



Department of Health
and Human Services

Office of Inspector General

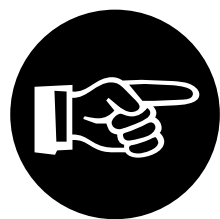
Semiannual Report

April 1, 2000 - September 30, 2000



June Gibbs Brown
Inspector General

WHO PAYS ?



YOU PAY.

Report Medicare Fraud.



Step One

Call your health care provider for an explanation of unusual or questionable Medicare charges. Most are honest and want to prevent fraud.



Step Two

If you still have questions, call your Medicare insurance company.



Step Three

If you continue to have questions, call the Medicare Fraud Hotline at:

**I-800-HHS-TIPS
(1-800-447-8477)**



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

A MESSAGE FROM THE SECRETARY

As this Administration concludes its second and final term, we can look back with pride at our achievements over the past several years in improving service to the American people in the areas covered by the programs administered by the agencies of the Department of Health and Human Services (HHS). With the vital leadership role played by the Office of Inspector General (OIG), we made great strides in protecting the financial integrity and enhancing the quality of programs and services we provide to the public.

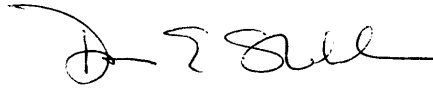
When this Administration took office in 1993, it set a policy of zero tolerance for health care fraud and abuse, and made the Department's efforts in this area a top priority. From the outset we focused unprecedented attention on the fight against fraud, abuse and waste in the Medicare and Medicaid programs. This intensified crack down, spearheaded by the OIG and coordinated with other Federal agencies, State and local officials, health care professions and consumers themselves, has produced record accomplishments.

As documented in the following pages, impressive results have been achieved in the number of civil settlements, criminal convictions and exclusions of unsuitable health care providers from doing business with the Federal and State health care programs. This aggressive enforcement combined with the implementation of policy and procedural changes recommended by OIG, has generated billions of dollars of savings that have contributed to the greatly improved solvency of the Medicare Trust Fund. Medicare is now projected to be solvent to 2025, a full 26 years more than when this Administration took office.

In addition to the critical contributions OIG has made in the health care area, it also can take credit for several other significant accomplishments. Among them were the several reviews and investigations completed during this reporting period in the area of safeguards for human subjects in clinical trials. The results of this work prompted the Department to take action to better protect the welfare of participants in human subject research.

In the area of child support enforcement, the OIG is collaborating with HHS' Office of Child Support Enforcement (OCSE) in "Project Save Our Children" (PSOC), the Administration's criminal child support enforcement initiative which is showing great success. The PSOC is aimed at chronic delinquent parents who owe large sums of child support and combines the efforts of OIG and OCSE, along with the Department of Justice, State child support agencies and local law enforcement organizations. Introduced in late 1998 as a three-State pilot program based in Columbus, Ohio, PSOC now boasts five multiagency, multijurisdictional regional task forces covering 17 States and the District of Columbia. As a result of the work of the task forces, 84 Federal and 264 State arrests have been executed, and restitution totaling about \$11.3 million has been ordered.

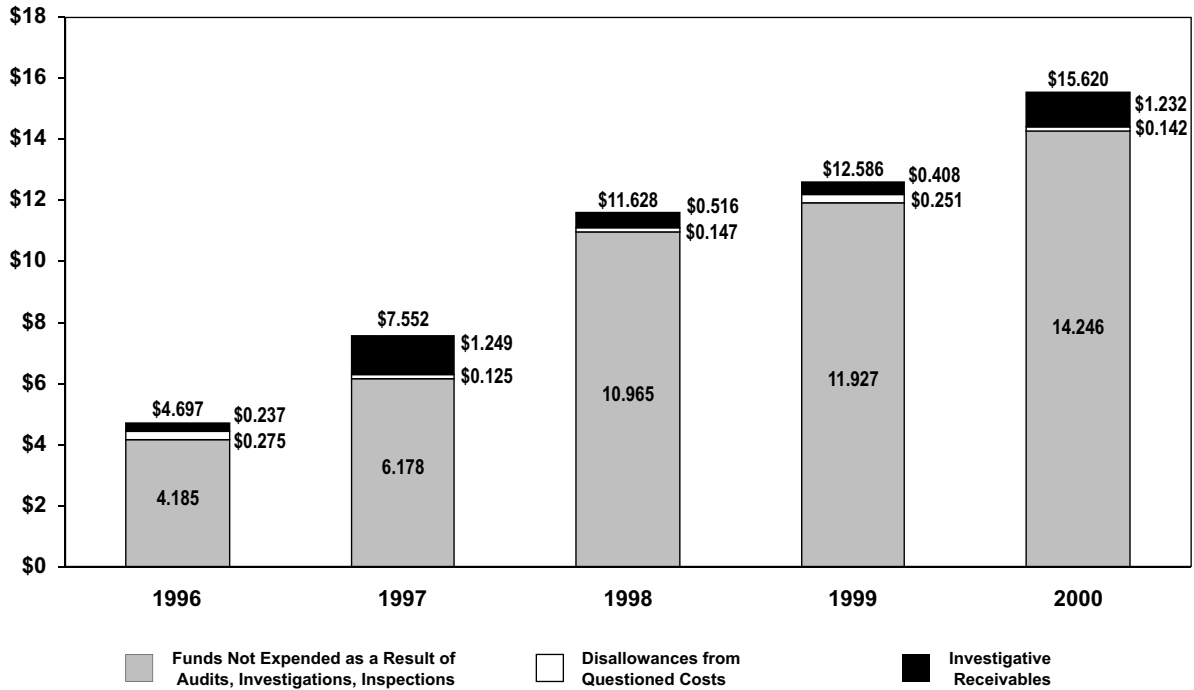
The OIG's accomplishments and history of facilitating savings to the Federal Government underscore its record as a solid investment. I extend my gratitude to the Inspector General and her staff for their efforts on behalf of the Department and the American taxpayer.

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Donna E. Shalala

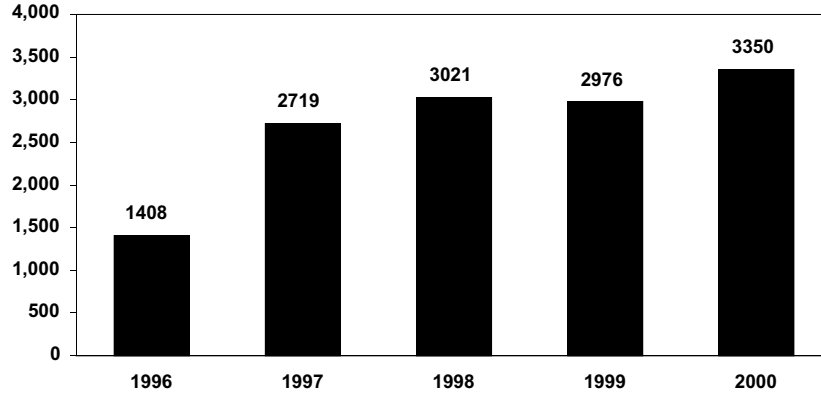
COST SAVINGS

FY 1996 – 2000
Dollars in Billions



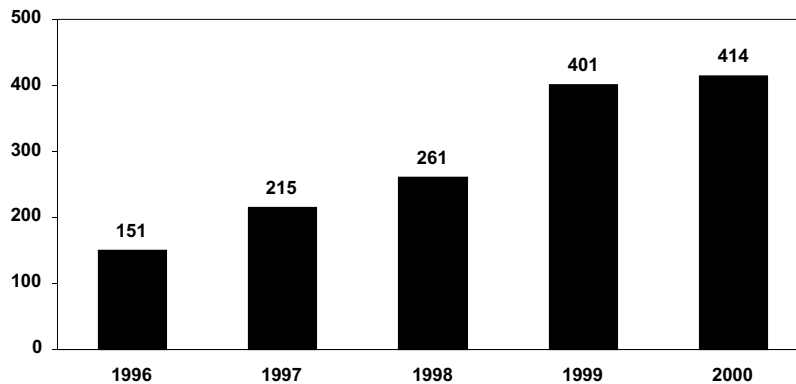
EXCLUSIONS

FY 1996 – 2000



CRIMINAL PROSECUTIONS

FY 1996 – 2000



1) 1,442 cumulative criminal prosecutions for FY 1996-2000.
2) 3,609 cumulative civil prosecutions for FY 1996-2000.

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 September 30, 2000. An overview of the most significant issues discussed in the report is provided in the Highlights section.

During this period we marked the midpoint of the 7-year Health Care Fraud and Abuse Control Program created by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In recognition of that milestone, I want to devote this space to a brief review of noteworthy achievements attained under HIPAA.

First, the significance of this landmark legislation to the OIG mission cannot be overstated. It brought much needed and powerful new criminal and civil enforcement tools, and for the first time provided predictable funding with which to combat waste, fraud and abuse in the Federal health care programs. With these increased resources and authorities, and with the support of the Congress and the Administration and the full cooperation of our various Federal, State and local partners, we are making remarkable progress in our campaign to protect the financial integrity of the Department's health care and other programs.

As reflected in the statistics on the facing page, our combined efforts have produced dramatic results. In the 4 fiscal years under HIPAA (FY 1997 through FY 2000), we have reported overall savings of more than \$47.3 billion. This is comprised of \$665 million in audit disallowances, \$43.3 billion in savings from implemented legislative or regulatory recommendations and actions to put funds to better use, and \$3.4 billion in investigative receivables. Medicare and Medicaid account for more than 98 percent of the total savings, with the balance attributable to various other HHS programs. In FY 2000 alone, Medicare and Medicaid accounted for more than \$15.42 billion of the record \$15.62 billion in overall savings.

In addition to our monetary successes, we have registered significant enforcement achievements over the past 4 fiscal years, including the exclusion of more than 12,066 abusive or fraudulent individuals and entities from doing business with Medicare, Medicaid, and other Federal and State health care programs. At the same time, we successfully pursued with the Department of Justice 1,291 criminal prosecutions and 3,080 civil actions against individuals or entities engaged in fraudulent conduct against departmental programs. As provided for in HIPAA, most of the money recovered in the form of judgments, settlements and administrative impositions from these cases has been or will be returned to the Medicare Trust Fund.

While impossible to quantify precisely, the Medicare program is benefitting enormously from the "sentinel" effect of this intensified crack down. Both the Congressional Budget Office and the Medicare Trustees stated that OIG's expanded enforcement and compliance activities contributed to the following salutary developments:

- The rate of growth in Medicare spending fell by 0.7 percent in 1999 for the first decline in the rate of spending in the program's history. A year earlier, in FY 1998, the rate of spending slowed to 1.5 percent, which at the time, was the smallest increase in the history of the program and the first time that Medicare spending grew more slowly than the Federal budget as a whole. Preliminary Treasury figures indicate a rise of only 1.5 percent in spending for FY 2000.
- Medicare fee-for-service improper payments declined 42 percent, from \$23.2 billion, or 14 percent in FY 1996, to \$13.5 billion, or 7.97 percent, in FY 1999, for an annual improvement of \$10 billion. This represents a cut in Medicare costs without a single beneficiary being denied a needed service or a health care provider being denied legitimate compensation.
- The Medicare hospital case-mix index declined for the third successive year in FY 2000 after having declined in FY 1998 for the first time in the history of the program. The case-mix directly influences the length of stay and the intensity, cost and scope of services that a hospital or other health program provides.
- As a result of these and other beneficial occurrences, the Medicare Trustees extended the solvency of the Medicare Trust Fund by 26 years to 2025.

While enforcement is essential to our anti-fraud and abuse campaign, so is prevention. In keeping with the provisions and spirit of HIPAA, we are engaged in numerous efforts designed to promote the health care industry's understanding of and compliance with Medicare rules. This includes issuing voluntary compliance program guidance by specific industry; publishing special fraud alerts and advisory bulletins; issuing advisory opinions to industry on proposed business practices; maintaining a program for the self-reporting of health care program violations; and undertaking beneficiary outreach and education initiatives.

Since the implementation of HIPAA, we have published 9 voluntary compliance guidance documents, promulgated 44 advisory opinions, issued 3 special fraud alerts and 3 special advisory bulletins, and received 100 self-reports of wrongdoing. As part of our public outreach initiative, an expanded toll-free hotline made possible by HIPAA funding is maintained for the purpose of receiving reports from beneficiaries and providers of suspected fraud. During FY 2000, the hotline received 526,780 calls, bringing to more than 1.5 million the number of calls processed since it began providing enhanced nationwide

service in 1997. Complaints to the hotline have led to recoveries in excess of \$38 million for departmental programs.

As these accomplishments attest, HIPAA has contributed immeasurably to our mission of preventing and detecting fraud, waste and abuse and promoting economy, efficiency and effectiveness in agency programs and operations. With the cooperation of our partners and the ongoing support of the Administration and the Congress, we are committed to continue the collaborative efforts forged under HIPAA to promote the integrity of Federal health care programs and safeguard the interests of the American taxpayers.

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

June Gibbs Brown
Inspector General

HIGHLIGHTS

INTRODUCTION

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

STATISTICAL ACCOMPLISHMENTS

For Fiscal Year (FY) 2000, OIG reported savings of \$15.620 billion, comprised of \$14.426 billion in implemented recommendations and other actions to put funds to better use, \$142 million in audit disallowances and \$1.232 billion in investigative receivables. (See Appendix A and the sections entitled "Resolving Office of Inspector General Recommendations, A. Questioned Costs" and "Investigative Prosecutions and Receivables" in the General Oversight chapter for details.)

In addition, for the fiscal year, OIG reported 3,350 exclusions of individuals and entities for fraud or abuse of the Federal health care programs and/or their beneficiaries, 414 convictions of individuals or entities that engaged in crimes against departmental programs, and 357 civil actions. (See sections entitled "Fraud and Abuse Administrative Sanctions" in the Health Care Financing Administration [HCFA] chapter and "Investigative Prosecutions and Receivables" in the General Oversight chapter.)

Included below are examples of some of OIG's most notable accomplishments for the 6-month period ending September 30, 2000.

SIGNIFICANT INVESTIGATIVE RESULTS

Following are some of the major settlements that were finalized during this reporting period.

Dialysis Services Company

An international provider of dialysis services based in Sweden, and two of its Florida subsidiaries, agreed to pay the Government more than \$53 million to settle health care fraud charges. The Swedish company allegedly submitted false claims through its subsidiaries to Medicare, Medicaid and TRICARE for end stage renal disease (ESRD) laboratory services. The \$53 million settlement figure is divided between two settlement agreements. The dialysis services company also entered into a 5-year corporate integrity agreement with OIG, governing any and all ESRD labs the company owns or operates. (See page 20)

Operator of Hospitals

One of the largest operators of hospitals in rural areas and small cities agreed to pay the Government \$31.8 million and entered into a corporate integrity agreement for allegedly submitting false claims to Medicare, Medicaid and TRICARE. The nationwide settlement

resolves allegations that 36 of the company's hospitals engaged in a chain wide upcoding program, designed by company officials in Tennessee to increase reimbursement by insurers. Under this program, the hospital chain billed for more expensive services than the hospitals provided by assigning inappropriate diagnostic codes to hospital inpatient discharges. (See page 11)

Medicare Managed Care Company

In the first False Claims Act settlement involving billing misconduct in the Medicare managed care program, a Medicare managed care company agreed to pay the Government \$14.5 million for allegedly providing false enrollment/payment data to Medicare. An OIG audit determined that the company inaccurately classified patients eligible only for Medicare coverage, as eligible for both Medicare and Medicaid. This improper classification led the company to receive higher reimbursement fees from the Government than appropriate. As part of the settlement agreement, the company also entered into a 5-year corporate integrity agreement. (See page 21)

MENTAL HEALTH SERVICES

Medicare pays for a variety of psychiatric services, ranging from inpatient hospital care to nonintensive outpatient services for those beneficiaries whose conditions do not require comprehensive, frequent care. Under the partial hospitalization program (PHP), authorized by the Omnibus Budget Reconciliation Act of 1990, Medicare also pays for intensive outpatient psychiatric services for acutely ill individuals who would otherwise require hospitalization. These PHP services can be provided by either hospital outpatient departments or community mental health centers. In this reporting period, OIG assessed HCFA's oversight of psychiatric hospitals and the propriety of provider claims for outpatient services.

Quality of Psychiatric Hospitals

Focusing on the role of contracted surveyors in quality reviews of free-standing psychiatric hospitals, OIG identified such deficiencies as an inadequate level of review, little accountability for surveyor performance, and a lack of coordination among surveyors and other external reviewers. The OIG recommended that HCFA deploy its contracted surveyors more strategically, take better advantage of their expertise, hold them more fully accountable for their performance, and determine an appropriate minimum cycle for their survey. The OIG further recommended that HCFA consider applying special Medicare conditions of participation to psychiatric hospitals and to psychiatric units of acute care hospitals. In response, HCFA noted its continuing work with the Joint Commission on Accreditation of Healthcare Organizations to improve hospital oversight. (See page 2)

Payments to Acute Care Hospitals

In a review of statistically selected partial hospitalization program and other outpatient psychiatric claims submitted by acute care hospitals in the 10 States with the highest charges for outpatient psychiatric services, OIG estimated that Medicare paid \$224 million for unsupported or unallowable services in CY 1997. These services were not documented in accordance with Medicare requirements, not reasonable and necessary, and/or rendered by

unlicensed personnel. The OIG recommended that HCFA consider implementing a first-claim medical review of a random sample of new outpatient psychiatric claims, further emphasize claim documentation, and require Medicare fiscal intermediaries to increase postpayment reviews of claims and to initiate recovery of overpayments. (See page 3)

Reviews at three individual hospitals found similar unallowable charges. Based on statistical samples, OIG estimated that outpatient psychiatric claims submitted over a 1-year period were overstated by about \$1.1 million for two hospitals and by over \$750,000 for the third. In all cases, OIG referred the review results to the fiscal intermediary for appropriate financial adjustments. The OIG also recommended that the hospitals strengthen their procedures to ensure that charges for outpatient psychiatric services are covered and properly documented. (See pages 3 and 4)

Payments to Community Mental Health Centers

The OIG reviewed PHP services at two community mental health centers and identified significant Medicare payments for unallowable or questionable services. At one center, 100 percent of the services in the sampled claims did not meet Medicare reimbursement requirements, resulting in estimated improper payments of more than \$4.4 million for one fiscal year. The OIG's review of the other center estimated that \$1.1 million in outpatient psychiatric service charges during the year were not reasonable and necessary or not appropriate for the patients' conditions. In both reviews, OIG recommended, in addition to financial adjustments, that the community mental health centers ensure that future services submitted for Medicare reimbursement are covered and properly documented. (See page 4)

ACCESS TO CARE

Skilled Nursing Facilities

On September 5, 2000 the OIG testified before the Senate Special Committee on Aging in order to discuss the variety of causes of recent nursing home bankruptcies with particular attention to the possible role of the Balanced Budget Act (BBA) in precipitating them, and what affect the bankruptcies have had on access to nursing home care by beneficiaries. The OIG testimony focused on recent work, requested by the Health Care Financing Administration, concerning access to care in nursing facilities since implementation of the BBA.

An OIG evaluation found that 80 percent of discharge planners can place all of their Medicare patients in SNFs. Another 15 percent estimate that they can place all but 1 to 10 percent of their patients. The remaining 4 percent say they cannot place over 10 percent. Over half state that some of their patients experience delays before being placed. Despite this, the average length of stay in hospitals before discharge to a nursing home has decreased. Multiple factors affect the placement process, including patients with particular medial conditions or service needs. Discharge planners also mention the decision making process by patients and their family members as a source of delays.

Interagency Initiative

The OIG has participated in an interagency initiative to improve the Government's efforts to enforce laws governing quality of care and fraud in the provision of nursing home services. A major feature of this initiative has been a series of training conferences for Federal, State, and local Government officials whose duties encompass enforcement of nursing home laws. (See page 31)

Home Health Care

Three OIG reports examined access and adequacy of home health care. OIG found that 88 percent of discharge planners can place all of their patients; 8 percent can place all but 1 to 10 percent. Four percent say they cannot place more than 10 percent of their patients who need home care. Seventy-eight percent reported that they rarely or never experience delays in placing patients. Although most discharge planners did not attribute any access problems to the interim payment system, many indicate they have noticed changes in the placement process. Another study showed that readmission of home health patients to hospitals and use of hospital emergency rooms have decreased since the new payment method went into effect. Finally, an inspection of survey and certification deficiencies found that they have increased by 26 percent, but there is no single explanation for the growth between the first 6 months of 1997 and 1999. Reasons that may account for this increase may include changes in the survey schedule, increased Federal involvement, lower quality of care, and the interim payment system.

CHILD SUPPORT ENFORCEMENT

In addition to its audit and inspection work in the area of child support enforcement, OIG has made the detection and prosecution of absent parents who fail to pay court-ordered child support a priority. The OIG has worked with the Office of Child Support Enforcement (OCSE) and other Federal, State and local partners to develop programmatic and operational procedures to expedite the collection of child support and to bring to justice those who willfully disregard their obligations. The OIG has opened 1,161 investigations of child support cases nationwide since 1995, which have resulted in 304 convictions and court-ordered restitution and settlements of over \$18.5 million.

Investigative Task Forces

In 1998, OIG and OCSE initiated "Project Save Our Children," (PSOC), a criminal child support initiative made up of multiagency, multijurisdictional investigative task forces. The task forces bring together enforcement units from different States within the following geographical regions: the Midwest, Mid-Atlantic, Southwest, Northeast and West Coast. The task forces are designed to identify, investigate and prosecute criminal nonsupport cases both on the Federal and State levels through the coordination of law enforcement, criminal justice and child support office resources; their goal is to create streamlined systems of referral, investigation and prosecution that will bring to justice the most egregious offenders. (See page 65)

Child Support Enforcement Evaluation Reports

The OIG continued to produce reports from an extensive series of evaluations on the broad issue of child support enforcement. Two reports examined the implementation of mandated child support enforcement State disbursement units and how States could improve their implementation efforts. Another eight reports examined the issues of paternity establishment and client cooperation with child support enforcement agencies. Two additional reports looked at ways that State child support enforcement agencies can improve the ability of low-income non-custodial parents to meet their obligations.

RETROACTIVE EMERGENCY ASSISTANCE CLAIMS

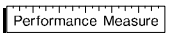
The Emergency Assistance (EA) program, eliminated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and replaced by the Temporary Assistance for Needy Families program, provided temporary financial assistance and social services to needy families in emergency situations. As part of an ongoing nationwide review of retroactive EA claims, OIG issued several reports in the current reporting period.

The OIG found that the States reviewed had not complied with eligibility requirements for Federal financial participation in the EA program. Multimillion dollar overpayments resulted. For instance, Pennsylvania was reimbursed \$129.1 million for unallowable or ineligible claims: \$77.6 million submitted on behalf of children in Philadelphia County and \$51.5 million claimed for children in juvenile detention facilities throughout the State. The OIG also estimated that ineligible Federal payments to Illinois totaled \$13.9 million, and to Nebraska, almost \$3 million. In all of these cases, OIG recommended that the States refund the overpayments to the Federal Government. In addition, as a result of OIG's review, New Jersey voluntarily withdrew its \$2.6 million Federal claim and returned the \$2 million it had received from the Government. (See page 70)

CIGAR LABELING

At the urging of the Federal Trade Commission and the Surgeon General, the nation's leading cigar makers agreed, on Monday, June 26, to put health labels on future packages of cigars. This action was supported by the OIG's inspection report, "Youth Use of Cigars", which was finalized in February 1999. The reports, which were requested by the CDC, showed a sharp increase of cigar smoking by young people and a lack of Federal regulation and oversight.

OIG WORK IN PERFORMANCE MEASUREMENT

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

missions and goals. These proposals are provided to management for their consideration as they develop their performance measures. (See Appendix F)

INTERNET ADDRESS

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

Table of Contents

Chapter I HEALTH CARE FINANCING ADMINISTRATION

| | |
|---|----|
| Overview of Program Area and Office of Inspector General Activities | 1 |
| External Quality Review of Psychiatric Hospitals | 2 |
| Outpatient Psychiatric Services at Acute Care Hospitals | 3 |
| A. Ten-State Review | 3 |
| B. Texas Hospital | 3 |
| C. New York Hospital | 4 |
| D. Connecticut Hospital | 4 |
| Partial Hospitalization Program Services | 4 |
| A. Colorado Community Mental Health Center | 5 |
| B. Michigan Community Mental Health Center | 5 |
| Outpatient Rehabilitation Facilities: Six-State Review | 5 |
| Restraint and Seclusion: State Policies for Psychiatric Hospitals | 6 |
| Hospital Closure: 1998 | 7 |
| HCFA Management of Provider-Based Reimbursement to Hospitals | 7 |
| Major Hospital Initiatives | 7 |
| A. Physicians at Teaching Hospitals | 8 |
| B. Diagnosis Related Group 3-Day Window Project | 9 |
| C. Hospital Outpatient Laboratory Project | 9 |
| D. PPS Patient Transfer Project | 10 |
| E. Pneumonia Upcoding Project | 11 |
| Other Hospital Investigations | 11 |
| Industry Guidance | 13 |
| Criminal Fraud | 13 |

| | |
|---|----|
| Kickbacks | 15 |
| Fraud and Abuse Sanctions | 17 |
| A. Program Exclusions | 17 |
| B. Civil Penalties for Patient Dumping | 19 |
| C. Civil Penalties for False Claims | 20 |
| D. Compliance Activities | 23 |
| Provider Self-Disclosure Protocol | 25 |
| Medicare Payments to OIG Excluded Physicians | 26 |
| External Quality Review of Dialysis Facilities | 26 |
| Payments to Managed Care Organizations for Beneficiaries on Dialysis | 26 |
| Medicare Conditions of Participation for Organ Donation: An Early Assessment of the New Donation Rules | 27 |
| Nursing Home Vaccination: Reaching Healthy People 2010 Goals | 27 |
| Medicare Beneficiary Access to Skilled Nursing Facilities: 2000 | 28 |
| Effect of Financial Screening and Distinct Part Rules on Access to Nursing Facilities | 28 |
| Fraud Involving Nursing Homes | 29 |
| Consolidated Billing Under the Prospective Payment System for Skilled Nursing Facilities | 30 |
| Nursing Home Quality of Care Conferences | 31 |
| Medicare Beneficiary Access to Home Health Agencies: 2000 | 31 |
| Adequacy of Home Health Services: Hospital Re-Admissions and Emergency Room Visits | 31 |
| Medicare Home Health Agency Survey and Certification Deficiencies | 32 |
| Home Health Agency Fraud | 32 |
| Unidentified Primary Health Insurance: Medicare Secondary Payer Auxiliary File | 33 |
| Employer Compliance with Medicare Secondary Payer Data Match Requirements | 34 |

| | |
|---|----|
| Medicare Payments for Services after Date of Death | 34 |
| Contractor Costs for Year 2000 Remediation of Medicare Computer Systems | 35 |
| Medicare Contractor Administrative Costs | 35 |
| Contractors' Pension Segmentation | 36 |
| A. New York Contractor | 36 |
| B. Missouri Contractor | 36 |
| Investment Income Earned on Medicare Funds by Risk-Based Managed Care Organizations | 36 |
| Expanded Coverage of Outpatient Diabetes Self-Management Training Services | 37 |
| Part B Services Billed by California Developmental Centers and State Hospitals | 37 |
| Chiropractic Care: Comparison of Medicare Managed Care and Fee-for-Service Plans | 38 |
| Reimbursements to Hospital Outpatient Laboratories for Additional Hematology Indices | 38 |
| Duplicate Payments for Medical Equipment and Supplies | 39 |
| Medicare Payments for Orthotics | 39 |
| Medicare Losses Resulting from Early Payments for Durable Medical Equipment, Prosthetics, Orthotics and Supplies | 40 |
| Blood Glucose Test Strips | 41 |
| A. Inappropriate Medicare Payments | 41 |
| B. Marketing to Medicare Beneficiaries | 41 |
| Fraud Involving Durable Medical Equipment Suppliers | 41 |
| Medicare Drug Reimbursement | 43 |
| A. Medicare Reimbursement of Albuterol | 43 |
| B. Medicare Reimbursement of End Stage Renal Disease Drugs | 44 |
| Transportation Fraud | 44 |
| Medicaid Program Safeguards | 46 |

| | |
|---|-----|
| Federal and State Partnership: Joint Audits of Medicaid | .46 |
| A. Ohio | .46 |
| B. Montana | .47 |
| Medicaid Fraud | .47 |

Chapter II PUBLIC HEALTH SERVICE OPERATING DIVISIONS

| | |
|---|-----|
| Overview of Program Area and Office of Inspector General Activities | .49 |
| Protecting Human Research Subjects | .50 |
| A. Status of Recommendations | .50 |
| B. Recruiting Human Subjects | .51 |
| C. Food and Drug Administration’s Oversight of Clinical Investigators | .51 |
| Food and Drug Administration Oversight of State Food Firm Inspections | .52 |
| Maternal and Child Health Training Grants: LEND Program | .53 |
| Health Professions Student Loans Program | .54 |
| Exclusions for Health Education Assistance Loan Defaults | .54 |
| Mashantucket Pequot Tribal Nation’s Use of Federal Discount Drug Programs | .55 |
| Indian Health Service Funds for the Cherokee Nation | .56 |
| Indian Health Service Equal Employment Opportunity Complaints Process: A Management Review | .56 |
| National Institutes of Health National Research Service Awards | .57 |
| Misuse of Grant Funds | .57 |
| Financial Capability of Potential Grantees | .58 |
| Superfund Financial Activities at the National Institute of Environmental Health Sciences | .59 |
| Fiscal Year 1999 Financial Statement Audits | .59 |
| A. Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry | .59 |
| B. Food and Drug Administration | .59 |

| | |
|--|----|
| C. Health Resources and Services Administration | 59 |
| D. National Institutes of Health | 59 |
| E. Substance Abuse and Mental Health Services Administration | 60 |
| Federal Occupational Health Billing Operations | 60 |

**Chapter III ADMINISTRATION FOR CHILDREN
AND FAMILIES, AND ADMINISTRATION ON AGING**

| | |
|--|----|
| Overview of Program Areas and Office of Inspector General Activities | 61 |
| Paternity Establishment | 61 |
| A. Administrative and Judicial Methods | 62 |
| B. Voluntary Paternity Acknowledgments | 62 |
| Establishment of Child Support Orders for Low-Income Noncustodial Parents | 63 |
| Client Cooperation with Child Support Enforcement | 63 |
| Medical Insurance for Dependents Receiving Child Support | 64 |
| Workplace Violence: Public Assistance and Child Support Offices | 64 |
| Child Support Enforcement: Investigations | 65 |
| Child Support Enforcement State Disbursement Units: State Implementation Progress | 68 |
| Child Support Enforcement State Disbursement Units: Sharing the Experiences of Six States | 68 |
| Child Support Operations: Tennessee | 69 |
| State Oversight of Residential Facilities for Children | 69 |
| Emergency Assistance Program Costs | 70 |
| A. Pennsylvania | 70 |
| B. Illinois | 70 |
| C. Nebraska | 71 |
| D. New Jersey | 71 |
| Retroactive Foster Care Claim: Mississippi | 71 |

| | |
|---|----|
| Head Start Grantee: Washington | 71 |
| Safeguarding Persons with Disabilities: District of Columbia | 72 |
| Grantee Costs Claimed | 72 |
| Fiscal Year 1999 Financial Statement Audit of the Administration for Children and Families | 73 |

Chapter IV GENERAL OVERSIGHT

| | |
|--|----|
| Introduction | 75 |
| Program Support Center's Personnel Service: Customer Service Evaluation | 76 |
| Results Act Review Plan | 76 |
| Reviews of Departmental Service Organizations | 77 |
| A. Center for Information Technology | 77 |
| B. Central Personnel and Payroll System, Human Resources Services | 78 |
| C. Division of Financial Operations | 78 |
| D. Division of Payment Management | 78 |
| Accounting for FY 1999 Drug Control Funds | 78 |
| Nonfederal Audits | 78 |
| A. Office of Inspector General's Proactive Role | 79 |
| B. Quality Control | 80 |
| Resolving Office of Inspector General Recommendations | 81 |
| A. Questioned Costs | 81 |
| B. Funds Put to Better Use | 82 |
| Legislative and Regulatory Review and Regulatory Development | 83 |
| A. Review Functions | 83 |
| B. Regulatory Development Functions | 83 |
| C. Congressional Testimony and Hearings | 84 |
| Pension Fund Settlement: California | 84 |

| | |
|--|------------|
| Investigative Prosecutions and Receivables | 85 |
| Program Fraud Civil Remedies Act | 85 |
| APPENDIX A - Savings Achieved through Policy and Procedural Changes Resulting from Office of Inspector General Audits, Investigations and Inspections April 2000 through September 2000 | A-1 |
| APPENDIX B - Unimplemented Office of Inspector General Recommendations to Put Funds to Better Use | B-1 |
| APPENDIX C - Unimplemented Office of Inspector General Program and Management Improvement Recommendations | C-1 |
| APPENDIX D - Notes to Tables I and II | D-1 |
| APPENDIX E - Reporting Requirements of the Inspector General Act of 1978, as Amended | E-1 |
| APPENDIX F - Performance Measures | F-1 |
| APPENDIX G - Status of Public Proposals for New and Modified Safe Harbors to the Anti-Kickback Statute Pursuant to Section 205 of the Health Insurance Portability and Accountability Act of 1996 | G-1 |

**Health Care
Financing
Administration**

Chapter I

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

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

The Medicaid program provides grants to States for medical care for certain low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for Supplemental Security Income or the former Aid to Families with Dependent Children program. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average. The State Children's Health Insurance Program (SCHIP), created under the new title XXI of the Social Security Act, will expand health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage. The SCHIP program is a partnership between the Federal and State governments in which States may choose to expand their Medicaid programs, design new child health insurance programs or create a combination of both.

