patients to remain in their own homes at less expense than would be incurred at a hospital or other institution. However, as one of the most loosely regulated, it is quite subject to fraud, as shown in the following examples.

- A Georgia HHA and the company merging with it entered a civil settlement agreement to pay the Government $255 million for defrauding the Medicare program. The former owners conspired to defraud Medicare of more than $1 million. The owners and the company were charged with filing cost reports that included personal expenses, political contributions, ghost employees and lobbying expenses. They were also charged with conspiracy, false statements, kickbacks, witness tampering and money laundering. The couple and their company were sentenced earlier on the criminal aspect of the case. In addition, the couple was excluded from participating in Medicare and State health care programs for a total of 25 years.

- An HHA employee was sentenced in Missouri after pleading guilty to making false Medicare claims. Over a 2-year period, she misrepresented herself as a licensed social worker, which cost Medicare more than $23,000 in overpayments. The HHA owner, a licensed social worker, allowed the employee to perform psychiatric services on nursing home patients, but she billed Medicare as if she herself performed the services. The employee was sentenced to 21 months imprisonment and 2 years probation, and ordered to pay $6,000 in restitution. She was also ordered to seek psychiatric help after her release from prison.

- Two former aides in a Missouri HHA entered into a pretrial diversion agreement for Medicare fraud. An internal audit conducted by the HHA showed they inflated mileage, which caused the HHA to file false cost reports to Medicare. They confessed to defrauding Medicare of $10,000. They were sentenced to 12 months probation, and ordered to pay restitution of $500 and perform 50 hours of community service.

- The former owner of a Texas HHA was sentenced to 27 months incarceration after pleading guilty to presenting a false claim to Medicare.

The lengthy sentence was partially due to her previous State conviction for embezzlement. She was indicted in the current case for billing for visits her company did not make. Her lawyer asked for a downward departure from sentencing guidelines because she had given birth 3 months earlier, but the judge ruled she should get help from family and others to care for the child. The owner was in business for only 6 months and submitted false Medicare claims for $49,000. She agreed to waive rights to $190,380 reflected in her 1994 Medicare cost report. No fines or restitutions were assessed because of her financial condition.

- The co-owner of a Washington, D.C. HHA was sentenced to 27 months in prison and ordered to pay full restitution of $100,000 defrauded from the Medicare and Medicaid programs. The HHA billed for 1,450 skilled nursing visits for which there are neither time slips nor nurses' notes. It also billed for home nurse visits when patients were actually hospitalized. Another co-owner was also convicted but has been in "escape status" since leaving his detention center assignment.

- In Texas, one man, his Texas HHA and his brother/employee agreed to pay $30,000 to resolve civil liability for submitting fraudulent Medicare cost reports. The two men conspired to include phoney expenses for medical supplies, office supplies and automobile leases on the claims. The brother/employee was president of a medical supply company that sold to the HHA at a 100 percent markup. He also altered invoices for supplies not purchased and fabricated automobile lease contracts from vendors who did not lease automobiles. He was convicted and fined $25,000. The owner was placed on a pre-trial diversion and had to pay restitution of $25,000.

Hospice Eligibility

The OIG is conducting reviews to assess the accuracy of beneficiary eligibility determinations and resultant reimbursements at selected hospices. Medicare regulations state that an individual must initially be certified by a physician as terminally ill with a life expectancy of 6 months or less in order to be eligible for hospice benefits. Election to the palliative care offered by this program requires beneficiaries to voluntarily relinquish their right to curative care for their terminal condition under the Medicare program.

During this semiannual period the following hospice reviews were completed:

A. Florida

The OIG found that Medicare paid a Florida hospice provider $4 million for care to 71 ineligible beneficiaries and another $2.5 million for 45 beneficiaries whose eligibility could not be determined based on the medical evidence in their files. The OIG review, which included reviews by physicians of the hospice's eligibility determinations, covered 147 beneficiaries who had been in hospice care for more than 210 days. Of the 147 cases, 93 were active in hospice at the time of the review and represented 36 percent of the total active Medicare hospice beneficiaries as of April 30, 1995.

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

In addition to financial adjustments, OIG recommended that the Medicare intermediary coordinate with HCFA in providing training to hospice providers and physicians on eligibility requirements for beneficiaries, and conduct periodic reviews of hospice claims to ensure that the hospice is obtaining sufficient medical information to make valid eligibility determinations. The intermediary generally concurred with OIG's recommendations relating to strengthening procedures to ensure proper payment of hospice claims. The OIG will continue to work with HCFA and the intermediary concerning recovery of any improper payments. (CIN: A-04-95-02110)

Operation Restore Trust **B. Texas**

This final report resulted from OIG's audit of Medicare hospice beneficiary eligibility determinations at a Texas hospice. The audit included medical evaluations, by physicians, of the records of 77 Medicare beneficiaries who had been in hospice care for more than 210 days. The OIG found that 25 beneficiaries (32 percent of the 77 reviewed) were not eligible for hospice coverage because hospice physicians made inaccurate prognoses of life expectancy based on the medical evidence in the beneficiaries' files. The OIG recommended a financial adjustment for the improper Medicare payments totaling more than $1.2 million which the hospice had received for the 25 ineligible beneficiaries. The OIG will continue to work with HCFA and the intermediary concerning recovery of any improper payments. (CIN: A-06-96-00027)

Operation Restore Trust **C. Texas**

This final report resulted from OIG's audit of Medicare hospice beneficiary eligibility determinations at a second Texas hospice. The audit included a medical evaluation, by physicians, of the records of 60 beneficiaries who had been in hospice care for more than 210 days. The review disclosed that 20 beneficiaries (33 percent of the 60 reviewed) were not eligible for hospice coverage because hospice physicians made inaccurate prognoses of life expectancy based on the medical evidence in the beneficiaries' files. The OIG recommended a financial adjustment for the improper Medicare payments totaling nearly $1 million which the hospice had received for the 20 ineligible beneficiaries. The OIG will continue to work with HCFA and the intermediary concerning recovery of any improper payments. (CIN: A-06-95-00095)

D. Puerto Rico

The OIG's series of reviews of hospice eligibility were a product of its 1994 work on Medicare hospice eligibility in Puerto Rico that had been requested by HCFA. This audit, which disclosed a large number of beneficiaries in hospice care who were not terminally ill and therefore not eligible for benefits, resulted in corrective action on a number of fronts -- and in a significant drop in hospice expenditures in Puerto Rico. Puerto Rico expenditures dropped from almost $50 million in 1993 (expenditures totaled about $42 million for the first 6 months of FY 1994) to $19 million in 1996. Corrective actions included HCFA's decertifying a substantial number of hospices (at least 15 hospices by March 1995), the launching of investigations by the FBI, OIG's development of a model for identifying aberrant providers and the collaborative Operation Restore Trust work in the continental United States.

Nursing Home Fraud

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

- A health care corporation paid $4.6 million in New Mexico to resolve civil liability for false claims. Earlier, the company had repaid $1.2 million when it learned about the OIG investigation. In 1994, the company acquired a chain of 19 rehabilitation facilities, which had not billed for certain ancillary medical supplies. Believing it had found an unclaimed income source, the company billed Medicare, Medicaid and other insurers for these supplies; however, the billings were improper. For example, since tracheostomy care is usually given 3 times a day, the company billed for 90 trach tubes, 90 trach care kits and other related items, per beneficiary, for each 30-day period. Intermediary personnel indicated that one trach tube a year was normal. The company billed Medicare $3.4 million from July to December 1994, and was paid $1.2 million. Treble damages were assessed because of a blatant disregard of proper billing requirements. However, the company cooperated fully in the investigation and is implementing specific compliance measures.

- A New Jersey company which employed psychologists to provide services to nursing home residents entered a civil settlement agreeing to pay $700,000 to settle allegations it submitted false Medicare claims. The company billed for 45 to 50 minutes of psychotherapy to nursing home residents when only 20- to 30-minute sessions were held. Some of the company’s psychologists billed for more than 14 hours of therapy a day -- one billed for the equivalent of more than 24 hours a day. The company will also implement a corporate compliance program.

- A California psychiatrist signed an agreement to pay the Government $300,000 to settle allegations related to Medicare fraud. He provided psychiatric care to Medicare beneficiaries in nursing homes in California, Rhode Island, Florida, Texas, New York, Washington and Oregon. His scheme involved duplicate billing through two separate entities, both of which he owned. During the investigation, his various companies were found to have 24 different mailing addresses, 23 different telephone numbers and at least 12 different provider numbers. In preparation for his defense, however, the psychiatrist got a statement from the American Medical Association that a physician who performed both a psychiatric and a physical examination concurrently could claim for both -- which he claimed was done, only through two different companies.

- In 1992, two sister co-owners of a third-party billing agency were convicted, through the efforts of OIG, of falsely billing Medicare and were imprisoned. Their company had contracted with a number of nursing homes in several States to retrieve so-called "lost charges" -- items for which the homes had not billed Medicare. The company received 50 percent of whatever the homes were reimbursed. The company used incorrect diagnostic codes for items not covered by Medicare -- or billed for items never provided -- to obtain $7 million in Medicare payments. During this reporting period, seven nursing homes in three States signed agreements to settle allegations that they caused the submission of the false Medicare claims, bringing to 12 the number settling, for a total of more than $3.6 million. Included in the settlements were agreements to conduct periodic internal audits and to educate employees on their commitment to ensure accurate billing and reporting.

- An Illinois ambulance company owner and one of his employees were sentenced after pleading guilty to Medicare and Medicaid fraud. They had been planning to go to trial when an OIG agent reviewing documents suspected the papers had been prepared to support their position. The agent found the printer who printed the forms and discovered they were printed long after the dates appearing on them. When told that the U.S. Attorney was considering charging the subjects with obstruction of justice, they decided to plead to the pending charges. The two had filed false and inflated claims for same-day round-trip transfers of nursing home patients as bed-confined, or for other higher levels of service than that performed. The company owner was sentenced to 5 months incarceration and 5 months home confinement, and was ordered to sell his business by November 23, 1996. He was fined $10,000 and must make restitution of $15,810 to Medicare and Medicaid. Earlier he agreed to a $367,000 civil settlement. The employee was given 2 years probation and fined $500.

Laboratory Fraud

The OIG, in coordination with DOJ and other law enforcement agencies, is concluding 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. The laboratory and its president pled guilty to criminal charges relating to the laboratory's billing practices.

During the course of this audit/investigation, OIG found numerous problems in the ways that most independent clinical laboratories were charging Medicare for clinical tests. For example, laboratories engaged in abusive marketing practices which caused doctors to order medically unnecessary tests. After determining which tests were profitable to perform, the laboratories created "profiles" containing these tests and the tests commonly ordered by physicians. Physicians were encouraged to order the new profile and strongly discouraged from ordering only those individual components of the profile needed for the care of the patient. Physicians often were told that the superfluous tests cost nothing or only a nominal additional amount. Unknown to the doctor, the laboratories unbundled these profiles and billed Medicare, Medicaid and other health care programs the full price for the unnecessary tests as if each test had been ordered and performed separately by the laboratory. In addition to marketing schemes, the laboratories also billed for services that had not been ordered. For example, Medicare was routinely billed for calculations and test indices performed simultaneously by the laboratories' automated equipment but not requested by the ordering physician.

In response to these industry-wide abuses, several of the agencies involved in the original investigation volunteered to form a task force to promote interagency cooperation and proactive investigations, unconstrained by geographic or agency boundaries. Such an approach would enable the Government to pursue criminal, civil and administrative actions on a national level, as well as recover millions of dollars.

When the task force began its investigation in 1993, the Inspector General subpoenaed documents from seven national independent laboratories. During the course of the investigations, through a series of mergers and acquisitions the seven combined to form three major independent laboratories in the country. Within the current reporting period, the following settlements have been made with these three:

- One laboratory agreed to pay $325 million, one of the highest financial settlements involving health care fraud in the history of the False Claims Act. It also entered a corporate integrity agreement to ensure stringent compliance in its billing practices.

- A second major clinical laboratory corporation agreed to pay $187 million to resolve its civil liabilities, and enhanced its existing corporate compliance program with comprehensive training, monitoring and reporting requirements imposed by OIG. One of its constituent laboratories pled guilty to fraud, paid a $5 million criminal fine, and was excluded from participation in Federal and State health care programs.

- The third major independent laboratory had "successor liability" for the conduct of laboratory companies which it purchased as part of its growth strategy in the early 1990s. During the current period, two settlements were made for civil liability in the amount of $130 million, bringing the total amount settled thus far to $185 million.

The laboratory industry's awareness of the Government's task force spawned a series of qui tam lawsuits. Under the qui tam provisions of the Civil 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.

As with the task force subjects, 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. For example, one laboratory case -- settled for $10 million during the present reporting period -- suggests that laboratory services provided to end stage renal disease (ESRD) patients are also vulnerable to fraud and abuse. The laboratory submitted Medicare Part B claims for tests for which Medicare Part A had already paid the dialysis centers under the ESRD composite rate. The investigation also uncovered a number of schemes to obtain payment for medically unnecessary laboratory tests, including: devising a test-ordering system which encouraged physicians to order identical batteries of tests for all current and future patients, regardless of medical necessity; paying sales commissions on the basis of Medicare revenues generated by the sales staff; and other marketing techniques and inducements which encouraged the ordering of medically unnecessary lab tests. In addition to the $10 million settlement agreement, the laboratory agreed to institute a comprehensive corporate integrity program which, among other things, requires implementation of a new system for ordering ESRD-related tests.

Separately Billable End Stage Renal Disease Laboratory Tests

The HCFA utilizes a prospective payment method for dialysis services by reimbursing end stage renal disease (ESRD) facilities through a composite rate per maintenance dialysis treatment. This composite rate is a comprehensive payment for dialysis related services provided to the patient and includes, among other services, payment for selected laboratory tests.

The OIG found that a significant control weakness exists in the Medicare payment system that allowed hospitals and independent laboratories to be reimbursed separately for laboratory tests even though payment for these tests was already included in each facility's composite rate. Based on a statistical sample, OIG estimates that $6.3 million out of $12.8 million was improperly paid to hospitals and independent laboratories for separately billed laboratory tests performed for ESRD beneficiaries during Calendar Year (CY) 1994.

