



Department of Health
and Human Services

Office of Inspector General

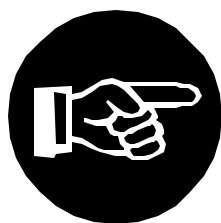
Semiannual Report

October 1, 1998 - March 31, 1999



June Gibbs Brown
Inspector General

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

A MESSAGE FROM THE SECRETARY

Because it is critical that every Federal dollar spent on programs of the Department of Health and Human Services (HHS) goes to meet the needs of the beneficiaries we serve, we must do all we can to eliminate fraud, waste and abuse in those programs. In the last few years, we have made great strides in that effort through a comprehensive strategy of tougher oversight and stricter enforcement. And the Office of Inspector General (OIG) has been at the forefront of that battle.

Forging partnerships within and beyond the Department, OIG has worked with others to develop innovative methods of preventing fraud when possible and prosecuting it when necessary. In the health care arena, OIG has sought ways to inform and educate the public, including the provider and beneficiary communities, and enlist their support in avoiding improprieties. In one such effort, OIG is encouraging health care providers to strengthen their internal controls and helping them do so through the issuance of model compliance guidance.

Although HHS still has a great deal to accomplish, I am heartened by our successes. In a recent audit of the Health Care Financing Administration's financial statements, OIG found that improper Medicare payments to health care providers dropped dramatically last year. The error rate in Fiscal Year (FY) 1998 was 7.1 percent; that amounts to a remarkable 45 percent reduction in overpayments in just 2 years.

The OIG is also collaborating with the HHS Office of Child Support Enforcement to sponsor a multiagency, multijurisdictional task force whose mission is to identify, investigate and prosecute the most egregious violators of the Federal and State child support laws. Based on the success of the initial task force in the Midwest, the President has announced expansion of this model to four additional areas of the Nation.

I share the Inspector General's pride in OIG's achievements. Her office has repeatedly proven its value to the American public and the Nation's decision-makers. I am confident that OIG will continue to be a solid investment for the taxpayers as it works with the Department to safeguard HHS programs for future generations.

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

Donna E. Shalala

FOREWORD

This semiannual report summarizes the activities and accomplishments of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) for the 6-months ending March 31, 1999. As evidenced by the achievements discussed throughout the report, this has been a highly productive period for OIG.

As an organization whose statutory mission is to prevent and detect fraud, waste and abuse and promote economy, efficiency and effectiveness in agency programs and operations, we play a pivotal role in assisting the Department to work better and spend its vital resources wisely. The issues confronted by the Department are often complex and defy easy solutions. In past audits of the Department's financial statements, for example, we found that the controls needed to ensure the integrity of program payments were not sufficiently reliable. However, we are beginning to see real progress in that area. Our most recent review of the Health Care Financing Administration's financial statements indicated a significant decrease in the Medicare payment error rate in Fiscal Year 1998.

Clearly, we cannot eliminate the errors, waste and fraud in HHS programs and operations without relentless oversight through audits, investigations and evaluations. But we can further heighten our effectiveness by collaborating with others who share our goals.

Authorized by the Health Insurance Portability and Accountability Act of 1996, the Health Care Fraud and Abuse Control Program established an antifraud partnership between our office and the Department of Justice (DOJ). We have recently filed our second joint report on the accomplishments of that collaborative crackdown on health care fraud and are pleased at the progress made as a result of the new statutory tools and dedicated funding provided us.

While enforcement remains one of our key resources, we are also expanding those activities that are designed to *prevent* fraud and abuse. In keeping with that posture, we have reached out to the health care industry in our antifraud efforts. We are seeking a constructive collaboration with health care providers that fosters compliance with program requirements. Therefore, in addition to publishing compliance guidance in the areas of clinical laboratories, hospitals, home health agencies and third-party billing companies, we have issued special fraud alerts, advisory opinions and a provider self-disclosure protocol.

We have employed a similar partnership approach in the area of child support enforcement, and are gratified at the Administration's decision to expand the child support enforcement task force based on its initial success.

The formation of these and other alliances has greatly enhanced our ability to pursue OIG's mission. I am proud of the teamwork, diligence and professionalism of my staff and am certain that we are equal to the challenges that lie ahead.

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

June Gibbs Brown
Inspector General

HIGHLIGHTS

Introduction

During the 6-month period ending March 31, 1999, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) carried out a number of initiatives in furtherance of its mission to protect HHS programs and the health and welfare of the beneficiaries served by them. Highlights of OIG's accomplishments for this period follow.

Statistical Accomplishments

For the first half of FY 1999, OIG reported savings of \$6.8 billion, comprised of \$6,446.1 million in implemented recommendations and other actions to put funds to better use, \$140.5 million in audit disallowances and \$175.8 million in investigative receivables. (See Appendix A and the sections entitled "Resolving Office of Inspector General Recommendations, A. Questioned Costs" and "Investigative Prosecutions and Receivables" in the General Oversight chapter of this report for details.)

In addition, for the first half of FY 1999, OIG reported 1,287 exclusions of individuals and entities for fraud or abuse of the Federal health care programs and/or their beneficiaries, 179 convictions of individuals or entities that engaged in crimes against departmental programs, and 287 civil actions. (See sections entitled "Fraud and Abuse Administrative Sanctions" in the Health Care Financing Administration chapter and "Investigative Prosecutions and Receivables" in the General Oversight chapter of this report.)

Mental Health Payment Abuse

As authorized by the Omnibus Budget Reconciliation Act of 1990, the Medicare partial hospitalization program pays for intensive outpatient psychiatric services provided to acutely ill individuals who would otherwise require hospitalization. These services can be provided by either hospital outpatient departments or community mental health centers. Several OIG reports issued this reporting period point out abuses in provider charges to the program.

Community Mental Health Centers

With the Health Care Financing Administration (HCFA), OIG reviewed Medicare payments for partial hospitalization services to community mental health centers (CMHCs) in five States. The OIG estimated that for the 12-month period ending September 30, 1997, Medicare paid these CMHCs \$229 million for unallowable and highly questionable services. This equaled 91 percent of the total \$252 million paid to all CMHCs in the five States (Florida, Texas, Colorado, Pennsylvania and Alabama). In response to OIG's recommendations, HCFA developed a 10-point initiative which included both immediate and long-term actions, such as termination of egregious CMHCs, intensified medical reviews, overpayment collections and various legislative actions. (See page 11)

Outpatient Psychiatric Services

The OIG determined that over \$600,000 in charges for outpatient psychiatric services claimed by one Massachusetts hospital did not meet Medicare criteria for reimbursement. The OIG also found that a New England Medicare carrier failed to apply the 62.5 percent Medicare limit for certain outpatient mental health services; as a result, the carrier overpaid providers an estimated \$1 million in Calendar Year 1996. Appropriate recovery was recommended in both situations. (See pages 12 and 13)

Medicare Managed Care

As of September 1998, almost 7 million Medicare beneficiaries received their health care services through managed care plans, such as health maintenance organizations (HMOs). During this reporting period, OIG looked at several aspects of managed care:

Payment Methodology

The OIG pointed out that the new payment methodology authorized by the Balanced Budget Act of 1997 still links managed care capitation rates to Medicare fee-for-service expenditures -- which past OIG financial statement audits determined to be substantially inflated with improper payments. While HCFA agreed that Medicare payments to managed care organizations have been overstated and should be reduced, it disagreed with OIG's recommended legislative correction. The OIG estimated that annual savings associated with a corrected 1997 base year could be \$5 billion in 2002 and increase to over \$10 billion in 2007. (See page 9)