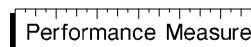
The Office of Inspector General (OIG) has devoted significant resources to investigating and monitoring the Medicare and Medicaid programs. These activities have often led to criminal, civil and/or administrative actions against perpetrators of fraud and abuse. They also have helped ensure the cost-effective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

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

The OIG's documentation of excessive payments led to recent statutory changes in the way and/or the amount Medicare reimburses rural health clinics, skilled nursing facilities, home health agencies (HHAs), hospices, ambulance services, oxygen suppliers, clinical laboratories, suppliers of certain Medicare-covered drugs and biologicals, teaching hospitals for indirect medical education costs and the States for Medicaid disproportionate share payments. To ensure quality of patient care, OIG has assessed clinical and physiological laboratories; evaluated the medical necessity of medical equipment and of services provided by HHAs; analyzed various State licensure and discipline issues; reviewed several aspects of medical necessity and quality of care under PPS, including the risk of early discharge; and evaluated the care rendered by itinerant surgeons and the treatment provided by physicians performing in-office surgery.

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

External Quality Review of Psychiatric Hospitals



In addition to the minimum health and safety requirements that must be met for participation in the Medicare program, free-standing psychiatric hospitals are subject to two special conditions involving record-keeping and staffing. The HCFA's contracted surveyors, mostly psychiatrists and psychiatric nurses, conduct reviews that cover these special conditions.

In a follow-up to its recent series of reports on the external review of hospital quality, OIG focused on the oversight of free-standing psychiatric hospitals and, in particular, the role of the contracted surveyors. Despite its finding that the current review system has some features that serve to protect patients, OIG identified some major deficiencies, including an inadequate level of review, a lack of coordination among the contracted surveyors and other external reviewers, and little accountability for surveyor performance.

The OIG recommended that HCFA deploy its contracted surveyors more strategically and take better advantage of their expertise; hold the surveyors more fully accountable for their performance; determine an appropriate minimum cycle for their survey; negotiate with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to achieve both a more patient-centered approach and a more rigorous assessment of discharge planning; and consider applying special Medicare conditions of participation both to psychiatric hospitals and to psychiatric units of acute care hospitals. The HCFA concurred with all of OIG's proposals and noted its ongoing work with JCAHO to improve hospital oversight. (OEI-01-99-00160)

Outpatient Psychiatric Services at Acute Care Hospitals

Medicare reimburses acute care hospitals for the reasonable costs associated with providing outpatient psychiatric services. The OIG conducted a 10-State review and 3 hospital-specific audits of outpatient psychiatric services.

A. Ten-State Review

For its review, OIG selected claims from acute care hospitals in the 10 States with the highest charges for outpatient psychiatric services: California, Connecticut, Florida, Illinois, Louisiana, Massachusetts, Michigan, New York, Pennsylvania and Texas. In reviewing 200 claims from the 10 States for Calendar Year (CY) 1997 totaling \$168,857, OIG concluded that \$94,716 of the charges did not meet Medicare criteria for reimbursement; they were not documented in accordance with Medicare requirements, not reasonable and necessary, and/or rendered by unlicensed personnel.

Based on its statistical sample, OIG estimated that for CY 1997, acute care hospitals submitted claims to Medicare totaling more than \$224 million (approximately 59 percent of the amount claimed) for unallowable or unsupported psychiatric services in the 10 States. The OIG recommended that HCFA consider implementing a first-claim medical review of a random sample of new outpatient psychiatric claims; require Medicare fiscal intermediaries (FIs) to increase postpayment review of outpatient psychiatric service claims; require FIs to initiate recovery of payments for claims found in error; and further emphasize its documentation requirements for all types of outpatient psychiatric services through seminars, education sessions and newsletters. The HCFA did not concur with the recommendation for first-claim review but concurred with OIG's other recommendations. (CIN: A-01-99-00507)

B. Texas Hospital

Based on a statistical sample, OIG estimated that almost \$1.1 million in outpatient psychiatric services claimed by a hospital in Texas for the fiscal year ended June 30, 1998 did not meet Medicare reimbursement requirements. These charges were for services that were not reasonable and necessary or were provided to ineligible beneficiaries. An additional \$200,000 in occupational therapy charges were estimated to be unallowable because they related to the questioned psychiatric services. The OIG also determined that \$45,000 of the \$1.4 million in outpatient psychiatric costs claimed on the hospital's FY 1998 Medicare cost report was for unallowable patient transportation costs. In addition, OIG could not determine the reasonableness of \$818,400 in costs because supporting documentation was not available.

The results of this review are being provided to the FI for appropriate financial adjustment. The OIG recommended that the hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are covered and documented in accordance with Medicare

requirements. In addition, OIG recommended that the hospital establish an effective procedure for excluding costs related to noncovered services from its cost reports. The hospital disagreed with most of OIG's findings. (CIN: A-06-99-00014)

C. New York Hospital

At a hospital in New York, OIG estimated, based on a statistical sample, that billings to Medicare for outpatient psychiatric services were overstated by more than \$1.1 million in CY 1997. These claims did not meet Medicare reimbursement criteria because they lacked sufficient patient treatment plans or sufficient medical record documentation and/or were not reasonable and necessary. Also, of the approximately \$295,000 that OIG reviewed on the hospital's cost report, \$46,000 was for unallowable meal and transportation costs.

The OIG is providing the results of this review to the FI for appropriate financial adjustment. The OIG also recommended that the hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are reasonable and necessary and are properly documented. It was further recommended that the hospital report costs not covered by Medicare as nonreimbursable on its cost reports. Hospital officials agreed with some of the findings. (CIN: A-02-99-01016)

D. Connecticut Hospital

In a review of outpatient psychiatric services rendered in the fiscal year ended September 30, 1997 at one Connecticut hospital, OIG estimated, based on a statistical sample, that over \$750,000 of the almost \$1.3 million of submitted charges did not meet Medicare reimbursement criteria. These included charges for psychiatric services not certified by a physician in accordance with Medicare requirements, not properly supported by medical records or not covered under Medicare. Further, OIG identified an additional \$126,480 in costs which were ineligible for Medicare reimbursement claimed by the hospital in its FY 1997 cost report for outpatient psychiatric services, including costs for patient transportation, patient meals and unallowable advertising.

The OIG recommended that the hospital strengthen its procedures to ensure that charges for psychiatric services are covered and properly documented and establish nonreimbursable cost centers or otherwise exclude costs related to noncovered services from its Medicare cost reports. The results of OIG's review are being provided to the FI for appropriate adjustments. The hospital disputed portions of OIG's findings. (CIN: A-01-99-00518)

Partial Hospitalization Program Services

Partial hospitalization program (PHP) services are intended to provide acutely mentally ill individuals with intensive outpatient psychiatric services to prevent hospitalization. Earlier OIG audits had identified sizable Medicare payments for unallowable or highly questionable services at community mental health centers.

A. Colorado Community Mental Health Center

In this review of PHP services at a Colorado community mental health center for the fiscal year ended June 30, 1996, OIG determined that 100 percent of the services included in the sampled claims should not have been paid by Medicare, resulting in estimated improper payments of more than \$4.4 million. The OIG recommended that the center ensure that any future services submitted to Medicare for reimbursement are covered and documented in accordance with Medicare requirements. The OIG provided the results of its review to the FI for appropriate financial adjustments and requested that the FI review PHP services provided by the center for other cost report periods. (CIN: A-07-98-01263)

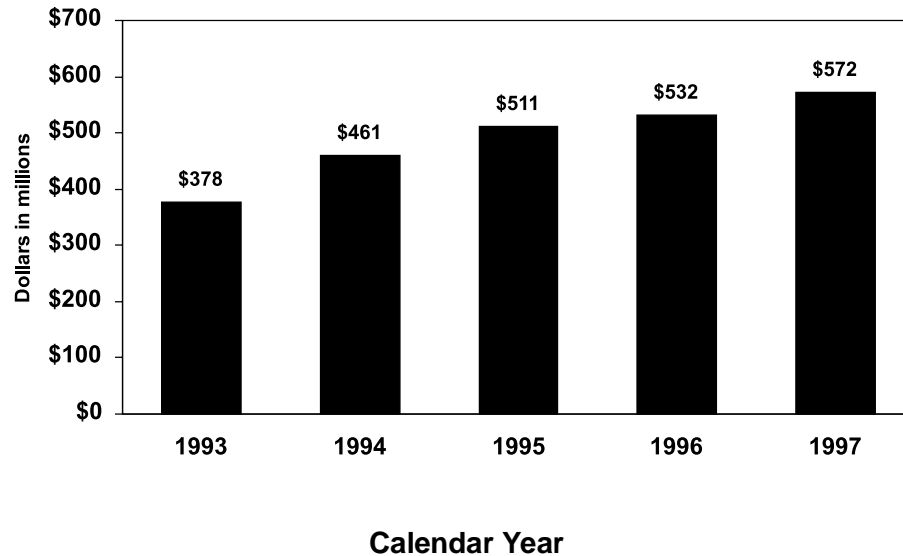
B. Michigan Community Mental Health Center

Based on a statistical sample of PHP services at a Michigan community mental health center, OIG estimated that \$1.1 million in CY 1997 charges were not reasonable and necessary or not appropriate for the patients' conditions. In addition, over \$71,400 in outpatient psychiatric service costs claimed by the center in its FY 1997 Medicare cost report were not allowable. The OIG recommended, in addition to financial adjustments, that the center ensure that any future charges submitted to Medicare for reimbursement are covered and documented in accordance with Medicare requirements and exclude costs not covered by Medicare from its cost reports. The center generally did not concur with OIG's findings. (CIN: A-05-00-00004)

Outpatient Rehabilitation Facilities: Six-State Review

In this audit, OIG reviewed outpatient physical therapy, occupational therapy and speech pathology services to determine if they were provided and billed in accordance with Medicare requirements. Over the past several years, Medicare payments for outpatient rehabilitation facility (ORF) services have increased substantially, as illustrated on the next page.

NATIONAL MEDICARE PAYMENTS FOR OUTPATIENT REHABILITATION FACILITY SERVICES



The OIG reviewed Medicare payments to ORFs for the fiscal year ended June 30, 1998 in six States which accounted for about 50 percent of total ORF payments nationwide during CY 1997. Based on a statistical sample, OIG estimated that Medicare paid \$173 million for unallowable or highly questionable ORF services. These payments were made to beneficiaries who exhibited no functional impairment, evidenced no active participation with the therapist, and/or had no expectation for significant improvement within a reasonable and predictable length of time.

The OIG recommended that HCFA consider implementing a review process for new providers to include an evaluation of whether the services provided to beneficiaries meet Medicare requirements, consider a periodic recertification requirement for ORFs, and instruct FIs to recover the identified overpayments and review other claims by the ORFs for the sampled beneficiaries and recover additional overpayments. Further, OIG proposed that HCFA require FIs to provide in-house educational services to new providers, conduct a prepayment medical review of claims submitted by new providers, and intensify medical review of claims submitted by ORFs. The HCFA concurred with OIG's recommendations. (CIN: A-04-99-01193)

Restraint and Seclusion: State Policies for Psychiatric Hospitals

At the same time OIG was conducting its field work for this study, HCFA established tough new requirements for psychiatric hospitals to protect residents from inappropriate use of restraints and seclusions. This report, then, provides a baseline for future measurement of hospitals' compliance with the new rules. In addition, it identifies the areas which will require the greatest attention to ensure compliance with them. At the time of the OIG study,

many State policies already met some of HCFA's new Patients' Rights Condition of Participation standards, but not all. State policies for private psychiatric hospitals more frequently fell short of the new standards. (OEI-04-99-00150)

Hospital Closure: 1998

The closure of hospitals generates public and congressional concern. The OIG has issued 11 annual reports on hospital closures in the U.S. for 1987 through 1997. The 1998 report continues OIG's analysis of the extent and effects of hospital closures. Forty-three hospitals closed in 1998 -- 0.9 percent of all hospitals. Five more hospitals closed in 1998 than closed in 1997; however, the additional closings were offset by the opening or reopening of 14 hospitals in 1998, 11 more than in 1997. Most of the hospitals that closed were small and had low occupancy rates. The average daily patient load in the year prior to closure was 14 in rural hospitals and 42 in urban hospitals. Although residents of a few communities had to travel greater distances for hospital care, most had emergency and inpatient medical care available within 10 miles of a closed hospital. After closure, 47 percent of the hospitals were being used for other health-related services -- such as 24-hour urgent care clinics and long-term care facilities. (OEI-04-99-00330)

HCFA Management of Provider-Based Reimbursement to Hospitals

Hospitals often purchase entities such as physician practices and nursing facilities. Under Medicare, when such hospitals account for those entities as "provider-based," it increases costs for Medicare and its beneficiaries with no commensurate benefits and hospitals can shift overhead costs to their off-site entities and receive higher Medicare reimbursement. The provider-based determination process provides little or no assurance that only qualified hospital owned entities are approved. The HCFA regional offices do not consistently follow established processes for reviewing and approving hospitals for provider-based status. Data systems are inadequate for determining which hospitals apply for the status, the disposition of such applications, and which hospitals bill for reimbursement for provider-based entities. Finally, hospitals often bill for reimbursement under the cost advantageous provider-based rules without HCFA approval or knowledge. The OIG made several recommendations to address these problems, including elimination of provider-based status as an accounting option for all types of hospital owned entities. (OEI-04-97-00090)

Major Hospital Initiatives

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

A. Physicians at Teaching Hospitals

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

Medicare, under Part A of the program, pays the costs of training residents through the graduate medical education (GME) program. Medicare also pays an additional amount in recognition of the additional costs associated with training residents (also known as indirect medical education or IME). These payments can total over \$100,000 per resident per year. Medicare paid approximately \$8 billion to teaching hospitals in 1998 for the cost of training residents. The Medicare payments described above include payments to teaching physicians for their role in supervising residents.

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

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

In sum, the PATH initiative has been undertaken as a result of OIG's extensive audit and investigative work in this area. To date, seven institutions have entered into settlements with the Federal Government to resolve potential False Claims Act liability related to improper claims for Part B physician services submitted in the teaching setting. These settlements have resulted in the Government's recovery of over \$76 million. As a condition of settlement, most of these institutions have also implemented compliance programs to prevent and detect future improper claims. Reviews completed at four other institutions disclosed no major problems with either billings in the teaching setting or upcoding, demonstrating that providers can and do bill the Medicare program correctly, and reviews at two institutions resulted in administrative overpayment settlements with the carriers.

Separately, six investigations not part of the PATH initiative, but which included billings for teaching physicians, concluded in False Claims Act settlements totaling over \$38.5 million. In all of these cases, the providers also entered into corporate integrity agreements with OIG.

To determine whether, and to what extent, problems similar to those noted above were present at other teaching institutions throughout the country, the PATH project was expanded into a national initiative, but limited to those institutions that received clear guidance before December 30, 1992 from the Medicare Part B carriers communicating the applicable HCFA reimbursement standards. As an alternative to OIG auditors conducting the audits, these providers are given the opportunity to conduct self-audits by contracting with an independent third party for a review of their Medicare billing practices, with Government oversight, and to report the audit results to OIG.

B. Diagnosis Related Group 3-Day Window Project

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

This national project identified 4,660 hospitals that submitted improper billings for outpatient services. The project is primarily coordinated by the U.S. Attorney's Office for the Middle District of Pennsylvania. As of the end of the reporting period, settlements had been executed with 2,799 hospitals and over \$73 million had been recovered.

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

C. Hospital Outpatient Laboratory Project

The OIG, DOJ and multiple States joined forces to target false or fraudulent Medicare and Medicaid claims in hospital outpatient laboratories. Based on the results of a project begun in Ohio by OIG, DOJ, the State of Ohio and the Medicare FI, United States Attorneys'

Offices in other States began their own investigations as part of an expanded effort. This project involved the recovery of multiple damages, when appropriate, for improper and excessive claims submitted for hematology and automated blood chemistry tests by hospital outpatient laboratories. These abuses stem from the improper unbundling and double billing of laboratory tests, and, in certain cases, the billing for certain tests that are not medically necessary. The investigations have also shown numerous instances of billing for hematology complete blood count (CBC) additional indices that were not ordered by physicians and were not medically necessary.

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

The OIG and DOJ, and in some districts, authorities from other Federal programs such as TRICARE (the health care benefits program for current and former military employees) and Federal Employees Health Benefits Program (FEHBP), worked together on the national project to provide targeting data to the United States Attorneys' offices interested in pursuing this recovery initiative in their districts. The OIG also collaborated with DOJ to produce a model settlement agreement that includes compliance measures, which was disseminated to all participating districts throughout the United States.

Thus far, 257 hospitals have entered settlements in the Hospital Outpatient Laboratory Project, with settlements totaling more than \$59.4 million. More hospitals are expected to settle in the near future.

D. PPS Patient Transfer Project

Another OIG/DOJ nationwide initiative is focused on improper payments to hospitals for patient transfers between two PPS hospitals. Under Medicare reimbursement rules, the hospital transferring a patient is to receive a per diem payment based on the length of stay and the DRG for the case, but no more than the full DRG payment amount, and the hospital receiving the transferred patient is to be paid a diagnosis-related payment based on the DRG for the case.

Since 1986, however, OIG has found that many transferring hospitals inappropriately claim full diagnosis-related payment rather than the per diem payment. The HCFA has already acted on OIG's first report, which identified \$227 million in recoveries and savings. The OIG's second report, issued in November 1996, and a more recent computer analysis of claims disclosed additional overpayments of approximately \$202 million. Currently, OIG is working with U.S. Attorneys' offices nationwide, along with HCFA, on this continuing

problem. The HCFA is preparing a program memorandum to address the collection of overpayments. To date, OIG has settled PPS cases with three hospitals, totaling over \$2.2 million.

E. Pneumonia Upcoding Project

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

The OIG is currently investigating the coding for pneumonia at over 100 hospitals. To date, 22 hospitals have settled their liability for such coding by paying over \$23.6 million and agreeing to corporate integrity requirements.

Other Hospital Investigations

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

- As the result of an OIG investigation and audit, one of the largest operators of hospitals in rural areas and small cities agreed to pay the Government \$31.8 million for allegedly submitting false claims to Medicare, Medicaid and TRICARE. The nationwide settlement resolved allegations of upcoding diagnostic codes for inpatient hospital discharges through which the company received increased reimbursement amounts at 36 of its hospitals. The OIG investigation revealed that the company initiated an aggressive coding procedure referred to as the optimization program. The program encouraged the chain's hospitals to meet very high, and often unrealistic, coding volume goals, which led to excessive rates of reimbursement by Medicare, Medicaid and TRICARE. The investigation further determined that the inappropriate coding occurred based on improper guidance and instruction provided by officials from the company's headquarters in Tennessee. As part of the settlement, the company also entered into a corporate integrity agreement with OIG.

- The Government entered into a settlement agreement with a California county, the county health care agency and the county medical center (collectively, the "County"). Based on a qui tam complaint filed, the Government alleged that the county medical center did not have the required medical treatment plans to support Medicare claims the center submitted for mental health outpatient clinic services. The County's own review showed the medical center did not have these plans in place from 1991 through 1998. Under the terms of the agreement, the County will pay the Government \$15.3 million. As part of the settlement agreement, the County entered into a 5-year corporate integrity agreement designed to ensure future compliance by the medical center.
- A Pennsylvania health system agreed to pay the Government \$12 million to resolve its successor liability under the False Claims Act for improper partial hospitalization program (PHP) billing practices by the hospital it acquired. Initiated through a qui tam suit, this settlement resolves allegations of billing misconduct that occurred between 1993 and 1997. The allegations include billing for patients who were so impaired they were unable to benefit from PHP services; billing for services of a purely recreational, non-therapeutic nature; billing for more time than was actually provided; and billing for improperly supervised services. In addition to paying \$12 million, the health system also agreed to extend the scope of its preexisting 3-year corporate integrity agreement for pneumonia upcoding violations to encompass PHP services as well. The health system also ceased operating the previous hospital's PHP programs which formed the basis for the case.
- An academic medical center that employs physician faculty to supervise medical residents and interns agreed to pay to the United States \$1.5 million to resolve its civil liability. The claims alleged that the physicians failed to appropriately document their presence during the provision of professional services by residents. The entity also submitted claims for physician services when physicians were not present. In addition, the entity submitted claims for upcoded services. As part of the settlement agreement, the entity entered into a 5-year corporate integrity agreement.
- A New York hospital agreed to pay the Government \$623,420 to resolve its civil liability for submitting improper Medicare claims. Between 1989 and 1995, the hospital billed Medicare Part B for certain ancillary pharmacy supplies which were not covered under the Part B ancillary benefit; the Part B pharmacy ancillary benefit is limited to a few particular drugs.

- A New Jersey hospital agreed to pay the Government \$449,607 for allegedly submitting improper claims to Medicare during the period from 1992 through 1998. The hospital wrongfully submitted claims for inpatient hospital stays for Medicare beneficiaries who actually received outpatient services. As a result, the hospital received higher reimbursement for the inpatient claims than it would have received had the claims been billed properly. As part of the settlement, the hospital also agreed to adhere to a 3-year integrity program to ensure compliance with the requirements of the Medicare program.

Industry Guidance

The OIG has continued to issue advisory opinions, special fraud alerts, special advisory bulletins and other guidance as part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry. For the period from April 1, 2000 through September 30, 2000, OIG accepted 66 advisory opinion requests and issued 5 advisory opinions. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), OIG has enlisted the help of the provider and beneficiary communities to prevent impropriety by soliciting proposals (via Federal Register notice) for modifying existing safe harbors to the anti-kickback statute. The OIG received 17 timely filed responses to the December 10, 1999 notice. (See Appendix G)

Criminal Fraud

One of the most common types of fraud perpetrated against Medicare, Medicaid and other Federal health care programs involves the filing of false claims or statements. Such false claims may be pursued civilly under the False Claims Act (see, for example, the hospital initiatives described in pages 7-11). In appropriate cases, false claims may also be prosecuted criminally as Federal offenses such as mail fraud, wire fraud, false statements and various health care fraud offenses. Following are descriptions of criminal prosecutions which resulted from the investigation of both false claims-related offenses and other health care-related offenses during this period:

- A New York ophthalmologist was sentenced to 4 years in custody, 3 years supervised release and a \$75,000 fine for conspiring to submit false claims to Medicare. In accordance with his plea agreement, the ophthalmologist also previously repaid the Government \$8.55 million, representing the second largest single provider recovery in the United States and the largest in the Eastern District of New York. He was also permanently excluded from participating in the Medicare program. Investigation by OIG into the ophthalmologist's activities revealed that he performed cataract surgeries on patients who did not have cataracts and performed glaucoma laser procedures on patients who did not have glaucoma. He also billed for other

ophthalmological procedures that were either not performed or were not medically necessary. As a result of the investigation, the New York State Office of Professional Medical Conduct revoked his license to practice medicine.

- In Oregon, a father and son were sentenced for intentional misapplication of money and funds of health care benefit programs. The father was sentenced to 3 months in a community corrections center, 3 years supervised release and payment of \$309,288 in restitution. His son was sentenced to 12 months and 1 day imprisonment, 3 years supervised release and payment of \$309,288 in restitution. The father and son were owner and president, respectively, of a billing service company. Over a 3-year period, they diverted funds from client insurance reimbursement checks, including Medicare checks, to their own business accounts. The son, who ran the company for most of the period in question, was primarily responsible for the diversion. Most of the money was repaid to clients before the business closed in January 1999. The two concealed their activities from clients by not including the amounts of diverted funds on the monthly statements mailed to clients.
- A woman was sentenced to 41 months imprisonment, payment of \$473,390 in restitution and 2 years probation for conspiracy, money laundering and mail fraud. The woman worked in the Medicare fraud section of a former Medicare carrier in California. After leaving the carrier, she began working for a billing company. She used the billing company to submit false claims electronically to another Medicare carrier. A friend still working in the Medicare fraud section where the woman previously worked assisted her in the billing scheme. The woman submitted the false claims, and along with her friend at the former carrier and her relatives, cashed the Medicare payment checks. The woman's friend, along with two other co-conspirators involved in the scheme, have already been sentenced. To evade prosecution, the woman fled to Australia in 1994, where she lived until extradited back to the United States in December 1999.
- A New York physician was sentenced to payment of \$39,560 in restitution, \$50,100 in fines and 3 years supervised probation for mail fraud. According to the terms of his probation, the physician cannot engage in, or associate in any way with, the practice of medicine for a period of three years. The physician submitted false claims to Medicare for services not rendered and double billed workers' compensation and private insurance companies for the same services rendered to the same patients. Previously, he entered into a civil settlement in which he agreed to pay \$700,000 and to be excluded for

a period of 5 years. The physician also resigned from employment at a local hospital.

- A physician's medical billing clerk was sentenced to 5 months imprisonment and 2 years probation for submitting false claims to a private health insurance company in Pennsylvania. The billing clerk previously pled guilty to health care fraud. In addition to her prison sentence, the judge ordered her to pay \$88,922 in restitution to the private insurer.
- A woman was sentenced to 5 months imprisonment and 2 years supervised release for conspiracy, wire fraud and impersonation of a Federal Government employee. She is one of three individuals involved in a scheme to provide fraudulent services to HHAs. The other two individuals are the owner of a HHA which lost its license and a CPA whose license was suspended. These two individuals offered to provide consulting services to HHAs in Oklahoma. Their services were to include falsified HHA cost reports as well as an assurance that their consulting firm could stop any audits or investigations. They provided one HHA that entered into an agreement with them with a list of deficiencies they could fix. When the HHA disagreed that the deficiencies existed and decided against further dealings with the two, they threatened the HHA by stating they would inform HCFA, the FBI and OIG of the deficiencies. Portraying herself as a HCFA employee, the woman who was sentenced informed the HHA that it would face a HCFA audit if it did not contract with the other two individuals, both of whom have been convicted and sentenced as well.

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 and 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 and to exclusion from participation in Federal health care programs. They may also be subject to civil monetary penalties (CMPs). The following cases are examples of the sentences for this crime:

- A Florida woman was sentenced to 3 years probation and restitution of \$400 for violating the Medicare anti-kickback statute. The woman owned and operated a company in south Florida which referred Medicare beneficiaries to several psychiatric hospitals in central Florida, as well as other States. The woman received illegal remunerations in exchange for these referrals. She was the fifteenth individual to be sentenced in an investigation targeting a combination of inpatient psychiatric hospitals, illegal kickback activities and patient brokering schemes. The investigation focused on the intricate relationship among hospital associates who pay kickbacks in return for patient referrals to hospitals; patient brokers who profit from the trade in patient referrals; and patient referral sources who accept money from hospitals or patient brokers in exchange for referrals.
- A Georgia podiatrist was sentenced to 2 years probation and payment of \$16,200 in restitution for violating the anti-kickback statute. The podiatrist illegally received kickbacks from a DME company owner in return for the referral of patients requiring lymphedema pumps.
- An employee of a New York diagnostic laboratory was sentenced in Connecticut to 3 years probation and a \$4,000 fine for conspiracy to violate the anti-kickback statute and tax evasion. The man paid kickbacks to a clinic manager in Connecticut in return for laboratory testing referrals. In January 1998, the man waived indictment and pled guilty to conspiracy and tax evasion for his role in the scheme.
- A woman was sentenced in New York for engaging in illegal kickback activity. Her sentence included 3 years probation and a \$3,000 fine. The sole proprietor of a radiology facility, the woman paid a physician kickbacks in exchange for the referral of patients in need of ultrasound testing.
- A woman was sentenced to 1 year probation and \$2,050 in fines for her role in accepting kickbacks as a middle person on behalf of a rheumatologist with a medical practice in New Jersey. The woman received money from a DME supplier for facilitating a kickback arrangement with the

rheumatologist. Her sentencing concludes a case involving several doctors and podiatrists who participated in a kickback conspiracy among health care providers in New York and New Jersey.