The OIG recommended an education program for ESRD providers and independent laboratories explaining proper ESRD billing practices, monitoring of providers' billing for laboratory tests outside the composite rate for possible post-payment reviews and recovery of the estimated overpayments. In response to the draft report, HCFA concurred with the OIG recommendations and proposed or implemented corrective actions. (CIN: A-01-96-00513)

Durable Medical Equipment Regional Carrier Overpayments

The OIG audited Palmetto Government Benefits Administrators, a DME regional carrier (RC), to determine whether it was identifying and collecting overpayments from Medicare DME providers in a timely manner. The OIG found problems with the DMERC's overpayment collection process. As of June 30, 1996, $112.6 million in overpayments and interest had not been collected from Medicare DME providers. A sample of 90 overpayments over $5,000 each (representing $97.5 million of the $112.6 million) showed that this occurred primarily because the DMERC did not adhere to HCFA's and its own collection procedures. The OIG recommended that the DMERC follow the collection procedures required by HCFA and use more aggressive collection efforts, especially during the first few months after an overpayment is identified. The HCFA reported that, since OIG's review, the $97.5 million had been reduced to $45.7 million through collection or referral by the DMERC to HCFA for appropriate action. (CIN: A-04-96-01144)

Fraud Involving Durable Medical Equipment Suppliers

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

- One of the highest-reimbursed Medicare suppliers of incontinent care products in the United States agreed to plead guilty in Florida to conspiracy to defraud Medicare of $70.8 million. It also agreed to forfeit $32 million seized in bank accounts. It distributed adult diapers to nursing homes but billed Medicare for female urinary collection pouches. It also billed throughout the country for components of incontinence kits that were not medically necessary. The owner pled guilty earlier to mail fraud in a similar case in Kansas and agreed to pay $5 million in restitution of overpayments resulting from false claims to Medicare, Medicaid and private insurers. The two cases have been consolidated, and the owner was sentenced in Kansas to 10 years imprisonment. He has agreed to cooperate fully and testify in ongoing investigations and future prosecutions.

- A New York judge sentenced a physician in absentia to 78 months in prison for Medicare fraud. The physician fled to the Dominican Republic after he was convicted of falsely signing CMNs for DME from a medical supply company. He was ordered to pay restitution of well over $3.5 million, but he cannot be extradited at this time. In the same case, the individual who prepared the false CMNs signed by this and other doctors became the 18th person to plead guilty or be convicted. The individual had been a fugitive in Sierra Leone but waived extradition to return to the United States.

- Also in New York, one of three owners of a former medical supply company agreed to pay the Government $2 million in settlement of false Medicare claims. The company submitted the claims between 1984 and 1987 for transcutaneous electrical nerve stimulator units and accessory kits. Negotiations with the other two owners are continuing. All three were previously prosecuted criminally.

- A California man was sentenced to 11 years and 3 months in Federal prison for defrauding Medicare and Medi-Cal of approximately $14 million and laundering the stolen money through overseas bank accounts. The man had been in prison for 6 years on unrelated charges and was due to be released 2 weeks after the sentencing in the current case. He was also ordered to repay Medicare $300,000 plus interest of $140,750, and Medi-Cal $12.7 million plus $7 million in interest. The man billed Medicare for transcutaneous electrical nerve stimulator units, the vast majority of which were either not medically necessary or not delivered, and billed Medi-Cal for diapers he never delivered. He was the leader of a group that all together defrauded Medicare and Medi-Cal of about $40 million. His sister served 33 months in jail for mail fraud, his wife is serving a 12-month sentence in a halfway house and his friend is serving a 46-month sentence. A fourth defendant remains a fugitive in Spain.

- In New York, a DME company was ordered to pay a criminal fine of $300,000. It had created a subsidiary to submit claims in Pennsylvania for equipment sold in Western New York in order to obtain higher Medicare reimbursement. The subsidiary pled guilty earlier and agreed to make full restitution of $1.1 million and to pay a civil penalty of $2.5 million. As part of the settlement agreement, the parent company entered a corporate compliance plan.

- A DME company based in New Jersey agreed to repay the Government $300,000 plus investigation costs ($30,000) for submitting false Medicare and Medicaid claims. The company billed for custom-fitted spinal body jackets that were actually comfort seats supplied to nursing home residents in New York and New Jersey.

- The owner of a Pennsylvania corporation that marketed a billing program for ostomy products entered a guilty plea for the corporation and was fined $100,000 for its actions. The corporation entered into contractual agreements with hundreds of pharmacies to use their accounts receivable to bill the Pennsylvania carrier for ostomy products they supplied Medicare beneficiaries. The corporation paid the pharmacies 100 percent of the retail price of the supplies, then billed Medicare for the separate parts of each ostomy product supplied. Also pleading guilty on behalf of his corporation was an individual who had agreed to let the Pennsylvania corporation owner use his sales force and extensive customer base to dramatically expand the billing program. He was fined $50,000. They will pay $202,000 and $50,000, respectively, to settle their civil suit obligations.

- A Florida DME company agreed to pay $200,000 to settle civil and criminal liabilities for submitting false Medicare claims. They were suspected of altering dates and qualifying data on CMNs for oxygen equipment, supplies and services.

- A Pennsylvania DME supply company entered an agreement to pay $110,000 to settle criminal and civil liabilities. The company submitted claims to Medicare for higher-quality body jackets marketed to long-term care facilities than those actually distributed. As part of the settlement, the company and its president agreed to be barred for life from participation in any departmental programs.

- A Florida physician who signed prescriptions for DME and vascular tests, and the man who acted as broker and sold the prescriptions to other companies, were sentenced after pleading guilty to one count related to Medicare fraud. The physician was sentenced to 3 years probation, and ordered to pay $22,000 in restitution and perform 500 hours of community service. The broker was sentenced to 9 months in prison and 3 years supervised release, and ordered to pay restitution of $75,000 and perform 500 hours of community service. The two were discovered through analysis of records of a doctor sentenced earlier for signing false prescriptions.

Lymphedema Pumps

One area of DME that has suffered significant abuse has been the purchase of lymphedema pumps. These pneumatic compression devices are used to treat swelling of tissues resulting from accumulation of fluid from lymphatic blockages. The blockages can result from malignancies, diseases, surgery or radiation. The pumps range in sophistication and can cost from $600 to $6,000.

In the early 1990's the only manufacturer of the expensive pumps complained that it was losing sales because DME suppliers were providing less expensive pumps but were billing for the most expensive. In the meantime, Medicare payments had soared from $6.3 million in 1990 to $118 million in 1995. The manufacturer's complaint prompted OIG to begin a series of investigations that showed that the practice of upcoding appeared widespread in the industry. Medicare required supporting CMNs in order to pay for the pumps, but some suppliers simply forged them to reflect the need for the expensive items or upgraded the billing code -- while supplying lower-cost pumps. In addition to criminal prosecutions, OIG joined DOJ in pursuing civilly suppliers that overbilled.

To counter the fraudulent practices, HCFA revised its coverage of the pumps only as treatment of last resort. Less intensive treatments had to be tried for a minimum of 6 months. Medicare then paid for pumps only if extensive documentation showed they were absolutely necessary, and even then it reimbursed only for an inexpensive pump. Even more extensive documentation and review was to be used on claims for the most expensive pumps.

Predictably, Medicare payments for lymphedema pumps dropped dramatically, from $118 million in 1995 to less than $14 million in the first 9 months of 1996. The successful interaction of OIG, HCFA, the DMERCs, DOJ and the industry clearly contributed to this result.

The OIG is undertaking a study to assess whether Medicare allowances for lymphedema pumps are excessive, if attending physicians have prepared required treatment plans governing their patients' use of the pumps, whether physicians and suppliers are providing required oversight and monitoring services for beneficiaries using these devices, and how physicians determine whether a patient gets the most or least expensive pump.

The following cases involving lymphedema pumps were concluded during this reporting period:

- In New Jersey, the former owner of the State's largest Medicare supplier of lymphedema pumps was sentenced for Medicare fraud and obstruction of justice. In a scheme involving beneficiaries in Florida and New Jersey, she billed Medicare for more expensive pumps reimbursable at $4,000 per pump, when in fact, much less expensive pumps were provided. Many of the pumps were not medically necessary. The total overpayment was more than $200,000. She was sentenced to 35 months incarceration and 3 years supervised release, fined $7,500 and ordered to pay a total of $220,100 in restitution. She was also barred from participating in the sale of DME during her 3-year release period.

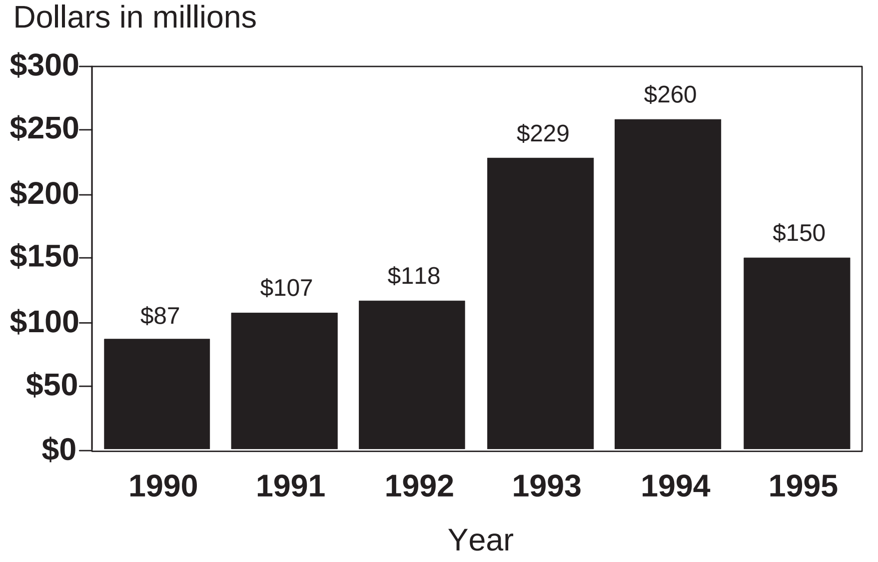
- The former owner/operator of a Washington State DME company was sentenced to 12 months and a day in prison and 3 years supervised release on charges related to Medicare fraud. He was ordered to pay $294,860 in restitution, fines and penalties. He billed Medicare and private insurance companies for lymphedema pumps at $4,500 each, but he delivered pumps that would have been reimbursed at $600 and pocketed the difference. The case was prosecuted in Washington, where the company was headquartered, but much of the sales were in California.

Incontinence Supplies

The findings from several OIG inspections conducted 2 years ago indicated that suppliers were engaged in questionable marketing practices and that beneficiaries were receiving unnecessary or noncovered incontinence supplies. (Those dealing with Medicare reimbursement were OEI-03-94-00770 and OEI-03-94-00772.) Since those reports were issued, a joint OIG/HCFA effort to address the problem resulted in the initiation of an OIG audit review of this area and a national investigation that examined potentially fraudulent practices by specific suppliers. The OIG supported ongoing activity in HCFA and the DMERCs to develop more specific coverage guidelines and educate providers about proper billing.

Since the targeted initiative began that put the abusive suppliers on notice, the combined efforts of OIG, HCFA and the DMERCs have put a stop to the abusive practices. Recent follow-up work indicates that Medicare payments for incontinence supplies dropped by $110 million in 1 year, as illustrated in the following chart.

MEDICARE REIMBURSEMENT FOR INCONTINENCE SUPPLIES



Of this $110 million drop in 1995, savings of $104 million are directly attributable to a halt in the abusive practices identified by OIG.

Medicaid Special Status Classifications Submitted by Health Maintenance Organizations

Risk-based HMOs receive fixed monthly payments for each enrolled Medicare beneficiary. The payment rate is increased for certain categories of beneficiaries designated as high cost.

Medicare beneficiaries who are also eligible for Medicaid are one of these high cost categories and are referred to as Medicaid special status beneficiaries. An HMO can receive several hundred dollars per month as an enhanced payment for each beneficiary designated as Medicaid eligible.

The OIG found that significant overpayments were made as a result of submissions of incorrect Medicaid special status by HMOs. Ninety percent of the HMO submissions reviewed were inappropriate because the beneficiaries were not eligible for Medicaid. The OIG estimates that approximately $15 million in overpayments occurred between October 1, 1990 and July 31, 1995 due to HMO submissions of erroneous Medicaid special status.

The OIG recommended that HCFA identify and recover the overpayments; implement policy and systems changes to prohibit HMOs from submitting Medicaid special status on behalf of beneficiaries who reside in States which automatically furnish Medicaid eligibility information to HCFA; develop policies to require HMOs in the other States to verify Medicaid eligibility with applicable State agencies prior to submitting Medicaid special status; and enforce current manual instructions which require HMOs to monitor the special status reports and report any changes in a beneficiary's Medicaid status. In response to the draft report, HCFA concurred with OIG's recommendations. (CIN: A-04-96-01119)

Pharmacy Acquisition Costs for Drugs Reimbursed under Medicaid

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

Through use of statistical sampling, OIG obtained pricing information from 315 pharmacies in 10 States (California, Delaware, Florida, Maryland, Missouri, Montana, Nebraska, New Jersey, North Carolina and Virginia) and the District of Columbia. The overall estimates of the extent to which AWP exceeded invoice prices were 18.3 percent for brand name drugs and 42.5 percent for generic drugs. The OIG recommended that States consider these results as a factor in any future changes to pharmacy reimbursement for Medicaid drugs. (CIN: A-06-95-00063; CIN: A-06-95-00064; CIN: A-06-95-00066; CIN: A-06-95-00067; CIN: A-06-95-00069; CIN: A-06-95-00070; CIN: A-06-95-00072)

Medicaid Reimbursement for Clinical Laboratory Tests

During this semiannual period, OIG issued several reports in connection with its nationwide review of States' procedures and controls over Medicaid payments for clinical laboratory services. The first presents the consolidated results of OIG audits in 14 States. The others present the results of audits in two of eight additional States to which the review was expanded.

A. Payments in 14 States

In its review in 14 States, OIG concluded that the States did not have adequate controls to detect and prevent inappropriate payments for laboratory tests. Contrary to applicable laws and guidelines, the States paid medical providers more for clinical laboratory services processed by physicians' offices, independent laboratories or hospital laboratories for their outpatients than the amounts Medicare recognizes for the same services. As a result, the 14 States potentially overpaid laboratory providers an estimated $27.4 million ($15.7 million Federal share) for chemistry, hematology and urinalysis tests during the 2-year audit period. Correction of the problem would result in projected savings of an estimated $13.8 million ($7.9 million Federal share) annually.

The OIG recommended that the States install system edits and controls to detect and prevent the types of errors disclosed, recover the Medicaid overpayments identified and reimburse the Federal Government for its share of any recoveries made. Four States agreed with reported findings and recommendations, three partially agreed and three disagreed. The final four States did not provide specific written comments.