Administrative Costs

An OIG review of administrative costs included in the adjusted community rate proposals submitted by five Medicare managed care contractors identified millions in administrative costs that would be considered inappropriate in other Medicare reimbursement situations. These results are being shared with HCFA for its consideration of appropriate legislative changes. (See page 10)

Patient Dumping

Referrals of potential Patient Anti-Dumping Statute (PADS) violations have continued to be received by OIG at a steady pace. A violation of PADS occurs if a Medicare participating hospital, or a physician associated with that hospital, did not provide an emergency medical screening examination and/or appropriate stabilizing treatment for an emergency medical condition to a patient who presented at that hospital. Currently, OIG is investigating over 140 cases of alleged patient dumping. These cases, however, represent more than 490 instances of potential violations. During the first half of FY 1999, OIG settled 34 cases and imposed \$985,000 in civil monetary penalties. The OIG also required community outreach obligations. In addition, OIG is litigating six PADS cases. These cases involve two hospitals and four physicians. (See page 21)

Drug Reimbursement

In a report that compared Medicare drug reimbursement to Department of Veterans Affairs (VA) drug costs, OIG found that Medicare and its beneficiaries could save \$1 billion per year if the Medicare allowed amounts for 34 drugs were equal to prices obtained by VA. This potential savings represents almost half of the \$2.07 billion that Medicare and its beneficiaries paid for these drugs in 1997. Shortly after the report's release, the President called for a reduction in reimbursement for Medicare prescription drugs, which was supported by this study and a number of previous studies on the same issue. (See page 32)

Outreach Efforts

The OIG has engaged in numerous proactive outreach initiatives designed to help the medical industry avoid fraud and waste, and to increase compliance with Medicare rules. In addition, OIG has sought to enlist the help of the public in fighting fraud and waste.

Compliance Guidance

The OIG continues its efforts to promote voluntarily developed and implemented compliance programs by providing guidance to the health care industry. During this reporting period, OIG developed and released a compliance program guidance for third-party medical billing companies; published in the Federal Register a draft guidance for the durable medical equipment industry; and issued notices with respect to its plan to develop compliance guidance for the nursing home and hospice industries, as well as Medicare+Choice organizations that offer coordinated care plans. (See page 25)

Beneficiary Outreach

On February 24, HHS joined the Department of Justice and the American Association of Retired Persons to launch a new national initiative against waste, fraud and abuse in the Medicare program. The OIG has spearheaded that effort from the beginning, working with HCFA and the Administration on Aging to develop educational materials, promote the OIG's fraud hotline and set up networks to get the campaign's message out. The campaign has been in development for 2 years.

Titled, "Who Pays? You Pay," the campaign is aimed at reducing waste, including simple billing errors as well as unnecessary or excessive spending, and criminal fraud and abuse against the Medicare program. It asks beneficiaries to raise billing questions first with their providers or Medicare insurance companies, since most problems can be resolved there. If beneficiaries believe they have detected fraud, or if they are not satisfied with the explanation of the Medicare carrier, they are asked to call the HHS Inspector General Hotline at 1-800-HHS-TIPS. (See page 26)

Youth Use of Cigars

The OIG issued a pair of inspection reports warning about cigar use among teenagers and recommending mandatory warning labels similar to those on cigarettes and other tobacco products. The study included 18 focus groups involving a mix of 227 young cigar users and nonusers of different backgrounds and locations across the country. The OIG found that 19

percent of the teenagers in the focus groups admitted to having smoked a cigar in the past 30 days, and half the smokers said they expect to be cigar users 5 years into the future. The participants reported widespread cigar use and experimentation among their peers, and disclosed that some teens create modified cigars called "blunts" by removing some or all of the core tobacco and replacing it with marijuana. The OIG also found that State level enforcement is uneven and is generally given a lower priority than enforcement of unlawful cigarette and spit tobacco sales. (See page 46)

Misuse of Grant Funds

Two significant cases involving allegations of misuse of departmental grant funds were resolved during this reporting period:

Sale of Unlicensed Drug

The University of Minnesota agreed to pay \$32 million to resolve its civil liability for the sale of an unlicensed, experimental drug over a period of more than 20 years. The lawsuit sought recovery of profits and damages for alleged violations of Food and Drug Administration regulations prohibiting the commercial sale of unlicensed drugs, and departmental rules governing the handling of program income earned with grant funds. This represents the largest settlement of allegations of grant fraud against a college or university. (See page 42)

Foster Care

The City and State of New York agreed to pay \$49 million to settle charges that a city agency had misused \$39 million over a 4-year period. The agency had not provided required foster care services, such as developing case plans and conducting periodic reviews. (See page 54)

Child Support Enforcement

The OIG has made the detection and prosecution of absent parents who fail to pay court-ordered child support an agency priority in the last several years. Through audits, inspections and investigations, 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. In the area of investigations, OIG has opened 559 child support cases nationwide since 1995. These cases have resulted in 112 convictions and court-ordered restitution of over \$7.8 million.

In 1998, as part of its effort to further increase child support collections, OIG and OCSE initiated a multiagency, multijurisdictional investigative task force which consisted of enforcement units from different States. The task force is 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. The goal of the task force is to create a streamlined system of referral, investigation and prosecution that will bring to justice the most egregious offenders. The success of this first

task force resulted in widespread interest in exporting the concept to more areas of the country. With the support of the Department of Justice, the Secretary and the White House, 4 more task force sites covering an additional 16 States have been chosen. The first additional site, Baltimore, Maryland, is now operational, and it is expected that all five task forces will be functioning by the end of this fiscal year. (See page 50)

Departmental Oversight

As part of its oversight responsibilities for departmental activities, OIG assessed the Department's progress toward Year 2000 computer system readiness and, through the financial statement audit process, accountability for taxpayer dollars.

Year 2000 System Compliance

As the millennium approaches, OIG is monitoring the Department's progress in renovating its mission-critical computer systems to recognize and process four-digit dates. This effort is part of an initiative by the President's Council on Integrity and Efficiency to monitor preparations throughout the executive branch.

To allow time for dealing with unanticipated problems, the Department set December 31, 1998 as its deadline for system compliance. Most Operating Divisions met this due date. (See page 60)

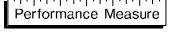
Federal Financial Accountability

Although OIG's recent audit of the departmentwide consolidated financial statements for FY 1998 noted an improvement in Federal financial accountability, OIG's opinion on the statements continues to be qualified. Continuing problems in documenting Medicare accounts receivable activity and difficulty in having available all accounting information needed for audit of statements of budgetary resources, financing, and custodial activity are the primary reasons for the qualification.

On a positive note, OIG reported a significant reduction in the estimated amount of improper Medicare fee-for-service payments in FY 1998 -- a 45 percent reduction since FY 1996. The error rate for FY 1998 was an estimated 7.1 percent, representing estimated improper payments of \$12.6 billion. This compares with an error rate of 11 percent in FY 1997, representing \$20.3 billion, and 14 percent in FY 1996, representing \$23.2 billion in improper payments.

In addition, OIG identified systemic internal control problems that were related to material financial statement amounts which affected a number of Operating Divisions. The OIG continues to work with the Department in its efforts to achieve full financial discipline. (See pages 2, 3, and 61)

OIG Work in Performance Measurement

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

Internet Address

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

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**Health Care
Financing
Administration**

Chapter I

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

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

The Medicaid program provides grants to States for medical care for low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for cash assistance programs. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average. The Federal/State Children's Health Insurance Program (CHIP), 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 CHIP 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, 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 home health agencies; analyzed various State licensure and discipline issues; reviewed several aspects of medical necessity and quality of care under PPS, including the risk of early discharge; and evaluated the care rendered by itinerant surgeons and the treatment provided by physicians performing in-office surgery.