- An Ohio osteopath was sentenced to 3 months in a halfway house, 2 years probation and a \$5,000 fine for filing falsified Medicare and Medicaid claims. The indictment charged the osteopath with accepting kickbacks from a home health care company.

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 2,231 administrative sanctions, in the form of program exclusions or civil actions, on individuals and entities for engaging in fraud or abuse or other activities deemed to be a risk to Federal health care programs and/or their beneficiaries.

A. Program Exclusions

Title XI of the Social Security Act provides for a number of bases for excluding individuals and entities from participation in Medicare, Medicaid and other Federal health care programs. Exclusion is mandatory for those convicted of program-related crimes, crimes related to patient abuse or neglect, felony convictions for defrauding other health care programs, and felony convictions for the illegal manufacture or distribution of controlled substances. Exclusion is discretionary for those who have lost a license to practice or the right to participate in a State health care program for reasons related to professional performance, professional competence or financial integrity, or provided substandard or unnecessary services. Exclusions may also be imposed on those convicted of private insurance fraud, or obstruction of an investigation, and on individuals who have failed to repay health education assistance loans (HEALs). (See page 56 for further information on exclusions for HEAL defaults.)

During this reporting period, OIG imposed exclusions on 2,072 individuals and entities. The following are examples of some of the exclusions that were imposed:

- A registered nurse, who permanently lost his Florida nursing license, was indefinitely excluded from Medicare, Medicaid and all Federal health care programs. The subject had repeatedly engaged in sexual misconduct with male children between the ages of 12 and 14 at their private residences, and had also fondled hospitalized male children while they slept. Currently, he is serving 15 years in prison.
- In Georgia, a pharmacist was excluded for 20 years based on his conviction for distribution of controlled substances and his previous 10-year exclusion

from Medicare and Medicaid participation, which was instituted after an earlier Medicaid fraud conviction. His second conviction was the result of a scheme in which he distributed detectable amounts of several narcotic controlled substances outside the scope of professional practice and without a legitimate medical purpose. The court ordered that the pharmacist be incarcerated for 60 months and pay more than \$55,000 in restitution, the balance owed on court-ordered restitution from his first conviction.

- A mother and daughter were each excluded for 5 years because they are the owners of a Kentucky DME company which was recently excluded from program participation. The company pled to one count of making false statements or representations regarding the purchase of respiratory supplies that were used to provide respiratory therapy services to Medicaid recipients.
- A physician was indefinitely excluded after he surrendered his license to practice medicine in New York. The State licensing board charged him with gross negligence, verbal and/or physical abuse, moral unfitness and practicing while impaired. The physician had demonstrated unprofessional conduct when he carved his initials into a patient's abdomen while performing a caesarian section and when he inappropriately tried to remove respiratory equipment from an infant in the neonatal intensive care unit. During this second incident, a nurse had to physically restrain the physician.
- A nurse's aide was excluded for 15 years from program participation because a Texas court convicted him of arson causing bodily injury. The aide set fire to a resident's room at the health care center where the aide worked. He is now serving 7 years in prison.
- In California, a psychiatrist, convicted of crimes related to patient abuse, was excluded for 15 years. He entered into a sexual relationship with a patient and supplied him with legal and illegal drugs. The psychiatrist also rented an apartment for the patient and provided the drugs there. During a sexual encounter, the doctor assaulted the patient with a hand axe and a hunting knife at least 10 times. The doctor was convicted of assault with a deadly weapon and sentenced to 5 years in prison.
- A Michigan osteopath was excluded for 15 years due to his conviction for involuntary manslaughter. The physician injected herbal tea into a cancer patient resulting in irreversible lung damage and death. In addition, the physician's license was revoked.

B. Civil Penalties for Patient Dumping

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

The OIG is authorized to impose civil monetary penalties (CMP) of up to \$25,000 against small hospitals (less than 100 beds) and up to \$50,000 against larger hospitals (100 beds or more) for each instance where the hospital negligently violated any of the section 1867 requirements. In addition, OIG may impose a CMP of up to \$50,000 against a participating physician, including an on-call physician, for each negligent violation of any of the section 1867 requirements.

Between April 1, 2000 and September 30, 2000, OIG collected \$535,750 in settlement amounts from 24 hospitals and physicians. The following is a sampling of the alleged violations involved in the FY 2000 Patient Anti-Dumping Statute settlements from this reporting period.

- A Georgia emergency physician agreed to pay \$22,500 for an allegation that he failed to provide an appropriate medical screening examination and treatment for a woman who came to the emergency room with an ectopic pregnancy.
- A hospital in California settled for \$70,000 allegations that it failed to provide appropriate medical screening examinations to seven individuals. Five of these individuals were 1-year old or younger and one of the babies was admitted for treatment at another hospital. In one instance, treatment ceased because the patient's HMO denied prior authorization for payment of

services provided at that hospital. In five other instances, financial inquiries were completed, but no appropriate medical screening was done.

- An Oklahoma hospital settled for \$18,250 an allegation that it refused to accept the appropriate transfer of a patient who had been critically injured in an automobile accident and required emergency vascular surgery. The transferring hospital did not have the specialized capabilities or facilities that were required to treat the life-threatening injury to the patient's abdominal aorta. After numerous calls to hospital emergency rooms and physicians, the patient was eventually transferred to a hospital where surgery was performed in an unsuccessful attempt to save his life.
- A small Illinois hospital agreed to pay \$60,000 to resolve allegations that it failed to provide appropriate medical screenings to three individuals who presented for treatment at the emergency room. This settlement resolved two separate investigations for alleged patient dumping.
- A California hospital paid \$61,000 to settle allegations that it failed to provide appropriate medical screening examinations to six patients. Five of these patients presented with significant medical issues which needed prompt attention, according to the California peer review organization. Instead, the patients were required to wait significant periods of time (up to 4 hours) and ultimately left the hospital without being screened or treated. The sixth case involved a sick child who was not medically evaluated because his insurance plan denied payment authorization. Instead, his mother was directed to take him to another hospital.

C. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers and others who submit false or improper claims to Medicare and other Federal health care programs. The OIG also assists DOJ in bringing (and settling) cases against wrongdoers under the False Claims Act. Many providers elect to settle their cases prior to litigation. As part of resolving these cases, OIG frequently imposes corporate integrity agreements on entities as a condition for being allowed to remain a provider in the Medicare program. The integrity programs established by these agreements are designed to prevent a recurrence of the fraudulent activities that gave rise to the case at issue. The Government, with the assistance of OIG, recouped more than \$228 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 dialysis services company based in Sweden, and two of its Florida subsidiaries, agreed to pay the Government more than \$53 million to settle

allegations of submitting false claims to Medicare, Medicaid and TRICARE for end stage renal disease (ESRD) laboratory services. The company's laboratories allegedly billed Medicare for medically unnecessary lab tests; double billed for lab tests included in ESRD composite rate payments; and violated the 50-50 rule, which prohibits billing for lab test panels of which 50 percent or more is already reimbursed through the composite rate. The \$53 million settlement figure represents the total of two settlement agreements reached with the Government. The first, involving the company and one of its Florida subsidiaries, resolves allegations of improper billing by the subsidiary's laboratory and calls for payment of \$40 million. The second, involving the company and its other Florida subsidiary, resolves allegations of improper billing by the other subsidiary's laboratory and calls for payment of more than \$13.1 million. As part of the settlement agreement, the company entered into a 5-year comprehensive corporate integrity agreement targeting ESRD lab billing risk areas and covering any and all ESRD labs owned or operated by the company.

- As the result of an OIG audit, a publicly traded Medicare managed care company (MCO) agreed to pay \$14.5 million to settle allegations that the company provided inaccurate enrollment data to Medicare. This is the first False Claims Act settlement that involved billing misconduct in the Medicare managed care program. Specifically, the audit revealed that the company received Medicare payments for Medicare beneficiaries who were members of the company's plans and were incorrectly listed by the plans as dually eligible for both Medicare and Medicaid. As part of the settlement, the company has entered into a comprehensive 5-year corporate integrity agreement.
- A regional Medicare carrier agreed to pay the Government close to \$9 million for allegedly submitting false final administrative cost reports for fiscal years 1990 through 1997. The company improperly charged HCFA for unallowable costs in connection with its Medicare carrier contract with the agency. As a result, the company received overpayments in reimbursement for costs incurred in operating the Medicare program. Initiated through a qui tam suit filed in Maryland, the OIG investigation and audit substantiated several allegations against the company. First, the company knowingly over-counted paper costs incurred in printing Medicare checks and explanation of benefits forms. Second, the company charged HCFA for unallowable overhead costs, including risk insurance costs not incurred. Finally, the company knowingly failed to disclose these known overcharges during an OIG audit. As part of the settlement, the company entered into a comprehensive corporate integrity agreement with OIG.

- One of the largest providers of mental health and substance abuse services in southern West Virginia agreed to pay \$2.5 million to the United States. An investigation and audit determined that the provider submitted false claims to the Federal health care programs (primarily Medicaid), and committed grant fraud. Specifically, the investigation revealed that the provider submitted claims for services not rendered and that it also submitted duplicate claims for various mental health and substance abuse services. Regarding the grant fraud allegations, the provider submitted false grant applications by inflating its costs and underreporting its revenues. As part of the settlement, the provider agreed to enter into a 5-year corporate integrity agreement.
- A medical practice, whose principal owner and shareholder is an internationally known cardiologist, agreed to pay the Government \$1.5 million to settle allegations of submitting false claims to Medicare. A qui tam suit initiated this investigation into the billing practices of the medical practice and the cardiologist. Based on a review by the carrier, a peer review organization nurse and an independent expert cardiologist, the Government found that between 1993 and 1998, the practice submitted, or caused to be submitted, improper Medicare claims for services provided to patients by the cardiologist. The claims contained numerous instances of upcoding for evaluation and management services; of double billing for certain services; and of billing medically unnecessary cardiology-related tests, procedures and office visits. In addition, the medical practice also agreed to enter into a 6-year comprehensive corporate integrity agreement.
- A Massachusetts mental health practice agreed to pay the Government \$850,000 to settle allegations of improper billing practices. From 1995 through 1999, the mental health practice used medical codes that improperly characterized services as being incident to services provided by a psychiatrist. The practice also used inappropriate medical codes in order to receive a higher rate of reimbursement. Finally, the practice failed to use a modifier to indicate that services were rendered by a social worker and should, therefore, be paid at the rate appropriate for that type of provider. As part of the settlement, the practice also entered into a corporate integrity agreement with OIG.
- An operator of physician clinics in Virginia agreed to pay the Government \$344,764 to settle allegations of submitting false claims to Medicare. The entity employed physicians, physician's assistants and nurse practitioners to visit patients in various nursing homes. Through an internal audit, the clinic operator determined that the services of the nurse practitioners and

physician's assistants were inappropriately billed under a physician's provider number. This improper billing practice led the clinic operator to receive higher reimbursement from Medicare than it should have. Moreover, the conduct violated Medicare's "incident to" billing rules requiring, in part, the direct supervision of physicians when services are provided by nonphysician personnel. As part of the settlement agreement, the clinic operator entered into a 5-year corporate integrity agreement with OIG.

- A nonprofit entity agreed to pay the Government \$296,000 to resolve allegations of submitting false cost reports in certain States. Based in Nebraska, the nonprofit entity provides services to physically and mentally handicapped Medicaid beneficiaries in 13 States. The nonprofit allegedly submitted false cost reports by submitting health care charges related to a self-insurance fund without appropriate actuarial support and by utilizing an allocation method which resulted in the submission of excess workers compensation costs. The self-insurance charges caused Medicaid in three States to pay the nonprofit prematurely for its self-insurance costs. By receiving the money prematurely, the nonprofit earned money in interest to which it was not entitled. As part of the settlement, the nonprofit also entered into a 3-year corporate integrity agreement.

D. Compliance Activities

The existence of an "effective" compliance program can offer an organization certain credit under the Federal Sentencing Guidelines. This and other benefits have served to encourage the private sector to develop methods to prevent the submission of improper claims and inappropriate conduct and to detect violations under the False Claims Act and the CMP law. The OIG has already initiated significant outreach efforts with the private sector to discuss these compliance endeavors.

The OIG continues in its efforts to promote voluntarily developed and implemented compliance programs by providing guidance for the various sectors of the health care industry. To this end, OIG has developed and released compliance program guidance for clinical laboratories, hospitals, HHAs, third-party billing companies, DME, prosthetics and orthotics suppliers, hospices, Medicare+Choice organizations that offer coordinated care plans, nursing homes, and individual and small group physician practices. The OIG is currently working on guidance for ambulance service providers. With respect to guidance and outreach to the physician community, OIG obtained significant input from physicians regarding its compliance program guidance for individual and small group physician practices. The physician guidance highlights the seven elements of effective compliance programs set forth in the Federal Sentencing Guidelines. However, OIG adapted these seven elements to reflect the staffing and financial constraints faced by many individual and small group physician practices. The guidance contains four main risk areas: coding and billing;

reasonable and necessary services; documentation, including medical record documentation and HCFA 1500 form; and kickbacks, inducements and self-referrals. The guidance is intended to serve as a useful resource for physician practices and includes several appendices providing additional information. These appendices contain additional risk areas that physician practices should be familiar with; summaries and examples of civil, administrative and criminal statutes related to the Federal health care programs; carrier contact information; and a listing of related Internet resources.

As noted in the Federal Sentencing Guidelines, the seven fundamental elements of an effective compliance program are: implementing written policies, procedures and standards of conduct; designating a compliance officer and compliance committee; conducting effective training and education; developing effective lines of communication; enforcing standards through well-publicized disciplinary guidelines; conducting internal monitoring and auditing; and responding promptly to detected offenses and developing corrective action initiatives.

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

In addition to developing compliance program guidance, which promotes the voluntary adoption of compliance measures by private industry, OIG monitors compliance and integrity obligations imposed on health care providers as part of global settlements of OIG investigations and audits. These compliance obligations are typically imposed through an agreement commonly referred to as a corporate integrity agreement. Presently, OIG is monitoring 470 Government-imposed corporate integrity agreements. These agreements cover the range of providers from small physician offices to large hospitals and laboratory corporations. The duration of most current corporate integrity agreements is 5 years and these agreements require the provider to take substantial measures to ensure that the organization is operating within HCFA rules and regulations and the parameters established by the corporate integrity agreement. A material failure to adhere to the corporate integrity agreement could result in financial penalties or exclusion of the provider.

To assist with efforts to verify compliance with the terms of the corporate integrity agreements, OIG staff conducts onsite visits to certain entities and providers subject to the compliance obligations. The OIG has 18 site visits scheduled for FY 2000. These site visits generally involve meeting with compliance staff and management, employee interviews, a claims review and a detailed discussion of assertions made in annual reports submitted to OIG by the provider. Site visits often verify compliance with the corporate integrity obligations, but they have also uncovered and confirmed instances of noncompliance, including improper claims reviews and the provider's placement of prohibited costs related to a false claims settlement agreement on provider cost reports.

As one of its six task orders awarded to program safeguard contractors, in November 1999, HCFA contracted with TriCenturion, LLC, a new company formed by three current Medicare contractors (Blue Cross Blue Shield of Florida, Blue Cross Blue Shield of South Carolina and TrailBlazer Health Enterprises) to assist OIG in its monitoring of providers subject to corporate integrity agreements. In the next contract year, TriCenturion will perform 26 onsite reviews of providers subject to corporate integrity agreements to assist OIG to determine if the providers are meeting the obligations in the agreements. In addition, TriCenturion will conduct claims reviews to determine whether the providers are complying with applicable laws. The OIG staff will work closely with HCFA and TriCenturion on this important project. This effort will complement the site visits conducted by OIG's compliance unit staff.

Provider Self-Disclosure Protocol

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

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

Unlike prior voluntary disclosure procedures (e.g., Voluntary Disclosure Pilot Program), there are no limitations as to the type of provider or supplier that can avail itself of the Protocol's guidance or with respect to geographical location. Nor is the fact that a provider or supplier is under investigation by another Government agency an automatic bar to submissions under the Protocol. OIG evaluates each submission to determine the appropriate course of action. To date, OIG has received 100 submissions. They comprise a variety of issues and types of providers throughout the Country.

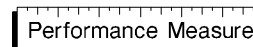
Among the benefits experienced by disclosing providers is the allocation of investigative resources that can contribute to an expedited inquiry and a prompt resolution of the matter. Additionally, disclosing providers that demonstrate the effectiveness of their compliance programs and that, as part of the resolution of the matter, agree to continue such compliance activities, may avoid entering into a corporate integrity agreement with OIG.

Overall, the Protocol provides helpful guidance to providers and the community at large on how to achieve resolution of identified misconduct through a cooperative and open relationship with the Government.

Medicare Payments to OIG Excluded Physicians

Few payments were made to excluded physicians in Medicare fee-for service. Twenty-one excluded physicians received improper Medicare payments totaling \$35,833 in 1997, mostly as the result of Medicare carrier employee errors. Questionable claims were paid to another 12 physicians excluded that year. Although the system seems to work well, it is not perfect. Medicare carriers need to ensure that staff responsible for processing exclusions receive this information timely and take action on it. This study was unable to determine if excluded health care providers other than fee-for-service physicians received improper payments. Most such providers do not have UPIN numbers, or are in a managed care setting. Identifying excluded individuals in these professions remains a cause for concern. (OEI-07-98-00380)

External Quality Review of Dialysis Facilities



The HCFA relies on two major entities to conduct external reviews of dialysis facilities: the end stage renal disease (ESRD) networks established under the Social Security Act and the State survey agencies. In a review of these mechanisms, OIG concluded that the system of oversight has major shortcomings and that HCFA does little to hold the networks and the State agencies accountable for their effectiveness.

The OIG recommended that HCFA revise Federal regulations to serve as a stronger foundation for accountability; use performance data to both improve the overall quality of care and ensure that minimum standards are met; integrate and enhance the complaint systems of the networks and the States; and determine a minimum cycle for routine onsite surveys. The HCFA concurred with OIG's recommendations. (OEI-01-99-00050)

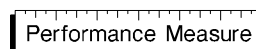
In a companion report, OIG described two efforts, one initiated by the renal network covering Indiana, Kentucky, Ohio and Illinois, and the other by the State of Texas, that were particularly instructive as to how facilities can be held more fully accountable. (OEI-01-99-00051)

Payments to Managed Care Organizations for Beneficiaries on Dialysis

In this review, OIG evaluated HCFA's actions to prevent erroneous classifications of the end stage renal disease (ESRD) status of beneficiaries enrolled in risk-based managed care organizations. Monthly payment rates for ESRD beneficiaries are approximately seven times greater than the non-ESRD rate.

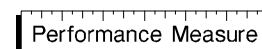
Based on a limited review of 76 beneficiaries classified as ESRD, OIG found that 14 beneficiaries (or 18 percent) had been misclassified during 1997, resulting in about \$112,500 in gross payment errors. Nine of these beneficiaries had their ESRD status terminated prematurely, resulting in underpayments of \$57,500, while five beneficiaries showed no sign of renal failure, resulting in overpayments of \$55,000. The OIG recommended that HCFA make procedural and systems changes to prevent further misclassifications and instruct all ESRD centers to verify the status of beneficiaries and to submit census data on a timely basis. The HCFA concurred with OIG's findings and recommendations. (CIN: A-14-98-00211)

Medicare Conditions of Participation for Organ Donation: An Early Assessment of the New Donation Rules



This inspection provides an early assessment of hospitals' and organ procurement organizations' responses to the Medicare hospital conditions of participation for Organ Donation. Hospitals and organ procurement organizations (OPOs) have made progress in implementing the rule, however hospitals and OPOs have not taken full advantage of the rule. Despite projections of a 10 percent increase in organ donors in the rule's first year, the increase was less than 1 percent. In addition, HCFA lacks data to assess how well the rule is working. This report recommended that HCFA revise the Medicare conditions for coverage for OPOs to make them more accountable for implementing the donation rule, by requiring OPOs to provide hospital-specific data on referrals and organ recovery and to make hospital-specific data on donation publicly available. We recommended that the Health Resources and Services Administration (HRSA) require that OPOs, as members of the Organ Procurement and Transplantation Network, submit hospital-specific data on referrals and on organ recovery. We also recommended that HRSA support demonstration projects on training and using designated requesters, and develop a recognition award for hospitals that show exemplary performance in donation. Both HCFA and HRSA responded positively to our report and recommendations. (OEI-01-99-00020)

Nursing Home Vaccination: Reaching *Healthy People 2010* Goals



One objective of the Department's *Healthy People 2010* public health goals is to increase vaccination rates for influenza and pneumococcal disease in nursing homes to 90 percent. Despite Medicare coverage of both vaccines, data suggest that nursing homes fall short of this mark: A 1995 survey by the Centers for Disease Control and Prevention (CDC) indicated that only 61 percent of nursing home residents received an annual influenza vaccination and only 22 percent had ever received the pneumococcal vaccine.

The HCFA and CDC have numerous efforts underway to encourage nursing homes to vaccinate their residents. To accelerate fulfillment of this *Healthy People 2010* goal, OIG

recommended options to strengthen the agencies' responses. The OIG proposed that HCFA consider requiring nursing homes to assess residents for vaccinations upon admission; add vaccination to the Minimum Data Set (MDS) which nursing homes are required to collect during in-depth, recurring evaluations of residents' health status; increase use of the peer review organizations, FIs and carriers to teach nursing homes about Medicare roster billing, a simplified procedure allowing homes to submit a list of beneficiaries who receive vaccines, rather than requiring individual bills. Also, HCFA and CDC could use the MDS to identify and reach out to nursing homes with low vaccination rates through their network of regional and field offices who are familiar with local nursing homes and the populations they serve.

The HCFA concurred with OIG's recommendations and agreed to take actions in each of the areas identified. (OEI-01-99-00010)

Medicare Beneficiary Access to Skilled Nursing Facilities: 2000

This inspection looks at Medicare beneficiary access to skilled nursing facilities under the Medicare prospective payment system. It is based on a survey of 202 hospital discharge planners and an analysis of Medicare claims data. The OIG found that almost all discharge planners can place all of their Medicare beneficiaries in SNFs. Medicare data showing a rise in the number of Medicare beds available support the response of discharge planners that there are adequate skilled nursing home beds available. While some Medicare beneficiaries do experience delays before they are placed in a SNF, Medicare data show a slight decrease in hospital lengths of stay before discharge to a SNF. (OEI-02-00-00330)

Effect of Financial Screening and Distinct Part Rules on Access to Nursing Facilities

In recent years, HCFA and the Office for Civil Rights have been alerted by nursing home advocacy groups and beneficiaries that nursing homes may be using financial screening and distinct part rules to limit access for Medicare and Medicaid applicants. Reportedly some nursing facilities require applicants to submit information about their finances so they can determine whether or not and for how long a person will be able to pay privately before they become eligible for Medicaid. Distinct part rules allow facilities to define the extent of their participation in the Medicaid or Medicare programs by certifying a specific number of their beds for either or both of these programs.

An OIG review found that, overall, distinct part rules do not appear to limit access for Medicaid or Medicare beneficiaries. Moreover, while financial screening may cause access problems for some Medicaid beneficiaries, these problems do not appear to be widespread. At the current time, any potential effects of distinct part rules and financial screening are being tempered by a bed supply that generally exceeds demand and by State initiatives that promote access.

The OIG suggested some options to the Department: take no present action but continue to monitor access and changes in nursing home occupancy rates; strengthen oversight by alerting survey and certification and ombudsman staff to potential abuses and alerting consumers to common screening practices through public service announcements; issue new regulations or seek legislation to eliminate Medicare distinct part and/or prohibit financial screening; or study the effects on access of the practices adopted by 23 States to promote access to nursing facilities. The HCFA agreed with the recommendation to strengthen oversight and cited action underway. (OEI-02-99-00340)

Fraud Involving Nursing Homes

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

- Three Ohio residents, a Massachusetts corporation and a New Hampshire corporation were sentenced in New Hampshire for conspiracy to defraud the Medicare program. Their offenses stemmed from a health care fraud scheme through which the defendants submitted false claims to Medicare. The claims were submitted in order to obtain payment for more than 160,000 transtelephonic electrocardiograph tests performed on more than 6,000 beneficiaries residing in approximately 200 nursing homes in 12 States. One individual was sentenced to 46 months imprisonment and 3 years supervised release; the second was sentenced to 72 months imprisonment and 3 years supervised release. In addition, the two individuals and the two corporations were ordered to be held jointly and severally responsible for payment of \$2.27 million in restitution. The third individual was sentenced to 6 months imprisonment, 3 years supervised release, and payment of \$5,150 in fines.
- In a civil self-disclosure case in Michigan, a rural nursing home reached a settlement with the Government for alleged misconduct the nursing home discovered during a routine self-audit. The nursing home agreed to pay the Government \$891,000 to resolve its civil liability for two improper practices. First, the nursing home improperly waived certain copayment amounts for nursing, clinical laboratory, occupational, physical therapy and physician services rendered to Medicare beneficiaries. Second, the nursing home obtained reimbursement for supplies to which it was not entitled. Since the nursing home voluntarily disclosed this matter and voluntarily

began implementing a compliance program, the OIG agreed to reduce the term of the corporate integrity agreement to 3 years.

- In Missouri, the co-owner of two rehabilitative therapy companies was sentenced to 12 months and 1 day incarceration, 3 years supervised release and payment of \$619,980 in restitution for mail fraud. He and the company's other co-owner provided false and inflated invoices to 11 nursing homes which caused the homes to provide false cost reports to the Medicare intermediary. The two individuals then improperly received reimbursement for physical and occupational therapy services not rendered. During negotiations for a plea agreement, the other co-owner died of a heart attack. A civil suit has been filed against his estate, and negotiations in that suit continue.
- Under the terms of a consent decree filed in Pennsylvania, two nursing homes agreed to resolve their liability for providing poor quality services to their Medicare and Medicaid patients. Owned by the same company, the two nursing homes allegedly provided such inadequate wound care, nutrition monitoring and medication services, that a resident died at each facility. Among the terms agreed upon, the nursing homes must pay the Government a total of \$160,000 and must appoint and pay for a temporary manager at each facility. In addition, the facilities must appoint and pay for an outside monitor selected by the Government. Finally, the facilities must implement specific best practice protocols to govern weight monitoring, wound care and pain management for their residents.
- An occupational therapist was sentenced for a false claims violation in California. The therapist caused a nursing home to improperly bill Medicare for services she did not render. She was sentenced to 6 months in a community corrections center, 3 years probation and payment of \$29,495 in restitution.

Consolidated Billing Under the Prospective Payment System for Skilled Nursing Facilities

Under consolidated billing, a skilled nursing facility (SNF) is reimbursed a prospective payment for all covered services rendered to its residents in a stay under Medicare Part A; outside providers and suppliers must bill the SNF for services rendered. In a review of a sample of Medicare Part A SNF PPS claims for dates of service from October 1, 1998 to April 30, 1999, OIG found that in over one-third of the claims, Medicare contractors had made separate Part B payments to outside suppliers for services subject to consolidated billing. As a result, Medicare paid twice for the same service.

The OIG concluded that improper payments to outside providers occurred because Medicare edits had not been established to detect and prevent such claims and because some suppliers may not have been fully aware of the consolidated billing provision. Concerned that these preliminary findings could portend a nationwide problem with substantial impact, HCFA indicated that it would prepare a fraud alert and a memorandum to advise contractors of the issue and direct them to educate providers. Pending implementation of program edits, OIG recommended that HCFA adopt interim remedies in addition to issuance of its fraud alert and memorandum to contractors; these included working with OIG on a computer application to identify and recover overpayments and monitoring contractors' recovery of the identified overpayments. The HCFA concurred with OIG's findings. (CIN: A-01-99-00531)

Nursing Home Quality of Care Conferences

Over the past 6 months, the OIG has continued its active participation in an interagency Government initiative to improve efforts to enforce the laws governing quality of care and fraud in the provision of nursing home services. A major part of that initiative has been a series of multi-day training conferences throughout the country for Federal, State and local Government officials whose duties encompass enforcement of nursing home laws. The conferences succeeded in bringing together a diverse group of people to enable them to better coordinate their efforts to achieve their common goals. OIG staff helped DOJ in its planning of the conferences. OIG staff led several of the training sessions, and OIG agents, auditors, and attorneys participated in others.

Medicare Beneficiary Access to Home Health Agencies: 2000

This inspection describes the effects of the interim payment system (IPS) on access to home health agencies for Medicare beneficiaries discharged from the hospital. The findings of this follow-up study are consistent with those in OIG's 1999 study, "Medicare Beneficiary Access to Home Health Agencies." Almost all Medicare beneficiaries can be placed with a home health agency. In fact, 88 percent of discharge planners report that they place all eligible Medicare patients in home health, while some patients experience delays. Most discharge planners report that delays are not more common now than before IPS. The OIG concluded that there appears to be no widespread problem with placing Medicare hospital patients with home health agencies. (OEI-02-00-00320)

Adequacy of Home Health Services: Hospital Re-Admissions and Emergency Room Visits

In examining the issue of hospital re-admissions and emergency room visits for patients discharged from the hospital to home health care, this OIG inspection did not find any significant increases in re-admission or emergency room visit rates since the implementation

of the interim payment system. In fact, they decreased. This was true in general and also for high volume diagnoses and diagnoses identified as at-risk. (OEI-02-99-00531)

Medicare Home Health Agency Survey and Certification Deficiencies

Overall, home health agency survey and certification deficiencies increased 26 percent between the first 6 months of 1997 and 1999. Reasons that may account for this increase include changes in the survey schedule, increased Federal involvement, declining quality of care, and the interim payment system. The OIG concluded that just as there is no single cause for the increase in home health agency deficiencies, there is no single course of action to be taken. Instead, a combination of approaches may be appropriate, including strengthened State survey protocols and continued close scrutiny of the care being provided. The upcoming prospective payment system will also address this problem. (OEI-02-99-00532)

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 might be incurred at a hospital or other institution. The OIG has become aware of a number of fraudulent arrangements by which home health care providers, medical professionals and others associated with the operation of HHAs, inappropriately bill Medicare and Medicaid. The following cases represent some examples of improper activities related to the provision of home health care services:

- In Texas, three former owners of a provider of home health care and infusion therapy services agreed to collectively pay the Government \$2.5 million and to be permanently excluded from all Federal health care programs for their alleged misconduct against the Medicare program. This settlement stemmed from an OIG audit of the provider, a subsidiary of a large home health care company in Texas. The defendants were responsible for a substantial portion of the alleged misconduct that led the company to agree to pay the Government \$10 million in 1999. Based upon the initial audit and subsequent investigation, the Government alleged that the subsidiary's home health component improperly charged Medicare for unallowable salaries and other unallowable items such as travel and legal fees not related to patient care. The second part of the case involved allegations of wrongdoing by the subsidiary when selling infusion therapy drugs, supplies, equipment and nursing services to SNFs, which then provided infusion therapy to Medicare beneficiaries.