The OIG also recommended that HCFA reemphasize the Medicaid requirement that State payments for such services not exceed the amounts recognized by Medicare for the same services, consider having the States update their provider billing instructions to reflect Medicare bundling procedures and follow up on the estimated $27.4 million ($15.7 million Federal share) in potential overpayments identified. The HCFA generally agreed with OIG's recommendations. (CIN: A-01-95-00003)

B. Virginia

The OIG determined that Virginia lacked adequate procedures and controls to ensure that chemistry and urinalysis tests were reimbursed in accordance with guidelines. In its review of 100 sample claims in Virginia, OIG found that 99 were overpaid. The OIG estimated that the State overpaid providers more than $1.4 million (Federal share over $700,000) during 1993 and 1994. The OIG recommended that the State implement a policy change to clearly define and mandate the use of bundled services for chemistry and urinalysis tests; install edits to detect and prevent payment for unbundled services and billings that contain duplicative tests; recover overpayments identified in this report; and make adjustments for the Federal share of the amounts recovered by the State on its quarterly report of expenditures to HCFA. The State disagreed, contending that it was inappropriate to apply Medicare reimbursement guidelines to Medicaid claims. (CIN: A-03-96-00202)

C. Illinois

The OIG determined that the Illinois Medicaid program did not have adequate controls in place to detect and prevent inappropriate payments for certain laboratory tests that exceeded amounts recognized by Medicare for the same tests. As a result, OIG estimated that the State overpaid providers $2.2 million (Federal share $1.1 million) during CY 1993 and 1994. In addition to financial adjustments, OIG recommended that the State ensure that its edits detect and prevent payments for unbundled and duplicative tests, and update and clarify its policies and instructions to providers to include additional procedures which are subject to edits for unbundled and duplicate tests. (CIN: A-05-95-00062)

Federal and State Partnership: Joint Audits of Medicaid

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

Active partnerships have been developed with 17 State auditors, 11 State Medicaid agencies and 2 State internal audit groups. Sixteen State auditor partnership reports have been issued with a financial impact of over $109 million affecting both Federal and State Government funds. The following partnership reports were issued during this semiannual period and several more reports are in process:

A. Montana: Drug Delivery System

The Montana Legislative Auditor determined that the State had adequate procedures in place in its Medicaid pharmacy program to contain costs in the acquisition and delivery of drugs. The State averted approximately $980,000 in annual program expenses at annual costs of approximately $590,000. In addition, the State collected over $5 million in manufacturers' rebates in FYs 1994 and 1995. The Montana Legislative Auditor also found that another type of drug delivery system did not appear to be more cost effective than the current system. (CIN: A-06-96-00072)

B. Montana: Transportation Services

Montana's Legislative Auditor reviewed the State's controls for ensuring that Medicaid payments for transportation to and from medical services were necessary and reasonable. A private contractor operates the State's Medicaid transportation management system. The Legislative Auditor found that while controls, such as appointment verification and formalized payment ceilings, provided needed assurance, these controls could be strengthened. The Auditor's recommendations included specifying in the contract the level of program monitoring required and developing a reimbursement method that complies with Federal requirements. The State concurred. (CIN: A-06-96-00073)

C. Utah

The Utah State auditor found that the State did not have adequate controls to ensure that Medicaid reimbursements for clinical laboratory tests did not exceed amounts recognized by Medicare for the same tests. The OIG estimated that the State reimbursed providers for potential overpayments totaling more than $300,000 (Federal share over $200,000) in CYs 1993 and 1994.

The Utah State auditor recommended that the State give providers information regarding bundling procedures; implement edit checks to allow for only properly bundled tests to be paid; determine if physicians ordered hematology indices; consider adopting policies and procedures to prevent payment of unnecessary indices charges; establish controls to prevent laboratory payments from exceeding Medicare rates; and recover overpayments and make adjustments for the Federal share of amounts recovered on the quarterly report of expenditures to HCFA. (CIN: A-06-95-00100)

Wisconsin's Medicaid Managed Care Program Financial Safeguards

The OIG determined that during the 3-year period ending December 31, 1994, Wisconsin's largest HMO's profit from the Medicaid managed care program was understated on its financial statements by $8.9 million. The understatement was due to inflated costs of related party transactions. The inflated costs related primarily to excessive management fees paid by the HMO to its parent company and excessive reinsurance payments to another affiliate. The OIG estimated that if the State had utilized this information in its determination of capitation rates, it could have realized about $4 million ($2.4 million Federal share) in Medicaid cost savings with regard to this HMO over the 3-year period.

The OIG recommended that the State establish policies and procedures to closely monitor the financial status of Medicaid managed care HMOs, and review and use financial information, specifically data relative to profit margin, when setting or adjusting HMO capitation payment rates. The State was already concerned about the cost effectiveness of their HMO initiative and intends to implement an action plan that will address many of OIG's concerns. (CIN: A-05-95-00060)

Effectiveness of Medicare and Medicaid Fraud Units

Based on the two reviews described below, OIG concluded that a concerted effort is called for to address concerns involving both the Medicare and Medicaid fraud units. Among its recommendations, OIG proposed that HCFA, in consultation with OIG, convene a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud unit operations. This would include clarifying goals and objectives for program integrity efforts; establishing guidelines for developing suspected fraud cases; developing a universal protocol for appropriately referring fraud and abuse cases; coordinating data systems to ensure reliable and consistent data across all entities in the fraud and abuse fighting network; and developing a training program designed to educate program integrity personnel on procedures, case referrals and best practices.

A. Surveillance and Utilization Review Subsystem Referrals

As part of the Medicaid Management Information System, the Surveillance and Utilization Review Subsystem (S/URS) applies postpayment screens to Medicaid claims adjudication to identify aberrant billing patterns which may indicate fraud or provider abuse. Where a preliminary review of systems output substantiates a pattern of fraud, the matter is supposed to be referred to the States' fraud control unit for investigation.

Based on its review, OIG determined that the number and percentage of suspected fraud referrals from S/URS declined significantly in the past 10 years. Officials at the State fraud control units were divided in their opinions as to the extent and quality of S/URS development of suspected fraud cases, and S/URS staff cited insufficient training in the identification and development of fraud allegations and edits. Moreover, OIG found that HCFA does not routinely monitor S/URS development to establish whether potential fraud issues are being appropriately and consistently analyzed and referred. (OEI-07-95-00030)

B. Carrier Fraud Units

In 1994, Medicare carriers processed over 165 million claims. That same year, carriers received about 118,000 complaints alleging fraud or abuse. Based on information obtained from 37 carrier fraud units, OIG compared carrier performance using the following criteria: accuracy of complaint disposition; case documentation; assessment of financial damage; internal proactive safeguards; and external proactive safeguards. The OIG determined that very few carriers were successful in meeting all five outcome criteria. The most effective program integrity efforts were found in corporations that accorded a high priority and adequate management attention to the fraud units. (OEI-05-94-00470)

Medicaid Fraud

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

During FY 1996, OIG administered approximately $74.8 million in grants to the MFCUs. The MFCUs reported 389 convictions and $16.5 million in fines, restitutions and overpayments collected for the period July 1, 1996 through December 31, 1996.

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

- An institutional pharmacy provider that operates in more than 30 States paid Nevada $325,000 to resolve potential liability to the State Medicaid program. At issue were the handling and crediting of returned medications, billing of dispensing fees and billing arrangements with certain nursing facilities. The provider agreed to assist in the investigation of company employees who may have been involved in wrongdoing.

- In Illinois, a man was sentenced to 3 years probation, 6 months of which are to be home detention, as a result of a national project that identified pharmacies suspected of submitting false Medicaid claims. He and his brother were found to be purchasing illegally obtained drug samples and prescription drugs from Medicaid recipients and selling them to a "non-con" (an individual who does not deal in controlled substances and is usually not concerned about refrigeration or sanitary storage of drugs). The non-con resold the drugs to pharmacies, causing Medicaid to pay for the same drugs multiple times. The man’s brother was sentenced earlier to 6 months in prison for his involvement in the scheme.

- As a result of a joint operation by agents from OIG, the Federal Bureau of Investigation, California Bureau of Medi-Cal Fraud and Defense Criminal Investigation Service, three of five owners/operators of laboratories who were arrested either pled guilty or no contest to paying kickbacks. Each was sentenced to 3 years probation, with one of them to serve 21 days in jail and pay $1,925 in restitution. All three must perform 200 to 300 hours of community service, and pay fines ranging from $200 to $500. The remaining two defendants are scheduled for trial later this year.

Public Health Service Operating Divisions

Chapter III

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Overview of Program Area and Office of Inspector General Activities

The activities conducted and supported by the Public Health Service (PHS) operating divisions represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. These 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. 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.

Indian Health Service's Tribal Management Grants Program

Performance Measure

At IHS's request, OIG reviewed the tribal management grants program intended to assist American Indian and Alaska Native tribes in assessing whether they want to provide health care services under contracts with IHS. Based on its findings, OIG concluded that there was no assurance that the most qualified projects were selected for funding or that the funded projects received sufficient program support to succeed.

The OIG recommended that IHS revise its application review process to ensure that all applications are reviewed consistently; emphasize to project officers the importance of providing needed support to the tribes and delineate relevant task in their performance plans; develop program performance criteria; implement a system to measure program accomplishments; and clearly define and communicate to tribes, reviewers and project officers the purpose of the program. The IHS agreed with OIG's findings and recommendations. (CIN: A-06-94-00049)

Medical Personnel Credentialing and Privileging

Performance Measure

A system for credentialing and privileging is a fundamental element of ensuring high quality patient care. Credentialing consists of verifying education, training and licensure documents, and contacting recent employers and professional associates to determine an applicant's current competence and skills. Privileging consists of determining whether a health care provider is qualified to perform specific medical functions and procedures which are supported by a particular facility.

In a review of policies and procedures, OIG found that credentialing and privileging policies used by facilities operated directly by IHS and NIH were adequate, while Federal credentialing and privileging requirements for nonfederally operated IHS and HRSA funded community-based programs needed to be strengthened.

The OIG recommended that: IHS advocate programs for quality and risk management, specifically those related to credentialing and privileging of medical personnel in self-determination tribal health care programs; HRSA disseminate information on the operation of a comprehensive credentialing and privileging program to community, migrant, homeless and public housing health center grantees; IHS and HRSA modify their employment credentialing policies and practices to require a search of OIG's Medicare and Medicaid exclusion list; and the PHS Interagency Advisory Council on Quality Assurance and Risk Management revise its credentialing policy to require a search of OIG's Medicare and Medicaid exclusion list. In response to the draft report, IHS, NIH and HRSA agreed with OIG's findings and recommendations. (CIN: A-15-94-00006)

National Marrow Donor Program

Performance Measure

The National Marrow Donor Program is a nonprofit organization that finds matching donors for patients seeking transplants and operates the congressionally authorized marrow donor registry under contract with HRSA. These four OIG inspection reports dealt with recruitment of bone marrow donors from minority groups; overall donor retention rates; geographic overlap of centers' service areas; and financing of donor centers.

In general, OIG found that progress had been made in recruitment of minority donors, but that more needs to be done to improve both recruitment and retention of minority donors. Overall, the retention rate has remained stable, but it has declined for second level confirmatory testing; while the decline is small, loss of donors at this stage can be costly to patients awaiting transplant. The OIG also determined that there is substantial geographic overlap among donor centers, but this overlap has little impact on center performance. Moreover, although per unit payments to contract centers are higher than payments to fee-for-service centers, the performance of contract centers is lower on most indicators. The OIG recommended using performance measures for minority recruitment, specifications of retention rates in future contracts with donor centers and a reexamination of financing methods. (OEI-01-95-00120; OEI-01-95-00121; OEI-01-95-00122; OEI-01-95-00123)

Ryan White Comprehensive AIDS Resource Emergency Act: New York Eligible Metropolitan Area

Performance Measure

The OIG conducted a study to determine whether the New York Eligible Metropolitan Area (EMA) and its Ryan White Comprehensive AIDS Resource Emergency Act (CARE Act) service providers ensured that all CARE Act clients were individuals with the human immunodeficiency virus (HIV) disease or family members of such individuals. The study included visits to seven contractors receiving $1.7 million, of the $4.7 million the EMA awarded to 35 contractors during Fiscal Year (FY) 1995.

The OIG found that the contractors it visited provided services predominantly to persons whose HIV status was unknown. The HRSA, which administers the CARE Act, agreed to: advise EMAs that outreach programs must have a high probability of identifying persons with HIV infection so that they can be enrolled in care; establish eligibility and documentation requirements for outreach services; and develop procedures for local grantees to evaluate the effectiveness of outreach and recovery/readiness risk reduction programs. (CIN: A-02-96-02502)

Exclusions for Health Education Assistance Loan Defaults

Through the Health Education Assistance Loan (HEAL) program, HRSA provides money to students seeking an education in a health-related field of study. Repayment of these loans is deferred until they have graduated and begun to earn some money. Although the

Department's Program Support Center (PSC) makes every effort to secure repayment, some loan recipients ignore their indebtedness.

The Social Security Act permits and, in some instances, mandates exclusion from Medicare and State health care programs for nonpayment of these loans. During this 6-month semiannual period, 557 individuals were excluded as a result of PSC referral of their cases to OIG.

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

At the conclusion of this reporting period, 707 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 $43 million. The following are examples of some of these settlements:

- Shortly after being notified he was being excluded because of failure to repay his HEAL, a California dentist entered into a settlement agreement to repay his debt of over $264,000.

- A Massachusetts podiatrist signed a settlement agreement to repay his HEAL debt of almost $181,000 a few months after his exclusion became effective.

- In order to stay his exclusion, a California chiropractor signed a settlement agreement to repay his HEAL debt of almost $145,000.

- The exclusion of an Illinois podiatrist was stayed after she entered into a settlement agreement to repay her HEAL debt of almost $142,000.

Grantee Fraud

Occasionally employees of agencies that receive PHS grants are found to be embezzling funds, as indicated in the following examples from this reporting period:

- The man who for 8 years headed Philadelphia's oldest AIDS service agency pled no contest to charges of embezzling approximately $100,000 of agency funds. He pocketed cash from agency donation boxes, misused the agency credit card, wrote checks to himself, diverted petty cash and put ghost employees on the payroll. He used the money for personal expenses, including repairs on his home and boat. He was sentenced to 48 months probation and ordered to repay the agency $52,000. The OIG worked the case jointly with local police.

- An accountant, formerly with the Texas Association of Community Health Centers, Inc., pled guilty to theft of Federal program funds. She admitted embezzling more than $20,800 from the agency, which is a PHS grantee. She made full restitution to the association and voluntarily forfeited her license. The court sentenced her to 10 months in jail.