The OIG also audits HCFA's financial statements, which account for more than 84 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.

Improper Fiscal Year 1998 Medicare Fee-for-Service Payments

Performance Measure

The OIG reports that improper payments under Medicare's fee-for-service system totaled an estimated \$12.6 billion during FY 1998. This year's estimate is \$7.7 billion less than last year's estimate of \$20.3 billion and \$10.6 billion less than the previous year's estimate of \$23.2 billion - a 45 percent decline since FY 1996.

The OIG developed the estimate of improper payments with the support of medical experts who together reviewed a comprehensive, statistically valid sample of Medicare fee-for-service claim expenditures and supporting medical records to determine the accuracy and legitimacy of the claims.

The OIG attributes the decline in improper payments to several factors: HCFA's efforts under the Medicare Integrity Program; fraud and abuse initiatives; improved provider compliance with Medicare reimbursement rules; HCFA/OIG outreach efforts emphasizing Medicare documentation requirements; and implementation of HCFA's corrective action plan. Although significant progress has been made, recommendations call for HCFA to continue its diligence in reducing past identified problems and to keep abreast of those issues that could negatively affect future error rates. The HCFA generally concurred with OIG's findings and recommendations. (CIN: A-17-99-00099)

Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1998

Performance Measure

In its audit report on HCFA's FY 1998 financial statements, OIG issued a qualified opinion on the statements, because again OIG was unable to express an opinion on the reliability of the Medicare accounts receivable balances.

Medicare contractors reported about \$23 billion in accounts receivable activity during the year, which resulted in gross accounts receivable of approximately \$5.8 billion, or about \$3.3 billion net, at fiscal year end. Because the contractors did not maintain adequate documentation, OIG could not determine whether these estimates and balances were fairly presented. Deficiencies were found in nearly all facets of Medicare accounts receivable activity at the 12 contractors in OIG's sample.

The HCFA concurred with OIG's recommendations and is in the process of taking corrective action. The OIG's report appears in HCFA's FY 1998 Financial Report. (CIN: A-17-98-00098)

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 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 \$8.1 billion to teaching hospitals in 1996 for the costs of training residents. The Medicare payments described above include payments to teaching physicians for their role in supervising residents.

The fundamental tenet of the PATH initiative is that in order to receive reimbursement from Medicare Part B for a service rendered to a patient, the teaching physician must have personally provided that service or have been present when the 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 loss 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, four 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 \$67 million. As a condition of settlement, these institutions have also implemented corporate integrity 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 a review at one institution resulted in an administrative overpayment settlement with the carrier.

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 Three-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 services. In addition, the project seeks to recover for those services rendered to beneficiaries during the inpatient admission that should be included in the diagnosis related group (DRG), but are separately charged. A prevalent pattern of abuse was identified through repeated OIG audits of hospital claims for inpatient services under PPS. Prior to the inception of this project, OIG had issued four reports to HCFA identifying approximately \$115.1 million in Medicare overpayments to hospitals caused by these improper billings.

This national project identified 4,660 hospitals that submitted improper billings for outpatient services. The project is primarily coordinated by the U.S. Attorney's Office - Middle District of Pennsylvania. As of the end of the reporting period, settlements had been executed with 2,550 hospitals and about \$66 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 have joined forces to target false or fraudulent Medicare and Medicaid claims in hospital outpatient laboratories. A project begun in Ohio by OIG, DOJ, the State of Ohio and the Medicare fiscal intermediary proved so successful, United States Attorneys' Offices in other States began their own investigations as part of an expanded effort. This project involves 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 medically unnecessary tests. The investigations have also shown numerous instances of billing for hematology complete blood count 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 reimbursement for blood chemistry tests bundled into a panel is significantly less than the sum of the costs for each test run separately.

The OIG and DOJ, and in some districts, authorities from other Federal programs such as Tricare and Federal Employees Health Benefits Program, are working together on the national project to provide targeting data to the United States Attorneys' offices interested in pursuing this recovery initiative in their districts. The OIG also collaborated with DOJ to produce a model settlement agreement that includes compliance measures, which has been disseminated to all participating districts throughout the United States.

Thus far, 206 hospitals have entered settlements in the Hospital Outpatient Laboratory Project, with settlements totaling more than \$47.8 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 hospital receiving the transferred patient is to be paid a diagnosis-related payment based on the final discharge code.

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

E. Pneumonia Upcoding Project

Medicare inpatient hospital stays are reimbursed based on the diagnosis-related group (DRG) that is assigned to the patient's illness. The determination of the appropriate DRG for a particular case depends upon the hospital's assignment of diagnosis code(s) from the International Classification of Diseases, 9th Revision, Clinical Modification 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 an admission 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 bacterial pneumonia at over 100 hospitals. To date, five hospitals have settled their liability for such coding by paying over \$7.7 million and agreeing to corporate integrity requirements.

Other Hospital Investigations

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

- A California corporation agreed to pay \$7.3 million to resolve its civil and administrative liability for submitting Medicare claims for unnecessary services. The main subjects in the case were two hospitals owned by the corporation. Allegations included the payment of kickbacks to physicians at one of the hospitals for patient referrals, and the submission of false

Medicare claims, resulting in improper payments to "management companies" involving psychiatric programs at the other hospital. The corporation also entered into a corporate integrity agreement for 5 years.

- A Pennsylvania hospital agreed to pay the Government \$415,000 to settle allegations the hospital submitted claims to Medicare for noncovered surgical procedures. The case involved billing for lung volume reduction surgery (LVRS), a surgical procedure not covered by Medicare. The hospital submitted inpatient bills for LVRS under the billing code of a Medicare-covered surgical procedure. As a result, the hospital improperly obtained Medicare reimbursement for LVRS. The established overpayment in this case totaled \$175,000. The hospital also agreed to enter into a corporate integrity agreement requiring new policies and procedures, training, auditing and reporting.
- A New York hospital agreed to pay \$290,000 to resolve its civil liability under the False Claims Act and the Civil Monetary Penalties (CMP) law for certain ancillary pharmacy charges that were billed but not covered under Medicare. Most of the improper charges occurred when a particular management consulting firm was in charge of the hospital's billing.

Monitoring the Accuracy of Hospital Coding

In an examination of HCFA's monitoring of hospital coding accuracy under Medicare's DRG payment system, OIG found that the system is vulnerable to abuse by providers who wish to increase reimbursement inappropriately through upcoding, particularly so within certain DRGs. The OIG's analysis identified noticeable, detectable and curable upcoding abuses among providers and within specific DRGs. The OIG recommended that HCFA perform routine monitoring and analysis of hospital billing data and clinical data to proactively identify aberrant patterns of upcoding. Further, OIG identified approaches for the agency to consider as it works to detect upcoding. The HCFA concurred with the recommendations and outlined actions it will take to increase monitoring of hospital coding. (OEI-01-98-00420)

Medicare Payments for DRG 475: Respiratory System Diagnosis with Ventilator Support

This DRG report identified a small number of hospitals (46) as having atypically high Medicare billings for DRG 475. The OIG estimated that potential overpayments in these hospitals for DRG 475 could be as high as \$11.5 million. However, the true impact of upcoding can only be determined by undertaking a detailed claims review at each hospital.