- In Colorado, the owner of HHAs, a DME company and several related entities, along with one of her HHAs, agreed to pay the Government \$75,000. The settlement resolves allegations that the owner submitted false claims by including personal expenses on her HHA cost reports to Medicare. The owner also pled guilty to two separate indictments charging mail fraud and bankruptcy fraud, respectively. She was sentenced to serve concurrent terms of 6 months in a community corrections facility and 30 months probation. She was also ordered to pay total restitution of \$37,505, in addition to the civil settlement amount. The Government also received \$20,184 through the liquidation of assets of another of her companies that went bankrupt. In addition, OIG excluded the owner and all her companies permanently.
- A Florida HHA agreed to pay the Government \$500,000 to settle allegations that the company submitted false claims for medically unnecessary services in 1993 and 1995. During that time, the HHA submitted false claims for home health care for patients not in need of the services. In most cases, the patients were not homebound or did not require any skilled nursing care.
- A Colorado man was sentenced for his part in submitting false cost reports to Medicare. Among the improper costs submitted were season tickets for professional ice hockey and basketball games, a trip to Greece and wages paid to his common law wife who never actually worked for his HHA. The man was sentenced to 1 year in custody, comprised of 4 months in a community corrections center and 8 months in home detention; 3 years probation; and payment of \$62,326 in restitution. He also agreed to a 15-year exclusion. His common-law wife must pay restitution of \$4,324 and serve 1 year probation.
- A HHA based in New Jersey agreed to pay the Government \$325,000 to settle allegations of submitting improper Medicare claims for services provided by a branch office in Pennsylvania. The HHA improperly billed Medicare for home health care for patients who were not homebound and who were not in need of skilled nursing services.

Unidentified Primary Health Insurance: Medicare Secondary Payer Auxiliary File

As a result of growing concern for rising Medicare program costs, a series of statutory provisions were passed that established Medicare as the secondary payer to other private health insurance in certain situations. The OIG determined that, overall, HCFA's Medicare secondary payer (MSP) auxiliary file accurately documents primary insurance. Less than one-half of one percent of beneficiaries with primary health insurance coverage in OIG's

sample for this inspection were not identified in the file. The OIG found only a few instances where other health insurance was undetected, with losses to Medicare of approximately \$56 million in 1997. Also, OIG noted that the Initial Enrollment Questionnaire, which is designed to capture primary coverage information at the point of Medicare entitlement, does not always do so because a number of beneficiaries do not respond.

The OIG recommended that HCFA emphasize to providers the requirement that they obtain and report insurance coverage information at each beneficiary office visit. To increase the response rate for the questionnaire, OIG proposed several options for HCFA to consider. The HCFA generally concurred with OIG's recommendations. (OEI-07-98-00180)

Employer Compliance with Medicare Secondary Payer Data Match Requirements

Performance Measure

Medicare is the secondary payer to certain employer group health plans. The objective of this follow-up review was to determine if HCFA had established effective procedures to ensure that employers respond to requests for information as part of the Medicare secondary payer (MSP) data match.

The OIG determined that HCFA had obtained group health plan information from approximately 1.7 million employers, or about 87 percent of those contacted as part of the data matches run from 1991 through 1997. The information obtained resulted in approximately \$2.5 billion in MSP savings. However, HCFA did not use all available remedies to obtain such information from the 13 percent of employers that did not respond to the legislatively mandated request for information. The OIG estimated that these missing data led HCFA to pay out as much as \$282 million in Medicare funds for which group health insurance plans were liable. The OIG recommended, among other things, that HCFA assess civil monetary penalties against employers that refuse to respond to requests for group health plan information on Medicare beneficiaries. The HCFA concurred and agreed to take corrective action. (CIN: A-02-98-01036)

Medicare Payments for Services after Date of Death

The OIG found that Medicare paid an estimated \$20.6 million in 1997 for services that started after a beneficiary's date of death. Medicare had not yet received beneficiary date of death information at the time the claim was processed for \$12.6 million of the services paid. However, Medicare paid \$8 million for services where the beneficiary's date of death was in its system at the time the claim was processed and approved for payment; over half the \$8 million was for DME claims.

The HCFA established the common working file (CWF) in 1991 to improve claims processing in the Medicare program. Under the CWF system, FIs and carriers send claims

information to one of nine CWF host sites for approval. The CWF host sites review updated beneficiary information from HCFA's enrollment data base on a daily basis.

The OIG recommended that HCFA require contractors to conduct annual postpayment reviews to identify and recover payments made for services after death; revise their CWF system edit to ensure that DME payments are not made for deceased beneficiaries; and periodically reconcile dates of death information between the enrollment data base and CWF files. The HCFA concurred with OIG's recommendations. (OEI-03-99-00200)

Contractor Costs for Year 2000 Remediation of Medicare Computer Systems

The Medicare contractors operate 75 "mission-critical" computer systems which are necessary both to establish the Medicare eligibility of beneficiaries and to authorize payments to fee-for-service providers and managed care plans. During FY 1998, HCFA increased the budget allocation of the contractors by over \$100 million for the Year 2000 (Y2K) remediation of their Medicare computer systems and related Y2K activities. To monitor the budget process associated with this additional funding, HCFA implemented a new structure for use by contractors in submitting their supplemental budget requests for Y2K funding and reporting Y2K expenditures on their interim expenditure reports.

At HCFA's request, OIG conducted a series of audits of costs reported by Medicare contractors for Y2K remediation of their Medicare computer systems and related activities. During this reporting period, OIG issued several reports on individual contractors, as well as a summary report consolidating the results at 35 contractors. The OIG found that of the approximately \$78.3 million in Y2K expenditures reported by the contractors, \$10 million should be disallowed as Y2K costs, \$5.4 million should be set aside for HCFA adjudication, \$4.6 million was improperly classified and \$1.3 million was incurred but not reported. Some of the Y2K costs recommended for disallowance may be otherwise allowable as Medicare program costs.

Recommendations called for HCFA to require that contractors make appropriate financial adjustments, accurately report Y2K expenditures by appropriate productivity investment codes and report costs incurred for Y2K remediation that were not previously reported. Contractor representatives, for the most part, agreed with the findings and recommendations. (CIN: A-02-99-01014; CIN: A-02-99-01028; CIN: A-02-99-01033; CIN: A-03-99-00039; CIN: A-04-99-02159; CIN: A-14-99-02400)

Medicare Contractor Administrative Costs

Under agreements with HCFA, an Illinois contractor reviews, audits and pays Medicare Parts A and B claims. Based on an independent audit of this contractor's administrative cost reports for the period October 1, 1994 through September 30, 1998, OIG recommended

financial adjustments totaling \$9.9 million: \$3.5 million for Part A and \$6.4 million for Part B. The questioned items included \$7.9 million that were part of an employee retention plan previously rejected by HCFA as unreasonable and unnecessary. The contractor disagreed with some of the findings. (CIN: A-05-99-00070)

Contractors' Pension Segmentation

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

A. New York Contractor

The OIG determined a New York contractor's Medicare segment pension assets to be \$38.6 million as of January 1, 1999, when segmentation requirements first became applicable to the contractor. Further, OIG recommended that the contractor periodically update the Medicare pension assets for contributions, income, benefit payments and expenses. The contractor agreed with OIG's findings and recommendations. (CIN: A-07-98-02534)

B. Missouri Contractor

In this review, OIG found that a Missouri contractor had understated the Medicare segment pension assets by over \$259,000 as of January 1, 1998, and had not updated the assets beyond that date. The OIG determined that the valuation of the Medicare segment pension assets was about \$6.2 million as of January 1, 1998, and recommended that the contractor establish assets of that amount. Contractor officials concurred with OIG's findings and recommendations. (CIN: A-07-99-02540)

Investment Income Earned on Medicare Funds by Risk-Based Managed Care Organizations

In this review, OIG estimated the financial impact on the Medicare program of holding risk-based managed care organizations (MCO) accountable for investment income earned on Medicare funds. The HCFA pays an MCO a predetermined amount (based on 95 percent of fee-for-service expenditures) for each Medicare enrollee by the first of every month. The MCO may then, at its discretion, invest the Medicare funds in interest-bearing instruments until the funds are needed for such purposes as paying health care providers or employees for services furnished to Medicare enrollees. However, an MCO is under no obligation to report, and is not held accountable to HCFA for any income generated by its investment of Medicare funds.

Based on an analysis of financial management information, OIG reported that risk-based MCOs may have earned annual investment income in excess of \$100 million on Medicare funds. Under the Medicare fee-for-service system and many other Federal programs, such

income is usually limited due to financing arrangements, is required to be returned to the Federal Government, or is used to benefit the program and its beneficiaries. The OIG believes that such should be the case with risk-based MCOs.

The OIG therefore recommended that HCFA pursue legislation to either (1) adjust the timing of Medicare's payments to MCOs to maximize the Health Insurance Trust Fund's earnings while minimizing MCOs' opportunities to earn investment income on Medicare funds or (2) adjust the MCO payment rates to recognize the impact of investment income on the total funding available to MCOs for servicing their Medicare enrollees. The HCFA agreed that its policies should hold risk-based MCOs accountable for interest income and that such income should be used to benefit Medicare enrollees. However, agency officials noted that they do not intend to pursue legislative changes at this time. (CIN: A-02-98-01005)

Expanded Coverage of Outpatient Diabetes Self-Management Training Services

The Balanced Budget Act of 1997 expanded Medicare coverage for outpatient diabetes self-management training (DSMT) services furnished by non-hospital-based programs and required that the payment amounts for DSMT services be established after consultation with appropriate organizations.

In a review of HCFA's proposed individual and group session payment rates, OIG concluded that they are both inflated. Based on its analysis, OIG found that Medicare could make improper payments totaling \$50 million for the period FYs 2000 through 2003 due to simple calculation errors. Because Medicare deductibles and copayments would also apply for these services, improper Medicare beneficiary copayments could total \$12.5 million for the same 4-year period. In addition, OIG determined that HCFA's group session payment rate was substantially higher than that being charged in the marketplace. The OIG believes that the payment rates will continue to be excessive if HCFA uses them as the planned baseline when incorporating DSMT services into the Medicare physician fee schedule.

The OIG recommended that HCFA further review the rates contained in the proposed rule. At a minimum, the rates should be adjusted downward to correct the calculation errors noted in this review. The OIG plans to expand its work in this area into a national study of the training services being rendered. (CIN: A-14-99-00207)

Part B Services Billed by California Developmental Centers and State Hospitals

The OIG audited Medicare Part B payments for services at 11 State facilities from January 1, 1993 through June 30, 1997 to determine if the approximately \$19 million in payments were appropriate. Of the 100 randomly chosen services reviewed, 73 were overpaid: 43 had no documentary evidence that the physicians had examined the patients, 14 had been

upcoded, 6 contained no documentation that any services had been rendered, 6 were mutually exclusive of other services already paid, and 4 were not covered by Medicare. Based on its statistical sample, OIG estimated the overpayments to be in excess of \$13 million.

The OIG recommended that the carrier, with HCFA's guidance, develop a monitoring plan to ensure the the State's future claims are brought into compliance with Medicare rules. The matter has been referred to DOJ. The State did not agree with OIG's findings. (CIN: A-09-98-00072)

Chiropractic Care: Comparison of Medicare Managed Care and Fee-for-Service Plans

Following an OIG report on the policies and practices for providing chiropractic services to Medicare beneficiaries in seven managed care organizations, HCFA requested that OIG conduct a national analysis of chiropractic utilization in managed care versus fee-for-service plans. Comparing data from 1996 through 1998, OIG found that chiropractic utilization in managed care plans was lower than in fee-for-service plans. Utilization was greater in managed care risk plans when direct access was allowed than when primary care physician referral was required, but it was still lower than in fee-for-service plans. In 1998, chiropractors performed over 91 percent of the chiropractic treatments in managed care risk plans and over 99 percent of the treatments under the fee-for-service program. The OIG also found that managed care risk plans did not use copayments to limit beneficiary access to chiropractic services. The HCFA concurred with OIG's findings. (OEI-04-97-00495)

Reimbursements to Hospital Outpatient Laboratories for Additional Hematology Indices

In a prior audit of hospital outpatient laboratory services, OIG found inappropriate Medicare payments for additional hematology indices that were separately billed along with hematology profiles. The HCFA agreed that these indices were not valid for reimbursement and removed the related procedure codes from the Medicare fee schedules effective January 1999. However, OIG's follow-up report noted that while the number of reimbursed indices had declined, payments remained significant from the time of the previous review to the date that the codes were eliminated from the fee schedules. Based on a random sample of claims, OIG estimated that Medicare's FIs overpaid providers by about \$14 million during this period.

The OIG recommended that HCFA direct the FIs to recover the overpayments. The HCFA concurred and indicated that it will ensure that the intermediaries begin appropriate recovery efforts. (CIN: A-01-99-00521)

Duplicate Payments for Medical Equipment and Supplies

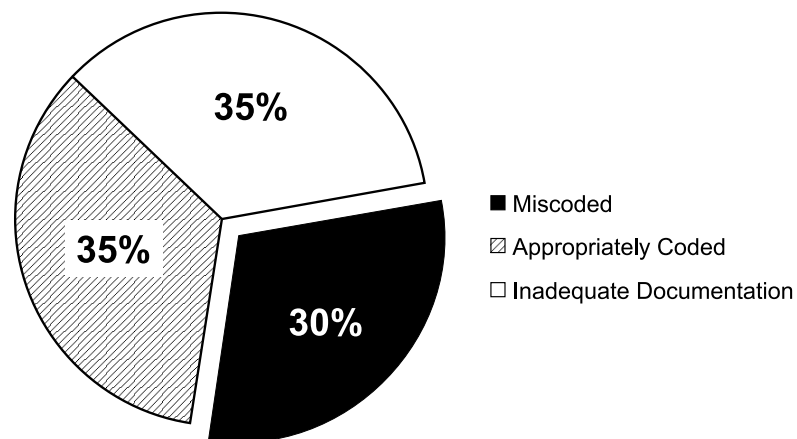
The OIG found that HCFA's payment process for equipment and supplies continues to be vulnerable to duplicate billing. Intermediaries do not know what supplies they are paying for because the coding system allows providers to submit claims for a wide variety of supplies using nondescriptive codes. In addition, only about 3 percent of home health providers are subjected to complete audits that would potentially reconcile supply claims. Moreover, CWF edits do not check for duplication of payments on most equipment and supplies. The OIG identified over \$530,000 in 1997 in such duplicate payments.

While the vulnerabilities involving supplies may be eliminated following the planned implementation of the home health prospective payment system, those involving equipment will continue unless further steps are taken. The OIG recommended that HCFA examine its payment, coding and editing practices to enable carriers and home health intermediaries to avoid duplicate payments and offered some specific suggestions to that end. (OEI-04-97-00460)

Medicare Payments for Orthotics

In this follow-up to a 1997 report on Medicare orthotics, OIG found that inappropriate Medicare reimbursement for orthotics continues at significant levels. Based on a random sample of 500 Medicare beneficiaries who had one or more orthotic claims in 1998, OIG determined that 30 percent had one or more miscoded orthotic devices, as illustrated below.

MEDICARE BENEFICIARIES USING ORTHOTICS: CODING REVIEW



The miscoded orthotics used by these beneficiaries represent over \$33 million in excessive Medicare payments when projected to the total Medicare population. This conservative estimate presumes that all beneficiaries for whom information was inadequate had appropriately coded orthotics. The OIG also found that qualifications of orthotic suppliers varied, with noncertified suppliers in the sample most likely to provide inappropriate devices.

The OIG presented options for HCFA 's consideration as the basis for action to improve Medicare billing for orthotic devices. Further, OIG recommended that HCFA require standards for suppliers of custom molded and custom fabricated orthotic devices to ensure that suppliers of these devices have the requisite skills and that the devices they supply are appropriate. (OEI-02-99-00120)

In a companion report, OIG reviewed policies and procedures at the four DME regional carriers (RCs) and obtained carrier perspectives. The OIG found that carriers still lacked policies for some groups of orthotics that represent a significant portion of all orthotic codes. All the carriers suggested strengthening the orthotics billing process with better documentation and improved coding, and all recommended developing standards for orthotic suppliers. The OIG suggested ways in which HCFA could work with the DMERCs to improve the billing process for orthotics and reiterated its call for supplier standards. The HCFA generally concurred with OIG's recommendations in both reports. (OEI-02-99-00121)

Medicare Losses Resulting from Early Payments for Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Medicare allowed approximately \$6.1 billion for DME, prosthetics, orthotics and supplies (DMEPOS) in 1998. For DMEPOS claims, expenses are incurred on the date the item is delivered to the beneficiary's home. This date is also known as the "date of service" and is the earliest date that a provider can submit a claim. For rental items, the day of delivery is the initial date of service for the monthly rental period, and subsequent rental periods start on that same day of the month.

The OIG determined that Medicare could have earned an additional \$7.2 million in interest on 1998 payments for DMEPOS claims that were billed before the end of the service period. A survey of seven other insurers disclosed that four of them do not pay for services before the service period is completed. To avoid losses to the Medicare trust fund in the form of unearned interest, OIG recommended that HCFA require providers to submit claims at the end of the service period, with accurate start and end dates of services, and require a common working file and/or contractor system edit to reject claims submitted prior to the end of the service period. The HCFA did not concur with the recommendations. (OEI-03-99-00620)

Blood Glucose Test Strips

Medicare covers home blood glucose monitors and test strips for beneficiaries who must periodically test their blood sugar levels as part of their diabetes management, regardless of insulin usage. Medicare allowances for test strips more than doubled between 1994 and 1997, increasing from about \$102 million to \$220 million, and allowances exceeded \$314 million in 1998. The OIG examined both the propriety of Medicare payments and marketing practices involving these products.

A. Inappropriate Medicare Payments

The OIG concluded that, in 1997, Medicare allowed \$79 million for blood glucose test strip claims with missing or flawed documentation. Orders for 25 percent of the sampled claims failed to establish beneficiaries' eligibility for the supplies. These claims represented \$33 million in allowances. An additional \$46 million of the \$79 million in test strip claims had incomplete orders or no supplier delivery records. Further, OIG found that suppliers submitted claims for test strips at irregular intervals; this can make it difficult to identify overlapping claims, claims without correct supporting documentation and claims for excessive numbers of test strips.

The OIG recommended several steps that could be taken to promote compliance with Medicare guidelines for blood glucose test strips. The HCFA concurred with OIG's recommendations. (OEI-03-98-00230)

B. Marketing to Medicare Beneficiaries

The OIG determined that some diabetic supply advertisements offer inducements to beneficiaries, some of which may be in violation of the anti-kickback statute. Also, the advertisements can be misleading, particularly with regard to deductibles and beneficiary coinsurance. The OIG also found that some suppliers did not always collect coinsurance from beneficiaries. In addition, many beneficiaries received test strips automatically in the mail, even after guidelines were issued prohibiting automatic shipping.

The OIG recommended that HCFA take several steps to increase supplier and beneficiary awareness of fraudulent and abusive practices relating to blood glucose test strips. The HCFA concurred with OIG's recommendations. (OEI-03-98-00231)

Fraud Involving Durable Medical Equipment Suppliers

The DME industry has consistently suffered from waves of fraudulent schemes in which Federal health care programs are billed for equipment never delivered, higher-cost equipment than that actually delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State from that billed in order to obtain higher reimbursement. During this reporting period, OIG obtained settlements and convictions of

unscrupulous DME suppliers for a variety of schemes as demonstrated by the following examples:

- In Texas, a corporation agreed to pay the Government \$10 million and entered into a comprehensive corporate integrity agreement to resolve its civil and administrative liabilities for misconduct on the part of two of its Florida subsidiaries. The corporate subsidiaries are mail-order pharmacies providing respiratory medications and diabetic supplies to Medicare beneficiaries nationwide. The agreement settles allegations that the parent corporation, through these subsidiaries, made, or caused to be made, improper payments to DME companies for the referral of Medicare beneficiaries and routinely waived coinsurance charges. An OIG investigation and audit showed that from 1990 to 1997, the subsidiaries made payments to numerous DME companies and individuals to induce the companies to refer patients to them for the purchase of supplies. The patients typically referred were patients whom the DME companies previously provided medical equipment and oxygen. During this same time period, both defendant corporations also routinely waived certain coinsurance amounts in connection with their sale of respiratory medication.
- Two men were sentenced in Texas for conspiracy to commit mail fraud and money laundering. The men formed a DME company that billed Medicare for orthotic body jackets not provided. The actual product provided was a vinyl-covered cushion manufactured in an automobile upholstery shop at a cost of \$45. One man, a real estate developer and the cofounder of an advertising agency, was placed on 5 years probation, fined \$20,050 and ordered to pay restitution toward the approximately \$1.4 million owed as a result of the scheme. The second man, an attorney, was placed on 5 years probation and ordered to pay the remainder of the restitution. The men were recruited to set up the DME company by a Texas dentist previously sentenced and ordered to pay restitution for his role in the DME fraud scheme.
- In Iowa, a former DME company owner was sentenced to 4 months in a halfway house and 2 years probation for making false, fictitious or fraudulent claims. He was also ordered to pay \$13,685 in restitution and a fine of \$20,100. The former DME company owner engaged in two schemes to defraud Medicaid. In one scheme, he submitted claims to, and received payment from, Medicaid after receiving full payment for the same equipment from a private insurer. In the second scheme, he solicited funds from charitable organizations after receiving full payment from Medicaid. In those instances, the man deceived the charitable organizations by

claiming services would not be rendered unless the charitable funds were provided. In many cases, the services had already been provided prior to deceiving the charities. In addition to the criminal case, a civil false claims proceeding is to follow.

- The sole owner of a DME company in Illinois was sentenced to 1 year incarceration, 2 years probation and a \$25,000 fine for mail fraud and filing false claims. The man was a respiratory therapist who worked at two different hospitals between 1994 and 1998. During that time, he contacted discharged patients and offered to supply them with home oxygen equipment from his company. While working at these hospitals, he also bid on equipment using bogus names of other companies to secure the lowest bid. Once he secured the bid, he sometimes supplied used equipment although he promised new. The hospitals at which the man worked were unaware of his DME company.
- A doctor from Puerto Rico was sentenced in Pennsylvania to 18 months incarceration, 2 years supervised probation and a \$5,000 fine for obstruction of justice (witness tampering). The doctor's conviction stemmed from an investigation into a DME fraud scheme involving sales representatives working in Puerto Rico for a Pennsylvania DME company. The sales representatives were convicted of mail fraud for changing orders for wound care surgical dressings which were then billed to Medicare. One of the sales representatives admitted to paying the doctor kickbacks for referring wound care patients for the company's surgical supplies. After denying to Federal agents that he received kickbacks for patient referrals, the doctor willfully attempted to coerce a witness to lie about paying him kickbacks.

Medicare Drug Reimbursement

Medicare does not pay for most over-the-counter or prescription drugs. However, Medicare Part B does cover certain drugs, including those necessary for the effective use of DME and some that are furnished by independent dialysis facilities. In earlier reports, OIG recommended that HCFA reexamine its Medicare drug reimbursement methodologies with the goal of reducing payments as appropriate.

A. Medicare Reimbursement of Albuterol

The OIG found that Medicare and its beneficiaries would save \$120 million yearly if albuterol were reimbursed at the rate available to Medicaid, or \$209 million yearly at the rate available to the Department of Veterans Affairs (VA). Even if Medicare reimbursement were set at the rates available at chain pharmacies or Internet pharmacies, Medicare and its beneficiaries would realize sizable savings: \$47 million or \$115 million, respectively.

Price differences and potential savings are illustrated below.

COMPARISON OF ALBUTEROL PRICES

| Pricing Source | Price per Milligram | Cost of Typical Individual Monthly Usage (250 milligrams) | Monthly Beneficiary Copayment Based on Source Price | Potential Annual Medicare and Beneficiary Savings |
|--|----------------------------|--|--|--|
| Medicare Reimbursement Amount | \$0.47 | \$117.50 | \$23.50 | N/A |
| Department of Veterans Affairs Median Cost | \$0.07 | \$17.50 | \$3.50 | \$209,478,193 |
| Medicaid Upper Limit Amount | \$0.24 | \$60.00 | \$12.00 | \$120,449,961 |
| Chain Pharmacy Median Price | \$0.38 | \$95.00 | \$19.00 | \$47,132,593 |
| Internet Pharmacy Median Price | \$0.25 | \$62.50 | \$12.50 | \$115,213,006 |

This report adds to the evidence showing that Medicare pays too much for albuterol. Recognizing that HCFA's ability to lower drug prices through the use of its inherent reasonableness authority was recently limited by the Balanced Budget Refinement Act of 1999, OIG reiterated a number of other options for lowering unreasonable albuterol payments. The HCFA concurred with OIG's recommendations. (OEI-03-00-00311)

B. Medicare Reimbursement of End Stage Renal Disease Drugs

The OIG determined that Medicare allowed amounts would be nearly halved for five ESRD drugs if amounts were based on VA acquisition costs. Further, OIG found that Medicare would save between 5 and 38 percent for five ESRD drugs if its allowed amounts were equal to Medicaid reimbursement rates including rebates.

If the percentage savings calculated for each drug were applied to the amount billed for the drugs, OIG estimated Medicare could have saved up to \$42 million in 1998 if reimbursement had been set at Medicaid amounts and up to \$162 million if reimbursement had been set at VA acquisition costs. Again, OIG offered options for HCFA's use in lowering current Medicare reimbursement rates for these ESRD drugs. The HCFA concurred with OIG's recommendations. (OEI-03-00-00020)

Transportation Fraud

Common Medicare and Medicaid fraud schemes associated with transportation and ambulance companies involve the submission of claims for transporting patients to a hospital when the patients are really taken to other facilities for which claims are nonreimbursable. Other schemes include billing singly for patients who were transported as

a group and falsely claiming reimbursement for ambulatory patients. The following examples of cases involving transportation fraud were resolved during this reporting period:

- An ambulance company agreed to pay the Government \$5.4 million to resolve various False Claims Act violations alleged in a qui tam suit filed in Missouri. The ambulance company is a nonprofit entity owned by two hospital systems also named in the suit. Of the improper practices alleged in the suit, the investigation corroborated the relators allegation that the company and its president engaged in a ticket managing scheme to ensure Medicare coverage. Through this scheme, the company billed for medically unnecessary ambulance trips and for noncovered ambulance trips to doctors' offices by altering or forging ambulance trip tickets. The company had its ambulance technicians or its billing personnel falsify, alter or forge Missouri Ambulance Reporting Forms to indicate that the trips were to hospitals and that the patients were not ambulatory. As part of the settlement, the company also agreed to a 5-year comprehensive corporate integrity agreement.
- An Arizona ambulance company agreed to pay the Government \$1.1 million to resolve allegations that the company provided medically unnecessary ambulance trips. The company obtained a county contract in which it agreed to provide stretcher van services for free; but when the county called the company for a stretcher van, the company would instead send an ambulance and bill Medicare for the service. As part of the settlement, the company agreed to withdraw over 1,200 claims on appeal, to drop all pending administrative proceedings and to enter into a 5-year corporate integrity agreement with OIG. The owners and operators of the ambulance company also resolved criminal charges related to this case.
- A Medicaid recipient was sentenced for his role in defrauding the Maine Medicaid program and the Social Security Administration. The man was sentenced to 5 years probation, payment of \$44,276 in restitution and ordered to receive mental health treatment. He submitted false claims to Medicaid for transportation reimbursement; a review of the transportation claims submitted revealed numerous instances where he falsely claimed to have seen a medical provider and submitted a claim for mileage reimbursement.
- An Illinois medical transportation company and its sole owner agreed to repay the Medicaid program \$35,000 and to be permanently excluded from Federal health care programs for allegedly submitting false claims to the Illinois Medicaid program. An OIG investigation and an audit by the Illinois

Department of Public Aid (IDPA) revealed that the transportation company was not keeping the transportation and medical records required to support its requests for reimbursement. In addition, the IDPA discovered that the company was claiming mileage in excess of the distances patients were actually transported.

Medicaid Program Safeguards

Performance Measure

In these three related inspection reports, OIG catalogued Medicaid program safeguards and identified opportunities for improvement of Medicaid safeguard measures. One report dealt with State proactive safeguards that anticipate problems and attempt to thwart, or ward off, wrongdoers before a patient receives services and before a claim for services is generated for payment. Another catalogued claims processing safeguards that help ensure that claims submitted for payment are properly adjudicated. The final report discussed postpayment safeguards that help ensure that paid claims have been properly processed and adjudicated. The OIG's intention in issuing these reports was that States use this information to evaluate their Medicaid safeguards and, where appropriate, strengthen them using techniques tried by other States. The HCFA plans to share these reports with the State Medicaid programs. (OEI-05-99-00070; OEI-05-99-00071; OEI-05-99-00072)

Federal and State Partnership: Joint Audits of Medicaid

One of OIG's major initiatives has been to work more closely with State auditors in reviewing the Medicaid program; the Partnership Plan was developed to foster these joint review efforts and provide broader coverage of the Medicaid program. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors. To date, partnerships have been developed in 23 States. Extensive sharing of audit ideas, approaches and objectives has taken place between Federal and State auditors. Completed reports have resulted in identifying potential program savings of \$187.7 million, of which over \$39 million in Federal and State overpayments has been recovered. During this reporting period, the following joint audits were completed:

A. Ohio

Ohio State auditors determined that from January 1, 1994 through September 30, 1999, the State paid \$82 million for services to Medicaid recipients after the recipients' dates of death. This consisted of 114,780 payments to 4,113 different providers for services rendered to 26,822 deceased recipients. Although the State was recovering payments for these services, \$14 million (\$8.5 million Federal share) remained outstanding as of September 30, 1999.