- The former business manager of the psychiatry department at the University of Pennsylvania pled guilty to embezzling NIH research funds. An internal university audit revealed that $176,600 had been misappropriated, of which $151,831 was Federal grant funds. Investigation showed that the business manager prepared false invoices for a fictitious consultant, resulting in checks totaling $49,000 that were traced to her personal bank account. She also embezzled money from the petty cash fund and submitted fictitious vouchers to obtain personal furniture and computers, among other items. She was sentenced to 6 months home confinement and 4 years probation, and ordered to pay $12,000 in restitution. The hospital reimbursed NIH the full amount embezzled.

- The former bookkeeper of a community center located on an Indian reservation in Wisconsin, which is funded by a grant from IHS, was sentenced for embezzlement. The accountant was ordered to serve 6 months imprisonment and to pay $22,415 in restitution. During the investigation, she admitted to being addicted to gambling and confessed to falsifying travel vouchers and checks, and to failing to make cash deposits to five accounts. The judge recommended alcohol and mental health counseling.

Superfund Financial Activities of the National Institute of Environmental Health Sciences

The Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended, requires the Inspector General from each Federal organization with Superfund activities to conduct audits of payments, obligations, reimbursements and other uses of the Superfund monies.

In FY 1995, the National Institute of Environmental Health Sciences (NIEHS) obligated \$58.7 million in Superfund resources, and disbursed \$56.2 million obligated during and prior to that year. The OIG found that NIEHS generally administered the fund according to Superfund legislation. The NIEHS agreed with an OIG recommendation to better ensure the accuracy of billings to the Superfund. (CIN: A-04-96-04576)

Administration for Children and Families, and Administration on Aging

Chapter IV

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

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

The Personal Responsibility and Work Opportunity Act of 1996 eliminated the AFDC, EA and JOBS programs as of Fiscal Year (FY) 1997 and created the Temporary Assistance for Needy Families (TANF) block grant, and 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 is reduced, OIG will continue to ensure program integrity, identify opportunities for program improvement, and provide Federal and State management with useful information regarding the goal of moving individuals and families from welfare dependency to self-sufficiency.

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

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

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

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.

The FBI fugitive squads continue to place a high priority on child support enforcement cases, and OIG works constantly to coordinate efforts. Since the cases can be pursued in either the place where the nonpaying parent or the custodial parent resides, the agencies involved have agreed that venue will be decided on a case-by-case basis.

The following child support cases were resolved during this reporting period:

- In Virginia, a man was sentenced after pleading guilty to failure to pay child support. His arrearages totaled more than $14,680. He resides in Florida, but failed to pay $275 in monthly support for one child in Virginia. In addition, he owed $8,705 in past arrearages for two children who no longer require custodial care. He was sentenced to 3 years of supervised probation and ordered to pay a fine of $1,000 during the probationary period. As part of his guilty plea, he agreed to pay $23,755 in restitution for past arrearages.

- A man was sentenced in Florida to pay more than $4 million for failure to abide by his divorce decree, including child support payments. With a net worth of more than $8 million, the man was ordered in a December 1992 divorce decree to pay his wife $3.9 million. He was also ordered to pay $2,500 a month for child support. He moved frequently from State to State to avoid making payments. During the current sentencing, he also was sentenced to time served (some 5 1/2 months from apprehension to conviction). He remains incarcerated on State charges related to contempt of court that arose in the original divorce decree.

Unpaid Child Support and Income Tax Deductions

In a joint review with the Internal Revenue Service (IRS), OIG found that an administratively simple and coordinated approach between the Office of Child Support Enforcement (OCSE) and IRS could help identify noncustodial parents misrepresenting their children's living arrangements on their tax returns. The OIG projected that this type of coordinated approach would have resulted in additional tax liabilities of $212 million in 1993. Based on this study and other information independently developed by IRS, OIG believes that there could be total annual tax losses of $1.4 billion or more as a result of noncustodial parents inappropriately claiming custody of children on Federal income tax returns.

The OIG recommended that OCSE and the States work with IRS to identify data available from State welfare agencies and child support record systems which would assist in the identification of inappropriate tax benefits claimed by noncustodial parents. In response, OCSE suggested delaying systems changes until the need for legislation to exchange this data is clarified. However, OIG feels that OCSE's and the States' capacity to exchange this data under current authorities should be explored at this time. (OIG-05-95-00070)

Head Start Grantees

A. Florida

The OIG found that a Florida Head Start grantee had not developed and implemented an adequate internal control system for the proper management of cash receipts, cash disbursements, procurement and accountability for property. As a result, there was no assurance that HHS funds were or could be expected to be expended and accounted for in accordance with grant terms and conditions. The internal control system was inadequate because the agency management had not implemented recommendations made by ACF, other funding sources and its independent auditors over a period of at least 15 years.

The OIG recommended that ACF take appropriate actions to address problems at this grantee, including consideration of suspension or termination of all ACF funding. The ACF agreed with OIG's findings and recommendation and is determining the feasibility of terminating the grantee's funding. (CIN: A-04-96-00099)

B. Colorado

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

In one such instance, OIG found that a Colorado grantee for FYs 1995 and 1996 did not comply with Head Start grant conditions and budget provisions. These instances of noncompliance resulted in questioned costs of almost $800,000, including an unauthorized payment of $47,000 as part of a settlement package given to its former executive director. Other findings included the improper allocation of administrative and shared costs, unauthorized equipment purchases, undocumented costs reported, matching shortages and bidding process violations. Recommendations called for a refund of almost $800,000 and procedural changes relating to allocation of administrative and other shared costs. (CIN: A-08-96-01024)

Welfare Fraud

Welfare assistance traditionally consisted of the AFDC, Medicaid, Food Stamp and general assistance programs, which were based on State determinations of eligibility. As a result, welfare fraud was usually perpetrated by providing false information about one's circumstances, such as claiming a nonexistent dependent child or concealing income which would render the applicant ineligible. Although the AFDC program was eliminated in Fiscal Year 1997, as described earlier, a few States and counties asked OIG for assistance in pursuing prior instances of AFDC fraud. The following cases are examples of some of these cases.

- In Ohio, four people were sentenced as a result of an ongoing investigation of welfare fraud. They were charged with defrauding the ACF. One couple fraudulently concealed the husband's employment to collect welfare benefits. The second couple submitted false claims to collect workman's compensation and welfare benefits. They were ordered to pay a total of more than $53,750 in fines and restitution, and all but one received suspended sentences. The husband who had falsely collected workman's compensation was sent to jail for 18 months.

- In South Dakota, nine people were sentenced also for welfare fraud and ordered to pay a total of over $60,000 in fines and restitution. The cases, which were on Indian reservations, were referred to OIG by the State because its enforcement officials are forbidden to follow up on reservations. The subjects failed to report employment or changes in household composition in applications and recertifications for AFDC, Food Stamps and Medicaid.

General Oversight

Chapter V

GENERAL OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities. The Program Support Center (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 is responsible for the development of the HHS budget and its execution, as well as the related activities of establishing and monitoring departmental policy for debt collection, cash management, and payment of HHS grants and contracts. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

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

The OIG's Fiscal Year (FY) 1997 work in departmental administrative activities and Governmentwide oversight focuses principally on financial statement audits, financial management and managers' accountability for resources entrusted, standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance.

Nonfederal Audits

The OMB Circulars A-128 and A-133 establish the audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under the two circulars, these entities are required to have an annual organizationwide audit which includes all Federal money they receive.

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the first half of FY 1997, OIG's National External Audit Review Center (located in Kansas City) reviewed almost 2,000 reports that covered over $564 billion in audited costs. Federal dollars covered by these audits totaled $127 billion, about $53 billion of which was HHS money.

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

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

A. Office of Inspector General's Proactive Role

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

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

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

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number (800-732-0679) and through training. During the past 6 months, 370 individuals were provided with technical assistance through OIG's toll free number. In addition, formal training was provided to certified public accountant societies and State auditor staff on issues related to Circulars A-128 and A-133.

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

B. Quality Control

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

Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 1,983 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,733
Reports issued with major changes	10
Reports with significant inadequacies	240
Total audit reports processed	1,983

The 1,983 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling $8.2 million as well as 3,516 recommendations for improving management operations. In addition, these audit reports provided information for 54 special memoranda which identified concerns for increased monitoring by departmental management.

Resolving Office of Inspector General Recommendations

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

A. Questioned Costs

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

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

	Number	Dollar Value	
		Questioned	Unsupported
A. For which no management decision had been made by the commencement of the reporting period[1]	335	$189,602,000	$48,667,000
B. Which were issued during the reporting period[2]	137	$72,939,000	$2,523,000
Subtotals (A + B)	472	$262,541,000	$51,190,000
Less:			
C. For which a management decision was made during the reporting period[3]:	166	$72,366,000	$26,946,000
(i) dollar value of disallowed costs		$62,754,000	$18,887,000
(ii) dollar value of costs not disallowed		$9,612,000	$8,059,000
D. For which no management decision had been made by the end of the reporting period	306	$190,175,000	$24,244,000
E. For which no management decision was made within 6 months of issuance[4]	178	$138,416,000	$26,400,000

See Appendix D for footnotes.

B. Funds Put to Better Use

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

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

	Number	Dollar Value
A. For which no management decision had been made by the commencement of the reporting period[1]	39	$33,364,000
B. Which were issued during the reporting period	15	$261,607,000
Subtotals (A + B)	54	$294,971,000
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	29	$154,304,000
(b) based on proposed legislative action	0	$0
Subtotals (a+b)	29	$154,304,000
(ii) dollar value of recommendations that were not agreed to by management[2]	__	$49,000
Subtotals (i + ii)	29	$154,353,000
D. For which no management decision had been made by the end of the reporting period[3]	25	$140,618,000

See Appendix D for footnotes.

Legislative and Regulatory Review and Regulatory Development

A. Review Functions

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. During this reporting period, OIG reviewed 50 of the Department's regulations under development and 172 departmental legislative proposals.

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

B. Legislative and Regulatory Development Functions

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

Among the regulatory initiatives promulgated during this reporting period were three OIG final regulations, two of which were a direct result of new or revised statutory authorities resulting from Public Law 104-191, the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

■ OIG Final Rule: Civil Money Penalty Inflation Adjustments

On October 7, 1996, OIG became the first Federal agency to publish final regulations (61 FR 52299) incorporating penalty inflation adjustments for certain CMPs for health care fraud and abuse. Specifically, in accordance with the Federal Civil Money Penalty Inflation Adjustment Act of 1990, as amended by the Debt Collection Adjustment Act of 1996, this final rule set forth the necessary inflation adjustment calculations for CMPs authorized by sections 421(c) and 427(b) of the Health Care Quality Improvement Act, and sections 6103 and 6104 of the Program Fraud Civil Remedies Act. The inflation adjustment calculations are not applicable to OIG's CMP authorities set forth in the Social Security Act, which are specifically exempt from this adjustment.

■ OIG Interim Final Rule: Issuance of Advisory Opinions by OIG

On February 19, 1997, OIG published an interim final rulemaking (62 FR 7350) establishing a new 42 CFR part 1008 to address the OIG advisory opinion process. In accordance with section 205 of HIPAA, these final regulations set forth the specific procedural aspects under which OIG receives and responds to advisory opinion requests from outside parties and, in consultation with the Department of Justice (DOJ), will issue advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to the Medicare and State health care programs.

■ OIG Notices

In addition to these final rules, OIG also developed and published three Federal Register notices, one of which was mandated by HIPAA. On November 15, 1996, OIG published a Federal Register notice (61 FR 58568) republishing its Medicare Beneficiary Advisory Bulletin that served to identify potential fraud and abuse issues relating to the enrollment, the provision of services and the disenrollment of Medicare beneficiaries in health maintenance organizations (HMOs). While this material was released in booklet form to beneficiaries and advocacy groups in October, this Federal Register notice ensured wider dissemination and a greater public awareness of these issues regarding HMO participation and service.

Also, in accordance with section 205 of HIPAA, OIG published a Federal Register notice on December 31, 1996 (61 FR 69060) that served to solicit proposals and recommendations for developing new and modifying existing safe harbor provisions under the Medicare and State health care programs' anti-kickback statute, as well as developing new OIG special fraud alerts. The notice specifically requested public input into this process, and set forth the specific criteria to be used in addressing the development of these items.

A third notice, issued jointly by OIG and DOJ on March 26, 1997 (62 FR 14443), announced the availability of $3.5 million in funds to support proposals from Federal, State and local agencies for projects or activities that promote the objectives of the Fraud and Abuse Control Program established under section 201 of HIPAA. Decisions on award of funds will be made by the Secretary and the Attorney General by the end of May 1997.

C. Congressional Testimony and Hearings

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

Proposed Changes to Office of Management and Budget Circular A-21 Regarding Financial Management of Recharge Centers

The OIG worked in partnership with 15 universities to assess controls over the financial management of their recharge centers. A recharge center operates as an in-house enterprise that provides goods and services to individual users and other operating units on a cost reimbursement basis. The universities performed the preliminary survey work, while OIG evaluated the policies and internal control procedures of recharge centers for compliance with OMB Circulars A-21 and A-133.

The OIG found that inadequate policies and controls over recharge centers at the 15 universities visited resulted in $1.9 million in overcharges to the Federal Government. Specifically, recharge centers: accumulated surplus fund balances and deficits which were not used in the computation of subsequent billing rates; overstated billing rates by transferring funds from center accounts or including unallowable costs in rate calculations; billed users inequitably; and used recharge center fund balances inappropriately to calculate facilities and administrative cost rates.

The OIG believes the starting point for improving university oversight of their recharge centers is the creation of criteria for developing and reviewing billing rates, and accounting for and applying surplus and deficit balances. Generally, OIG recommended policies that are patterned after those used by State and local governments. The Deputy Assistant Secretary for Grants and Acquisition Management concurred with the OIG recommendation to request OMB to clarify the criteria in OMB Circular A-21. (CIN: A-09-96-04003)

Compliance with the Prompt Payment Act

The OIG reviewed compliance with the Prompt Payment Act by PSC. The OIG determined that PSC generally met the OMB Circular A-125 "Prompt Payment" standard for paying bills on time and remitting interest penalties when payments were made late. However, OIG found that the PSC lost opportunities for taking discounts and submitted the Prompt Payment Status Report for FY 1994 to OMB with material inaccuracies. Further, OIG determined that quality assurance assessments of the reliability of the PSC payment process are insufficient and the follow-up process for confirming that goods and services paid for are received could be improved for invoices of $2,500 or less that are processed at headquarters. The PSC generally agreed with OIG recommendations for corrective action. (CIN: A-15-96-40001)

Review of Cost Transfers

As requested by the Department's Division of Cost Allocation (DCA), OIG reviewed cost transfers processed by the New York State Department of Social Services for the 2-year period ending March 31, 1994. The DCA noted internal control and other accounting weaknesses cited in the State's single audit reports for FYs 1993 and 1994.