In the report described above, OIG recommended that HCFA monitor and analyze hospital billing data and clinical data to proactively identify problems of DRG upcoding. The HCFA agreed with the recommendation and outlined an extensive program to respond to it. The information in this report is offered for insight into another possible problem DRG for HCFA to consider when refining its plan. (OEI-03-98-00560)

Hospital Closure: 1997

The closure of hospitals generates public and congressional concern. The OIG has issued 10 annual reports on hospital closures in the U.S. for 1987 through 1996. The 1997 report continues OIG's analysis to determine the extent and effects of hospital closures. Thirty-seven hospitals closed in 1997 -- 0.8 percent of all hospitals. One more hospital closed in 1997 than in the previous 2 years. At the same time, three hospitals opened. Most of the hospitals that closed were small and had low occupancy rates. The average daily patient load in the year prior to closure was 13 in rural hospitals and 47 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, 66 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-04-98-00200)

Medicare Beneficiary Interest in Health Maintenance Organizations in 1997

Performance Measure

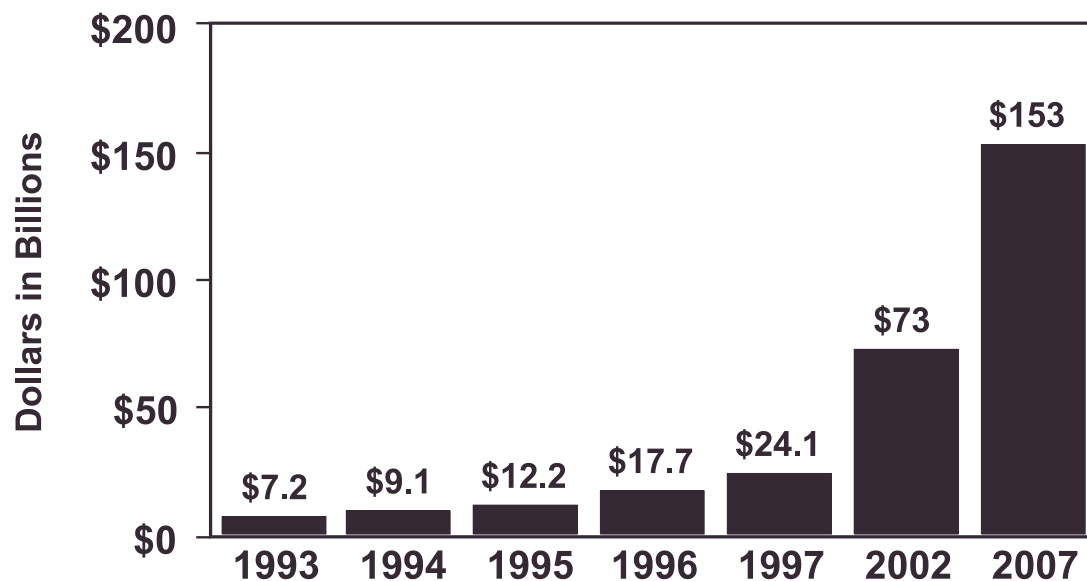
The 1997 beneficiary satisfaction survey also asked beneficiaries enrolled in fee-for-service plans about their awareness of Medicare-contracted health maintenance organizations (HMOs) and their interest in joining one. Comparing the results to those of earlier years, OIG found that general awareness of HMOs had increased each year. However, about 75 of those surveyed were unaware that they could appeal HMO decisions about their health care. Also, there was no change in the percentage of beneficiaries who said they knew whether there was a local HMO they could join. Only 23 percent of those surveyed expressed an interest in joining an HMO, a statistically significant decrease from 1995; of those who cited a reason for not joining an HMO, approximately 46 percent said that inability to select their own physician was the main reason.

Since the Balanced Budget Act (BBA) of 1997 expanded the types of managed care plans that will be available to beneficiaries, HCFA is currently negotiating contracts with managed care providers and developing educational materials for beneficiaries. In preparing those materials, OIG proposed that HCFA consider providing beneficiaries with information on managed care plans in their areas. Further, OIG suggested that those materials emphasize beneficiaries' rights to appeal managed care decisions. (OEI-04-97-00032)

Inflated Capitation Rates for Medicare Managed Care Plans

Under the Medicare risk-based program, managed care organizations (MCOs) assume responsibility for providing all Medicare-covered services in return for a predetermined capitated rate. Enrollment in managed care plans, particularly risk-based plans, has been steadily increasing, especially during the last 5 years. As illustrated below, Medicare payments to risk-based managed care plans have also grown significantly in this period and the Congressional Budget Office estimates large increases to come.

MEDICARE PAYMENTS TO RISK-BASED HMOS ARE RAPIDLY INCREASING



While the BBA of 1997 revised the payment calculation methodology for MCOs effective January 1998, the new methodology still links capitation rates to Medicare fee-for-service (FFS) expenditures. In auditing HCFA's financial statements, OIG estimated that the Medicare FFS program improperly paid providers \$23.2 billion and \$20.3 billion for Fiscal Years (FYs) 1996 and 1997, respectively. Accordingly, OIG recommended that HCFA pursue legislation to allow modifications to MCO capitation rates, which would include an adjustment for the estimated amounts of unrecovered improper payments currently included in these calculations.

In response to the draft report, HCFA agreed that Medicare payments to MCOs have been overstated and should be reduced, but thought it inappropriate to seek legislation at this time. The OIG believes that, without any legislative correction, the FFS payment errors will

continue to be locked into all future MCO payments. Adjusting the capitation payments by the lower limit of improper payments found in OIG's financial statement audits would result in managed care payment savings of at least 7 percent. Based on the anticipated growth of MCO payments, annual savings associated with a corrected 1997 base year could be \$5 billion in 2002 and increase to over \$10 billion in 2007. (CIN: A-14-97-00206)

Adjusted Community Rate Proposals for Risk-Based Managed Care Organizations

The adjusted community rate (ACR) process is designed for managed care organizations to present to HCFA their estimates of the funds needed to cover the costs (both medical and administrative) of providing the Medicare package of services to enrolled Medicare beneficiaries. In an earlier audit which examined the allocation of administrative costs on ACR proposals for contract years 1994 through 1996, OIG concluded that the methodology allowing managed care organizations to apportion administrative costs to Medicare was flawed and that Medicare covered a disproportionate amount of the contractors' administrative costs.

During this reporting period, OIG reviewed selected administrative costs included in the 1997 ACR proposals of five Medicare managed care risk contractors. The OIG identified millions in administrative costs that would be considered inappropriate and unallowable in light of the Medicare program's general principle of paying only reasonable costs. One contractor, for instance, included over \$1.4 million for lobbying, entertainment and unsupported costs. Such costs would not have been allowable had they been submitted by managed care organizations under cost contracts or by health care providers paid under a Medicare cost reimbursement system. The OIG believes that these administrative costs should not be included in the ACR proposal; an unjustifiably increased ACR reduces the amount available to Medicare beneficiaries for additional benefits or reduced premium amounts.

Because there is presently no statutory or regulatory authority governing the allowability of costs in the ACR process, OIG did not address recommendations to the individual contractors. However, OIG believes that these results highlight a significant problem and has shared them with HCFA so that appropriate legislative changes may be considered. (CIN: A-01-98-00510; CIN: A-02-98-01004; CIN: A-03-98-00022; CIN: A-05-98-00049; CIN: A-06-98-00046)

Risk-Based Medicare Health Maintenance Organization Payments for Out-of-Area Beneficiaries

The amount of Medicare reimbursement for services provided to a beneficiary enrolled in an HMO depends, in part, on the beneficiary's county of residence. Beneficiaries generally must reside in the plan's approved service area to remain enrolled in the plan. As

demonstrated in an OIG review at a national HMO chain (which had nine Medicare HMO contracts in effect), HCFA made incorrect payments on behalf of beneficiaries who were reported living out of the HMO's service areas. Specifically, for the 2 months reviewed, a statistical sample showed that payments were incorrect or inconclusive for 158 of 200 beneficiaries (79 percent) who were reported living out-of-area. The effect of the address changes on the monthly Medicare payments was a net underpayment to the HMO of almost \$48,000. The OIG made several recommendations to HCFA to preclude this problem in the future, and HCFA generally concurred. (CIN: A-06-97-00034)

Partial Hospitalization Services Provided through Community Mental Health Centers

Performance Measure

Community mental health centers (CMHCs) provide treatment and services to mentally ill individuals in the community. The Omnibus Budget Reconciliation Act of 1990 authorized Medicare coverage and payment of partial hospitalization services provided by CMHCs. From 1993 through 1997, there was rapid growth in total program payments and average per patient payments, as illustrated below.