The State auditors recommended that the State ensure that county Departments of Human Services comply with procedures to accurately enter death notices into the computerized recipient master file within 10 days of the information being reported by nursing homes and

other reliable sources; recover outstanding overpayments, where feasible and cost effective; establish a computer link with the State's vital statistics file to periodically update the Medicaid recipient master file; and propose legislation giving the State authority to develop and apply sanctions against providers that do not report a recipient's death in a timely manner or that bill for or retain unearned reimbursements, including reimbursements for services after a recipient's date of death. The State generally agreed with the recommendations. (CIN: A-05-00-00045)

B. Montana

A partnership report was issued on Montana's third party liability program. The State auditors found that the Montana Medicaid management information system properly denied payment for medical services that were the responsibility of a third party and appropriately denied duplicate claims that were submitted for the same services, thus ensuring that Medicaid was the payer of last resort. However, the auditors also found that the State had not established policies to ensure compliance with State law requiring recording and collection of third party "pay and chase" receivables (established when Medicaid payments are authorized even though reimbursement from a third party is likely).

The State auditors recommended that the State establish policies to ensure compliance with statute requiring the recording of receivables and disposition of uncollectible revenue, require the State's contractor to develop formal procedures to ensure that second bills to third parties are sent in a timely manner, and complete an analysis of the recovery of Medicaid dollars to determine if the process maximizes collection efforts. The State concurred with the recommendations. (CIN: A-07-00-01302)

Medicaid Fraud

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

The Inspector General is delegated the authority to annually certify each MFCU as eligible to receive Federal grant funds under the Medicaid fraud control program. The MFCUs receive 90 percent Federal funding for the first 3 years of operation and 75 percent thereafter. During FY 2000, OIG provided oversight and administered approximately \$95.1 million in funds granted by HCFA to the MFCUs to facilitate their mission.

Since the inception of the Medicaid fraud control program, the MFCUs have successfully convicted thousands of Medicaid providers and have recovered hundreds of millions of

program dollars. Although most Medicaid fraud cases are investigated by the MFCUs, OIG works with the units and/or other law enforcement agencies on such cases as well. The following instances of OIG's successful efforts in Medicaid fraud cases bear noting:

- A publicly traded pharmacy benefit management (PBM) company agreed to pay \$2 million to the United States to settle allegations that it committed fraud against the Medicaid program. This is the first False Claims Act settlement that involved PBM misconduct in health care programs. In 1993, the State of Tennessee obtained a waiver to pursue its own Medicaid program, which it named TennCare. It contracted with a dozen managed care organizations (MCOs) to provide health care to all TennCare beneficiaries. A for-profit PBM contracted with a corporate predecessor to provide PBM services to the TennCare MCOs. The corporate predecessor paid kickbacks to officers of the for-profit PBM to secure the PBM contract. In addition, the corporate predecessor diverted TennCare funds that were intended to pay for pharmacy benefits and used those funds to personally benefit its officers and as kickbacks to certain officers of the for-profit organization. As part of the settlement agreement, the PBM agreed to enter into a 5-year corporate integrity agreement.
- In Illinois, a recently retired psychiatrist agreed to pay the Government \$194,766 to settle allegations of submitting improper claims to Medicaid. The psychiatrist treated patients in area nursing homes. Between January 1993 and May 1998, he billed his services using a procedure code for a 50-minute visit when he actually spent an average of 2 to 3 minutes with these patients.
- An Illinois man was sentenced to 6 months home confinement and 5 years probation for mail fraud. In 1994, he was convicted of committing vendor fraud against the Illinois Department of Public Aid (IDPA). As a result of this conviction, OIG sanctioned him for a 5-year period from 1996 to 2001. In order to continue submitting claims for payment to the IDPA during that period, the man executed a scheme to run his medical transportation business in the name of an unsanctioned individual. He gave the individual 10 percent of the profits as payment for using his name.

**Public Health Service
Operating Divisions**

Chapter II

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

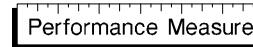
Overview of Program Area and Office of Inspector General Activities

The activities conducted and supported by the Public Health Service (PHS) operating divisions (OPDIVs) represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. These independent OPDIVs within the Department include: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed food, 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, and 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 Healthcare Research and Quality (AHRQ), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), to assist States in refining and expanding treatment and prevention services.

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

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

Protecting Human Research Subjects



In June 1998, OIG released a series of reports on the Federal system for human subject protections that center on institutional review boards (IRBs). At that time, OIG warned that the effectiveness of IRBs was in jeopardy. The IRBs were overwhelmed by their workloads and lacked the necessary resources to keep up. They were being pressured to do more in a shorter time frame and with limited information on many trials. Of particular significance, they conducted very little oversight of clinical trials once the trials began. Further, OIG found that Federal oversight of protections was limited, leaving the Department with little sense of how well IRBs were performing. These findings led OIG to present numerous recommendations to NIH, its Office for Protection from Research Risks (OPRR) and FDA. During this reporting period, OIG issued a number of reports involving this issue.

A. Status of Recommendations

The OIG conducted a follow-up study to determine how fully its earlier recommendations had been implemented. While the Department has taken several promising steps to strengthen subject protections, OIG determined that, overall, few of its recommended reforms have been enacted. There has been minimal progress in granting IRBs greater flexibility and holding them more accountable, or in strengthening continuing protections for human subjects participating in research. No educational requirements have been enacted for investigators or IRB members, and there has been no movement towards insulating IRBs from conflicts that can compromise their mission. Little has been done to moderate IRBs' workload pressures or to reengineer the Federal oversight process.

Many of OIG's recommendations call for changes in the Common Rule, a policy on human subject protections adhered to by HHS and 16 other agencies; any changes to the Rule call for the concurrence of all 17 agencies. The OIG acknowledges that this requirement inhibits a prompt and effective Department response, and recognizes that legislative change may be necessary to achieve a timely implementation of many of its recommendations.

The problems identified by OIG's work in this area call for action on a broad front, involving not only IRBs, but also other parties in the clinical research process, including sponsors and investigators. The Department has a significant new opportunity to exert Federal leadership in protecting human subjects with the move of OPRR to the Office of the Secretary and the establishment of a new advisory committee on subject protection issues. The OIG urges that the new office, the Office of Human Research Protections, give significant attention to OIG's earlier recommendations and those that are forthcoming from the National Bioethics Advisory Commission. Both NIH and FDA have established a series of on-going outreach and educational initiatives and programs. (OEI-01-97-00197)

On June 5, 2000, the NIH announced a major initiative requiring investigators involved in human subject research to be educated in the protection of human subjects. Investigators must comply prior to funding. On the same day, the NIH announced that investigators submitting an application to the NIH for support of phase I or II clinical trials must provide a monitoring plan for these trials. The plans are subject to the approval of the NIH component providing the funding. Additionally, the NIH has conducted 10 site visits of grantee organizations to assess their understanding and compliance with various NIH policies, including data and safety monitoring, and conflict-of-interest strictures.

B. Recruiting Human Subjects

Recent changes in the research environment are causing sponsors of clinical research to vie more aggressively to be the first to bring their products to market, and are causing sites and investigators to compete more intensely for research contracts. For this review, OIG reviewed industry-sponsored clinical trials. The OIG found that there is significant pressure for research investigators to recruit subjects quickly, and that some of the methods used by sponsors and investigators raise concerns about informed consent, patient confidentiality and eligibility for enrollment that are troubling to IRBs and others involved in clinical research. Further, OIG determined that oversight of the recruitment of human subjects is minimal and largely unresponsive to emerging concerns.

The OIG recommended that FDA, NIH and OPRR provide IRBs with direction regarding oversight of recruitment practices; facilitate the development of guidelines for all parties on appropriate recruiting practices; ensure that IRBs and investigators are adequately educated about human subject protections; and strengthen Federal oversight of IRBs. The Department has made a commitment to establish education requirements and to work with outside parties in developing consensus about appropriate recruitment practices. (OEI-01-97-00195)

In a related report, OIG presented other sources of guidance for IRBs and investigators. The report focused on guidance provided by IRBs, medical associations and by Canada's research community on recruitment practices not covered in HHS guidelines. (OEI-01-97-00196)

C. Food and Drug Administration's Oversight of Clinical Investigators

Companies develop new drugs, biologics and medical devices with the assistance of clinical investigators. Sponsors, IRBs and FDA all oversee clinical investigators' research. Reviews by FDA have identified serious problems with sponsors' monitoring of clinical investigators and OIG studies have found problems with IRB oversight. In this review, OIG examined FDA's selection of clinical investigators for review and FDA's discipline of those clinical investigators found in violation of FDA regulations.

The FDA's bioresearch monitoring program inspects clinical investigators involved in clinical research to ensure the quality and integrity of data submitted to the agency and to protect the rights and welfare of human subjects; in most cases, these inspections occur after clinical work is completed. In FY 1999, FDA inspected only 468 clinical investigators out of nearly 14,000 clinical investigators potentially involved in clinical trials. Although respondents indicated that program goals are ensuring data integrity and protecting human subjects, OIG found that FDA's monitoring of clinical investigators is more directly focused on verifying data, thus limiting overall oversight.

In addition, OIG concluded that the bioresearch monitoring program lacks clear and specific guidelines. While regulations state that a clinical investigator may be disqualified for repeatedly or deliberately failing to comply with regulations, at the time of this inspection there was no required review of complaints or clinical investigator inspection histories as part of the clinical investigator selection process. There is little staff training on how to select clinical investigators or how to assess what action to take when violations are found. Moreover, there are no agencywide program measures for the bioresearch monitoring program. The OIG recommended that FDA define cross-center goals for the bioresearch monitoring program and develop criteria to determine whether the program is achieving those goals. Further, FDA should develop internal guidance on the thresholds that violations must meet to justify disqualifying a clinical investigator from receiving investigational products. (OEI-05-99-00350)

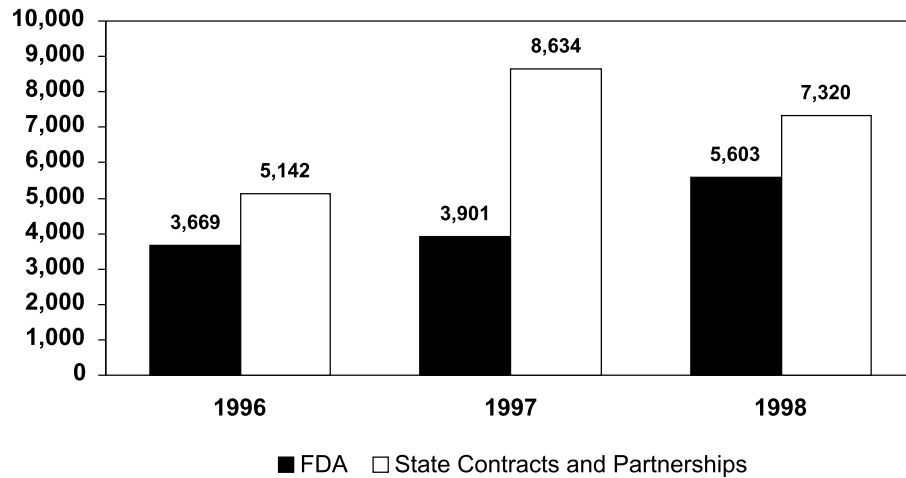
Food and Drug Administration Oversight of State Food Firm Inspections

Performance Measure

One of FDA's primary roles in food safety is to inspect the conditions under which food is manufactured, processed, packed and stored. Over the past 25 years, FDA has extended its inspection coverage by utilizing the resources and expertise in the States to fulfill its responsibility. For many years, FDA relied on contract arrangements, through which it paid the States to conduct inspections in accordance with Federal regulations. More recently, FDA has initiated partnership agreements with a number of States, under which the States agree to conduct inspections under their own authorities, without Federal funding, and to share the results with FDA.

The OIG found that FDA relies heavily on State food firm inspections. As illustrated on the next page, States inspect a greater number of food firms than FDA.

FDA VERSUS STATE FOOD FIRM INSPECTIONS



The OIG concluded that FDA's current oversight of both the contracts and partnership agreements is insufficient to assure the quality of State inspections carried out on its behalf. Based on a template of effective oversight, OIG offered numerous recommendations which apply to both the contracts and the partnership agreements. The OIG emphasized the need for FDA to strengthen its system of onsite audits and to develop meaningful channels to provide States with useful feedback on their performance. The OIG also proposed that FDA enhance its own internal capacities to conduct effective oversight, such as by training FDA investigators in both inspector and audit functions. As a longer term objective, OIG proposed that FDA work with the States to achieve basic equivalency in food safety standards and laws, and in inspection programs and practices. In general, FDA agreed with OIG's recommendations. (OEI-01-98-00400)

Maternal and Child Health Training Grants: LEND Program

Performance Measure

The Interdisciplinary Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disabilities (LEND) is a training grant program which seeks to achieve its mission through funding of graduate level, interdisciplinary training designed to produce professionals to work with special needs children.

The OIG found that the LEND program does produce leaders in interdisciplinary treatment of children with developmental disabilities and plays an important role in helping to support university clinics serving special needs children. However, grantees have mixed success in tracking the program's graduates and in demonstrating that these graduates have assumed leadership roles. Further, oversight of the grantees by HRSA's Maternal and Child Health Bureau (MCHB) is minimal.

The OIG recommended that MCHB develop outcome measures for determining the success of the LEND program; work with its grantees to develop more effective tracking of LEND graduates; use onsite visits to aid in program oversight and in making funding decisions; and clearly distinguish between categories of funding. The HRSA concurred with OIG's recommendations. (OEI-04-98-00090)

Health Professions Student Loans Program

Performance Measure

Under HRSA's Health Professions Student Loans Program, participating schools are required to assess the collectibility of any loan that is more than 3 years past due. If a school determines that a loan is uncollectible or if the 10-year repayment period has expired, the school should either request HRSA's permission to write off the loan within 30 days or reimburse HRSA for the full amount of the uncollectible loan balance, plus interest and penalty charges.

Of the 10 schools OIG audited, 8 were carrying uncollectible loans totaling over \$565,000 in their accounting records. These schools did not assess the collectibility of their loans on a regular basis, and 5 of them did not have a mechanism to identify loans that were about to exceed the 10-year repayment period. The OIG recommended that HRSA reemphasize program requirements to participating schools. The HRSA concurred and stated that it would take action to implement the recommendations. (CIN: A-05-99-00017).

Exclusions for Health Education Assistance Loan Defaults

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

After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Once the individual has been declared in default, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid and all Federal health care programs for nonpayment of these loans. During this 6-month period, 303 individuals were excluded as a result of PSC referral of their cases to OIG.

Individuals who have been excluded as a result of their default may enter into settlement agreements whereby the exclusion is stayed while they pay specified amounts each month to satisfy their debt. If they default on these settlement agreements, they can then be excluded until their entire debt is repaid, and they cannot appeal these exclusions. Some health professionals, upon being notified of their exclusion, immediately repay their HEAL debt.

After being excluded for nonpayment of their HEAL debts, a total of 1,328 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debt. This figure includes the 117 individuals who have entered into such a settlement agreement or completely repaid their debt during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals over \$89.5 million. Of that amount, \$7.6 million is attributable to this reporting period. The following are examples of some of these settlements:

- After being notified that he was excluded from participation in Medicare, Medicaid and all Federal health care programs because he failed to repay his HEAL debt, a New York dentist entered into a settlement agreement to repay more than \$303,000 in student loans.
- In order to repay his HEAL debt, a Florida osteopathic physician entered into a settlement and agreed to pay \$186,000.
- In New Jersey, a settlement agreement was signed by a podiatrist to repay her \$158,000 HEAL debt.
- A Virginia podiatrist entered into a settlement agreement to repay her \$123,000 HEAL debt.
- Also in Virginia, a dentist agreed to repay her HEAL debt of more than \$120,000.

Mashantucket Pequot Tribal Nation's Use of Federal Discount Drug Programs

The Mashantucket Pequot Tribal Nation is a federally recognized tribe that operates various commercial enterprises, including a casino and the Pequot Pharmaceutical Network. In 1996, the nation contracted with the Secretary of HHS to manage the health care programs, previously administered by IHS, that benefit its members and other eligible recipients. The OIG initiated this review to determine whether the nation followed Federal requirements for using the Public Health Service (PHS) 340B discount drug program administered by HRSA and the Federal Supply Schedule (FSS) discount drug program administered by the Department of Veterans Affairs (VA).

The OIG found that in FYs 1998 and 1999, the nation dispensed to its ineligible non-Indian employees \$5.8 million worth of drugs that were acquired through the two Federal discount drug programs. The OIG also found that the nation did not follow guidelines that require entities to identify their 340B drug purchases and noted that the unauthorized use of discount drug programs by the nation and other tribes could result in their having to

reimburse manufacturers for the differences in cost. The OIG recommended that IHS and HRSA instruct the nation to determine the extent that drugs dispensed to ineligible employees in FYs 1998 and 1999 were acquired through the PHS 340B program, maintain records of the drugs purchased through this program in the future, and follow HRSA guidelines that apply to contract pharmacies. Both IHS and HRSA agreed with the recommendations. (CIN: A-01-99-01502)

Indian Health Service Funds for the Cherokee Nation

In response to congressional concerns about possible improper transfers of IHS funds, OIG reviewed those funds made available to the Cherokee Nation in FY 1997 through a compact. The OIG's audit revealed that compact fund receipts and expenditures were accurately reported in the Cherokee Nation's FY 1997 Comprehensive Annual Financial Report, which contained financial statements prepared in conformance with generally accepted accounting principles. During the year, however, the nation made 25 improper transfers of compact funds totaling more than \$21 million to cover deficits in its operating fund. The nation returned all of these IHS funds by the end of FY 1998.

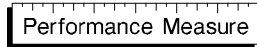
As a result of OIG's review, the Cherokee Nation issued a policy statement establishing procedures to preclude transfers of compact funds to the general operating fund. To ensure that future expenditures charged or allocated to the compact meet applicable Federal laws and guidelines, OIG made several recommendations to the nation on ways to further improve its control procedures. For the most part, the nation disagreed with the recommendations. (CIN: A-06-99-00011)

Indian Health Service Equal Employment Opportunity Complaints Process: A Management Review

At the request of the director of the Indian Health Service (IHS), OIG conducted a management review of the IHS Equal Employment Opportunity (EEO) complaint process. The OIG found that the IHS faces unique conditions that affect its EEO program. Health care professionals and support staff from native populations, Commissioned Corps officers and others work together to serve Indian health care needs. The OIG determined that laws governing the rights of tribes and Indians sometimes create misconceptions regarding the rights and responsibilities among these groups. Also, OIG found that IHS is inconsistent in handling its EEO processes. The IHS EEO program lacks direction, potentially weakening its effectiveness, and IHS employees distrust the process.

The OIG recommended that IHS undertake a series of steps to address these problems. Also, OIG proposed that the Assistant Secretary for Management and Budget (ASMB) follow up on IHS' progress and review this program periodically. The ASMB agreed to do so. (OEI-05-99-00290)

National Institutes of Health National Research Service Awards



By legislation, certain National Research Service Award (NRSA) recipients are required to pay back the Federal Government by engaging in health-related biomedical or behavioral research, teaching, or a combination of these activities. If such a recipient fails to perform the service, the Government is entitled to recover financial debts. However, OIG's review revealed that NIH had not maintained a complete and accurate database to adequately monitor the current payback status of over 4,100 NRSA recipients. Problems occurred because NIH components did not always follow established policies and procedures for maintaining the database and because NIH's automated system did not always perform the functions needed to update the database when new information was entered.

The OIG offered several corrective actions, including a recommendation that NIH consider centralizing the responsibility for maintaining the database and ultimately ensuring that NRSA recipients fulfill their payback requirements. Concurring with all recommendations, NIH indicated that it had taken steps to establish procedures on maintaining and processing recipient records. Additionally, NIH is planning to centralize, under a single unit, the responsibility for ensuring that NRSA recipients fulfill their payback requirements. (CIN: A-15-99-80002)

Misuse of Grant Funds

Resolution of charges of misusing Department of Health and Human Services grant funds occurred in the following cases:

- A Pennsylvania university entered into a global settlement with the Government, agreeing to pay \$2.6 million to resolve allegations raised in two separate investigations. The university allegedly made false statements and submitted false claims to the NIH in order to obtain Federal funds related to AIDS and cancer research. In the first investigation, the university agreed to pay \$450,000 to settle allegations of using false and/or fabricated research data to apply for funding for gene therapy research to combat HIV. In the second investigation, the university agreed to pay \$2.15 million to settle allegations of submitting false statements and false claims related to cancer research. The second investigation substantiated two major allegations: one, the individual reported to NIH as the cancer study's principal investigator, actually spent the majority of the grant period overseas working for another university; and two, the university improperly charged salaries for post doctorate fellows not involved in the grant research, to the grants. As part of the settlement, the university must also do the following: enter into a 3-year institutional integrity agreement to ensure compliance with all Federal laws and regulations pertaining to Federal grant

funds; request that various scientific journals publish further corrections to previous scientific papers reporting gene therapy research findings; and work closely with NIH representatives to develop and implement corrective actions to improve the university's administrative and grants management systems and practices.

- The OIG audited an NIH grantee's cash withdrawals from the Department's Payment Management System to assess the validity of allegations of misuse of Federal funds made to the U.S. Attorney's Office. The OIG found that, contrary to HHS guidance provided to grant recipients, the grantee withdrew from the Payment Management System about \$4.2 million more than needed and carried forward cost overruns from one grant period to another on seven of its grant awards. The Payment Management System and NIH could not detect these actions because the grantee submitted false reports and statements to the Federal Government.

As a result of these improper practices, the grantee agreed to pay the Federal Government \$4 million to settle its civil liability. As part of the settlement, the grantee signed an integrity agreement with OIG stating that it would establish a compliance program, retain an independent auditor to perform comprehensive annual audits, and provide specific types of training and education to its employees. Further, NIH has designated the grantee as a high-risk organization requiring closer monitoring to ensure compliance with Federal funding requirements.

Financial Capability of Potential Grantees

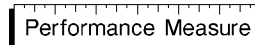
At CDC's request, OIG performed financial capability audits of 17 potential grantees, most of whom had little or no experience managing Federal funds. Pursuant to its HIV prevention efforts, CDC funds community-based organizations to develop, implement, and evaluate state-of-the-art model HIV prevention programs for at-risk racial and ethnic minority populations. The organizations reviewed by OIG applied for annual grant awards of up to \$225,000 each. Total funding for the 17 organizations over the 4-year project period could total over \$15 million.

The OIG's audits assessed the adequacy of the organizations' accounting and administrative systems and their financial capabilities to satisfactorily manage and account for Federal funds. The results provided CDC management with the information needed to strengthen oversight of new grantees.

Superfund Financial Activities at the National Institute of Environmental Health Sciences

The National Institute of Environmental Health Sciences (NIEHS) receives funds through an interagency agreement with the Environmental Protection Agency to carry out health-related and other functions mandated by the Superfund legislation. As required by statute, OIG audited Superfund financial activities at NIEHS. During FY 1998, its obligations of Superfund resources totaled about \$61.2 million, and disbursements totaled about \$55.8 million of the funds obligated during and prior to the same fiscal year. The OIG concluded that NIEHS administered the fund according to the Superfund legislation. (CIN: A-04-99-04227)

Fiscal Year 1999 Financial Statement Audits



In support of its audit of the consolidated HHS-wide financial statements for FY 1999, OIG audited, through contracts with independent public accounting firms, the financial statements of the major PHS operating divisions. Improvements were noted at many of the OPDIVs since the previous year. Officials are taking corrective action on most of the recommendations.

A. Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry

The accounting firm issued an unqualified opinion on the CDC and ATSDR FY 1999 financial statements and noted no material weaknesses in the system of internal controls. (CIN: A-17-99-00013)

B. Food and Drug Administration

The FDA received an unqualified opinion on the FY 1999 financial statements, with no material weaknesses noted in the system of internal controls. (CIN: A-17-99-00011)

C. Health Resources and Services Administration

The HRSA received an unqualified opinion on the FY 1999 financial statements, with one material weakness noted for lacking an integrated financial reporting system. (CIN: A-17-99-00005)

D. National Institutes of Health

The accounting firm issued an unqualified opinion on the NIH FY 1999 financial statements, with one material weakness noted for lacking an integrated financial system. (CIN: A-17-99-00012)

E. Substance Abuse and Mental Health Services Administration

The SAMHSA received an unqualified opinion on the FY 1999 financial statements, with one material weakness noted for lacking an integrated financial reporting system. (CIN: A-17-99-00004)

Federal Occupational Health Billing Operations

Performance Measure

The HRSA's Federal Occupational Health (FOH) office provides occupational health services to approximately 160 Federal agencies through interagency agreements. The OIG contracted with an independent public accounting firm to perform agreed-upon procedures to assist FOH in evaluating the billing operations in place during FY 1999. The firm noted minor exceptions in billing operations and made recommendations for improvements. (CIN: A-17-99-00020)

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

Chapter III

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. Some of the major programs include: Temporary Assistance for Needy Families (TANF), Child Support Enforcement (CSE), Foster Care, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant program.

With respect to TANF, 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 a number of 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 programs among the Federal, 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. Socially and economically disadvantaged elderly and low-income minority elderly are targeted for assistance, including supportive services, nutrition services, education and training, low-cost transportation and health promotion. The OIG has reported opportunities for program improvements to target the neediest for services; expand available financial resources; upgrade data collection and reporting; and enhance program oversight.

Paternal Establishment

Performance Measure

Federal regulation requires States to design administrative processes for paternity establishment in an effort to remove the disposition of many paternity actions from the

traditional court-based adjudication approach. The Office of Child Support Enforcement (OCSE) has provided both guidance and funding specifically related to expediting paternity establishment procedures, and States have worked to streamline their court processes and to make available fully administrative methods of establishing paternity.

A. Administrative and Judicial Methods

The OIG found that, despite Federal encouragement and inherent advantages to using administrative methods, many States still had a fairly significant court involvement in their paternity establishment practices. Although all States utilized elements of both approaches, they were evenly divided between those using primarily administrative and primarily judicial methods. Child support staff perceived advantages and disadvantages in the two methods and identified several specific problem areas.

The OIG recommended that OCSE assist States in sharing effective practices for notifying putative fathers; encourage States to strengthen child support agency authority and capability, enabling them to establish paternity without the courts when practical; provide technical assistance to States aimed at streamlining and rationalizing their paternity establishment methods, administrative or judicial; and encourage States to further explore the usefulness of combining separate child support functions, including paternity establishment, into a single process. The ACF generally agreed with OIG's recommendations. (OEI-06-98-00050)

B. Voluntary Paternity Acknowledgments

Voluntary paternity acknowledgments potentially reduce staff time and effort needed to establish paternity and may also result in an increased number of paternities established. In reviewing State use of this process, OIG found that all States had created acknowledgment forms that were largely uncomplicated and easy to read, and all conducted some form of outreach to increase parent awareness and understanding. However, only 18 States had implemented all the primary Federal provisions regarding acknowledgment, including use of voluntary acknowledgment as binding paternity establishment, a 60-day administrative rescission period and creation of a statewide database of acknowledgments. Most States had rescission procedures, but some rescissions may have been occurring informally, and use of both administrative and judicial rescission methods appeared erratic. Despite the many advantages of voluntary acknowledgment, some child support staff reported favoring other administrative and judicial methods which they perceived as less likely to be overturned.

The OIG recommended that OCSE encourage State child support agencies to clarify for the courts the legal standing of acknowledgments as conclusive findings of paternity; assist States in training local child support staff in the use of acknowledgments; provide guidelines for States regarding circumstances which may constitute fraud, duress or material mistake of fact, to reduce the number of acknowledgments overturned; and encourage child support and vital records agencies to develop uniform statewide rescission procedures, including methods

for notifying all interested parties. The ACF agreed with OIG's recommendations. (OEI-06-98-00053)

Establishment of Child Support Orders for Low-Income Noncustodial Parents

In two related inspection reports, OIG examined the establishment of child support orders for low-income noncustodial parents. The OIG found that the methods used to determine financial obligations for low-income obligors often yielded poor payment compliance results. The OIG suggested that OCSE work with the States to emphasize parental responsibility and improve the ability of low-income noncustodial parents to meet their obligations. This would require a dual approach of setting realistic support obligations and providing employment support with work requirements. Specifically, OIG recommended that OCSE facilitate and support State experiments in the use of retroactive charges and debt negotiation, and encourage States to decrease income imputation and strengthen job programs. The ACF and the Assistant Secretary for Planning and Evaluation concurred with OIG's findings and suggested approaches. (OEI-05-99-00390; OEI-05-99-00391)

Client Cooperation with Child Support Enforcement

Performance Measure

Federal law requires TANF clients to cooperate with State child support enforcement by providing information about noncustodial parents and appearing for appointments as needed. State child support agencies are required to determine if clients are cooperating in good faith and notify the public assistance agency of each client's cooperation status. If the child support agency determines that a client has not cooperated, the public assistance agency must reduce the family's cash assistance by at least 25 percent and, at State discretion, may deny the family all cash assistance. The OIG issued a series of reports on how States gain TANF client cooperation.