The OIG's examination of $15.9 million of the $43.3 million transferred during the review period found that, in general, the transfers were adequately documented and proper. However, the review found posting errors which resulted in overcharges of $159,000 to Federal programs plus another $5,000 of unallowable interest costs. The OIG proposed appropriate refund as well as procedural recommendations. (CIN: A-02-95-02004)

Ohio Pension Costs

The OIG reviewed pension costs charged to grants and contracts by the State of Ohio to determine compliance with Federal regulations, generally accepted accounting principles and actuarial standards. The OIG found that the State's practices resulted in excessive charges of pension costs to Federal programs. The State should have used surplus pension investment earnings to reduce its unfunded actuarial accrued liability. Instead, contrary to requirements, the State established a $200 million contingency reserve for future retirement benefits and potential retirement liabilities, and transferred $374 million in excess retirement fund earnings to a reserve to support future health care benefits. The elimination of these practices would reduce the pension costs allocable to Federal programs by approximately $75 million in future years.

The OIG recommended that the Department's Division of Cost Allocation consider these issues in rate negotiations with the State agencies and other entities whose employees participate in the State's retirement system. Future pension costs allocable to Federal programs should be reduced by the actuarial gains inappropriately transferred to the contingency and health care reserves. (CIN: A-05-96-00071)

In another review, OIG found that additional cost savings could be achieved if delays in forwarding contributions to the Public Employees Retirement Systems (PERS) for investment were eliminated. The OIG estimated that by eliminating the delay in forwarding the pension contributions to PERS, the increased investment earnings could result in potential annual savings of as much as $1.9 million (Federal share $380,000). The Code of Federal Regulations requires that States minimize the time elapsing between the transfer of funds and recipient's disbursements, and that States establish procedures to minimize the time elapsing between the advance of Federal grant funds and their disbursement by the recipient. The State concurred with the findings and recommendations and will implement a mechanism to reduce the delays. (CIN: A-05-95-00014)

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 113 successful criminal actions. Also during this period, 254 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 131 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over $1.1 billion 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.

In keeping with its commitment to Operation Restore Trust, OIG has concentrated on the five States where most of the Department's health care dollars are spent.

Appendices

APPENDIX A

Implemented Office of Inspector General Recommendations to Put Funds to Better Use October 1996 through March 1997

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

Legislative savings are annualized amounts based on Congressional Budget Office estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected. Total savings from these sources amount to $2,320.7 million for this period.

OIG Recommendation	Status	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 coverage of personal care services and allows the States to cover personal care services furnished outside the home, effective October 1, 1994.	$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.	511
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)	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.	199.2
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)	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.	119

OIG Recommendation	Status	Savings in Millions
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)	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.	$78
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)	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.	65
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)	Section 13566 of OBRA 1993 reduced the reimbursement rate for Epogen to $10 per thousand units.	62
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)	The OIG accepted the PROs' 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.	54.8
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

OIG Recommendation	Status	Savings in Millions
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.	$108

APPENDIX B

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

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

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

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

OIG Recommendation	Status	Savings in Millions
Home Health Agencies: The HCFA should intensify efforts to scrutinize claims submitted by high cost home health agencies, explore ways to prevent unscrupulous agencies from engaging in abusive practices and consider legislation to restructure the benefits to prevent fraud, waste and abuse. (CIN: A-04-95-01103; CIN: A-04-95-01104; CIN: A-04-95-01103; OEI-04-93-00262; OEI-04-93-00260; OEI-12-94-00180; OEI-02-94-00170, CIN: A-04-94-02087; CIN: A-04-94-02078)	The HCFA concurred with the recommendations, and among other actions, has advanced a legislative proposal as part of the President's 1997 budget.	$500
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt policy. The OIG presented an analysis of four options for HCFA to consider including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system (PPS) hospitals which are profitable, and the inclusion of a bad debt factor in the diagnosis related group (DRG) rates. (CIN: A-14-90-00339)	This proposal was not included in the President's current budget.	487.7
Flexible Benefit Plans: The value of flexible benefit plans, as defined by section 125 of the Internal Revenue Code, should be included in the hospital insurance portion of the Federal Insurance Contributions Act taxable wage base. (CIN: A-05-93-00066)	While HCFA agreed with the report findings related to revenue to the Hospital Insurance Trust Fund, a legislative proposal has not been included in the President's budgets.	420
Terminate Medicare Disproportionate Share Adjustments: Terminate disproportionate share adjustment payments without redistribution of the funds to PPS hospitals. Payments under PPS adequately compensate hospitals for services provided to Medicare patients, including low-income patients. (CIN: A-04-87-00111)	Although the President's past budgets contained a proposal to phase down Medicare disproportionate share payments, no legislative proposal was included in the President's current budget.	410

OIG Recommendation	Status	Savings in Millions
Prospective Payment System's Capital Cost Rates: The HCFA should consider reducing payment rates by 7.5 percent to more accurately reflect costs of the base year used for the capital cost component of PPS, and continue to monitor the most current data and make any necessary further adjustments to the base rate. (CIN: A-07-95-01127)	The HCFA agreed with OIG's analysis that the Federal capital rate reflects a known over-estimation of base year costs. The HCFA also stated that comments from individual hospitals and hospital associations were uniformly opposed to making any of the possible rate reductions that were discussed in HCFA's proposed rule. The Prospective Payment Assessment Commission (ProPAC) acknowledged that there are legitimate issues regarding the appropriate level of the rates in light of the current data. The HCFA does not intend to adopt any of the possible approaches at this time, in anticipation of congressional action to realize savings in this area.	$249
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality. (CIN: A-05-89-00055; CIN: A-05-92-00006)	The OIG's follow-up report (CIN: A-05-92-00006) indicated that problems still exist with inappropriate admissions and that the volume of 1-day admissions on a national basis have increased approximately 150 percent over 1985 levels. The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's current budget.	210
Eliminate Separate Enteral Nutrient Payments in Nursing Homes The HCFA should eliminate separate payments for enteral nutrients for beneficiaries in nursing homes. (OEI-06-92-00861)	The HCFA concurred with the recommendation and is considering alternative payment mechanisms and enhanced control of utilization to contain costs while it examines a legislative remedy.	174
Graduate Medical Education: Revise the regulations to remove from a hospital's allowable graduate medical education (GME) base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020)	The President's FY 1997 budget contains proposals to slow the growth in Medicare spending in GME.	157.3

OIG Recommendation	Status	Savings in Millions
Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 chemistry tests identified by the OIG audit. (CIN: A-01-93-00521)	The HCFA agreed with 8 of the 10 tests recommended for addition to the list. In November 1995, HCFA updated its carrier manual adding three of the tests recommended in the OIG report. A legislative proposal to add tests (including those identified in OIG's review) was included in the President's December 7, 1995 Medicare savings package.	$130
Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing and begin to plan now for the policy changes that will become necessary to achieve an almost completely paperless environment for processing Medicare claims. (CIN: A-05-94-00039; OEI-01-94-00230)	The HCFA concurred with OIG's recommendations. However, with respect to the policy options suggested, HCFA believes that mandating paperless claims is impractical.	126
Medicaid Drug Rebate Program: Best price calculation in the Medicaid drug rebate program should be indexed in a manner similar to the average wholesale price, which is indexed to the consumer price index-urban. (CIN: A-06-94-00039)	The OIG is continuing its review of the Medicaid drug rebate program.	123
Reduce Medicare Payments for Hospital Outpatient Department Services: Establish a legislative initiative to reduce the current payments for services in outpatient departments to bring them more in line with ambulatory service center (ASC) approval payments. Pay outpatient departments the ASC-approved rate or adjust hospital payments by a uniform percentage. (CIN: A-14-89-00221; OEI-09-88-01003)	The HCFA sent a report to the Congress on developing a PPS for outpatient departments. In addition, the President's FY 1997 budget contains a proposal to eliminate a formula-driven overpayment which allows Medicare to fully deduct beneficiary coinsurance payments received by the hospital before the program makes its payments, and establish a budget-neutral PPS for outpatient department services starting in 2002.	120
Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The fiscal intermediaries should recover improper payments made to hospitals for nonphysician outpatient services (such as diagnostic tests and laboratory tests) rendered within 72 hours of the day of an inpatient admission, and refund the beneficiaries' coinsurance and deductible related to these payments. The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)	The HCFA agreed to recover the improper billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and OIG. The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's current budget.	83.5

OIG Recommendation	Status	Savings in Millions
Preclude Improper End Stage Renal Disease Payments to Health Maintenance Organizations: The HCFA should advise all risk-based health maintenance organizations (HMOs) and comprehensive medical plans that ESRD capitation rates are only effective for beneficiaries who currently are diagnosed as having ESRD; identify and recover all payments to HMOs and comprehensive medical plans for beneficiaries misclassified as having ESRD; and make systemic and procedural changes to prevent future overpayments. (CIN: A-04-94-01090)	The HCFA agreed with OIG's findings and recommendations. The systems changes were implemented in August 1996. The HCFA continues to recoup improper payments.	$50.7
Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)	The HCFA considered a proposal recommending that the 190-day lifetime limit for psychiatric hospitals be extended to general hospitals; however, such a proposal was not included as part of the President's current budget.	47.6
Generic Drugs: The HCFA should identify and alert States to methods which would encourage the use of lower priced generic drug products in the Medicaid program. The HCFA should also take a more active role to encourage States to use generic drugs; provide stronger incentives for States to adopt policies that encourage use of generic drugs; monitor the States' efforts to encourage the use of lower priced drugs; and formally assess those activities. (CIN: A-06-93-00008)	The HCFA has provided a copy of the OIG report to States and encouraged them to use lower priced generic products. On February 2, 1996, States were requested to provide a description of any policies adopted that encourage use of equivalent generic drugs. This information will be included in the 1995 State Drug Utilization Review Annual Report due to regional offices by June 30, 1996.	46
Medicaid Payments for Employer Group Health Insurance: The HCFA should continue to strongly support States implementing Section 1906 of the Social Security Act, and should propose legislation that allows States to pay employer group health plan (EGHP) deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules. (OEI-04-91-01050)	The HCFA concurred with the first recommendation and has been working in partnership with regional offices and States to promote full implementation. The HCFA deferred comment on the second recommendation.	32
Establish Medicaid Credit Balances Reporting : The HCFA should establish and monitor a national Medicaid credit balance reporting mechanism similar to the Medicare Part A credit balance reporting procedures. (CIN: A-05-93-00107; CIN: A-04-92-01023)	The HCFA agreed to establish a national reporting system; however a follow-up audit indicates that Medicaid credit balances continue to exist.	25

OIG Recommendation	Status	Savings in Millions
Reduce End Stage Renal Disease Rates: The HCFA should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)	The HCFA agreed that ESRD facilities have become more efficient in their operations and that the composite payment rate should reflect the costs of outpatient maintenance dialysis treatment in an efficiently operated facility. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing the ESRD composite rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatments. The study undertaken by ProPAC was presented to the Congress in March 1996 and recommended an increase to the current rates.	$22*
Medicaid Cost Sharing: The HCFA should promote the development of effective cost sharing programs by: allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services; and allowing for higher beneficiary cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800)	The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. It plans to solicit information from States implementing cost sharing and distribute it to States that do not impose it. Several States have submitted waiver applications to HCFA to develop demonstration projects which include experimental cost sharing provisions.	19.8
Minimize Incorrect Payments for Durable Medical Equipment Billed During Skilled Nursing Facility Stays The HCFA should minimize the opportunity for incorrect durable medical equipment (DME) payments by: improving the place of service coding system; improving the supplier knowledge of beneficiary location; reviewing the DME regional carriers' processes; and improving processes for identifying skilled nursing facilities for DME reimbursement purposes. (OEI-06-92-00860; OEI-06-92-00862; OEI-06-92-00865)	HCFA concurred with the recommendations and is currently developing a corrective action plan.	19
Reduce Medicare Part B Payment for Enteral Nutrition at Home Reduce payments through competitive acquisition strategies for patients receiving enteral nutrition at home. (OEI-03-94-00021)	A plan for a DME competitive bid demonstration that includes enteral nutrition is underway. Payment changes are likely to be implemented at the same time changes are made in Part B coverage for enteral nutrients for nursing home patients.	15

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

OIG Recommendation	Status	Savings in Millions
Preclude Improper Medicaid Reimbursement for Clinical Laboratory Services: State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings which contain duplicate tests, recover overpayments and make adjustments for the Federal share of the amounts recovered. (CIN: A-01-95-00005; CIN: A-05-96-00031; CIN: A-01-96-00001; CIN: A-06-95-00078; CIN: A-04-95-01108; CIN: A-07-95-01139; CIN: A-07-95-01147; CIN: A-04-95-01113; CIN: A-07-95-01138; CIN: A-09-95-00072; CIN: A-05-96-00019; CIN: A-10-95-00002)	The HCFA is evaluating the OIG results.	$14
Nonemergency Advanced Life Support Ambulance Services: The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513; CIN: A-01-94-00528)	The HCFA prepared a draft regulation in late 1995 that would shift the policy focus away from the type of vehicle used and towards the medical condition of the beneficiary. No final regulation has been issued to date.	12.8
Medicare Payments for Orthotic Body Jackets: The HCFA should require the DME regional carriers (DMERCs) to closely monitor claims for body jackets, including: analysis of payment trends, provision of an early warning of abusive practices and monitoring of suppliers who have engaged in abusive practices. (OEI-04-92-01080)	The HCFA concurred and has instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices. However, payments continue at high levels. The OIG plans to revisit this issue as part of an ongoing study on orthotics.	10.4
Medicare Claims for Railroad Retirement Beneficiaries: Discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)	While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.	9.1
Limit Reimbursement for Hospital Beds: The HCFA should develop a new approach for reimbursing suppliers for hospital beds used by Medicare beneficiaries at home. A new reimbursement methodology should reflect a hospital bed's useful life and the number of times a bed can customarily be rented over that period. (CIN: A-06-91-00080)	Although a past budget of the President contained a proposal that authorized competitive bidding for DME, no legislative proposal was included in the President's current budget. The HCFA awarded a demonstration project on this subject in 1996. The project is expected to run in at least 3 sites for 2 cycles of 2 years each beginning in January 1997.	6.2