NATIONAL MEDICARE PAYMENTS FOR CMHC SERVICES

Calendar Year	Number of CMHCs	Total Payments	Average Per Patient
1993	296	\$60,000,000	\$ 1,642
1994	475	108,000,000	2,190
1995	581	142,000,000	3,524
1996	646	265,000,000	6,874
1997	769	349,000,000	10,352

In collaboration with HCFA, OIG reviewed Medicare payments for partial hospitalization services to CMHCs in five States. The OIG estimated that for the 12-month period ending September 30, 1997, Medicare paid these CMHCs \$229 million for unallowable and highly questionable services; this equaled 91 percent of the total \$252 million paid to all CMHCs in these five States for partial hospitalization services. The CMHCs in the five States (Florida, Texas, Colorado, Pennsylvania and Alabama) accounted for approximately 77 percent of CMHC partial hospitalization payments nationally during Calendar Year (CY) 1996.

In a program designed to pay for intensive outpatient psychiatric services for acutely ill individuals who would otherwise require inpatient services, OIG determined that Medicare was paying for services to beneficiaries who had no history of mental illness or who suffered

from mental conditions that would preclude their benefitting from the program. Further, Medicare was paying for therapy sessions that involved only recreational and diversionary activities, such as drawing, arts and crafts, watching television, and playing bingo and other games. The OIG found that the lack of State oversight and the use of a self-attestation process permitted unscrupulous providers to participate in the Medicare program.

In view of the severity of the problems disclosed, OIG recommended that HCFA evaluate the propriety of allowing CMHCs to provide the partial hospitalization benefit and, if appropriate, recommend a legislative change to repeal Medicare coverage for this benefit in the CMHC setting. The OIG also reiterated recommendations, made in an earlier review of 14 CMHCs in Florida and Pennsylvania, that HCFA either develop conditions of participation for CMHCs or conduct onsite surveys during the provider enrollment process to address qualification issues; instruct fiscal intermediaries to perform a detailed medical review of the first claim submitted for each new beneficiary receiving partial hospitalization services from a CMHC; and, as part of its oversight activities, perform medical reviews of selected partial hospitalization claims. The HCFA developed a 10-point initiative which included both immediate and long-term actions, such as terminating egregious CMHCs, conducting intensified medical reviews, collecting overpayments and undertaking various legislative actions. (CIN: A-04-98-02145; CIN: A-04-98-02146)

Outpatient Psychiatric Services Provided by a Massachusetts Hospital

The OIG conducted a review at one Massachusetts hospital to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicare requirements. The results of this audit will be used in conjunction with OIG's reviews of Medicare's partial hospitalization program at CMHCs to structure its planned audit of partial hospitalization services in the hospital outpatient setting.

The OIG determined that at least \$646,517 in charges for outpatient psychiatric services claimed by the hospital did not meet Medicare criteria for reimbursement. Specifically, OIG identified nursing home psychiatric services provided by clinical social workers who were not properly supervised by a physician; charges for psychiatric care not properly supported by medical records or otherwise found medically unnecessary; and hospital overhead charges submitted to Medicare for the associated costs of hospital employees working offsite at area nursing homes. The OIG recommended that the hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are for covered services and are properly documented in accordance with Medicare requirements. The OIG will provide the results to the fiscal intermediary so that it can adjust the hospital's FY 1996 Medicare cost report. The hospital disagreed with the audit findings. (CIN: A-01-98-00503)

Payment Edits for Outpatient Psychiatric Services

Medicare limits reimbursement for certain outpatient mental health services to 62.5 percent of the Medicare allowed amount. An OIG review found that the Medicare carrier serving Maine, Massachusetts, New Hampshire and Vermont failed to apply this limitation to some services to which it pertained. As a result, the carrier overpaid providers an estimated \$1 million in CY 1996. The OIG recommended that HCFA initiate overpayment recovery actions, apprise all Medicare carriers of this potential payment error and take the necessary steps to prevent future errors from occurring. The HCFA concurred with OIG's findings and recommendations.

Subsequently, OIG expanded its review to include three additional Medicare carriers in Florida, New York and Texas. The expanded review showed that the New York and Texas carriers had edit systems which correctly applied the limitation. The OIG's review at the Florida carrier continues. (CIN: A-01-98-00520)

Prospective Payment System for Hospital Outpatient Department Services

The Balanced Budget Act of 1997 requires implementation of a prospective payment system (PPS) for hospital outpatient department services. While HCFA has done extensive work to construct reasonable rates, OIG is concerned that the methodology employed will cause PPS payment rates to be inflated. The rate-setting methodology does not adjust for factors such as unallowable costs and improper payments which were included in the base period when calculating the fee schedule amounts and targeted expenditure ceiling. The OIG believes that hospitals will realize windfall profits at Medicare's expense if these factors are not taken into account. If further study reveals excessive unallowable costs and improper payments, appropriate adjustments should be made to the fee schedule and expenditure ceiling.

In addition, since HCFA intends to move toward instituting uniform payment rates across service settings, OIG proposed that such rates be established to reflect only the costs necessary to efficiently deliver a Medicare service regardless of the service setting. The OIG recommended that HCFA carefully consider the potential efficiencies demonstrated in various service settings when establishing uniform payment rates. The HCFA concurred with OIG's recommendations. (CIN: A-14-98-00400)

Beneficiary Hospice Eligibility at Michigan Provider

At DOJ's request, OIG evaluated Medicare eligibility determinations of terminal illness for beneficiaries enrolled in hospice care at one Michigan provider. Working with OIG, physicians from the Michigan peer review organization determined that 130 of the 180 beneficiaries whose files were reviewed were not eligible for hospice coverage. Overpayments of Medicare funds amounted to approximately \$2.6 million for these beneficiaries.

The OIG did not recommend that HCFA independently recoup the \$2.6 million since these financial findings are included in a civil complaint filed by DOJ against the provider's previous owners. However, OIG did reemphasize previous recommendations made in its November 1997 roll-up report on national hospice audits. In that report, OIG identified problems with hospice coverage in nursing facilities as an underlying factor that contributed to high levels of beneficiary ineligibility. These problems are further highlighted by the conditions found in the current audit, where about 98 percent of the 130 ineligible beneficiaries were residents of nursing facilities. The OIG believes that HCFA should give high priority to its work in developing a legislative proposal to address this issue. (CIN: A-05-97-00015)

Medicare Contractor Costs

For a number of years, HCFA contracted with Aetna Life Insurance Company to process Medicare Parts A and B claims submitted by hospitals, physicians and other medical suppliers in various States. Aetna terminated these contracts as of September 30, 1997. Two reviews assessed costs claimed by the contractor before and during its transition from the Medicare program.