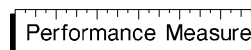
In a review in six States, OIG determined that all had implemented client cooperation policies in keeping with the Federal mandates. Staff in both the public assistance and child support agencies appeared to value client cooperation, and attempted to implement State policy in flexible and client-focused ways. Although most TANF clients were found to cooperate readily, some proved difficult; in response, staff typically provided multiple opportunities for clients to give information and to make appointment deadlines, and appeared concerned about legitimate barriers to cooperation. (OEI-06-98-00040)

Three companion reports were also issued. In one, OIG examined why some clients did not cooperate and how States attempted to gain their cooperation. Another report discussed the responsibilities of public assistance agencies and collaboration between agencies. A fourth report described how clients may be exempted from cooperation requirements under certain

circumstances, especially when enforcement might put the child at risk of violence. (OEI-06-98-00041; OEI-06-98-00042; OEI-06-98-00043)

Related to these studies, OIG issued a separate report on cooperation from custodial parents who receive Medicaid coverage only. The OIG found that the proportion of Medicaid-only clients in the workload of child support and public assistance offices is increasing and that many workers and clients do not understand that Medicaid clients are obligated to cooperate with child support enforcement efforts. In addition, OIG found that sanctions often are not applied when Medicaid-only clients fail to cooperate. The OIG submitted its findings to ACF for consideration along with the findings and recommendations of the Secretary's Medical Child Support Working Group. While OIG concluded that further study is necessary before developing specific corrective action, it did suggest that encouraging Medicaid-only client cooperation appears to depend primarily on ensuring staff and client understanding and promoting use of appropriate sanctions. (OEI-06-98-00045)

Medical Insurance for Dependents Receiving Child Support



The OIG found that considerable progress has been made by child support agencies in the identification and enforcement of medical support as compared to outcomes from its previous work in this area. Ninety-three percent of the child support orders reviewed included a provision requiring medical coverage for the dependent children compared to 24 percent in OIG's previous study. Undetected available medical insurance dropped from \$32 million to \$5.2 million.

However, OIG determined that weaknesses still exist in the detection of health insurance availability and enrollment of the dependents. Also, managed care premiums present a new challenge in the enforcement of medical support for child support children. The OIG recommended that ACF ensure that State child support agencies comply with current regulations requiring them to fully enforce medical support, and that it collaborate with the Health Care Financing Administration to examine alternatives to recover the costs of managed care premiums from noncustodial parents. (OEI-07-97-00500)

Workplace Violence: Public Assistance and Child Support Offices

This report summarizes information gathered by OIG in a survey of local public assistance and child support enforcement offices about workplace violence. Seventy-eight percent of local child support enforcement and 61 percent of local public assistance managers contacted expressed fear for the safety of their staff, although actual reported violence was rare. Staff reported that the nature of their work often contributed to the stress levels of the individuals they serve, potentially leading to the threat of violence or actual violence. A variety of security measures have been installed in some offices to reduce or prevent workplace violence.

The OIG observed that local safety is primarily the responsibility of States, but suggested that ACF might wish to discuss the extent and severity of workplace violence with its State partners with a view to promoting the development and sharing of strategies that effectively address this issue. (OEI-06-98-00044)

Child Support Enforcement: Investigations

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

The OIG has also made the investigation of these matters a high priority. The OIG and OCSE are the sponsors of Project Save Our Children: five multiagency, multijurisdictional investigative task forces whose missions are to identify, investigate and prosecute the most egregious violators of the Federal and State child support laws in the regions covered by the task forces. The task forces are comprised of personnel from the OIG Office of Investigations, U.S. Marshals Service, U.S. Attorneys Offices, DOJ, State and local child support offices, State and local law enforcement, State and local prosecutors, representatives from the judiciary (both State and Federal), and representatives from the corrections and probation offices at both the Federal and State levels.

The task forces are structured to identify, investigate and prosecute criminal nonsupport cases both on the Federal and State levels through the coordination of law enforcement, criminal justice and child support office resources. There are investigative units in each of the States which conduct the actual investigations. The units work with the State child support offices to identify the cases that the States then refer to the task force. The units also work with prosecutors at State and Federal levels to ensure that the cases worked are those that will be prosecuted in a volume consistent with the resources of those offices.

Central to the task forces are the screening units located in each task force region and staffed by analysts and auditors from both OIG and OCSE. The units receive child support cases from the States, conduct preinvestigative analyses of these cases through the use of information databases and then forward the cases to the investigative task force units where they are assigned and investigated. This streamlines the process by which the cases best suited for criminal prosecution are identified, investigated and brought to fruition. As the task forces bring in more law enforcement partners on the State level, the number of cases adjudicated will rise dramatically. At this point, the task force units have received over 2,650 cases from the States. As a result of the work of the task forces, 84 Federal arrests have been executed and 55 individuals sentenced. The total recovered amount related to Federal

investigations is \$2.7 million. There have been 264 arrests on the State level and 220 convictions or civil adjudications to date, resulting in \$8.6 million in restitution.

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

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

- In New York, a man was sentenced to 3 years probation and restitution of \$242,092 for failing to pay child support for his three children who reside in New Jersey. Since his arrest in August 1999, a percentage of his wages has been garnished and forwarded to his former spouse. A construction worker earning between \$12 and \$28 per hour, the man must also forfeit 10 percent of his gross income until restitution is paid. In addition, he must forward any inheritance received as a result of pending litigation to the local OCSE.
- Also in New York, a man was sentenced for failure to pay child support to a \$5,000 fine. A multi-millionaire, the man previously produced financial affidavits attesting to having assets in excess of \$5 million during family court hearings. His family owns large amounts of valuable real estate in California; and the man lived off the income from the real estate holdings and did not work during most of his marriage and thereafter. Shortly after his arrest in California, the man promptly paid his child support arrearage of over \$160,000.
- A man was sentenced to 14 months imprisonment, 1 year probation and payment of \$120,000 in restitution for failing to pay child support for his two minor children who reside in New York. At the time of his arrest, the man resided in Florida. A key piece of evidence obtained during the investigation showed that he owned an import/export business which was not in his name. He will serve the remainder of his prison sentence in New York.

- A man was sentenced for failing to pay child support for his two daughters who reside with their mother in New York. His sentence included payment of \$110,240 in restitution and 20 months incarceration, to run consecutively with a 77-month prison sentence he received in Ohio on unrelated charges. The man is still legally married to the custodial parent. He is also a career criminal whose record reflects violations in several States and includes various narcotics violations, robbery, assault, use of a handgun in a felony, resisting arrest, passing false documents, criminal mischief and other crimes.
- In California, a man was sentenced to 5 years probation and was ordered to pay his remaining arrearage of \$27,547 for failure to pay child support. As part of an arranged plea agreement, he also provided the court with a \$20,000 cashier's check to avoid being indicted on a felony count. After the child support order was issued in 1985, the man moved to Nevada. Asserting that his own business faced financial trouble, he made only sporadic child support payments when compelled by State court action. The investigation showed that the man actually held preferred customer status at several prestigious casinos which he and his wife frequented daily. In addition to spending large sums of money to place bets, the couple enjoyed complimentary hotel suites and meals.
- In Virginia, a man was sentenced to 2 years incarceration and payment of \$35,824 in restitution for failure to pay child support. When initially charged with a misdemeanor for his failure to pay in 1998, the man agreed to plead guilty to the charge in Texas. He failed to appear for his scheduled plea, and a bench warrant was issued for his arrest. As a result of his failure to appear, the misdemeanor charge was dismissed, and a grand jury in Virginia indicted him on the felony charge to which he pled guilty.
- A man was sentenced in Illinois after pleading guilty to failure to pay child support. He was sentenced to 5 years probation, payment of \$30,000 in restitution to the custodial parent and compliance with a special condition that he remain current in his child support payments. He was also ordered to pay \$3,091 in restitution to the Illinois Department of Public Aid for monies paid out for his child's care.
- In Ohio, a man was sentenced to 5 years probation and payment of \$28,336 in restitution for failure to pay child support. In the past, he made only sporadic child support payments and recently failed to make any payments for over a year. At one time, the man was a licensed stockbroker involved in a stock partnership with his father that earned approximately \$800,000 a

year. After the partnership ended, he moved to California where he played golf and worked at various jobs in the golf industry earning about \$6 an hour. When he became aware of OIG's CSE investigation, the man moved back to Ohio where he began making his monthly payments.

- In Arizona, a woman was sentenced for failure to pay child support to 5 years probation and was ordered to pay \$300 a month toward her arrearage of \$11,451 and to pay her current obligation of \$799 a month. An engineer with her Master's degree in business administration, the woman decided to quit gainful employment related to her field of study and to move home with her mother and attend school part time.

During this period, OIG investigations of child support cases nationwide resulted in 85 convictions and court-ordered restitution of over \$4.6 million. Prosecutions in this area are unique in that sentences ordered by a judge take into account the need for the defendant to continue to be able to pay. Therefore, alternative sentencing options -- such as work release, home detention and probation where nonpayment is a violation -- are often ordered.

Child Support Enforcement State Disbursement Units: State Implementation Progress

Performance Measure

Thirty-eight States report they have fully implemented legislatively mandated centralized State units intended to expedite the receipt of child support payments from the employers of absent parents and the disbursement of these payments to custodial parents. Three States received Federal waivers to the requirement, and 12 States have yet to complete the implementation. Thirty-two States chose to centralize the payment processing for all child support cases, rather than only those required by Federal law. This approach is noteworthy in that it facilitates relationships with employers. While almost half of State child support agencies directly operate their centralized disbursement units, many contract with private companies and clerks of court to perform some or all of these new functions. This report and its companion are intended to be shared among all States in order to promote a better understanding of potentially promising implementation approaches. (OEI-06-00-00040)

Child Support Enforcement State Disbursement Units: Sharing the Experiences of Six States

Following an often problematic implementation period for newly required centralized State disbursement units, six States which we reviewed in our study report that they disburse payments faster and provide better customer service than when payments were processed locally. These States have surmounted the most significant early challenges which sometimes resulted in payment delays, but they continue to deal with problem payments and cases. These difficulties are often caused by poor labeling and misdirection of payments. This report recommended that all States centralize pre-1994 income withholding cases and

consider centralizing all cases, not just those required by law. We also recommended that States promote the use of electronic payment methods. In addition, we pointed out the potential advantage of States exploiting information available from the new disbursement system to enhance other aspects of child support enforcement. We recommended that the Office of Child Support Enforcement provide technical assistance on interstate payment processing and encourage improved performance by Federal Government payers. (OEI-06-00-00041)

Child Support Operations: Tennessee

Performance Measure

In this congressionally requested review, OIG determined whether Tennessee (1) properly processed child support payments and provided adequate customer service in 16 cases referred by the Congressman and (2) properly handled interest earned on child support payments. The OIG found that the State properly handled interest earned on undisbursed child support payments. However, in the 16 specific cases, problems were noted in customer service operations, the child support enforcement system, and the child support payment process. Custodial and noncustodial parents had difficulty reaching or obtaining assistance through customer service phone lines, and child support payments were received either late or not at all.

The OIG recommended improvements to the State's customer service and payment-processing operations. In response to the draft report, State officials agreed with the recommendations and outlined corrective actions either underway or planned. (CIN: A-04-00-00136)

State Oversight of Residential Facilities for Children

To be eligible to receive Federal reimbursement for foster care, a State must place a child in a facility that is licensed or approved by the State in which it is situated. States are also required to establish and maintain standards for federally funded residential facilities, covering admissions policies, safety, sanitation and protection of civil rights.

In a study undertaken at ACF's request, OIG found that the nine sample States had licensing standards and that they focused on ensuring a safe environment. The initial licensing process generally consisted of a review of written policies followed by an onsite inspection of the facility, and almost all sample States reported onsite monitoring of all facilities annually. States rarely revoked licenses or denied a renewal, but used other techniques to deal with facility weaknesses. In addition, facilities were commonly monitored by multiple agencies that included local fire and health departments and the contracting placement agency.

While OIG found that most States addressed most standards, it noted some differences in standards and licensing procedures. Given this variability, OIG encouraged ACF to take a leadership role in strengthening State licensing by working with States and others to provide

training and technical assistance where needed and serving as a focal point for information sharing. The ACF concurred with OIG's recommendation. (OEI-02-98-00570)

Emergency Assistance Program Costs

The Emergency Assistance (EA) program provided temporary financial assistance and social services to needy families in emergency situations. The program was eliminated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and replaced with the Temporary Assistance for Needy Families program. The following reports were issued as part of OIG's nationwide review of retroactive EA claims.

A. Pennsylvania

Over a 2-year period, Pennsylvania experienced tremendous growth in Federal reimbursement of EA claims, from \$2.9 million in FY 1994 to \$250.3 million in FY 1996. The State's reclassification of juvenile detention services as EA-eligible costs contributed to this growth.

In reviewing \$60.5 million in claims submitted on behalf of children in juvenile detention facilities in FYs 1995 and 1996, OIG found numerous, multiple violations of Federal eligibility criteria. Claims totaling an estimated \$51.5 million, or about 85 percent of the amount reviewed, were unallowable. The OIG recommended that the State refund this amount to the Federal Government. The State generally did not agree with OIG's findings and recommendation. (CIN: A-03-99-00594)

Another review focused on \$99.6 million claimed by Pennsylvania for EA services provided to children in Philadelphia County in FYs 1995 and 1996. Again, widespread violations of Federal eligibility criteria were found, resulting in unallowable costs of \$77.6 million. The OIG recommended that the State refund this amount to the Federal Government and determine whether the same conditions existed in other counties and in Philadelphia County for the period following the audit until program termination. The ACF concurred with OIG's position. However, the State generally disagreed with the findings and recommendations. (CIN: A-03-98-00592)

B. Illinois

In Illinois, OIG identified \$27.8 million (\$13.9 million Federal share) in improperly claimed EA payments from October 1, 1993, through June 30, 1997. Contrary to Federal regulations, costs were claimed on behalf of children who did not live with a specified relative within 6 months before assistance was requested. Instead, if a child in the family was determined to be eligible for EA assistance, the State considered all members of the family to be eligible, regardless of their living arrangements. The State agreed to cooperate with ACF in making the \$13.9 million adjustment recommended by OIG. (CIN: A-05-99-00063)

C. Nebraska

In this review of selected EA claims submitted by Nebraska in the 27-month period ended December 31, 1996, OIG found that the State had claimed Federal reimbursement for ineligible children and services. Based on a statistical sample of claims, OIG projected that Nebraska was overpaid about \$6 million (almost \$3 million Federal share). The OIG recommended that the State refund the overpayment to the Federal Government. In general, the State did not concur with the findings and recommendations. (CIN: A-07-99-01041)

D. New Jersey

New Jersey retroactively claimed \$5.2 million (\$2.6 million Federal share) in juvenile justice and youth incentive program costs to the EA program for the 9 months ended March 31, 1997. Based on a review of selected claims, OIG determined that none met Federal reimbursement requirements. The State and its consultant had submitted claims for cases that did not meet multiple eligibility criteria, and the State had not reviewed the consultant's work. As a result of OIG's review, the State withdrew the entire claim and returned the Federal share of funds received (almost \$2 million). Consequently, OIG made only procedural recommendations to the State. (CIN: A-02-98-02005; CIN: A-02-99-02006)

Retroactive Foster Care Claim: Mississippi

In reviewing Mississippi's retroactive claim for Title IV-E foster care costs, OIG determined that over \$15 million of the claim did not meet the criteria for Federal financial participation. Among the unallowable costs were over \$9.4 million in administrative and training costs, more than \$3.3 million in maintenance costs, and over \$2.5 million in consultant fees. The OIG determined that the State did not have adequate administrative and internal controls in place and did not adequately monitor its consultants to ensure that the retroactive claim was prepared properly, that the costs claimed met ACF reimbursement requirements, and that the consultants' contingency fee arrangement met Office of Management and Budget reimbursement requirements.

The OIG recommended that the State refund nearly \$14.3 million to the Federal Government (after adjustments of \$755,000 made by the State), monitor more closely the work of its consultants, and verify that foster care facilities have cost allocation systems that exclude unallowable cost items and compute foster care rates based on the proportion of Title IV-E children to non-Title IV-E children. The State did not concur with all the findings and recommendations. (CIN: A-04-98-00126)

Head Start Grantee: Washington

In reviewing a Head Start grantee in Washington, OIG found that the grantee did not (1) have an acceptable cost allocation system to ensure that costs were allocated reasonably among the various Federal and State programs; (2) maintain adequate financial and program management systems to meet the uniform administrative requirements for awards to

nonprofit organizations; (3) comply with the nonfederal match requirements for the Migrant Head Start program; or (4) adequately involve its board of directors in the management, direction, and control of its business activities.

The OIG recommended that the grantee develop a cost allocation plan and designate a specific management official with the overall responsibility for administering the plan. The OIG also recommended that the grantee incorporate the provisions of the cost allocation plan into its official written policies and negotiate with ACF to resolve the issue of disproportionate charges between the Migrant Head Start program and the State-funded Seasonal Child Care program. The grantee did not concur with all findings and recommendations. (CIN: A-10-99-00050)

Safeguarding Persons with Disabilities: District of Columbia

This review, part of a nationwide review of States' practices for safeguarding persons with disabilities, focused on District of Columbia agencies that provide services to persons with mental retardation or other developmental disabilities. The OIG found that District agencies did not adequately track or, in many instances, promptly investigate reported allegations of abuse or neglect and that existing policies and practices did not ensure that residential facility operators or other service providers always reported such incidents. As a result, OIG concluded that these District residents had not been adequately safeguarded and remain at risk until needed safeguards are implemented.

The OIG identified some 30 recommendations relating to needed safeguards, including centralized reporting of allegations, screening of care workers, and investigation of reported incidents. The District generally concurred with these recommendations and provided details on actions taken or planned to implement them. (CIN: A-12-99-00008)

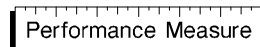
Grantee Costs Claimed

The OIG, in a joint audit with the Department of Education (DOE), reviewed the financial management practices, fiscal records and expenditures of a grantee for the period October 1, 1992 through the cessation of its operations in the summer of 1995. This private, nonprofit agency was designated as the responsible agency to provide protection and advocacy services to eligible citizens of the District of Columbia; its central mission was the protection of the legal, civil and human rights of all persons with developmental disabilities and/or mental illness.

During the audit period, the grantee received almost \$3.1 million, of which \$1.8 million was from three Federal funding sources: ACF, SAMHSA, and DOE. Of the total \$3.1 million claimed, OIG recommended financial adjustments of \$725,000 from the District of Columbia, which had fiscal responsibility over this operation. The Federal share of the recommended adjustment was about \$395,000. The OIG proposed that the Department's

Assistant Secretary for Management and Budget (ASMB) coordinate actions to recover \$339,000 of the Department's Federal share of questioned costs and referred recovery of the remaining \$56,000 to DOE. The OIG also proposed that ASMB determine the Federal share of almost \$259,000 in questioned costs attributed to programs funded through the District's Department of Human Services, alert the ACF and SAMHSA onsite review teams to focus on the internal control weaknesses identified in this report, and seek disbarment of the grantee's executive director from eligibility for Federal assistance. (CIN: A-03-00-00500)

Fiscal Year 1999 Financial Statement Audit of the Administration for Children and Families



In support of its audit of the consolidated Departmentwide financial statements for FY 1999, OIG contracted with an independent accounting firm to audit ACF's financial statements. The ACF received an unqualified opinion on its financial statements, with one material weakness noted for lacking an integrated financial reporting system. The ACF officials agreed with the findings and are taking corrective action on most of the recommendations. (CIN: A-17-99-00003)

General Oversight

Chapter IV

GENERAL OVERSIGHT

Introduction

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

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

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133, which designates HHS as the cognizant audit entity for most States and major research organizations. The OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG became responsible for auditing the Department's financial statements beginning with the FY 1996 statements.

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

Program Support Center's Personnel Service: Customer Service Evaluation

Performance Measure

The PSC provides personnel services for the Administration on Aging, the Office of the Secretary and the PSC itself in three broad business areas: human resources, financial management and administrative operations.

Based on interviews with a random sample of Department employees, OIG found that personnel transaction error rates reported by PSC were significant but not statistically different from those of non-PSC customers. However, PSC customers were less satisfied with their personnel service than non-PSC customers, and processing delays accounted for most of their dissatisfaction. Since that time, PSC revised its personnel staffing and organization to improve customer service, and OIG noted some improvement in customer satisfaction. However, vulnerabilities persisted in some key processes.

The OIG recommended that PSC continue its efforts to improve customer service; establish timeliness standards for personnel transaction processing; expand its "help desk" model of customer assistance; date stamp and log employees' requests; maintain accurate Official Personnel Files; and continue its plans to replace the Improved Management of Personnel Administration through Computer Technology system. The PSC reported that it continues to implement service improvements. (OEI-09-98-00140)

Results Act Review Plan

Performance Measure

The Government Performance and Results Act (GPRA) of 1993 mandates that Federal agencies establish strategic planning and prepare annual performance plans, beginning with a plan for FY 1999. The annual performance plans are to set out measurable goals that define what will be accomplished during the year. The GPRA also requires that a program performance report, comparing actual performance with performance goals established in the annual performance plan, be submitted no later than March 31 of each year following the submission of a plan. With the Act now in its second year of implementation, OIG's work continues to focus on assessing data collection methods and controls over the HHS systems that produce performance data. The OIG's review plan is directed toward those measures related to mission-critical issues and areas at high risk of fraud, waste and abuse.

For instance, OIG's continuing financial statement audit work at the Health Care Financing Administration (HCFA) relates directly to assessment of HCFA-generated financial performance data. The HCFA uses OIG's annual estimate of the Medicare fee-for-service error rate as a basis for setting performance goals and for measuring performance. For FY 1999, OIG reported an estimated 7.97 percent error rate. As stated in its FY 2000 performance plan, HCFA's goal is to reduce this rate to 7 percent by 2000, 6 percent by 2001 and 5 percent by 2002. The HCFA also hopes to develop a new methodology by 2000 to

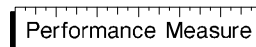
project an error rate below the national level, such as by individual contractor or type of benefit or provider.

At the Administration for Children and Families (ACF), OIG completed a review of the Adoption and Foster Care Analysis and Reporting System (AFCARS) during the previous semiannual reporting period. The ACF performance measures pertaining to children in foster care and children adopted under the auspices of a State welfare agency are based on data from this system. Since States collect and transmit case management information to ACF through this system, OIG assessed the reliability of the AFCARS data submitted by two States for the first half of FY 1999. While some errors were noted in the information from both States, these errors did not affect the data used to develop ACF's performance measures or were not pervasive enough to affect reported measures.

In addition, OIG is currently assessing the reliability of the data in the State Agency Child Welfare Information System, which is being developed with the Department's financial assistance (75 percent matching). The system is designed to allow child welfare workers online access to other State human service and health programs, such as Temporary Assistance for Needy Families, child support and Medicaid. And during FY 2001, OIG plans to examine both ACF's and the Administration on Aging's (AoA) use of State-supplied data for performance measurement. The OIG will determine whether these agencies take adequate steps to screen State data for reliability and whether selected States have adequate controls in place to ensure that data are reliable and valid. Also, OIG plans to assess selected Public Health Service agencies' processes for implementing GPRA and to report any deficiencies in internal controls for properly recording, processing, and summarizing performance data.

The OIG also notes that an ongoing objective of its audits, inspections and investigations is to identify performance results and offer recommended improvements. As in past years, these reviews are identified throughout this semiannual report by the ruler symbol and are listed in Appendix F.

Reviews of Departmental Service Organizations



In support of its HHS-wide FY 1999 financial statement audit, OIG contracted for examinations of four service organizations that provide common administrative, data processing, and accounting services to individual operating divisions. In accordance with Statement on Auditing Standards No. 70, independent accounting firms examined the organizations' controls and tested their operating effectiveness.

A. Center for Information Technology

The accounting firm issued a clean opinion and noted no significant exceptions at the Center for Information Technology. (CIN: A-17-99-00015)

B. Central Personnel and Payroll System, Human Resources Services

In FY 1999, the Human Resources Services office made tremendous progress over the previous year. The accounting firm issued a clean opinion and noted no significant exceptions. (CIN: A-17-99-00009)

C. Division of Financial Operations

The firm concluded that controls tested for the Division of Financial Operations (DFO) were operating effectively, but with exceptions. Problems were noted with access controls, software development and change controls, and segregation of duties. The DFO officials did not agree with all aspects of the findings. (CIN: A-17-99-00008)

D. Division of Payment Management

At the Division of Payment Management, the accounting firm issued a clean opinion and noted no significant exceptions. (CIN: A-17-99-00014)

Accounting for FY 1999 Drug Control Funds

Agencies that participate in the National Drug Control Program are required to annually submit to the Office of National Drug Control Policy (ONDCP) a detailed accounting of all funds expended on program activities during the previous year. The agencies' respective Inspectors General are responsible for expressing an opinion on the reliability of the assertions in the accounting reports.

The OIG reviewed the submissions of the eight HHS agencies required to submit detailed accounting reports for FY 1999: ACF, CDC, FDA, HCFA, HRSA, IHS, NIH, and SAMHSA. Based on these reviews, OIG was able to determine that management assertions were reliably presented in the reports submitted by ACF, FDA, and HRSA. (CIN: A-15-00-80006; CIN: A-15-00-80007; CIN: A-15-00-80008; CIN: A-15-00-80009; CIN: A-15-00-80010; CIN: A-15-00-80011; CIN: A-15-00-80012; CIN: A-15-00-80013).

Nonfederal Audits

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

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the second half of FY 2000, OIG's National External Audit Review Center (located in Kansas City) reviewed

about 1,320 reports that covered over \$1.06 trillion in audited costs. Federal dollars covered by these audits totaled \$314 billion, about \$149.3 billion of which was HHS money.

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

A. Office of Inspector General's Proactive Role

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

- Through evaluation of reported data, OIG is able to provide basic audit coverage and analyze reports to identify entities for high-risk monitoring and trends that could indicate problems within HHS programs. These problems are brought to the attention of departmental management who can take steps to improve program administration. In addition, OIG profiles nonfederal audit findings of a particular program or activity over a period of time to identify systemic problems.
- To ensure audit quality, OIG maintains a quality control program (discussed below) and has taken steps to ensure that adequate guidance is available to the nonfederal auditor. The OIG actively assists the National Association of State Auditors, Controllers and Treasurers in performing peer reviews of State audit organizations.
- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number (800-732-0679). In addition, OIG offers various training; for example, formal training was provided to certified public accountant societies and State auditor staffs on issues related to Circular A-133.
- The OIG is also very much involved with OMB and the American Institute of Certified Public Accountants in developing authoritative guidance for nonfederal auditors.
- The OIG chairs both a work group sponsored by OMB to revise the data collection form for single audit reporting and a committee of the President's Council on Integrity and Efficiency (PCIE) to revise the Orange Book, which addresses audit cognizance assignments.

B. Quality Control

To rely on the work of nonfederal auditors, OIG maintains a quality control review process which assesses the quality of the nonfederal reports received and the audit work that supports selected reports. Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 1,321 nonfederal audit reports. The following table summarizes those results:

| | |
|--|-------|
| Reports issued without changes or with minor changes | 1,286 |
| Reports issued with major changes | 15 |
| Reports with significant inadequacies | 20 |
| Total audit reports processed | 1,321 |

The 1,321 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling \$9.8 million as well as 4,147 recommendations for improving management operations. In addition, these audit reports provided information for 59 special memoranda which identified concerns for increased monitoring by departmental management.

Resolving Office of Inspector General Recommendations

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

A. Questioned Costs

The following chart summarizes the Department's responses to OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs which are challenged because of violation of law, regulation, grant conditions, etc. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and section 5 of the Inspector General Act. These costs are separate from the amount ordered or returned as a result of OIG investigations (see page 85).

| | <u>Number</u> | <u>Dollar Value</u> | |
|--|---------------|----------------------|---------------------|
| | | <u>Questioned</u> | <u>Unsupported</u> |
| A. For which no management decision had been made by the commencement of the reporting period ¹ | 496 | \$423,792,000 | \$64,928,000 |
| B. Which were issued during the reporting period | <u>91</u> | <u>\$236,715,000</u> | <u>\$14,515,000</u> |
| Subtotals (A + B) | 587 | \$660,507,000 | \$79,443,000 |
| Less: | | | |
| C. For which a management decision was made during the reporting period ^{2,3} : | 172 | \$146,843,000 | \$4,018,000 |
| (i) dollar value of disallowed costs ⁴ | | \$142,337,000 | \$2,609,000 |
| (ii) dollar value of costs not disallowed | | \$4,506,000 | \$1,409,000 |
| D. For which no management decision had been made by the end of the reporting period | 415 | \$513,664,000 | \$75,425,000 |
| E. For which no management decision was made within 6 months of issuance ⁵ | 330 | \$286,015,000 | \$26,000,000 |
| See Appendix D for footnotes. | | | |

B. Funds Put to Better Use

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

| TABLE II OFFICE OF INSPECTOR GENERAL REPORTS WITH RECOMMENDATIONS THAT FUNDS BE PUT TO BETTER USE | | |
|--|---------------|----------------------|
| | <u>Number</u> | <u>Dollar Value</u> |
| A. For which no management decision had been made by the commencement of the reporting period ¹ | 26 | \$535,036,000 |
| B. Which were issued during the reporting period | <u>3</u> | <u>\$143,788,000</u> |
| Subtotals (A + B) | 29 | \$678,824,000 |
| Less: | | |
| C. For which a management decision was made during the reporting period: | | |
| (i) dollar value of recommendations that were agreed to by management | | |
| (a) based on proposed management action ² | 5 | \$307,879,000 |
| (b) based on proposed legislative action | | |
| Subtotals (a+b) | 5 | \$307,879,000 |
| (ii) dollar value of recommendations that were not agreed to by management | <u>1</u> | <u>\$7,838,000</u> |
| Subtotals (i + ii) | 6 | \$315,717,000 |
| D. For which no management decision had been made by the end of the reporting period ³ | 23 | \$363,107,000 |
| See Appendix D for footnotes. | | |

Legislative and Regulatory Review and Regulatory Development

A. Review Functions

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

B. Regulatory Development Functions

The OIG is responsible for the development and promulgation of a variety of sanction regulations addressing civil money penalty (CMP) and program exclusion authorities administered by the Inspector General, as well as safe harbor regulations related to the anti-kickback statute. Among the regulatory initiatives promulgated during this reporting period were:

- Final regulations, in conjunction with HCFA rulemaking addressing the prospective payment system for hospital outpatient services, that authorize the OIG to impose a CMP against any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for items and services furnished under Medicare that is inconsistent with the "unbundling" arrangements set forth in section 1866(a)(1)(H) of the Social Security Act (65 FR 18434; April 7, 2000).
- Final regulations that revise the OIG's CMP authorities, in conjunction with new and revised provisions set forth in the Health Insurance Portability and Accountability Act of 1996 (65 FR 24400; April 26, 2000).
- Proposed regulations setting forth a new CMP safe harbor for unlawful inducements to beneficiaries to provide protection for independent dialysis facilities that pay premiums - for Medicare Part B or Medigap - for financially needy Medicare beneficiaries with end-stage renal disease (65 FR 25460; May 2, 2000).
- Proposed regulations setting forth a new safe harbor to protect certain arrangements involving hospitals that replenish drugs and medical supplies used by ambulance providers when transporting emergency patients to the hospitals (65 FR 32060; May 22, 2000).
- A final rule exempting the new system of records established under the Healthcare Integrity and Protection Data Bank from certain provisions of the Privacy Act. The

exemption specifically applies to investigative materials compiled for law enforcement purposes (65 FR 34986; June 1, 2000).