OIG Recommendation	Status	Savings in Millions
Third Party Liability Settlements and Awards: The HCFA should develop legislative proposals to close the loopholes in the Omnibus Budget Reconciliation Act of 1993 that allow Medicaid beneficiaries, who receive settlements and awards from third parties as a result of accidents, to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. The HCFA should also develop guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties. (CIN: A-09-93-00033)	The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g. health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements.	$3
Hospital General Administrative and Fringe Benefit Costs: Revise the Provider Reimbursement Manual (PRM) to provide explicit guidelines on the allowability of certain general administrative and fringe benefit costs. (CIN: A-03-92-00017)	The HCFA has published changes to the PRM to clarify the allowability of several of the cost categories identified in OIG's report. The HCFA has not yet clarified the remaining cost categories noted in OIG's report.	to be determined
PUBLIC HEALTH SERVICE OPERATING DIVISIONS		
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)	In the absence of specific authorizing legislation, the Food and Drug Administration is precluded by statute from imposing user fees to cover additional functions.	44.4
Billings and Collections to Private Health Companies: The Indian Health Service (IHS) should establish the necessary internal controls, assign adequate resources to its business offices, and provide additional training to business offices to ensure that underbillings to private insurance companies are properly filed and collected. (CIN: A-06-93-00080)	The IHS fully concurred with OIG's recommendations. The IHS is in the process of, or has plans for: implementing an automated system to achieve the necessary internal controls; allocating resources to improve methods for billings and collections; meeting the training needs of business office staff; implementing fee schedules on a timely basis; ensuring adequate accounting and medical records are maintained for each patient; providing adequate resources to carry out claims follow-up; and improving policies and procedures for follow-up of unpaid claims.	28
Medical Malpractice Coverage: The Health Resources and Services Administration (HRSA) should consider seeking a legislative proposal to limit malpractice settlements or judgments involving community and migrant health centers to $1 million. (CIN: A-04-95-05018)	The HRSA has drafted a legislative proposal to amend the Federal Tort Claims Act to include the $1 million limitation.	10

OIG Recommendation	Status	Savings in Millions
Limit Graduate Student Compensation: The Assistant Secretary for Management and Budget (ASMB) should work with the Office of Management and Budget (OMB) to revise Circular A-21 to stipulate a reasonableness standard for graduate student compensation charged to federally sponsored research based on assigned responsibilities and not to exceed compensation paid to other individuals of similar experience for similar work. (CIN: A-01-94-04002)	The ASMB endorsed the OIG recommendation, concluding that a prudent person would not provide greater compensation to individuals who are less qualified by education and practical experience than others performing similar work. The National Institutes of Health (NIH) issued a notice in its Guide for Grants and Contracts on compensation of graduate students (NIH Guide, volume 25, number 8, March 15, 1996). The guidelines reiterate the requirements of OMB Circular A-21 that costs applicable to Federal agreements be allowable, allocable, reasonable, necessary and treated consistently, and provide guidance for assessing reasonableness.	$5.7
Recharge Center Costs: Universities should: improve their oversight of recharge centers; develop and implement policies and procedures for the operation of recharge centers that are consistent with OMB Circular A-21; establish and maintain adequate accounting and recordkeeping procedures for recharge centers; and analyze and adjust billing rates to eliminate deficit and surplus funds. (CIN: A-09-92-04020)	The ASMB concurred with the recommendations and has recommended to OMB that Circular A-21 be revised to provide more definitive guidance on the financial operations of recharge centers.	3.2
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Limit Federal Participation in States' Costs for Administering the Foster Care Program: Limit Federal participation in foster care administrative costs through one of the following actions: limit future increases in administrative costs to no more than 10 percent per year; fund administrative activities via a single block grant with future increases based on the consumer price index; limit administrative costs to a percentage of maintenance payments; or restrict, through legislation, the filing period for retroactive claims, namely require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. (CIN: A-07-90-00274; OEI-05-91-01080)	This proposal was not included in the President's current budget.	247

OIG Recommendation	Status	Savings in Millions
Unpaid Child Support and Income Tax Deductions: The Office of Child Support Enforcement and States should work with the Internal Revenue Service to identify data available from State welfare agencies and child support record systems which would assist in the identification of inappropriate tax benefits claimed by noncustodial parents. (OIG-05-95-00070)	The Administration for Children and Families favors delaying system changes pending a possible need for legislation to permit the data exchange proposed in the report.	$212
GENERAL OVERSIGHT		
Simplify Administrative/Indirect Cost Allocation Systems: The OMB should simplify the process for charging administrative/indirect costs to Federal programs through reform of the cost allocation plans. Options for reform include: use of block grant awards, a flat percentage rate for administrative/indirect costs, and negotiation of a nonadjustable rate for predetermined numbers of years. (CIN: A-12-92-00014)	Some of OIG's recommendations are cited in the National Performance Review report that calls for reform of the cost allocation process. The OMB's revision of Circular A-87 addressed those recommendations. However, further reform is needed to address the bulk of administrative/indirect costs charged to the Federal Government.	660

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

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

OIG Recommendation	Status
Medicare Trust Funds' Accounts Receivable Internal Controls: The HCFA needs to improve its internal controls and the controls of its fiscal intermediaries (FIs) and carriers related to the recording and reporting of accounts receivables. Additionally, HCFA needs to properly estimate the allowance for uncollectible receivables and determine the amounts to be written off as uncollectible. In a review conducted in accordance with the Chief Financial Officers Act, OIG continued to find weaknesses in contractors' controls. (CIN: A-01-92-00516; CIN: A-14-93-03027; CIN: A-01-94-00520; CIN: A-17-94-03032; CIN: A-17-95-00051)	The HCFA concurred with the intent of most of the recommendations and is taking corrective actions. However, HCFA has still been unable to resolve all the critical problems. The HCFA and OIG will continue to work together to develop corrective action plans to resolve these deficiencies. The HCFA has established a work group to review Medicare contractor operations and systems, analyze contractor controls and identify internal control weaknesses. The work group has contracted with a Medicare contractor and a certified public accounting firm to develop an approach to evaluate internal controls at Medicare contractors. The HCFA has also requested a clarification of the reporting of Medicaid financial information from the Federal Accounting Standards Advisory Board.
Review Medicare Trust Funds' Accounts Payable Internal Controls: The HCFA should improve its internal controls and the controls of its FIs and carriers related to the recording and reporting of accounts payable. The HCFA should also perform Federal Managers' Financial Integrity Act (FMFIA) sections 2 and 4 reviews on all carrier accounts payable internal controls and financial management systems. (CIN: A-04-92-02054; CIN: A-05-92-00106)	The HCFA concurred with the recommendations. Regarding recommendations to perform FMFIA section 2 and 4 reviews at contractors, HCFA has contracted with a Medicare contractor and a certified public accounting firm to evaluate internal controls at Medicare contractors.
Improve Financial Management Systems to Enhance Financial Reporting: The HCFA should develop and implement financial management systems and related accounting and administrative internal controls to ensure that all Medicare liabilities are reported to the HCFA general ledger at fiscal year end. (CIN: A-14-92-03015)	The HCFA agreed that reasonable data should be included in the reporting of Medicare liabilities. However, HCFA asserts that the process for developing a reasonable estimate of a liability for provider reports would be too cumbersome. The HCFA is currently developing the Medicare Transaction System that will include an integrated accounting subsystem to estimate the amount of appealed cost reports.
Clarify the Allowability of General and Administrative Costs at Medicare Hospitals: The HCFA should revise the Provider Review Manual (PRM) to further clarify the allowability of specific types of general and administrative and fringe benefit costs. (CIN: A-03-92-00017)	The HCFA has published changes to the PRM to clarify the allowability of several of the cost categories identified in OIG's report. The HCFA has not yet clarified the remaining cost categories noted in OIG's report.
Consider Recommended Safeguards over Medicaid Managed Care Programs: The HCFA should consider safeguards available to reduce the risk of insolvency, and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)	The HCFA generally concurred with OIG's recommendations, but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.

OIG Recommendation	Status
Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program: The HCFA should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The HCFA should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)	The HCFA did not concur stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP but did not provide specific written methodology for computing AMP.
Physician Office Surgery: The PROs should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)	The HCFA continues to work with the PROs to refine a methodology for review of quality of care for ambulatory services. The implementation plan is to expand the review of ambulatory services to additional States, first on a pilot basis, then on an implementation basis in other States.
Patient Advance Directives - Early Implementation Experience: The HCFA should develop and issue specific regulatory guidelines clarifying acceptable documentation methods to assist providers in meeting the requirements of the Federal statute. The statute requires providers to inform individuals of any rights they have under State law regarding self-determination. (OEI-06-91-01130)	The HCFA did not concur with the recommendation, but is willing to provide assistance to States by issuing interpretive guidelines for survey and certification containing examples of what would constitute acceptable documentation of whether a patient has an advance directive.
Implementing the New Medicare Transaction System: The HCFA should take steps early to ensure that the new nationwide Medicare claims processing system, the Medicare Transaction System, is designed to assure flexibility and adaptability to meeting future program requirements. (CIN: A-14-93-02543)	The HCFA concurred with OIG's recommendations and is working with the system's design contractor to address issues raised by OIG.
Review Determinations of Graduate Medical Education Costs: The HCFA should take steps to ensure that FIs 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)	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.
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; OEI-07-90-00763)	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.
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)	The HCFA concurred with OIG's recommendations.

OIG Recommendation	Status
PUBLIC HEALTH SERVICE OPERATING DIVISIONS	
Improve Blood Establishments' Errors and Accidents Reporting: The FDA should work to ensure that error and accident reports are submitted timely 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 agreed to take corrective actions, including developing and implementing revisions to regulations to require unlicensed blood establishments to submit error and accident reports.
ADMINISTRATION FOR CHILDREN AND FAMILIES AND ADMINISTRATION ON AGING	
Undistributed Child Support Payments: The Administration for Children and Families (ACF) should remind States to: monitor and expedite the distribution of collected child support payments; place undistributed payments in interest bearing accounts; and report escheated payments and interest as State income. (CIN: A-09-93-00030)	The ACF agreed to participate in a joint effort with OIG to determine the extent of these problems, but disagreed with the need to remind States of ACF's policies and procedures for undistributed collections. The ACF expected considerable alleviation of the undistributed collections as States complete their automated systems. The ACF is in the process of reviewing 12 selected States' undistributed collection balances in order to address the wide disparity in the level of balances reported by the States, as well as problems cited in the OIG report. When all 12 reviews are complete, a national report will be issued to outline problems encountered and suggested solutions for the handling and reporting of undistributed collections.
Strengthen Head Start Grantees' Financial Management Systems: The ACF should intensify efforts to assure that Head Start grantees have adequate systems of internal controls; maintain proper accounting records; have systems for assuring program requirements are met; and obtain acceptable independent audits and submit reports in accordance with Federal requirements. The ACF should also take appropriate action when grantees do not meet these requirements. (CIN: A-17-93-00001)	The ACF generally agreed with OIG's recommendations.
Measure Head Start Grantees' Performance: The ACF should establish and implement performance measures and procedures for determining Head Start grantees' compliance with program requirements, and as a basis for establishing uniform ratings and identifying management practices that create high-risk conditions. (CIN: A-04-90-00009)	The ACF agreed with the importance of strengthening performance measurement criteria but disagreed with OIG's conclusions relative to high-risk conditions. The ACF is now completing a major initiative to develop Head Start performance measures designed to assess the quality and effectiveness of the program nationally through stating outcomes for children and families and through program indicators.

OIG Recommendation	Status
Ensure that Head Start Program Attendance Goals and Matching Requirements are Met: The ACF should establish and implement procedures to ensure that center-based Head Start grantees attain the expected attendance goal of 85 percent of funded enrollment. The ACF should also seek a legislative change to require that funding levels be based on current conditions (not historic funding levels) and require current information to support requests for waivers of nonfederal matching requirements. (CIN: A-04-90-00010)	The ACF noted that it is obtaining information from its grantees to improve internal reporting procedures. As far as average daily attendance, ACF states that an average daily attendance of 85 percent is a service goal, not a program requirement of Head Start grantees. The ACF is also reviewing Head Start procedures to grant waivers.
Health and Safety Standards at Child Care Facilities: The ACF should work with States to improve the health and safety practices of child care facilities. In addition to actions ACF is already taking, OIG recommended that ACF provide State agencies with identified best practices including: parental involvement, provider self-appraisals and private/public partnerships. (CIN: A-04-94-00071; CIN: A-07-93-00718; CIN: A-12-92-00044)	The ACF generally concurred with OIG's findings and recommendations, and is taking actions to enhance the health and safety standards of child care facilities.
Improve the Federal Foster Care Program: The OIG provided options for ACF to consider in its efforts to improve its partnership with State and local governments in administering the Federal Foster Care program. The options included streamlining the process; determining whether legislative change is needed; and determining if certain program requirements could be changed to facilitate compliance. (CIN: A-12-93-00022)	The ACF concurred on the issues raised in OIG's report. The ACF convened two teams whose task was to redesign the titles IV-B and IV-E child welfare reviews. The objectives of the teams are consistent with issues and options described in OIG's report. A draft notice of proposed rulemaking is currently in preliminary clearance.
Improve Oversight of Audits of Office of Community Service Grantees: The ACF should track Office of Community Services grantees' implementation of recommendations made as a result of single audits, and follow up with grantees to ensure actions taken were effective. (CIN: A-12-92-00043)	The ACF agreed and will take steps to implement the recommendations within the limitation of current staffing resources.
Strengthen State Practices Relating to Wage Withholding for Child Support Collections: The ACF, in consultation with State agencies, should work to strengthen and standardize State practices to effectively implement wage withholding for child support collections. (CIN: A-09-12-91-00016)	The ACF is in the process of implementing OIG's recommendation.
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.

OIG Recommendation	Status
Improve Financial Practices of Head Start Grantees: The ACF should strengthen procedures to monitor grantee accountability over program funds, and to ensure that all grantees use interest bearing accounts and properly refund interest income. (CIN: A-07-91-00425)	The ACF is implementing OIG's recommendations.
Colocating Intergenerational Programs: The Administration on Aging (AoA) and ACF should examine whether demonstrated successes in colocating programs and facilities in the private and public sector can be more broadly applied to departmental programs on a voluntary basis. (CIN: A-05-94-00009)	The AoA and ACF generally agreed with OIG's recommendations.
Improving Administration on Aging's Nutrition Program for the Elderly: The AoA and the Department of Agriculture (USDA) should remove barriers to increase States' use of commodities by fostering better communications and working relationships with State distribution agencies which handle USDA commodities; assuring a better variety of commodities; and improving dependability, quality and packaging of commodities. (CIN: A-01-93-02510)	The AoA and USDA generally agreed to address these issues through joint efforts.
Coordination of Specialized Transportation Services: The AoA needs to actively promote transportation consortiums, and provide the assistance needed by State agencies and local providers to promote improvements in coordinated transit systems. It should continue its work with other Department of Health and Human Services (HHS) agencies and Federal Departments to promote further development of coordinated transportation systems for the elderly, persons with disabilities and others in need of services. (CIN: A-05-95-00023)	The AoA concurred with the OIG recommended actions to increase implementation of coordinated transportation services nationwide. The AoA will work with the Joint Department of Transportation/HHS Coordinating Council to develop a strategic plan for improving transportation services.
GENERAL OVERSIGHT	
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify HHS's disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to the Public Health Service, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040)	The OS and OASH have consolidated into one unit. The OASH had taken the lead in this area and has met with headquarters operating division emergency preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved.