A. Administrative Costs

From October 1994 through September 1997, Aetna claimed administrative costs of \$125 million to process 32 million Part A claims and \$198 million to process 136 million Part B claims. In a review of these costs, OIG determined that the contractor had generally established adequate systems of internal control, accounting, and reporting for administrative costs. Further, most of the costs claimed for the 3-year audit period were allowable. However, OIG recommended adjustments of approximately \$2.9 million. Aetna agreed with all proposed adjustments. (CIN: A-01-97-00529)

B. Termination and Severance Costs

The HCFA agreed to reimburse Aetna for reasonable and allocable costs incurred in transferring responsibilities to other contractors and for allocable severance costs. For the period through April 1998, Aetna claimed total termination and severance costs of almost \$27 million. The OIG determined that \$1.8 million of this total was either unallowable under Medicare regulations or represented cost savings to the program. Specific financial adjustments were recommended. After completing audit fieldwork, OIG was informed that Aetna and HCFA had reached a tentative cost reimbursement agreement. (CIN: A-01-98-00509)

Fiscal Intermediary Fraud Units

Fiscal intermediaries (FIs), under contract with HCFA, are responsible for processing approximately 75 percent of Medicare claims involving about \$130 billion. While they vary in many ways, all must meet requirements outlined in the Medicare Intermediary Manual.

Both FIs and carriers have discrete units to detect and deter fraud and abuse. These units are part of HCFA's overall Medicare integrity program and are monitored by HCFA regional offices.

In a survey of all 41 FI fraud units under contract in 1996 and still under contract, OIG found that there were substantial differences in the number of complaints and cases handled, and that some units produced few, if any, significant results. Moreover, half the fraud units did not open any cases proactively and more than a third of them did not identify program vulnerabilities.

The variation in fraud detection, especially among units with similar resources, raised concern about possible poor performance by some fraud units. Accordingly, OIG recommended that HCFA refocus its evaluation efforts to include some type of return on investment analysis. The OIG proposed that HCFA improve the contractor performance evaluation system so that it holds contractors accountable for meeting specific objectives; require that all contractor performance evaluations list HCFA's national and regional objectives and address whether or not the fraud unit is meeting those objectives; establish a standard set of data that can be used to measure fraud units' performance in meeting established objectives and require that all reports contain this data; establish clear definitions of key words and terms and require program integrity staff and fraud unit staff to use the same definitions; and provide opportunities for fraud units to exchange ideas, compare methods and highlight best practices. In response to the draft report, HCFA concurred with OIG's recommendations and outlined corrective actions to be taken. (OEI-03-97-00350)

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 on pages 3-6, above). 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 successfully concluded during the reporting period:

- A man was sentenced for his part in a scheme to defraud HCFA. His sentencing resulted from a major investigation of the former Medicare contractor for Illinois and Michigan where he worked as a manager. He, along with seven other managers, falsified and altered data used by HCFA to evaluate the contractor's performance. Misinformed by the contractor's fraudulent performance reports, HCFA awarded the company \$1.2 million in incentive payments which were not earned. For his part in the scheme, the manager was sentenced to 8 months imprisonment, 8 months home confinement, 2 years supervised probation, and fined \$6,000. His sentence

was based on an earlier guilty plea to conspiracy to defraud the Government, wire fraud and obstruction of a Federal audit. Of the other managers involved in the scheme, five have been indicted and two have pled guilty (one of whom has been sentenced). The corporation previously agreed to pay \$140 million in civil fines and penalties and \$4 million in criminal fines.

- A man was sentenced in Florida for conspiracy to submit false Medicare claims in connection with his two DME companies and his medical diagnostic company. His sentence included 21 months incarceration, payment of \$1 million in restitution (offset by any money the Government recovers from the sale of his house) and 3 years supervised release. From 1992 to 1996, the company owner paid patient recruiters to bring Medicare beneficiaries to certain licensed physicians whom he paid to order DME and diagnostic testing. Through his companies, he then submitted Medicare claims for DME and oximetry tests that were not rendered or were medically unnecessary.
- In California, a physician was sentenced to 24 months imprisonment, 2 years supervised release, and payment of a \$50,000 fine. The physician had previously pled guilty to charges of Medicare fraud related to submitting false claims for house calls. Claims were submitted for persons who had died before the date of claimed services, persons living in other States, persons who were incarcerated, etc. He also previously pled guilty to submitting false documents to the Small Business Administration for a low cost, disaster loan arising out of the Northridge earthquake. Additionally, there was a prior civil judgment of \$1.5 million in this case.
- In Illinois, a psychologist was sentenced to 5 years and 10 months in Federal prison for mail fraud, money laundering and obstruction of justice. She submitted approximately 11,000 false claims to Medicare for psychological testing and treatment. In addition, she was ordered to pay restitution of \$480,618.
- In Louisiana, two former owners of a home health agency (HHA) were sentenced for participating in a scheme to defraud Medicare. The co-owners included \$296,000 in expenses not related to patient care in their cost reports. These expenses were fictitiously claimed as consulting and salary payments to family and friends. One of the HHA owners was sentenced to 8 months incarceration followed by 2 months in a halfway house as part of a 3-year supervised release program. The other was

sentenced to 5 months imprisonment and 3 years supervised probation. The owners were also ordered to pay restitution totaling \$244,472.

- A neurologist was sentenced in California for his part in a scheme to defraud the Medicare and Medi-Cal programs. He previously pled guilty to four felony counts of mail fraud. The physician submitted claims for nerve conduction studies and upcoded claims for office visits and EMGs. He was sentenced to 6 months home detention and 3 years probation. He was also ordered to pay \$118,750 in restitution and perform 3,000 hours of community service.
- A Michigan podiatrist was sentenced to 15 months incarceration followed by 2 years supervised probation, and ordered to pay \$188,860 in restitution for defrauding the Medicare program. He billed Medicare for incision and drainage of wounds and abscesses when he only performed noncovered routine nail care. In addition, he prescribed Tylenol #3 to patients although some of them had not even removed their shoes for examination. The loss to the Medicare program was over \$180,000.
- In New York, two sisters were each sentenced to 5 years probation and ordered to pay \$32,458 in restitution for illicitly cashing stolen checks from both Medicare and Social Security Administration (SSA) programs. Among the checks were three Medicare checks payable to Medicare Part B providers totaling \$39,717. The sisters cashed the stolen Medicare and SSA checks and deposited them into money transfer accounts belonging to their businesses. The money was then funneled to family members in the Dominican Republic.

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, or exclusion from participation in the Medicare or Medicaid program, or both. The following cases are some of the examples of the sentences for this crime:

- A New York podiatrist was sentenced to 24 months imprisonment and 3 years supervised release for mail fraud and illegal kickback activity. He was also ordered to make full restitution to Medicare in the amount of \$292,800 and to private insurance carriers in the amount of \$103,860. The podiatrist accepted kickbacks from a DME supplier for referring Medicare patients for medically unnecessary lymphedema pumps. While the podiatrist was on prepayment review, he hired podiatrists to work at his office and paid them a salary. He then billed Medicare for podiatric services using the other podiatrists' provider numbers. In addition, he solicited several privately-insured individuals to permit him to bill their insurance carriers in return for a percentage of the reimbursement checks, and in some instances, for prescriptions for controlled substances.
- In Florida, a DME company was sentenced as a result of pleading guilty to receiving an illegal kickback of \$489,000. The DME company received the kickback payment as inducement to permit another DME supplier to provide incontinence kits to Medicare beneficiaries. These beneficiaries lived in a chain of nursing homes owned by the same management as the DME company. As a result of the kickback payment, Medicare paid approximately \$3.6 million for incontinence supplies which were not medically necessary. The court ordered that the company pay a fine of \$293,400 and that the defendant corporation be placed on probation for 2 years. During that period, the company was directed to implement and submit to the court a corporate compliance program, including a schedule for implementation. The court further ordered that the company make restitution in the amount of \$489,000, but noted that the company had already paid that amount.
- A Texas mail-order pharmacy agreed to pay the Government \$100,000 to settle allegations that it submitted false Medicare claims for patients referred

through kickback arrangements. The pharmacy paid kickbacks to DME companies in exchange for Medicare patient referrals for the purchase of respiratory medications. The pharmacy then submitted claims for the sale of these medications to receive Medicare reimbursement. The pharmacy also agreed to adopt a corporate integrity program for a period of at least 3 years.