In addition, during this period, the Inspector General signed and the Secretary approved proposed regulations designed to address several revisions and technical corrections to parts 1001, 1003, 1005 and 1008 of the OIG regulations. Through the ending of this reporting period, these proposed regulations were awaiting final clearance by the Office of Management and Budget.

Also, during this period, OIG prepared and published a variety of Federal Register notices that addressed the ongoing development of compliance program guidances and compliance risk guidances. These included the publication of:

- Final OIG Compliance Program Guidance for Nursing Facilities (65 FR 14289; March 16, 2000).
- Draft Compliance Program Guidance for Individual and Small Group Physician Practices (65 FR 36818; June 12, 2000), and final Compliance Program Guidance (65 FR 594434; October 5, 2000).
- A solicitation notice for developing Compliance Risk Guidance for the Ambulance Industry (65 FR 50204; August 17, 2000).

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 significant annual savings to the Government. These recommendations are contained in the OIG Cost Saver Handbook, also known as the Red Book. The hearing process offers OIG the opportunity to meet its statutory obligation of keeping the Congress informed of its work with regard to the effective and efficient operation of Department programs. The OIG continues to track all relevant congressional hearings and pending legislation relative to a wide range of issues.

Pension Fund Settlement: California

In July 2000, the Department announced that California had agreed to pay \$240 million in five annual payments of \$48 million each related to a disallowance of Federal funds involving the State pension fund for public employees. In a prior audit, OIG found that the State had used \$816 million of excess pension funds to reduce State pension costs paid from the general fund but did not credit a proportionate share of the reduction to the Federal programs that had contributed to the pension fund. The audit report, issued in August 1994, estimated that the Federal share of the \$816 million was \$111 million. Subsequent to the

report, OIG obtained additional information which resulted in increasing the recommended repayment by the State to \$122 million.

The HHS Division of Cost Allocation (DCA) upheld the audit findings and disallowed the \$122 million plus \$19 million in interest earned on that amount. California appealed to the HHS Departmental Appeals Board, which sustained DCA's decision. The State subsequently appealed to the Federal courts, and in June 1999, the United States District Court for the Eastern District of California affirmed the decision by the Departmental Appeals Board. At that time, DCA estimated that California would be required to refund to the Federal Government \$224 million, including debt collection interest that had accrued during the appeals process. The \$240 million agreement was reached a year later. (CIN: A-09-92-00116)

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 209 successful criminal actions. Also during this period, 550 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 262 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over \$264 million was ordered or returned as a result of OIG investigations during this semiannual period. Civil settlements from investigations resulting from audit findings are included in this figure.

Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act (PFCRA), 31 U.S.C. sections 3801-3812, authorizes the imposition of civil money penalties (CMPs) and assessments against anyone who makes a false, fictitious, or fraudulent claim or written statement to a Federal agency. It was modeled after the CMP law (42 U.S.C. 1320a-7a) which is applicable to false or otherwise improper claims presented to Medicare, Medicaid or other Federal health care programs. Under PFCRA, a person who presents a false, fictitious or fraudulent claim to a Federal agency may be subject to a CMP of up to \$5,000 per claim or statement, as well as an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims and statements presented to the Department, and for reporting at the end of each fiscal year the number of investigations completed and matters referred for administrative action under PFCRA.

During FY 2000, no matters were specifically referred for administrative action solely under PFCRA. While all cases are routinely analyzed for potential action under PFCRA, at HHS the availability of other criminal, civil and administrative remedies (particularly the CMPL) often renders unnecessary the referral of cases for action solely under PFCRA. However,

OIG does assert its administrative authority under PFCRA as one basis in settlement agreements, in which OIG is a party, that resolve cases arising under the False Claims Act and other Federal statutes. In addition, as part of these settlements, the defendant is released from liability under PFCRA.

Appendices

APPENDIX A

Savings Achieved through Policy and Procedural Changes Resulting from Office of Inspector General Audits, Investigations and Inspections April 2000 through September 2000

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

Legislative savings are annualized amounts based on Congressional Budget Office (CBO) estimates for a 5-year budget cycle. Consistent with OIG policy, savings from the Medicare provisions of the Balanced Budget Act (BBA) of 1997 were adjusted downward to reflect CBO estimates for related provisions of the Balanced Budget Refinement Act (BBRA) of 1999. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected or for multiple years, if applicable. Total savings from these sources amount to \$5.798 billion for this period.

| OIG Recommendation | Implementing Action | Savings in Millions |
|--|--|--------------------------------|
| HEALTH CARE FINANCING ADMINISTRATION | | |
| Medicare Home Health Payments: Restructure the payment system for home health care to eliminate inappropriate incentives which unnecessarily increase cost and utilization; prevent unscrupulous providers from gaining entry into the program; and improve program controls, such as eligibility determinations and approval of plans of care and services. (OEI-04-93-00260; OEI-09-96-00110; CIN: A-04-96-02121) | Chapter I of Subtitle G of the BBA of 1997 (as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998), which pertains to home health benefits, addresses OIG's concerns regarding the need to restructure and control the payment system for these services. For example, it mandates that a prospective payment system be developed and that the total payments in fiscal year (FY) 2000 be equal to the amount that would have been paid under the prior system if cost limits were reduced by 15 percent. It also eliminates periodic interim payments to home health agencies. | \$2,130 |

| OIG Recommendation | Implementing Action | Savings in Millions |
|--|--|------------------------|
| <p>Hospital Outpatient Policy: Extend congressionally mandated reductions in hospital costs. Hospitals should limit 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. (CIN: A-14-89-00221; CIN: A-09-91-00070; OAI-85-09-0046; OEI-09-88-01003)</p> | <p>Section 13521 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 mandated a reduction of 10 percent for outpatient capital costs. Sections 4521-4523 of the BBA of 1997 eliminated formula-driven overpayments in FY 1998, extended reductions in payments for costs of hospital outpatient services, and established a prospective payment system (PPS) for hospital outpatient services for FY 1999.</p> | <p>\$1,690</p> |
| <p>Medicare Indirect Medical Education: The Health Care Financing Administration (HCFA) should base the indirect medical education adjustment factor on the level supported by HCFA's empirical data. (CIN: A-07-88-00111)</p> | <p>Section 4621 of the BBA (as amended by the BBRA of 1999) reduced the indirect teaching adjustment factor from 7.7 percent in FY 1997 to 7.0 percent in FY 1998; 6.5 percent in FY 1999; 6.0 percent in FY 2000; 5.5 percent in FY 2001 and thereafter.</p> | <p>940</p> |
| <p>Medicare Secondary Payer - Initial Enrollment Questionnaire: The HCFA should take steps to collect primary insurance information in a more timely and accurate manner, requiring beneficiaries to disclose other health insurance information, and should revise all Medicare claims forms to require spousal information before claims can be paid. (CIN: A-09-89-00100; OEI-07-90-00760)</p> | <p>Since 1995, all Medicare beneficiaries are being asked to complete the Initial Enrollment Questionnaire and list any other health insurance they have. The HCFA has reported that two-thirds of all new beneficiaries are voluntarily completing the questionnaire and this has helped HCFA document 110,000 cases each year in which new beneficiaries have other coverage.</p> | <p>425</p> |
| <p>Graduate Medical Education Payments: The HCFA should reevaluate Medicare's policy of paying graduate medical education (GME) costs for all physician specialties and should consider submitting legislation to reduce Medicare's investment in GME to arrive at a more representative and accurate sharing of GME costs. (CIN: A-06-92-00020)</p> | <p>Sections 4623 and 4626 of the BBA provided for limits in the number of residents and offered payments for voluntary reductions in the number of residents to limit Medicare's share of GME costs.</p> | <p>180</p> |
| <p>Medicare Disproportionate Share: The disproportionate share adjustment should be reduced, if not eliminated, without redistribution of the funds to PPS hospitals. (CIN: A-04-87-01004)</p> | <p>Section 4403 of the BBA provided for reducing disproportionate share payments by 1 percent in FY 1998, 2 percent in FY 1999, 3 percent in FY 2000, 4 percent in FY 2001, 5 percent in FY 2002 and 0 percent thereafter.</p> | <p>120</p> |

| OIG Recommendation | Implementing Action | Savings in Millions |
|--|--|------------------------|
| <p>Fraud and Abuse Provisions of the Balanced Budget Act: Require durable medical equipment (DME) suppliers and home health agencies (HHAs) to provide Social Security numbers (SSNs) and employer identification numbers (OEI-04-96-00240; OEI-09-96-00110); refuse to enter into a provider agreement with any HHA whose owners or principals have prior criminal records or are the relatives of the owner of a provider who had defrauded the Medicare program (OEI-09-96-00110); allow HCFA to apply "inherent reasonableness" provisions when assessing the appropriateness of Medicare payments (OEI-03-94-00392); authorize competitive bidding as a means of providing Medicare services (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230); and require DME suppliers and HHAs to post surety bonds as a condition of participation (OEI-04-96-00240; OEI-09-96-00110). Also, clarify which general and administrative and fringe benefit costs at hospitals and HHAs are related to patient care; specifically, distinguish between employee benefits and/or perquisites to entertainment and patient care, and specify that cost of entertainment, goods or services for personal use, alcohol, all fines and penalties and associated interest, dues, and membership costs associated with civic and community organizations are unallowable. (CIN: A-03-92-00017; CIN: A-04-93-02067)</p> | <p>Subtitle D of the BBA contained a number of provisions that corresponded to and were supported by OIG work: for example, the BBA authorized the Secretary to collect SSNs and employer identification numbers from entities under Medicare, Medicaid and Title V; authorized the Secretary to refuse to enter into contracts with physicians or suppliers that have been convicted of felonies; authorized the exclusion of entities owned or controlled by the family or household members of excluded individuals; authorized HCFA to make inherent reasonableness adjustments up to 15 percent to all Part B services except physician services; authorized up to 5 demonstration projects to be completed by December 31, 2002 (one must be oxygen and oxygen equipment), which can have multiple sites, to allow competitive bidding; and prohibited "reasonable cost" payments for items such as entertainment, gifts and donations, education expenses and personal use of automobiles. The BBA also required DME suppliers, HHAs and others to post a surety bond of a minimum of \$50,000.</p> | \$50 |
| <p>Hospital Sales: The HCFA should eliminate the requirement that Medicare make adjustments for gains and losses when hospitals undergo changes of ownership. (OEI-03-96-00170)</p> | <p>Section 4404 of the BBA eliminated the requirement that Medicare make adjustments by setting the Medicare capital asset sales price equal to the net book value.</p> | 50 |
| <p>Rural Health Clinics: The oversight and functioning of the current cost reimbursement system should be improved by implementing caps on provider-based rural health clinics (RHCs) and allowing States to do so, or finding other ways to make reimbursement between provider-based and independent RHCs more equitable. In addition, the certification process should be modified to increase State involvement and ensure more strategic placement of RHCs. Recertification should be required of RHCs within a specific time limit (for example 5 years), applying new criteria to document the need and impact on access. (OEI-05-94-00040)</p> | <p>Section 4205 of the BBA extended the per-visit payment limits to provider-based clinics and stipulated that the shortage area requirements designation be reviewed triennially.</p> | 40 |

| OIG Recommendation | Implementing Action | Savings in Millions |
|--|--|------------------------|
| <p>Hospice Certification: The HCFA should restructure hospice benefit policies to curb inappropriate growth in the program, particularly with regard to the fourth benefit period. (OEI-05-95-00250; CIN: A-05-96-00023)</p> | <p>Sections 4441-4449 of the BBA of 1997 contained provisions to control hospice payments and practices, such as replacing the current unlimited fourth benefit period with an unlimited number of 60 day benefit periods (each requiring recertification).</p> | \$40 |
| <p>Payments for Ambulance Services: The HCFA should seek legislative authority to develop a fee schedule for ambulance transportation and examine the inherent reasonableness of current allowable charges. (OEI-05-95-00300)</p> | <p>Section 4531 of the BBA of 1997 made interim reductions in ambulance payments by limiting the allowed rate of increase and mandated the establishment of a fee schedule by January 1, 2000. Such fee schedule is to be set so that aggregate payments are reduced by 1 percent.</p> | 10 |
| <p>Medicare Payments for Home Blood Glucose Monitors: The HCFA should ensure that Medicare payments for monitors are net of any available rebates. (CIN: A-09-92-00034)</p> | <p>The HCFA issued final regulations on the fee schedule for home blood glucose monitors. These regulations refer to the OIG report for support of fee schedule changes.</p> | 5 |

| Other | Implementing Action | Savings in Millions |
|---|--|------------------------|
| HEALTH CARE FINANCING ADMINISTRATION | | |
| <p>Incontinence Supplies: Information from OIG inspections indicated that suppliers engaged in questionable marketing practices and that beneficiaries were receiving unnecessary or noncovered incontinence supplies. A joint OIG/HCFA effort to address this problem resulted in the initiation of an OIG review of this area and a national investigation examining potentially fraudulent practices by specific suppliers. In addition to issuing reports, OIG dramatized the problem in speeches and congressional testimony. The OIG issued fraud alerts on this topic in December 1994 and August 1995. As a result of OIG investigations, approximately \$50.2 million was recovered through seizures and restitutions from abusive providers, further highlighting the intensity of the OIG/HCFA initiative. In these ways, OIG supported ongoing activity in HCFA and the durable medical equipment regional carriers (DMERCs) to control Medicare outlays for these supplies and equipment. (OEI-03-94-00770; OEI-03-94-00772; OEI-03-94-00773)</p> | <p>The DMERCs issued single national coverage guidelines in October 1995 and educated providers about proper billing. Since the initiative began in 1994, Medicare payments dropped by \$110 million a year, of which \$104 million in 1996 was directly attributable to the problems discussed in the OIG reports.</p> | \$108 |
| VARIOUS OPERATING DIVISIONS | | |
| <p>Results of Investigations: In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the operating division.</p> | <p>The operating division takes action based on the results of the OIG investigation to suspend or terminate payments to the offending individual or entity.</p> | 4.8 |
| ADMINISTRATION FOR CHILDREN AND FAMILIES | | |
| <p>Availability of Health Insurance for Title IV-D Children: The OIG recommended that Connecticut either (i) implement policies and procedures to require noncustodial parents (NCPs) to pay all or part of the Medicaid premiums for their dependent children or (ii) establish a statewide health insurance plan that provides reasonably priced comprehensive coverage for children, with premiums paid by NCPs. (CIN: A-01-97-02506)</p> | <p>The BBA of 1997 established Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), to enhance Medicaid coverage provided to children and allow States to create insurance options for families who exceed Medicaid resource and income limits. Connecticut received HCFA approval in April 1998 to initiate a child health program. Under Connecticut law, applicants include noncustodial parents under court orders to provide health insurance.</p> | 5.7 |

APPENDIX B

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

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

| OIG Recommendation | Status | Savings in Millions |
|---|---|--------------------------------|
| HEALTH CARE FINANCING ADMINISTRATION | | |
| Modify Formula for Costs Charged to the Medicaid Program: The Health Care Financing Administration (HCFA) should consult with the Congress on modification of the Federal medical assistance percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per capita income relationships. (CIN: A-06-89-00041) | The HCFA did not agree with the recommendation. | \$4,100 |
| 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 this approach has merit and could be pursued on an experimental basis at this time. | 2,040 |
| Medicare Coverage of State and Local Government Employees: Require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (CIN: A-09-88-00072) | The HCFA agreed with the recommendation to mandate Medicare coverage for all State and local government employees but did not agree with the recommendation to make Medicare the secondary payer. | 1,559 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|------------------------|
| <p>Clinical Laboratory Tests: Develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CIN: A-09-89-00031; CIN: A-09-93-00056)</p> | <p>The HCFA agreed with the first recommendation but not the second. The BBA of 1997 reduces Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002; the budget would increase payments at consumer price index-urban minus 1 percentage point for 2003 through 2005. The FY 2001 budget includes a proposal to restore 20 percent coinsurance for clinical diagnostic laboratory tests.</p> | \$1,130* |
| <p>Excessive Medicare Payments for Prescription Drugs: The HCFA should examine its Medicare drug reimbursement methodologies. (OEI-03-97-00290; OEI-03-97-00292; OEI-03-97-00293; OEI-03-97-00390; OEI-03-95-00420; OEI-03-94-00390)</p> | <p>The BBA of 1997 reduced Medicare payments by limiting them to 95 percent of the average wholesale price (AWP). The OIG believes additional corrective action is warranted. The President's FY 2001 budget proposes paying for Medicare-covered drugs at 83 percent of the AWP.</p> | 1,000 |
| <p>Reduce Hospital Capital Costs: Determine the extent that capital reductions are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070; CIN: A-14-93-00380)</p> | <p>The HCFA did not agree with the recommendation. Although the BBA of 1997 reduces capital payments, it does not include the effect of excess bed capacity and other elements included in the base year historical costs.</p> | 820 |

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

| OIG Recommendation | Status | Savings in Millions |
|--|--|------------------------|
| <p>Medicaid Payments to Institutions for Mentally Retarded: The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and/or seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)</p> | <p>The HCFA nonconcurred with OIG's recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA and OIG negotiated an agreement for HCFA to send the report to all State Medicaid directors. This action has been taken. However, pursuant to section 4711 of the BBA of 1997, the Secretary shall conduct a study on the effect on access to, and the quality of services provided to beneficiaries of the rate-setting methods used by States.</p> | \$683 |
| <p>Modify Payment Policy for Medicare Bad Debts: The OIG presented an analysis of four options for HCFA to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable, and the inclusion of a bad debt factor in the diagnosis-related group (DRG) rates. The HCFA should seek legislative authority to further modify bad debt policies. (CIN: A-14-90-00339)</p> | <p>The HCFA agreed with the recommendation to include a bad debt factor in the DRG rates. The BBA of 1997 provides for some reduction of bad debt payments to providers. The President's FY 2001 budget proposes to reduce the percentage (from 55 percent to 45 percent) that Medicare pays for bad debts and to extend this policy to providers beyond hospitals. However, additional legislative changes are needed to implement the modifications that OIG recommended.</p> | 340 |
| <p>Flexible Benefit Plans: The value of flexible benefit plans should be included in the definition of wages for the hospital insurance portion of the Federal Insurance Contributions Act. (CIN: A-05-93-00066)</p> | <p>The HCFA agreed with the recommendation to subject flexible benefit plans to the hospital insurance tax.</p> | 291 |
| <p>Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services. (CIN: A-05-89-00055; CIN: A-05-92-00006)</p> | <p>The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services.</p> | 210 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|------------------------|
| <p>Graduate Medical Education: Revise the regulations to remove from a hospital's allowable graduate medical education (GME) base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020)</p> | <p>The HCFA did not concur with the recommendations. Although the BBA of 1997 contains provisions to slow the growth in Medicare spending on GME, OIG believes that its recommendations should be implemented and that further savings can be achieved.</p> | <p>\$157.3</p> |
| <p>Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 tests identified by the OIG audit. (CIN: A-01-93-00521)</p> | <p>The HCFA agreed with 8 of the 10 tests recommended for addition to the list and added 6 of these tests to its carrier manual. The HCFA will periodically review applicable tests and related equipment. The Congress decided (through the BBA of 1997) to achieve savings through other means, including freezing laboratory payments through 2002 and reducing the national payment cap to 74 percent of the median of all fee schedules. The President's FY 2001 budget would reduce payments for four high-volume laboratory tests.</p> | <p>130</p> |
| <p>Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing by physicians who submit claims on paper and who have a moderate to high level of interest in making the switch. This effort should be coordinated with efforts to promote further use of electronic data interchange by providers under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996. The HCFA should also begin to plan now for the policy changes that will be necessary to achieve an almost completely paperless environment for processing Medicare claims. These policy changes can include targeting a date when all physicians will be mandated to submit paperless claims, targeting a date when paperless claims submission will become a condition for Medicare participation, or continuing to accept paper claims but imposing a filing fee to cover the incremental cost of doing so. (CIN: A-05-94-00039; OEI-01-94-00230)</p> | <p>The HCFA concurred with OIG's recommendations. The President's FY 2001 budget proposes to allow an assessment of a \$1 fee on claims not submitted electronically.</p> | <p>126</p> |

| OIG Recommendation | Status | Savings in Millions |
|--|--|------------------------|
| <p>Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (CIN: A-06-94-00039)</p> | <p>The FY 2001 budget proposes applying the consumer price index-urban adjustment to generic as well as brand name drugs. The OIG is continuing to monitor the Medicaid drug rebate program.</p> | \$123 |
| <p>Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)</p> | <p>The HCFA agreed to recover the improper Medicare billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and OIG. The HCFA did not concur with the recommendation to further expand the payment window.</p> | 83.5 |
| <p>Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)</p> | <p>The HCFA agreed with the recommendation that the Medicare 190-day lifetime limit for psychiatric admissions be extended to general hospitals.</p> | 47.6 |
| <p>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)</p> | <p>The HCFA issued a final regulation which addresses the coverage of ambulance services and vehicle and staff requirements. The Balanced Budget Act of 1997 required that HCFA link payments to services provided and that the definitions of basic life support and advanced life support ambulance services be subject to negotiated rulemaking. The Negotiated Rulemaking Committee Statement on the Medicare Ambulance Services Fee Schedule was signed in February 2000. The HCFA published the proposed rule, which includes revised physician certification requirements, in the Federal Register in September 2000.</p> | 47 |
| <p>Limit Reimbursement for Hospital Beds: The HCFA should take immediate steps to reduce Medicare payments for hospital beds used in the home. This should include the elimination of the higher reimbursement rate currently paid during the first 3 months of rental. (CIN: A-06-91-00080; OEI-07-96-00221; OEI-07-96-00222)</p> | <p>The HCFA concurred with the recommendations and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency has included hospital beds and supplies as part of its ongoing competitive bidding demonstration project for durable medical equipment.</p> | 40 |

| OIG Recommendation | Status | Savings in Millions |
|--|---|------------------------|
| <p>Reduce End Stage Renal Disease Payment Rates:</p> | <p>The HCFA agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing these rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatment. A March 1996 study by ProPAC recommended an increase to the current rates, but HCFA did not believe an across-the-board increase was warranted and intended to monitor facilities' costs and other factors to determine if a rate increase would be appropriate. Toward this end, the BBA of 1997 requires the Secretary to audit the cost reports of each renal dialysis provider at least once every 3 years. The HCFA began these audits in the fourth quarter of FY 1999.</p> | \$22* |
| <p>Preclude Improper Medicaid Reimbursement for Clinical Laboratory Services:</p> | <p>The HCFA wrote to all State Medicaid directors on January 15, 1997, alerting them to the OIG review, encouraging them to use Medicare's bundling policies and urging them to install appropriate payment edits in their claim processing systems. Currently, OIG is conducting several follow-up reviews in this area.</p> | 17.8 |
| <p>State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings that contain duplicate tests, recover overpayments and make adjustments for the Federal share of the amounts recovered. (CIN: A-01-95-00005; CIN: A-05-95-00035; CIN: A-01-96-00001; CIN: A-06-95-00078; CIN: A-06-95-00031; CIN: A-04-95-01108; CIN: A-04-95-01109; CIN: A-07-95-01139; CIN: A-07-95-01147; CIN: A-04-95-01113; CIN: A-07-95-01138; CIN: A-09-95-00072; CIN: A-05-96-00019; CIN: A-10-95-00002; CIN: A-01-95-00006; CIN: A-02-95-01009; CIN: A-03-96-00200; CIN: A-03-96-00202; CIN: A-03-96-00203; CIN: A-05-95-00062; CIN: A-06-96-00002; CIN: A-06-95-00100; CIN: A-04-98-01185)</p> | | |

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

| OIG Recommendation | Status | Savings in Millions |
|---|--|------------------------|
| <p>Medicare Orthotics: HCFA should take action to improve Medicare billing for orthotic devices. HCFA should also require standards for suppliers of custom-molded and custom-fabricated orthotic devices. (OEI-02-99-00120)</p> | <p>The HCFA generally concurred with the recommendations. However, HCFA did not agree to set specific standards for suppliers of custom-molded and custom-fabricated devices.</p> | \$33 |
| <p>Medicare Claims for Railroad Retirement Beneficiaries: Discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)</p> | <p>The FY 2001 budget does not include this type of legislative proposal.</p> | 9.1 |
| <p>Indirect Medical Education: Reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (CIN: A-07-88-00111)</p> | <p>The HCFA agreed with the recommendation, and the BBA of 1997, as amended by the BBRA 1999, reduces the IME adjustment to 5.5 percent in 2002 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.</p> | to be determined |
| <p>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)</p> | <p>The HCFA was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. The HCFA favored indefinitely extending the MSP provision for all other services. Although the BBA of 1997 extends MSP policies for individuals with ESRD to 30 months, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.</p> | to be determined |
| <p>Home Health Agencies: The HCFA should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (CIN: A-04-95-01103; CIN: A-04-95-01104; OEI-04-93-00262; OEI-04-93-00260; OEI-12-94-00180; OEI-02-94-00170; CIN: A-04-94-02087; CIN: A-04-94-02078; CIN: A-04-96-02121; CIN: A-04-97-01169; CIN: A-04-97-01166; CIN: A-04-97-01170; CIN: A-04-99-01194)</p> | <p>Although the Congress and the Administration included provisions to restructure home health benefits in the BBA of 1997, HCFA still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. While agreeing in principle, HCFA said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. The OIG will continue to do work in this area.</p> | to be determined |

| OIG Recommendation | Status | Savings in Millions |
|--|---|-------------------------|
| <p>Establish Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement:</p> | <p>The HCFA disagreed with the recommendation to seek a legislative change, believing that such legislation was not feasible at the time. However, HCFA stated that changing AMP to AWP would reduce the administrative burden involved in the AMP calculations and planned a comprehensive study of AWP.</p> | <p>to be determined</p> |
| <p>The HCFA should seek legislation that would require participating drug manufacturers to pay Medicaid drug rebates based on AWP or study other viable alternatives to the current program of using average manufacturer price (AMP) to calculate the rebates. This legislation would have resulted in about \$1.15 billion in additional rebates for 100 brand name drugs with the highest total Medicaid reimbursements in Calendar Years 1994-96. (CIN: A-06-97-00052)</p> | | |

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

| | | |
|--|---|---------------|
| <p>Institute and Collect User Fees for Food and Drug Administration Regulations:</p> | <p>In the absence of specific authorizing legislation, the Food and Drug Administration (FDA) is precluded by statute from imposing user fees to cover additional functions. The FY 2001 President's budget request for FDA proposes that FDA be given new user fee authority to perform premarket review of direct food additives, food export certificates, and medical device review of 510(k)s.</p> | <p>\$75.9</p> |
| <p>Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)</p> | | |
| <p>Medicare Rates for Indian Health Service Contracted Health Services:</p> | <p>The IHS concurred with OIG's recommendations and is continuing its efforts to obtain discount rates throughout its service area. However, no legislative proposal is included in the FY 2001 budget.</p> | <p>8.2</p> |
| <p>The Indian Health Service (IHS) should revise its legislative proposal to incorporate OIG's updated savings figures and should identify elements to be included in the implementing regulations. Also, IHS should continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates and should strategically identify and pursue other opportunities where lower rates may be negotiated. (CIN: A-15-97-50001)</p> | | |

| OIG Recommendation | Status | Savings in Millions |
|--|---|------------------------|
| <p>Recharge Center Costs: The Assistant Secretary for Management and Budget should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (CIN: A-09-96-04003)</p> | <p>The Deputy Assistant Secretary for Grants and Acquisition Management concurred with the recommendations. In addition, the Council on Government Relations generally agreed and stated that the proposed criteria should be included in the Compliance Supplement to OMB Circular A-133, which provides guidance to independent auditors in conducting compliance audits of educational institutions.</p> | 1.9 |

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

| OIG Recommendation | Status |
|---|---|
| HEALTH CARE FINANCING ADMINISTRATION | |
| <p>Implement Proper Accountability over Billing and Collection of Medicaid Drug Rebates:</p> <p>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)</p> | <p>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 also has a task force to help with rebate resolution.</p> |
| <p>Ensure that the Medicare Accounts Receivable Balance Is Fairly Presented:</p> <p>The HCFA should require contractors to implement or improve internal controls and systems to ensure that reported accounts receivable are valid and documented. (CIN: A-17-95-00096; CIN: A-17-97-00097; CIN: A-17-98-00098; CIN: A-17-00-00500)</p> | <p>The HCFA hired consultants to assist in validating the FY 1999 accounts receivable activity and balance, as well as the activity for the first 6 months of FY 2000. The agency also provided training on accumulating and verifying receivable balances.</p> |
| <p>Consider Recommended Safeguards over Medicaid Managed Care Programs:</p> <p>The HCFA should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)</p> | <p>The HCFA generally concurred with OIG's recommendations but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.</p> |
| <p>Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program:</p> <p>The HCFA should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The HCFA should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)</p> | <p>The HCFA did not concur stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP, but did not provide specific written methodology for computing AMP.</p> |
| <p>Physician Office Surgery:</p> <p>The peer review organizations (PROs) should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)</p> | <p>The HCFA has issued policy guidance and manual instructions to explicitly state that PROs have the responsibility to review all care in physician offices when a beneficiary complains.</p> |

| OIG Recommendation | Status |
|---|---|
| <p>Properly Account for Medicare Secondary Payer Overpayments: Although agreement was reached to relieve Blue Cross and Blue Shield plans of past due Medicare secondary payer (MSP) overpayments, HCFA should continue to implement financial management systems to ensure that all overpayments (receivables) are accurately recorded. (CIN: A-09-89-00100)</p> | <p>The HCFA is currently pursuing the recommended administrative action through improved information systems to guard against making improper Medicare payments to the Blue Cross and Blue Shield plans.</p> |
| <p>Investigate Patient Dumping Complaints: The HCFA should improve its processes for investigating and resolving complaints involving potential violations of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act, commonly referred to as patient dumping. (CIN: A-06-93-00087)</p> | <p>The HCFA concurred with OIG's recommendations.</p> |
| <p>Medicare Beneficiary Satisfaction with Durable Medical Equipment Regional Carrier Services: The HCFA should evaluate ways to increase beneficiary satisfaction with the one durable medical equipment regional carrier with a low rating, and review effective ways to educate beneficiaries on what constitutes fraud and abuse. (OEI-02-96-00200)</p> | <p>The HCFA concurred. The HCFA conducts annual evaluations to identify ways to improve performance. The HCFA is also working to develop new outreach techniques to increase beneficiaries' knowledge on detecting fraud and abuse.</p> |
| <p>Pressure Reducing Support Services: The HCFA should establish the requirement for periodic review and renewal of the medical necessity for beneficiaries' use of group 2 support surface equipment. (OEI-02-95-00370)</p> | <p>The HCFA did not concur.</p> |
| GENERAL OVERSIGHT | |
| <p>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)</p> | <p>The Department is revising hospital cost principles to be consistent with OMB circulars.</p> |

APPENDIX D

Notes to Tables I and II

Table I

¹ The opening balance was adjusted downward by \$27.7 million.