OIG Recommendation	Status
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The OASH should issue guidelines to improve disaster planning. The plans of each operating and staff division should spell out lines of communication with each other, and should specify headquarters and regional lines of communication with the Federal Emergency Management Agency. (OEI-09-90-01040)	The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department. The OASH and OS have consolidated.
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 in the development of guidelines related to the determination of administrative costs, including standards for the use of random moment time studies.

APPENDIX D

Notes to Tables I and II

Table I

[1] The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of $4.4 million.

[2] Included in the reports issued during the period are management decisions to disallow $9,326 in costs attributable to the audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

[3] During the period, revisions to previously reported management decisions totaled $995,825.

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

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

CIN: A-05-94-00064	Michigan Blue Cross/Blue Shield, Audit of Administrative Costs, June 1996, $15,609,718
CIN: A-07-95-01009	Review of AFDC Emergency Assistance-Selected States, February 1996, $10,114,980
CIN: A-03-91-00552	Independent Living Program, March 1993, $6,529,545 (Related recommendation outstanding on Table II for $10,161,742)
CIN: A-07-92-00578	BC/BS of Texas Inc.-Unfunded Pension Costs, October 1992, $6,244,637
CIN: A-03-89-00046	Maryland Blue Cross/Blue Shield Administrative Costs, September 1991, $5,996,278
CIN: A-05-96-00013	IL DCFS IV-E Training Cost Allocation, August 1996, $5,812,360
CIN: A-07-95-01010	Review of MO Title IV-E Retro Claim, February 1996, $4,246,295
CIN: A-05-94-00080	Associated Insurance-Medicare Administrative Costs, July 1996, $3,954,632
CIN: A-09-95-00056	Review of Training Activities-CA Dept. of Social Services, August 1996, $3,934,717
CIN: A-05-93-00054	IL-Associated Insurance Group Contract Audit, October 1993, $3,355,560
CIN: A-07-93-00633	Pension Segmentation-AETNA Life Insurance Co., October 1993, $3,011,376
CIN: A-05-93-00013	Michigan BC/BS Contract-Medicare Audit, April 1993, $3,010,916
CIN: A-07-92-00585	Pension Segmentation BC/BS of California, January 1994, $2,973,504
CIN: A-01-95-00504	Medicare Parts A&B Administrative Cost-AETNA, January 1996, $2,938,223
CIN: A-01-96-00508	Medicare Administrative Cost Parts A&B and RRB-Travelers, March 1996, $2,803,269
CIN: A-07-92-00579	BC/BS of Michigan Unfunded Pension Costs, October 1992, $2,535,698
CIN: A-05-92-00026	Associated Insurance Co. Medicare Administrative, February 1992, $2,530,409

CIN: A-02-91-01006	Blue Shield of Western NY Medicare Adm CTS Porter, September 1991, $2,379,239
CIN: A-03-90-02003	BC of Western PA Administrative Cost-FY86-89, August 1993 $2,218,528
CIN: A-02-93-02001	Manpower Demonstration Res Corp., October 1994, $2,024,444
CIN: A-02-94-01029	Hospice Eligibility RVW Puerto Rico-San German-ORT, June 1995, $1,598,837
CIN: A-03-92-19733	State of Maryland, August 1992, $1,505,462
CIN: A-06-96-00008	Arkansas BC/BS Administrative Cost, September 1996, $1,442,193
CIN: A-03-90-00051	Maryland Blue Cross/Blue Shield Administrative Cost Audit, Part A-FY85-88, August 1991, $1,438,414
CIN: A-09-93-00083	Child Support Intercept Programs-California, August 1995, $1,429,837
CIN: A-02-96-42454	City of New York City HRA Agency for Child Development, May 1996, $1,410,441
CIN: A-05-93-00057	Michigan BC/BS Contract Audit, July 1993, $1,409,954
CIN: A-10-91-00011	WPS-Keystone Computer Acquisition, October 1992, $1,346,681
CIN: A-05-95-00042	BC/BS Administrative Costs-Contract Audit, December 1995, $1,333,598
CIN: A-07-93-00700	BC/BS of Mass-Unfunded Pension Cost Audit, May 1994, $1,290,740
CIN: A-07-93-00679	AETNA-Unfunded Pension Cost Audit, May 1994, $1,290,740
CIN: A-01-96-00508	State of Kentucky, April 1996, $1,271,907
CIN: A-07-94-00762	Health Care Service Corp-Unfunded Pension Cost, July 1994, $1,233,337
CIN: A-07-93-00665	Travelers Insurance Co-Unfunded Pension Cost Audit, October 1993, $1,218,963
CIN: A-07-94-00763	Health Care Service Corp-Pension Segmentation, August 1994, $1,055,458
CIN: A-05-94-00047	Nationwide Ins., Medicare Part B Administrative Cost, September 1995, $1,049,309
CIN: A-07-93-00634	Pension Segmentation-Travelers Insurance Co., October 1993, $1,026,460
CIN: A-06-95-00035	Fees Retained by Child Placing Agencies, February 1996, $988,680
CIN: A-09-94-01010	Contract Close-out-Stratagene, March 1994, $983,208
CIN: A-05-92-00060	Contractor Audit-BC/BS Administrative, February 1993, $879,609
CIN: A-04-95-02096	Review of FY92 Unsupported G&A Costs-ABC Co., July 1995, $857,684
CIN: A-04-94-01078	Monitoring Administrative Cost Audit Medicare BC/BS of South Carolina, July 1994, $839,740
CIN: A-07-96-01193	Pro Closeout-Mcbride CPA, August 1996, $751,789
CIN: A-07-95-01175	Mutual of Omaha-Administrative Cost, August 1996, $13,564
CIN: A-05-91-00136	Community Mutual Ins. Co. Administrative Costs, August 1992, $720,668
CIN: A-07-93-00699	BC/BS of Mass-Pension Segmentation Audit, April 1994, $658,471
CIN: A-03-93-00353	D.C. Dept.of Human Services-Block Grants Drugs, April 1995, $657,048
CIN: A-06-96-39974	Albuquerque-Bernalillo County Economic Opportunity, February 1996, $648,700

CIN: A-07-95-01121	BC/BS of LA-Pensions-Contract Termination, February 1996, $647,127
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 BC/BS of South Carolina, July 1994, $594,092
CIN: A-04-93-01069	Monitoring Administrative Cost-Audit Medicare Part B BC/BS South Carolina, July 1994, $590,844
CIN: A-07-93-00679	AETNA-Unfunded Pension Cost Audit, May 1994, $590,207
CIN: A-02-91-03508	Audit of NJ Child Care and Supportive Services, June 1993, $506,710
CIN: A-09-94-00058	Tranamerica Occidental Medicare Administrative Cost, March 1995, $491,479
CIN: A-06-92-00017	IHS Creek Contract Close-Out, May 1992, $468,217
CIN: A-06-93-00042	BC/BS of Texas Administrative Costs-Medicare Parts A&B, January 1993, $434,134
CIN: A-03-95-00451	Escheated Warrants-District of Columbia, August 1995, $420,607
CIN: A-05-95-00034	BC/BS-Medicare Part A Administrative Costs, February 1996, $416,524
CIN: A-05-92-00126	Wisconsin Westcap Head Start ACF/RO Request, March 1993, $347,576
CIN: A-05-93-25697	West Central Wisconsin Community Action Agency Inc., August 1993, $324,759
CIN: A-09-94-30178	State of Arizona, June 1994, $267,021
CIN: A-07-95-01151	Oregon BC/BS Unfunded Pension Costs, October 1995, $260,335
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	BC/BS of Connecticut-Unfunded Pension Cost Audit, March 1994, $237,392
CIN: A-04-96-40781	State of Alabama, May 1996, $230,724
CIN: A-15-95-50003	Review of Indirect Costs at CTS, June 1996, $221,626
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-07-95-01141	BC/BS of LA-Pension Contract Termination Part B, February 1996, $194,177
CIN: A-07-95-01150	Oregon BC/BS Pension Segmentation, October 1995, $191,312
CIN: A-05-94-29229	West Central Wisconsin Community Action Agency, March 1994, $167,977
CIN: A-05-96-00031	Wipro Equipment Depreciation, August 1996, $167,033
CIN: A-03-94-26611	State of Delaware, December 1993, $163,100
CIN: A-09-92-06850	Santa Ysabel Band Mission Indians, September 1992, $151,081
CIN: A-05-92-00048	Wisconsin Physicians Svcs., Pension-Medicare vs. Erisa, October 1992, $130,577 (Related recommendation outstanding on Table II for $2,068,964)
CIN: A-06-96-41681	Texas Migrant Council Inc., March 1996, $129,886
CIN: A-07-93-00709	BC/BS of Connecticut-Pension Segmentation Audit, April 1994, $119,472

CIN: A-01-96-38370	State of Rhode Island & Providence Plantations, May 1996, $105,049
CIN: A-04-93-20785	State of Florida, June 1993, $103,486
CIN: A-07-95-01159	NE BC/BS Pension Segmentation, January 1996, $96,955
CIN: A-06-96-00063	Community Action Committee of Victoria, August 1996, $94,950
CIN: A-06-96-43195	Pueblo of Isleta, June 1996, $92,969
CIN: A-07-95-01164	Medicare Administrative Costs-General American, December 1995, $89,929 (Related recommendations outstanding on Table II for $16,632)
CIN: A-03-94-27083	Pennsylvania State Univ., March 1994, $86,479
CIN: A-02-95-34278	Puerto Rico Dept. of Health, June 1995, $86,064
CIN: A-02-95-34279	Puerto Rico Dept. of Health, June 1995, $85,266
CIN: A-04-93-00059	Refugee Social Services and Targeted Assistance-Fl, September 1994, $84,676
CIN: A-04-96-38655	State of North Carolina, April 1996, $83,237
CIN: A-07-95-01166	Unfunded Pension Costs Nebraska BC/BS, January 1996, $73,509
CIN: A-02-93-02518	Beiderman Kelly & Shafer, Feb.1994, $72,883
CIN: A-08-96-42696	Blackfoot Tribe of the Blackfeet Indian Reservation, July 1996, $71,988
CIN: A-01-94-00521	Audit of Non PPS And Capital Costs of N.E Rehabilitation, January 1995, $69,161
CIN: A-09-96-43765	Arizona Affiliated Tribes Inc., Sept.1996, $66,526
CIN: A-02-95-34275	Puerto Rico Dept.of Health, June 1995, $64,841
CIN: A-04-96-43179	Community Medicine Foundation Inc., June 1996, $64,468
CIN: A-05-95-37615	Illinois Dept. of Children & Family Services, July 1995, $64,000
CIN: A-05-96-42077	City of Rockford Ill., March 1996, $59,283
CIN: A-01-94-00521	Audit of Non PPS A/G and Capital Cost, January 1995, $59,161
CIN: A-06-92-19887	Central Tribes of the Shawnee Area Inc., July 1992, $57,944
CIN: A-03-96-41385	National Assoc. for Equal Opportunity, March 1996, $51,654
CIN: A-09-96-41388	Fresno County Economic Opportunities Commission, February 1996, $50,040
CIN: A-09-95-00095	Health Services Advisory Group,Inc (HSAG), December 1995, $49,585 (Related recommendation outstanding on Table II for $1,389,723)
CIN: A-09-96-39877	Amity Inc., November 1995, $49,358
CIN: A-03-93-03306	Survey Research Assoc., December 1993, $48,779
CIN: A-02-95-34276	Puerto Rico Dept. of Health, June 1995, $46,842
CIN: A-09-94-01022	Intelligenetics, October 1994, $44,590
CIN: A-05-96-40815	Two Rivers Head Start, February 1996, $44,349
CIN: A-09-96-42584	East Los Angeles Alcoholism Council, June 1996, $43,880
CIN: A-09-96-39877	Amity Inc., November 1995, $42,725

CIN: A-01-93-20875	State of Maine, May 1993, $40,540
CIN: A-03-95-33937	Koba Institute Inc., August 1995, $32,575
CIN: A-01-94-27881	State of Maine, June 1994, $32,460
CIN: A-03-95-35319	Porter/Novelli, February 1995, $31,332
CIN: A-03-93-24682	Medlantic Research Institute, June 1993, $31,038
CIN: A-09-93-00106	Review of RSS and TAP Grants-CDSS, February 1995, $31,001
CIN: A-09-96-42547	Maricopa County Arizona, April 1996, $30,766
CIN: A-05-95-35498	Independent School District-Duluth Minn., April 1995, $30,000
CIN: A-03-95-03313	Quality Resource Systems Inc., March 1995, $28,387
CIN: A-10-96-41391	Klamath Family Head Start, April 1996, $26,530
CIN: A-09-94-27868	Inyou Mono Advocates for Community Action, November 1993, $22,875
CIN: A-04-96-38361	Mid-South Foundation for Medical Care, Inc., November 1995, $22,208
CIN: A-05-96-39685	Michigan Family Resources, December 1995, $20,799
CIN: A-05-96-43041	Hoosier Valley Economic Opportunity Corp., June 1996, $20,438
CIN: A-05-93-21928	Wright State Univ., July 1993, $18,308
CIN: A-06-96-42704	Eight Northern Indian Pueblos Council Inc., July 1996, $18,165
CIN: A-05-95-34584	Wood County Head Start Inc., December 1994, $14,896
CIN: A-01-95-39748	Indian Township Tribal Government Passamaquoddy, April 1996, $14,597
CIN: A-10-92-20781	Tulalip Tribes of Washington, September 1992, $14,525
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-09-95-00091	Walter R. McDonald and Associates-Direct Cost, September 1995, $11,812
CIN: A-03-93-21579	State of West Virginia, April 1993, $11,380
CIN: A-09-92-06864	San Juan Southern Paiute Tribe, September 1992, $10,433
CIN: A-01-95-36087	State of Maine, May 1995, $10,250
CIN: A-05-96-42758	Cooperative Educational Service Agency, May 1996, $10,030
CIN: A-09-96-42238	San Pasqual Band of Mission Indians, May 1996, $9,531
CIN: A-09-96-40115	Marianas Assoc. for Retarded Citizens, November 1995, $8,870
CIN: A-02-95-34277	Puerto Rico Dept. of Health, June 1995, $8,486
CIN: A-09-95-33652	Hawaii Dept.of Health, December 1994, $7,613
CIN: A-03-91-02004	West Virginia BC/BS Administrative Cost-FY85/90 and Termination Cost, 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 Corp., November 1995, $7,285
CIN: A-08-96-43199	American Indian Health Care Assoc.,Inc., July 1996, $6,863
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-09-96-43526	Nevada Disability Advocacy & Law Center,.Inc., August 1996, $6,230
CIN: A-04-95-38272	State of Florida, August 1995, $6,101
CIN: A-07-95-01167	Pension Costs Claimed Nebraska BC/BS, January 1996, $6,075
CIN: A-04-96-43156	State of South Carolina, June 1996, $5,996
CIN: A-07-96-38172	State of Iowa, May 1996, $5,762
CIN: A-01-96-38016	Univ. of Maine System, January 1996, $5,500
CIN: A-02-96-39964	State of New Jersey, April 1996, $5,497
CIN: A-06-91-00034	Audit of Collection & Credit Activities of TDHS, January 1992, $5,081
CIN: A-09-96-40114	Marianas Assoc.for Retarded Citizens, November 1995, $5,040
CIN: A-05-96-42799	National Reparative Medicine Foundation, June 1996, $4,726
CIN: A-01-95-32620	State of Connecticut, January 1995, $4,070
CIN: A-07-95-01123	Review of CPA Administrative Cost-BCBS of Kansas City, May 1995, $4,045
CIN: A-02-93-26106	Second Street Youth Center Foundation Inc., July 1993, $3,989
CIN: A-05-96-38947	American Assoc. of Cardiovascular and Pulmonary, December 1995, $3,827
CIN: A-09-95-39056	Hawaii Dept. of Health, September 1995, $3,601
CIN: A-07-94-25955	State of Kansas, December 1993, $2,783
CIN: A-02-96-42965	Seneca Nation of Indians, June 1996, $2,720
CIN: A-03-95-34716	West Virginia Medical Institute Inc., March 1995, $2,688
CIN: A-05-96-38861	Menominee Indian Tribe of Wisconsin, February 1996, $2,636
CIN: A-03-94-30398	Medlantic Research Institute, June 1994, $2,306
CIN: A-08-96-43556	State of Utah, September 1996, $2,134
CIN: A-03-96-44076	St. Pauls College, August 1996, $2,029