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 1,574 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 (HEAL).

During this reporting period, OIG imposed exclusions on 1,287 individuals and entities. The following are examples of some of the exclusions that were imposed:

- A medical clinic in Florida was excluded for a period of 20 years due to its affiliation with its excluded owner. The clinic owner, excluded from participation for the same number of years, was convicted for his involvement in a scheme to defraud the Medicare program by filing approximately \$3 million in false claims for physician services, respiratory equipment, related medication and cardiovascular testing. The owner also solicited and received approximately \$85,000 in illegal kickbacks for patient referrals and fraudulent prescriptions for cardiovascular testing. He was ordered to pay restitution of almost \$3.5 million and is currently serving a sentence of 51 months in Federal prison.

- A dentist in Pennsylvania was excluded for 15 years following his conviction of involuntary manslaughter involving the death of a child who was his patient. The dentist failed to perform a physical evaluation sufficient to determine whether the child was a suitable candidate to receive general anesthesia. In addition, he failed to receive informed consent from the child's parents prior to administering general anesthesia and failed to supply appropriate equipment to continuously monitor the child's heart activity, adequacy of respiration, delivery of oxygen and continuous adequacy of tissue perfusion.
- A nurse's aide in Texas was convicted of recklessly causing bodily harm to a nursing home patient. While roughly taking the elderly patient out of his wheelchair to a whirlpool, the aide caused the patient's right foot to get caught in his wheelchair, resulting in a fractured ankle. She then dragged the elderly man across the floor, causing him to sustain rug burns. The aide was sentenced to 1 year community supervision and excluded for 10 years.
- With the expansion of exclusion authority under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to include the sanctioning of individuals controlling previously sanctioned entities, a Maryland doctor was excluded from program participation for 10 years. The doctor was the owner of a methadone clinic in Maryland which had been convicted for knowingly and willfully making false statements in applications for payment to Medicaid. The clinic paid restitution in the amount of \$290,000 based upon an overpayment of \$95,000, and was excluded for 10 years.
- The HIPAA established OIG mandatory authority to exclude any individual who has been convicted of a felony relating to controlled substance violations. A pharmacist in Ohio was excluded for a period of 5 years after pleading guilty in a local court to illegally processing drug documents. The pharmacist, a drug user, illegally forged prescriptions for himself. The court ordered that the pharmacist be required to enter into a drug treatment program for 3 years.
- The HIPAA also expanded the mandatory exclusion authority to exclude any individual convicted of a felony relating to health care fraud. In Arizona, a certified provider for the developmentally disabled was excluded for 5 years after being found guilty of a felony related to health care fraud. The provider submitted documents for reimbursement claiming that she had purchased clothing for a patient in the disability home in which she worked. She did purchase clothing; however, the clothing was actually for herself

and not the intended patient. The provider was placed on supervised probation for a period of 3 years.

- An anesthesiologist was indefinitely excluded because his medical license was suspended in Texas for reasons bearing on his professional performance. The doctor's license suspension was due to several complaints, including placing an epidural catheter in a patient's abdomen during child birth, instead of properly placing the catheter in the spinal canal. The patient and her unborn child died.
- A podiatrist in Ohio was excluded for a period of 15 years after being found guilty in a local court of unlawful sexual conduct against a patient and tampering with evidence. In addition, the State Medical Board of Ohio permanently revoked the doctor's license to practice podiatric medicine and surgery. He was sentenced to serve 6 months in a halfway house which included work release.
- In Texas, a vocational nurse was indefinitely excluded because his professional license was revoked by the State. This was predicated on his felony conviction of aggravated sexual assault of a child. As a result of the conviction, the nurse was sentenced to 40 years incarceration in State prison.
- After a respiratory care practitioner in California had his professional license revoked by the State, OIG excluded him indefinitely from program participation. The practitioner pled guilty to continuous acts of sexual abuse of a child under age 14. He was placed on formal probation for a period of 6 years, forbidden to have unsupervised contact with any minor without the presence of a responsible adult and ordered to be registered a sex offender.
- A clinical laboratory in New Jersey was excluded for an indefinite period after the State suspended the laboratory from Medicaid participation. Because of the laboratory's high earnings the previous year, the State Medicaid agency conducted a prepayment review of all claims which the laboratory submitted to Medicaid for payment. The review showed over 70 percent of the claims to be fraudulent. In addition, a number of claims reviewed lacked physicians' signatures on the requisition forms.

B. Civil Penalties for Patient Dumping

Section 1867 of the Social Security Act (42 U.S.C. 1395dd) provides that when an individual presents to the emergency room for examination or treatment, a hospital which has a Medicare provider agreement is required to provide an appropriate medical screening

examination to determine whether that individual has an emergency medical condition. If an individual has such a condition, the hospital must provide, within the capabilities of the staff and facilities available at the hospital, treatment to stabilize the condition, unless a physician certifies that the individual should be transferred because the benefits of medical treatment elsewhere outweigh the risks associated with transfer. If a transfer is ordered, the transferring hospital must arrange for a safe transfer, which includes providing stabilizing treatment to minimize the risks of transfer, making sure the receiving hospital has agreed to accept the transfer and effecting the transfer through qualified personnel and transportation equipment. A hospital is prohibited from delaying provision of examination or treatment 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 CMPs 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, and impose a program exclusion in certain cases.

Between October 1, 1998 and March 31, 1999, OIG collected \$985,000 in CMPs from 34 hospitals and physicians. The following is a sampling of the alleged violations involved in the FY 1999 Patient Anti-Dumping Statute settlements from this reporting period:

- A Georgia hospital agreed to pay \$45,000 to resolve two allegations of dumping. The hospital failed to provide an appropriate medical screening examination and stabilizing treatment to a psychiatric patient. In addition, an on-call surgeon refused to accept an appropriate transfer of an individual who required the hospital's specialized facilities when the hospital had both the capacity and capability to treat the individual.
- An Illinois hospital agreed to pay \$50,000 to resolve allegations that it failed to provide necessary surgery to stabilize a woman who presented with a piece of meat lodged in her throat. Instead, the hospital inappropriately transferred the patient to a hospital approximately 25 miles away. During the transfer, the patient suffered cardiac arrest, was diverted to another hospital and died.
- A small California hospital agreed to pay \$40,000 to resolve two allegations that it inappropriately transferred two patients. An 11-month-old baby, in unstable condition, was transferred in a private vehicle to a hospital 75

miles away. A 74-year-old man was transferred to another hospital in an unstable condition in a case where the treating physician did not certify that the benefits of transfer outweighed the risks.