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

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|--------------------|--|
| CIN: A-03-98-00590 | PAEAP: The auditee provided documentation to support \$626,292 in expenditures. |
| CIN: A-10-96-43200 | Bannock Tribes: Based on further review it was determined that \$366,194 in expenditures were allowable. |
| | Not detailed are revisions to previously disallowed management decisions totaling \$483,100. |

³ Included are management decisions to disallow \$526,902 in audits performed by the Defense Contract Audit Agency.

⁴ Included are management decisions to disallow \$10.5 million that was identified in nonfederal audit reports.

⁵ Audits on which a management decision had not been made within 6 months of issuance of the report:

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

| | |
|---------------------|--|
| CIN:: A-07-99-00980 | Assist. Review of Medicare A/R HCFA RO KCMO, January 2000, \$39,730,982 |
| CIN: A-04-98-00122 | Emergency Assistance Claims - NC HHS/Div. Mental Hlth., September 1999, \$25,993,849 |
| CIN: A-05-94-00064 | MI Blue Cross/Blue Shield, Audit of Admin. Costs, June 1996, \$15,609,718 |
| CIN: A-07-96-01176 | Medicare Excess Pension Assets - BC Mich, November 1996, \$11,904,263 |
| CIN: A-03-97-00013 | BCBSM FY 89-92 Incremental Claim, September 1998, \$11,723,785 |
| CIN: A-05-99-00070 | Monitoring - Contract Audit of HCSC & Termination, March 2000, \$9,921,720 |
| CIN: A-09-97-44262 | State of California, April 1997, \$7,419,900 |
| CIN: A-03-91-00552 | Independent Living Program " National, March 1993, \$6,529,545 |
| CIN: A-07-99-02537 | Blue Cross & Blue Shield of Massachusetts, November 1999, \$5,270,461 |
| CIN: A-05-96-00058 | Close - Out Audit of Medicare Contract -BCBS - MI, December 1997, \$5,226,443 |
| CIN: A-09-99-57988 | State of Arizona, June 1999, \$4,950,000 |
| CIN: A-01-97-00516 | Admin. Costs - Part A&B, Railroad Retire Board, June 1999, \$4,939,184 |
| CIN: A-07-96-02001 | Medicare Part B Admin. Costs at BC/BS Colorado, December 12, 1996, \$4,483,104 |
| CIN: A-05-94-00080 | Associated Ins. Medicare Administrative Costs, July 1996, \$3,954,632 |

CIN: A-02-98-02002 NYS-REV. of Retroactive State Foster Care Claims, February 2000, \$3,636,657

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

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

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

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

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

CIN: A-05-93-00013 MI-Blue Cross/Blue Shield - Contract Medicare Audit, April 1993, \$3,010,916

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

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

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

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

CIN: A-07-92-00579 BC/BS of Michigan Inc. -Unfunded Pension Costs, October 1992, \$2,535,698

CIN: A-05-92-00026 Associated Insurance CO - Medicare Admin., August 1992, \$2,530,409

CIN: A-07-98-02523 BC/California -FACP, April 1999, \$2,408,019

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

CIN: A-04-97-01166 Rev. Home Health Services By Staff Builders Home Health, April 1999, \$2,300,000

CIN: A-04-97-01170 Review Home Health Services By Medicare Home Hlth. Srvcs., April 1999, \$2,200,000

CIN: A-01-99-00501 Psychiatric Outpatient Services At Waterbury Hosp., October 1999, \$2,122,333

CIN: A-04-97-01169 Review Home Health Services By Staff Builders Home HLTH SRVCS., April 1999, \$1,900,000

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

CIN: A-01-98-02505 Rev. of Retro Adj. Filed By MA. UNDR I V-E F/C PRGM, February 2000, \$1,850,000

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

CIN: A-05-95-00059 Audit of Administrative Costs - BC/BS Michigan, January 1997, \$1,787,345

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

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

CIN: A-06-99-00006 Contract Audit of BC/BS Administrative Costs , November 1999, \$1,615,063

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

CIN: A-06-96-00008 Arkansas BCBS Admin Cost - Contracted, September 1996, \$1,442,193

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

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

CIN: A-09-96-00064 ORT - Hospice - California, March 1997, \$1,350,000

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

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

CIN: A-02-98-52102 NA-Puerto Rico Family Dept. Of Children & Families, March 1998, \$1,321,656

CIN: A-02-96-01016 Empire Admin. Costs Part B Gardiner, Kamy & Assoc., April 1997, \$1,296,098

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

CIN: A-02-97-01026 EDDY VNA (#337152) HHA Eligibility Review, September 1999, \$1,131,593

CIN: A-04-00-61448 State of Georgia, February 2000, \$1,108,829

CIN: A-02-94-01029 Hospice Eligibility RVW IN PR - San German -ORT, June 1995, \$1,070,814

CIN: A-05-98-00050 Follow-Up Medicaid Clinical Laboratories, July 1999, \$1,097,036

CIN: A-09-98-00052 California Medical Review Inc. (CA. Pro), January 1999, \$1,067,991

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

CIN: A-01-98-00500 Payment Edits For Psychiatric At MA Part B Carrier, September 1998, \$1,000,000

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

CIN: A-09-94-01010 Closeout Audit--Cont No. N01-ES-75196 (STRATAGENE), March 1994, \$983,208

CIN: A-04-97-02142 Rev. St. Jude Behav. Hlth. Ctrs Part. Hosp. Program., December 1999, \$927,845

CIN: A-08-99-55285 South Dakota Urban Indian Health Inc., June 1999, \$902,377

CIN: A-08-99-55284 South Dakota Urban Indian Health Inc., June 1999, \$902,046

CIN: A-05-92-00060 Contractor Audit - BCBS - Admin., February 1993, \$879,609

CIN: A-02-97-01034 Dr. Pila Foundation Home Care Program (Ponce), September 1999, \$857,208

CIN: A-07-98-02533 Travelers FACP, December 1998, \$854,214

CIN: A-06-99-00013 Medicare Part A Admin. NM Blue Cross Blue Shield, December 1999, \$817,487

CIN: A-02-98-01040 Niagara City Dept. Of Health -#337001 -HHS Elig. Review, December 1999, \$807,679

CIN: A-03-99-00008 Blue Cross Blue Shield of Delaware - Part a, January 2000, \$798,939

CIN: A-07-99-00981 Assist. Review of Medicare A/R HCFA RO Denver, January 2000, \$754,926

CIN: A-06-99-00001 Oklahoma Foster Care Program Maintenance Payments, March 1999, \$737,239

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

CIN: A-09-97-00078 Physician Billings Dr. Spencer, January 1999, \$683,264

CIN: A-04-99-54416 State of Florida, November 1998, \$668,791

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

CIN: A-02-96-01015 Empire Admin. Cost Par A-Gardiner, Kamy & Assoc., April 1997, \$652,492

CIN: A-01-98-00503 Psychiatric Outpt. Services At the Franklin Med Ctr, November 1998, \$646,517

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

CIN: A-04-94-01078 Monitoring Admin. Cost - Audit M Care P. B. BCBSSC, July 1994, \$594,092

CIN: A-10-99-57240 State of Idaho, January 1999, \$594,000

CIN: A-04-93-01069 Monitorg Admin Cost Audit MCARE Part A BCBSSC, July 1994, \$590,844

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

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

CIN: A-04-97-02141 Rev. St. Francis Behav. Hlth. Ctr. Part hosp. Prog., December 1999, \$573,506

CIN: A-04-00-61620 State of North Carolina, March 2000, \$528,952

CIN: A-04-00-60897 State of Florida, March 2000, \$525,210

CIN: A-04-98-01191 Review World Gym Phy. Therapy Ctr. - Compre. Outpatient, January 2000, \$518,479

CIN: A-04-99-01200 OIG-HCFA Joint Review of GEM Physical Therapy Inc., Dec. 1999, \$490,600

CIN: A-09-99-56858 Hawaii Dept. Of Human Services, February 1999, \$502,000

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

CIN: A-04-98-01192 Review Americas Behav. Hlth. Cares Part. Hospitalize, December 1999, \$452,928

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

CIN: A-06-99-56489 State of Louisiana, January 1999, \$421,206

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

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

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

CIN: A-01-99-57863 State of Connecticut, May 1999, \$361,315

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

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

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

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

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

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

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

CIN: A-08-99-59826 NA-Crow creek Sioux Tribe, July 1999, \$291,718

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

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

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

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

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

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

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

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

CIN: A-04-96-01135 PARTIC Part of HCFA Surv. Wash. Manor Nursg - ORT, February 1997, \$220,483

CIN: A-06-99-56489 State of Louisiana, January 1999, \$213,709

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

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

CIN: A-05-00-63219 Bayfield County Rural Health Center Inc., March 2000, \$204,247

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

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

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

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

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

CIN: A-06-00-57470 Jicarilla Apache Tribe, October 1999, \$198,188

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

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

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

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

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

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

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

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

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

CIN: A-09-00-62575 Hawaii Dept. Of the Attorney General, March 2000, \$155,339

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

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

CIN: A-04-96-01147 ORT REV. Parker Jewish Geriatric CTR, New Hyde, NY, April 1997, \$140,188

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

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

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

CIN: A-04-00-61620 State of North Carolina, March 2000, \$135,821

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

CIN: A-02-99-59294 City of New York, August 1999, \$134,835

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

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

CIN: A-09-00-62110 Golden Valley Health Centers, January 2000, \$113,192

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

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

CIN: A-02-96-02001 International Rescue Committee-Refugee Program, January 1998, \$108,604

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

CIN: A-06-99-56908 Pueblo of Acoma, July 1999, \$104,186

CIN: A-09-00-58580 NA-Turtle Mountain Band of Chippewa Indians, November 1999, \$104,590

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

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

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

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

CIN: A-03-98-00007 Delmarva Pro/CCAS/Maryland, DC/HHS -100-95-0029, December 1998, \$95,709

CIN: A-09-98-00065 CSBG Disc. Grant -Latino Resource, January 1999, \$95,102

CIN: A-01-99-00507 Nat.-Wide Ref. Opnt. Psych SVC at Acute Care Hospital, March 2000, \$94,716

CIN: A-10-97-00003 ADM Costs Remote Network Activities FY 93 & 94, February 1998, \$94,643

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

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

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

CIN: A-09-00-63181 Delta Head Start Program, March 2000, \$89,219

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

CIN: A-02-95-34277 Puerto Rico Dept. Of Health, June 1995, \$86,064

CIN: A-02-95-34279 Puerto Rico Dept. of Health, June 1995, \$85,266

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

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

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

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

CIN: A-04-96-01137 Partic. PART of HCFA Surv. Team - Daytona Nursg-ORT, December 1996, \$76,130

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

CIN: A-02-99-58263 Puerto Rico Office of The Governor Office of Child, July 1999, \$73,819

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

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

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

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

CIN: A-06-99-56886 NA-Cheyenne-Arapaho Tribes of Oklahoma, July 1999, \$64,635

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

CIN: A-04-00-60897 State of Florida, March 2000, \$62,649

CIN: A-01-97-49174 MI Dept. Of Community Health/Medicaid Lab Services, August 1997, \$59,956

CIN: A-06-00-62014 Alabama-Coushatta Tribe of Texas, March 2000, \$59,874

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

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

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

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

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

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

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

CIN: A-07-99-59813 State of IOWA, August 1999, \$54,662

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

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

CIN: A-07-98-50741 Citizen Housing Information Council Inc., March 1998, \$52,758

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

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

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

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

CIN: A-02-95-34275 Puerto Rico Dept. Of Health, June 1995, \$46,842

CIN: A-06-00-62531 NA-Five Sandoval Indian Pueblos Inc., February 2000, \$46,772

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

CIN: A-06-00-62101 Vermilion Parish Police Jury, January 2000, \$44,915

CIN: A-09-99-56858 Hawaii Dept. Of Human Services, February 1999, \$44,144

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

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

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

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

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

CIN: A-09-99-59787 Palau Community Action Agency, June 1999, \$40,212

CIN: A-04-00-63370 Chatham-Savannah Youth Futures Authority, March 2000, \$37,463

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

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

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

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

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

CIN: A-05-99-59494 Sheboygan Human Rights Association Inc., May 1999, \$35,786

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

CIN: A-06-00-62566 Five Sandoval Indian Pueblos Inc., February 2000, \$34,300

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

CIN: A-03-99-56842 National Association for Equal Opportunity In High, February 1999, \$33,585

CIN: A-01-99-60258 State of Connecticut, July 1999, \$33,377

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

CIN: A-03-99-0004 PSU - Geisinger / Phy. Credit Balances / Medicare, December 1999, \$32,165

CIN: A-04-00-60759 State of Mississippi, January 2000, \$32,011

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

CIN: A-04-00-62871 Community Health of South Dade Inc., March 2000, \$31,000

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

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

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

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

CIN: A-04-00-61897 American Cancer Society Inc. National Home Office, January 2000, \$28,654

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

CIN: A-02-99-58263 Puerto Rico Office of the Governor Office of Child, July 1999, \$27,980

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

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

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

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

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

CIN: A-03-003-0004 Guthrie Clinic / Physician Credit Balances / Medicare, December 1999, \$23,759

CIN: A-01-98-00531 Medicare CR bal Recoup ESRD FAC Florida Blue Cross, January 2000, \$23,586

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

CIN: A-07-99-01290 MOH Admin Cost, November 1999, \$20,548

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

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

CIN: A-01-99-59104 Planned Parenthood of Connecticut Inc., & Subsidiary, August 1999, \$18,791

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CIN: A-05-00-59830 Ho-Chunk Nation, February 2000, \$14,029

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

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

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

CIN: A-05-00-61810 State of Indiana, March 2000, \$13,392

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

CIN: A-03-98-50338 National Medical Association, February 1998, \$12,968

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

CIN: A-10-00-61717 State of Oregon, September 2000, \$11,625

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

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

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

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

CIN: A-04-0060661 NA-Montgomery Community Action Committee Inc., October 1999, \$10,104

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

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

CIN: A-04-97-01153 MS Found. - MCAL Care, MCAre, MCAre Pro Contract Audit, September 1997, \$9,070

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

CIN: A-08-99-56446 Sisseton-Wahpeton Sioux Tribe, May 1999, \$9,000

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

CIN: A-05-99-59468 Community Care in Union County Inc., July 1999, \$8,464

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

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

CIN: A-01-99-57863 State of Connecticut, May 1999, \$7,686

CIN: A-03-91-02004 W. VA B/C Admin Cost FY 85/90 and Term. Cost, November 1992, \$7,556

CIN: A-10-00-61326 Maniilaq Manpower Inc., January 2000, \$7,401

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

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

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

CIN: A-03-99-58532 Advocates for Youth, May 1999, \$7,138

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

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

CIN: A-09-00-60051 Navajo Nation, November 1999, \$6,660

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

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

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

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

CIN: A-02-96-02001 International Rescue Committee - Refugee Program, January 1998, \$6,027

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

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

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

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

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

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

CIN: A-10-00-61327 Maniilaq Manpower Inc., January 2000, \$4,820

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

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

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

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

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

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

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

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

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

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

CIN: A-07-98-02502 CT. BC/BS Pension Costs Claimed, March 1998, \$2,725

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

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

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

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

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

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

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

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

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

CIN: A-07-97-01221 Pro Closeout - Doshi CPA - Ark FDN for Med Care, March 1997, \$2,096

CIN: A-05-98-53899 Stanford Univ., June 1998, \$2,058

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

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

CIN: A-06-00-61714 State of Oklahoma, January 2000, \$1,792

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

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

CIN: A-03-93-20882 United States Pharmacopeil Convention Inc., October 1992, \$989

Table II

¹ The opening balance was adjusted downward by \$1.1 million to reflect a revaluation.

² Included in the total recommendations agreed to by management is \$79,307 resulting from Defense Contact Audit Agency recommendations.

³ Management decision has not been made within 6 months of issuance on 21 reports:

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

| | |
|--------------------|--|
| CIN: A-01-99-00507 | Nat-Wide REF Opnt. Psych SVC at Acute Care Hospital, March 2000, \$224,466,692 |
| CIN: A-07-98-02534 | Empire BC/BS Pension Plan Termination, March 2000, \$38,626,351 |
| CIN: A-04-97-00109 | Emergency Assistance Claims - NC, July 1998, \$13,000,000 |
| CIN: A-03-91-00552 | Independent Living Program--National, March 1993, \$10,161,742 |
| CIN: A-07-96-01177 | Medicare Post Retirement Claim BC MICH, November 1996, \$8,978,998 |
| CIN; A-01-97-02506 | Review of the Avail. of Medical Coverage/CSE Support, June 1998, \$5,704,585 |
| CIN: A-04-98-01188 | Review Admin. Costs @ MCare Managed Risk Plan, August 1999, \$2,559,357 |
| CIN: A-09-95-00095 | Health Services Advisory Group, Inc. (HSAG), December 1995, \$1,389,723 |
| CIN: A-07-97-01230 | OFMO - DOSHI Oklahoma, June 1997, \$203,510 |
| CIN: A-07-97-01231 | Prowest -DOSHI Washington, June 1997, \$163,552 |
| CIN: A-02-96-02001 | International Rescue Committee-Refugee Program, January 1998, \$90,528 |
| CIN: A-07-97-01235 | DOSHI-Texas, June 1997, \$51,334 |
| CIN: A-07-97-01232 | Prowest - DOSHI Alaska, June 1997, \$21,218 |
| CIN: A-09-00-60029 | Cocopah Indian Tribe, December 1999, \$20,830 |
| CIN: A-05-96-00069 | CPA Audit of Hooper Holmes HHA G&A - OI Case Open, February 1998, \$17,555 |
| CIN: A-07-95-01164 | Medicare Admin. Costs - General American, December 1995, \$16,632 |
| CIN: A-06-00-61714 | State of Oklahoma, January 2000, \$15,827 |
| CIN: A-07-97-01227 | MT-WY Foundation for Medical Care, June 1997, \$13,461 |
| CIN: A-06-97-45023 | CADDO Community Action Agency Inc., November 1996, \$8,880 |
| CIN: A-01-97-00526 | Psychiatric Outpatient Services, March 1998, \$7,245 |
| CIN: A-09-94-01022 | Intelligenetics #N01-GM-72110, October 1994, -\$31,852 |

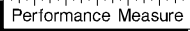
APPENDIX E

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 | 83 |
| 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 | 85 |
| 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 | 81 |
| Section 5(a)(9) | Statistical table II - reports with recommendations that funds be put to better use | 82 |
| Section 5(a)(10) | Summary of previous audit reports without management decisions | appendix D |
| Section 5(a)(11) | Description and explanation of revised management decisions | appendix D |
| Section 5(a)(12) | Management decisions with which the Inspector General is in disagreement | none |

Performance Measures

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

| | Page |
|---|-------------|
| External Quality Review of Psychiatric Hospitals | 2 |
| External Quality Review of Dialysis Facilities | 26 |
| Medicare Conditions of Participation for Organ Donation: An Early Assessment of the New Donation Rules | 27 |
| Nursing Home Vaccination: Reaching Healthy People 2010 Goals | 27 |
| Employer Compliance with Medicare Secondary Payer Data Match Requirements | 34 |
| Medicaid Program Safeguards | 46 |
| Protecting Human Research Subjects | 50 |
| Food and Drug Administration Oversight of State Food Firm Inspections | 52 |
| Maternal and Child Health Training Grants: LEND Program | 53 |
| Health Professions Student Loans Program | 54 |
| National Institutes of Health National Research Service Awards | 57 |
| Fiscal Year 1999 Financial Statement Audits | 59 |
| Federal Occupational Health Billing Operations | 60 |
| Paternity Establishment | 61 |
| Client Cooperation with Child Support Enforcement | 63 |
| Medical Insurance for Dependents Receiving Child Support | 64 |
| Child Support Enforcement State Disbursement Units: State Implementation Progress | 68 |
| Child Support Operations: Tennessee | 69 |
| Fiscal year 1999 Financial Statement Audit of the Administration for Children and Families | 73 |
| Program Support Centers Personnel Service: Customer Service Evaluation | 76 |
| Results Act Review Plan | 76 |
| Reviews of Departmental Service Organizations | 77 |

APPENDIX G

Status of Public Proposals for New and Modified Safe Harbors to the Anti-Kickback Statute Pursuant to Section 205 of the Health Insurance Portability and Accountability Act of 1996

Pursuant to section 205 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, the Inspector General is required annually to solicit proposals (via Federal Register notice) for modifying existing safe harbors to the anti-kickback statute and for developing new safe harbors and special fraud alerts. In accordance with this requirement, on December 10, 1999, the Office of Inspector General published a notice in the Federal Register soliciting such proposals. The OIG received 17 timely-filed responses from a cross-section of organizations, associations, and other interested parties. Some of these respondents commented generally on areas of concern; others provided detailed proposals for new or modified safe harbor regulations.

In crafting safe harbors for a criminal statute, it is incumbent upon OIG to engage in a complete and careful review of the range of factual circumstances that may fall within the proposed safe harbor subject area, so as to uncover all potential opportunities for fraud and abuse by unscrupulous providers. Having done so, OIG must then determine, in consultation with the Department of Justice, whether it can develop regulatory limitations and controls that will be effective in permitting beneficial or innocuous arrangements within the subject area, while at the same time protecting the Federal health care programs and their beneficiaries from abusive practices.

In response to the 1999 annual solicitation, OIG received the following suggestions for safe harbors:

- "Gainsharing" arrangements between hospitals and physicians that provide quality assurances. The OIG does not anticipate implementing this suggestion. As explained in the OIG Special Advisory Bulletin on Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries (July 8, 1999), many "gainsharing" arrangements violate section 1128A(b)(1) & (2) of the Social Security Act and may implicate the anti-kickback statute. Because there are numerous permutations of "gainsharing" arrangements, such arrangements require case-specific evaluation under the anti-kickback statute.
- De minimis gifts made to beneficiaries for recommending a new customer, and to providers and suppliers more generally, along the lines of the proposed regulations under section 1877 of the Act (the physician self-referral law). These suggestions are under study.
- Loans between parties who may be in a position to refer business if the loans are entered into on commercially reasonable terms. This suggestion is under consideration.
- Investment interests in situations where the investors are potential *recipients* of referrals and the investment entity is the potential *source* of referrals. The suggested safe harbor would protect the investment itself, not the return on the investment (as is the case with the existing investment safe harbors). The OIG is studying this suggestion.
- Transactions protected under section 1877 of the Act. The OIG will not adopt this suggestion. It believes Congress intended section 1877 of the Act to establish a minimum threshold for acceptable financial relationships, and that potentially abusive financial relationships that may be permitted under section 1877 of the Act could still be addressed through other statutes that address health care fraud and abuse, including the anti-kickback statute.
- A generic safe harbor setting forth criteria to be considered in determining whether a specific transaction affects the Government's financial interests and patients' care. The OIG will not implement this suggestion, as it does not think it is feasible to develop a set of generic criteria applicable to the wide range of health care arrangements in the marketplace.

In response to the 1999 annual solicitation, OIG received the following suggestions for modifying existing safe harbors:

- Modifying the personal services and management contracts safe harbor and the rental safe harbors to eliminate the requirement that the aggregate compensation over the term of the agreement be set in advance. The OIG will not make this modification to the safe harbor. The requirement that aggregate compensation be set in advance over the term of the

agreement ensures that compensation is not adjusted to reward or induce referrals. Compensation arrangements that are not set in advance in the aggregate are not necessarily illegal and must be evaluated on a case-by-case basis for compliance with the anti-kickback statute.

- Expanding the safe harbor for physician investment in Medicare-certified ambulatory surgical centers (ASCs) to other types of facilities, such as clinical laboratories, cardiac labs, and renal dialysis centers, or creating a new safe harbor for such ventures. The OIG is not prepared to expand the safe harbor or create a separate safe harbor at this time. Investments by referring physicians or combinations of referring physicians and hospitals in non-ASC clinical joint ventures do not share the same background of supportive Federal policy and are not subject to the same prospectively-fixed reimbursement structure as investments by physicians in ASCs. The OIG is concerned that investments in ancillary services may create incentives for overuse and lead to increased Federal health care program costs.
- Modifying the employment safe harbor to conform it more closely to the employee exception in section 1877 of the Act (the physician self-referral law) by adding fair market value and commercial reasonableness standards. The OIG is studying this suggestion.
- Replacing safe harbor conditions that rely on Health Professional Shortage Area (HPSA) designations with alternate measures of underserved areas. The OIG is studying this suggestion.
- Revisiting the existing safe harbor for group purchasing organizations in light of evolving fee arrangements in the marketplace. The OIG is studying this suggestion.
- Modifying existing safe harbors to reflect the expansion of the anti-kickback statute to all Federal health care programs, not just Medicare and Medicaid. The OIG intends to adopt this suggestion in future rulemaking.
- Modifying the investment interests safe harbor to create a presumption that manufacturers are not "tainted" investors on the grounds that they are rarely in a position to refer or influence patient referrals. The OIG declines to adopt this suggestion for a categorical presumption with respect to manufacturers. Whether a particular party to a transaction is in a position to make or influence referrals requires a case-by-case evaluation. The OIG believes there are circumstances where manufacturers may be in a position to make or influence referrals.

Finally, OIG is continuing to study safe harbor suggestions received in response to prior annual solicitations and reported in prior semiannual reports.

ACRONYMS

| | |
|--------|---|
| AARP | American Association of Retired Persons |
| ACF | Administration for Children and Families |
| ACR | adjusted community rate |
| ADR | adverse drug reaction |
| AHRQ | Agency for Healthcare Research and Quality |
| ALJ | administrative law judge |
| AoA | Administration on Aging |
| ASMB | Assistant Secretary for Management and Budget |
| ATSDR | Agency for Toxic Substances and Disease Registry |
| AWP | average wholesale price |
| BBA | Balanced Budget Act of 1997 |
| CBO | Congressional Budget Office |
| CDC | Centers for Disease Control and Prevention |
| CIN | common identification number |
| CMP | civil monetary penalty |
| CSE | child support enforcement |
| CY | calendar year |
| DME | durable medical equipment |
| DOJ | Department of Justice |
| DRG | diagnosis-related group |
| ESRD | end stage renal disease |
| FDA | Food and Drug Administration |
| FEHBP | Federal Employees Health Benefits Program |
| FFP | Federal financial participation |
| FI | fiscal intermediary |
| FY | fiscal year |
| GME | graduate medical education |
| HCFA | Health Care Financing Administration |
| HEAL | health education assistance loan |
| HHA | home health agency |
| HHS | Department of Health and Human Services |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| HIPDB | Healthcare Integrity and Protection Data Bank |
| HMO | health maintenance organization |
| HRSA | Health Resources and Services Administration |
| IDPN | intradialytic parenteral nutrition |
| IHS | Indian Health Service |
| IME | indirect medical education |
| MCO | managed care organization |
| MFCU | Medicaid fraud control unit |
| MSP | Medicare secondary payer |
| NIH | National Institutes of Health |
| OBRA | Omnibus Budget Reconciliation Act |
| OCSE | Office of Child Support Enforcement |
| OMB | Office of Management and Budget |
| OPDIV | operating division |
| PATH | physicians at teaching hospitals |
| PHS | Public Health Service |
| PIN | provider identification number |
| PPS | prospective payment system |
| PRO | peer review organization |
| PSC | Program Support Center |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SCHIP | State Children's Health Insurance Program |
| SNF | skilled nursing facility |
| TANF | Temporary Assistance for Needy Families |
| UPIN | unique physician identification number |
| UPN | universal product number |

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

| | |
|--|---|
| P.L. 96-304 | Supplemental Appropriations and Rescissions Act of 1980 |
| P.L. 96-510 | Comprehensive Environmental Response, Compensation and Liability Act |
| P.L. 97-255 | Federal Managers' Financial Integrity Act |
| P.L. 97-365 | Debt Collection Act of 1982 |
| P.L. 99-499 | Superfund Amendments and Reauthorization Act of 1986 |
| P.L. 101-576 | Chief Financial Officers Act of 1990 |
| P.L. 102-486 | Energy Policy Act of 1992 |
| P.L. 103-62 | Government Performance and Results Act of 1993 |
| P.L. 103-355 | Federal Acquisition Streamlining Act of 1994 |
| P.L. 103-356 | Government Management Reform Act of 1994 |
| P.L. 104-156 | Single Audit Act Amendments of 1996 |
| P.L. 104-191 | Health Insurance Portability and Accountability Act of 1996 |
| P.L. 104-193 | Personal Responsibility and Work Opportunity Act of 1996 |
| P.L. 104-208 | Federal Financial Management Improvement Act of 1996 |
| Office of Management and Budget Circulars: | |
| A- 21 | Cost Principles for Educational Institutions |
| A- 25 | User Charges |
| A- 50 | Audit Follow-up |
| A- 76 | Performance of Commercial Activities |
| A- 87 | Cost Principles for State, Local and Indian Tribal Governments |
| A-102 | Grants and Cooperative Agreements with State and Local Governments |
| A-110 | Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations |
| A-122 | Cost Principles for Nonprofit Organizations |
| A-123 | Management Accountability and Control |
| A-127 | Financial Management Systems |
| A-129 | Policies for Federal Credit Programs and Non-Tax Receivables |
| A-133 | Audits of States, Local Governments and Non-Profit Organizations |
| A-134 | Financial Accounting Principles and Standards |

General Accounting Office Government Auditing Standards

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

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

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

Title 31, United States Code, section 3729-3733, (the False Claims Act) and 3801-3812 (the Program Fraud Civil Remedies Act)

Title 42, United States Code, sections 1320a-7, 1320a-7a, 1320b-10, 1320c-5, 1395l, 1395m, 1395u, 1395dd and 1396b

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