B. Reports in litigation:

CIN: A-09-91-00155	Blackburn Care Home, November 1991, $1,772,944 (Related recommendation outstanding on Table II $662,370)
CIN: A-03-92-16229	State of Pennsylvania, March 1992, $496,876
CIN: A-09-93-00091	Walter McDonald-Indirect Cost Rate Audit, June 1994, $68,663
CIN: A-05-95-35315	Lake County Economic Opportunity Council, January 1995, $2,650

C. Reports that have subsequently been resolved:

CIN: A-04-95-05022	Mt. Sinai Medical Center, September 1996, $441,413

CIN: A-04-96-42796	Univ. of Louisville, June 1996, $50,000
CIN: A-03-92-00033	BC/BS of West Virginia Termination, November 1992, $25,200
CIN: A-09-96-38647	Univ. of California, October 1995, $12,150
CIN: A-01-96-43461	State of Connecticut, August 1996, $3,011

Table II

[1] The opening balance was adjusted to reflect an downward revaluation of recommendations in the amount of $36.3 million.

[2] The amount shown represents a partial nonconcurrence of the recommendation estimate. The report is included in the amount shown on line C(i)(a).

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

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

CIN: A-01-95-00508	Medicare Payments for Nonphysician Overpayments PPS, May 1996, $27,000,000
CIN: A-01-96-43461	State of Connecticut, August 1996, $2,000,000
CIN: A-06-91-00089	Audit of CN B Accounts to Determine Status of the IHS Cash On-Hand, April 1992, $445,890
CIN: A-05-96-43154	Muskegon-Oceana Community Action Against Poverty, June 1996, $130,993
CIN: A-02-95-34946	City of Caguas Puerto Rico, March 1995, $64,206
CIN: A-06-96-43307	Nueces County Community Action Agency, June 1996, $22,667

APPENDIX E

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

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

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	60
Section 5(a)(1)	Significant problems, abuses and deficiencies	throughout
Section 5(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	throughout
Section 5(a)(3)	Prior significant recommendations on which corrective action has not been completed	appendices B and C
Section 5(a)(4)	Matters referred to prosecutive authorities	63
Section 5(a)(5)	Summary of instances where information was refused	none
Section 5(a)(6)	List of audit reports	under separate cover
Section 5(a)(7)	Summary of significant reports	throughout
Section 5(a)(8)	Statistical table I - reports with questioned costs	58
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	59
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none

APPENDIX F

Performance Measure

Performance Measures

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

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APPENDIX G

Audits, Inspections and Investigations Related to Operation Restore Trust

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

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ACRONYMS

ACF	Administration for Children and Families
AFDC	Aid to Families with Dependent Children
AHCPR	Agency for Health Care Policy and Research
AoA	Administration on Aging
ASC	ambulatory surgical center
ASMB	Assistant Secretary for Management and Budget
ATSDR	Agency for Toxic Substances and Disease Registry
AWP	average wholesale price
CDC	Centers for Disease Control and Prevention
CHAMPUS	Civilian Health and Medical Plan of the Uniformed Services
CMN	certificate of medical necessity
CMP	civil monetary penalty
CSE	child support enforcement
CY	calendar year
DME	durable medical equipment
DOJ	Department of Justice
DRG	diagnosis-related group
EA	Emergency Assistance
EGHP	employer group health policy
ESRD	end stage renal disease
FDA	Food and Drug Administration
FI	fiscal intermediary
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GME	graduate medical education
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHA	home health agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IME	indirect medical education
IOL	intraocular lens
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
OBRA	Omnibus Budget and Reconciliation Act
OMB	Office of Management and Budget
OPD	outpatient department
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 to Needy Families

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 98-502	Single Audit Act of 1984
P.L. 99-499	Superfund Amendments and Reauthorization Act of 1986
P.L. 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

Office of Management and Budget Circulars:

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

General Accounting Office "Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

Title 5, United States Code, section 552a(i)

Title 18, United States Code, sections on crime and criminal procedures as they pertain to OIG's oversight of departmental programs and employee misconduct

Title 42, United States Code, sections 263a(l), 274e, 290dd-2, 300w-8, 300x-8, 707, 1320a-7b and 1320b-10, the Social Security and Public Health Service Acts

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

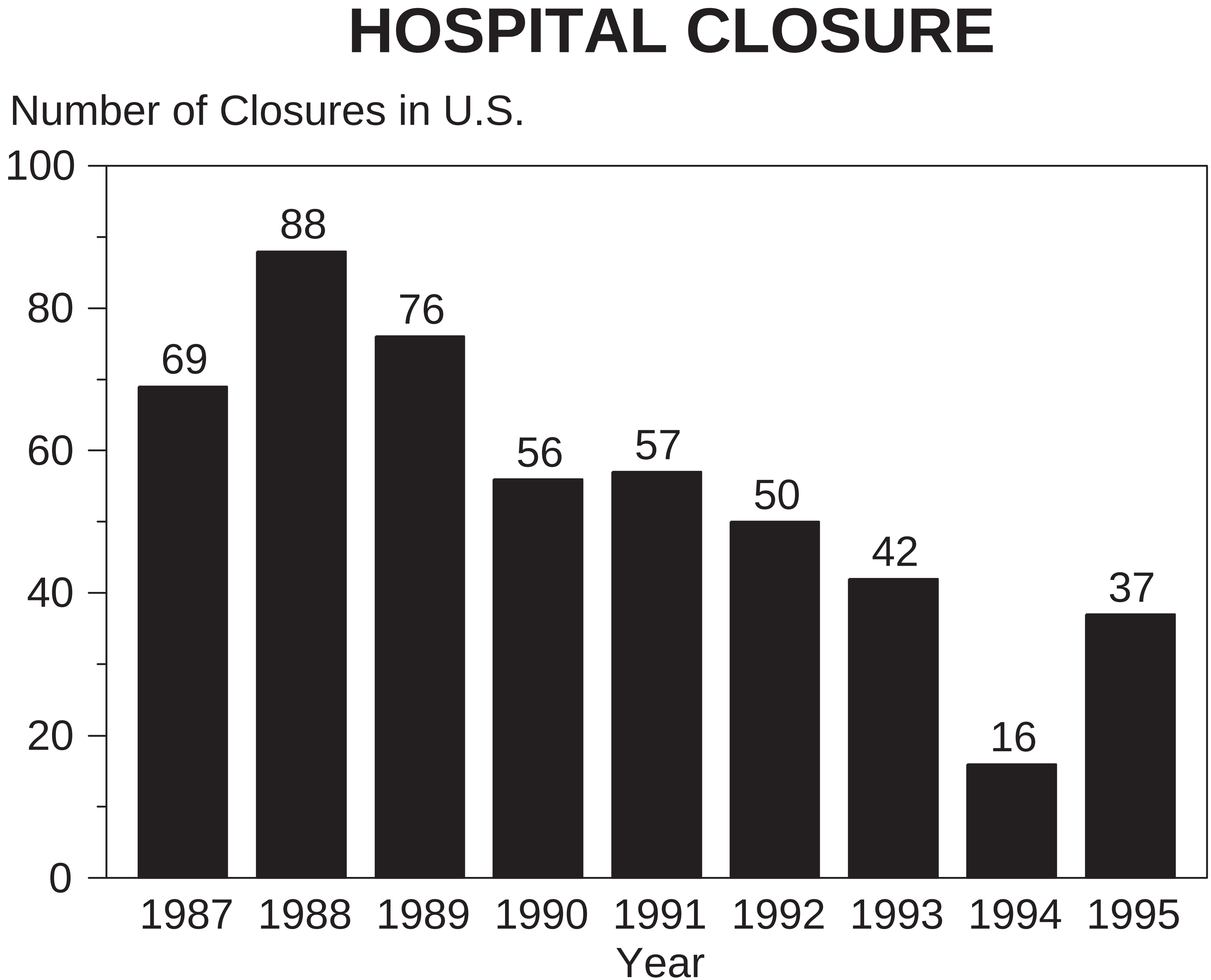
Title 31, United States Code, section 3729 et seq., the Civil False Claims Act and 3801 et seq., the Program Fraud Civil Remedies Act

Title 42, United States Code, sections 1320a-7, 1320a-7a, 1320c-5, 1395l, 1395m, 1395u, 1395dd and 1396b

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Office of Inspector General
330 Independence Avenue, S.W.
Washington, D.C. 20201

Internet Address
http://www.sbaonline.sba.gov/ignet/internal/hhs/hhs.html


HOSPITAL CLOSURE
Number of Closures in U.S.
100
80
60
40
20
0
69
88
76
56
57
50
42
16
37
1987
1988
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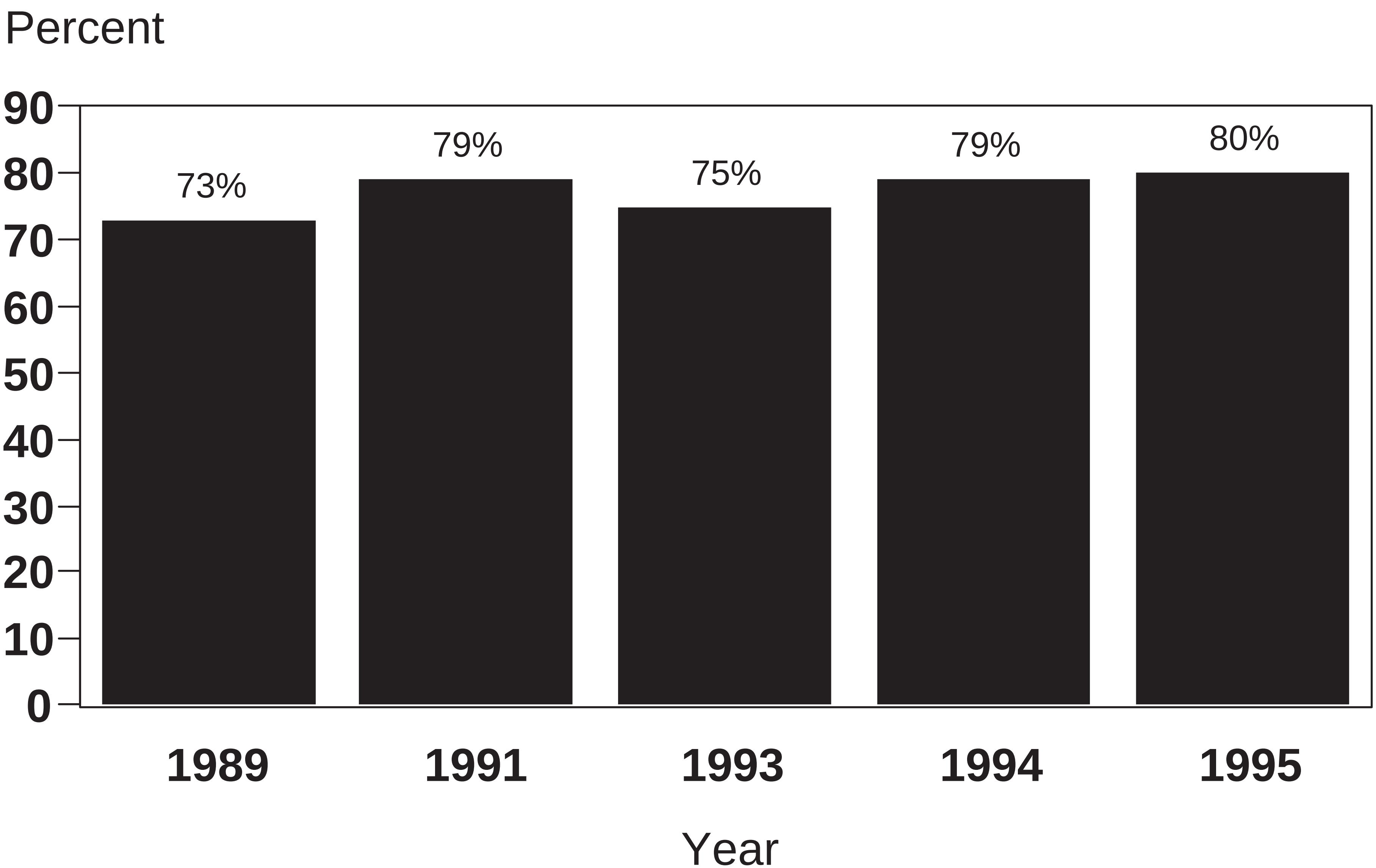
Year

BENEFICIARIES UNDERSTAND THE MEDICARE PROGRAM



MEDICARE REIMBURSEMENT FOR INCONTINENCE SUPPLIES