- An urban New Jersey hospital agreed to pay \$85,000 to resolve allegations that it failed to provide appropriate medical screenings to a number of individuals who presented to its emergency department. These individuals had a variety of medical conditions, some of which were serious. In some of the cases, the hospital failed to properly document the reasons it failed to screen and/or treat the patients, and failed to document the treatment that was offered or provided to the patients.
- A small psychiatric hospital in Virginia agreed to pay \$40,000 to resolve allegations that it failed to provide stabilizing treatment and/or an appropriate transfer to actively suicidal individuals who presented to the hospital for treatment.
- A large California hospital agreed to pay \$40,000 to resolve an allegation that it refused to accept an appropriate transfer of an individual who required the specialized capabilities and facilities of the hospital. The decision to refuse the transfer was allegedly due to the emergency room physician's refusal to call the hospital's on-call specialist.
- Another California hospital agreed to pay \$22,000 to resolve allegations that it failed to provide stabilizing treatment and an appropriate transfer to a pregnant woman who presented with pre-term labor and bleeding. She was transferred to the receiving hospital approximately 30 miles away by private car.
- An Oregon hospital paid \$60,000 to resolve allegations that it did not provide an appropriate medical screening exam to several patients who presented to the hospital emergency room for evaluation and treatment. All the patients were covered under Oregon's Medicaid program and in each instance, the hospital contacted the patient's primary care physician for payment authorization. Such authorization was denied and the patients were sent elsewhere for treatment without first being screened for a medical emergency.

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 the Medicare and State 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 as 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 \$67.2 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:

- The former Medicare carrier and intermediary for Massachusetts agreed to pay the Government \$4.75 million to resolve allegations of receiving overpayments from Medicare. Between 1990 and 1997, the insurer improperly paid certain Medicare claims as if Medicare were the primary payer, when in fact, Medicare should have been the secondary payer. Allegedly, the insurer failed to properly develop these claims prior to payment and to determine whether the primary payment obligation belonged to Medicare insurance or private insurance in cases where the patients were insured by both. As a result, the insurer received overpayments from Medicare, resulting in a loss to the Federal health care program. Under the guidance of a corporate integrity agreement imposed by OIG, the insurer still retains a Medicare HMO contract. This represents the third civil settlement entered into by this insurer and the Government.
- In Florida, a medical company and two of its subsidiaries signed a settlement agreement in response to allegations that it submitted false Medicare claims. The company formerly provided behavioral health services to long term care recipients through group practices in twelve States. Its licensed clinical social workers, psychologists and psychiatrists rendered individual and group psychotherapy services to Medicare beneficiaries in Florida nursing homes over a 2-year period. During that time, the company allegedly submitted false claims to Medicare for medically unnecessary individual and group psychotherapy services. This fraudulent activity resulted in an estimated Medicare overpayment of \$3 million. The settlement calls for payment of \$3 million to the United States and a comprehensive corporate integrity agreement. The proceeds from the company's recent sale of its group practice division will pay the bulk of the settlement amount.
- In California, an occupational health care firm agreed to pay \$306,670 to resolve its liability for submitting false claims to Medicare. The firm submitted claims as though physical therapy services were "incident to" professional services of the physician, although the physician provided no

professional services. When therapy was performed, the physician had no initial or subsequent contact with the beneficiaries.

- A Texas home health agency and its owners reached a settlement with the Government totaling \$251,000, resolving their civil liability for improper submission of Medicare claims. Investigation confirmed that the improper billings were for submitting home aide service claims without the required physician authorization. The owners were unable to obtain signed physician orders because the beneficiaries were not homebound. The defendants agreed to be excluded from participating in Medicare, Medicaid, and Federal health care programs for 10 years.
- In Florida, a pain control center and its president agreed to pay the Government \$75,215 to settle allegations of submitting false Medicare claims. During the period 1991 through 1994, the center and its president falsely represented acupuncture services provided to beneficiaries as physical therapy treatments in claims submitted to Medicare; Medicare does not cover acupuncture. They also submitted claims for physical therapy that was not medically necessary or not authorized and prescribed by a physician. The settlement additionally called for a 5-year exclusion of the codefendants.

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 and 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 endeavors.

The OIG continues in its efforts to promote voluntarily developed and implemented compliance programs by providing guidance for the various parts of the health care industry. To this end, OIG has developed and released compliance program guidance for clinical laboratories, hospitals, home health agencies and third-party billing companies. The OIG is currently working on guidance for other sectors of the industry, including DME, prosthetics and orthotics suppliers, Medicare+Choice organizations that offer coordinated care plans, nursing homes and hospices. 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 fraud, are available on the Internet at <http://www.dhhs.gov/progorg/oig>.

In addition to developing compliance program guidance, OIG monitors corporate integrity obligations imposed on health care providers as part of global settlements of OIG investigations and audits. Presently, OIG is monitoring 356 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 corporate integrity agreements is 5 years and these agreements require a substantial effort by the provider to ensure that the organization is operating within HCFA rules and regulations and the parameters established by the corporate integrity agreement. Failure to adhere to the corporate integrity agreement could result in exclusion of the provider in addition to other penalties.

Outreach Campaign to Educate Medicare Beneficiaries About Fraud and Abuse

On February 24, HHS joined with DOJ and the American Association of Retired Persons (AARP) to launch a new national initiative against waste, fraud and abuse in the Medicare program. The OIG has spearheaded the efforts leading up to the event for 2 years, working with HCFA and the Administration on Aging to develop educational materials, promote OIG's fraud hotline and set up networks to get the campaign's message out.

The campaign is titled, "Who Pays? You Pay." It is aimed at reducing waste, including simple billing errors as well as unnecessary or excessive spending, and criminal fraud and abuse against the Medicare program. The campaign asks beneficiaries to raise most billing questions first with their providers or Medicare insurance companies, since most problems can be resolved there. If beneficiaries believe they have detected fraud or if they are not satisfied with the explanation of the Medicare carrier, they are asked to call the HHS Inspector General Hotline at 1-800-HHS-TIPS.

At the national launching of the campaign, Inspector General June Gibbs Brown joined with HHS Secretary Donna Shalala, Attorney General Janet Reno and Deputy Attorney General Eric Holder, HCFA Administrator Nancy Ann DeParle, Assistant Secretary for Aging Jeanette Takamura, and AARP President Joe Perkins to help kick off the effort. In addition, more than 30 OIG managers and staff participated in local training events for seniors across the country, speaking to them about Medicare fraud and abuse, and encouraging them to play close attention to their Medicare statements and call OIG's fraud hotline if they suspect improprieties.

This "event" was just the first step in a campaign to reach not only seniors, but to seek the participation and cooperation from major health care provider and industry groups as well. Those efforts will begin in earnest in the second half of 1999.

Provider Self-Disclosure Protocol

In keeping with its longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, 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 and can be found on OIG's Internet site or as published in 63 Federal Register 58,399 (October 30, 1998).

Essentially, the Protocol guides providers and suppliers through the process of structuring a disclosure to 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, such as the 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. The OIG will evaluate each submission and reach conclusions as to the appropriate resolution of the matter on a case by case basis.

Clinical Laboratory Tests Performed by Hospital Outpatient Department Laboratories

This report presented the results of OIG's nationwide audit of Medicare reimbursement for clinical laboratory tests performed by hospitals as an outpatient service. The audit followed up on HCFA's corrective actions relating to unbundled and duplicative charges for chemistry and hematology tests, taken in response to a 1994 OIG review of this area. The current audit also covered the same type of payments involving urinalysis tests.

The OIG estimated that, nationwide, Medicare fiscal intermediaries overpaid hospital outpatient department laboratories about \$43.6 million for chemistry, hematology and urinalysis tests in CYs 1994 and 1995. Moreover, OIG determined that an additional \$15.6 million could have been saved for the same period if policies had been developed to preclude payment for additional automated hematology indices. About 75 percent of the claims containing these overpayments and potential savings were billed by less than 20 percent of the hospitals reviewed.

The OIG also found that HCFA's corrective actions had resulted in a significant decrease in the number of potential overpayment situations, saving approximately \$37.2 million in the 2-year audit period. However, based on the current audit, OIG determined that further improvements were needed. Accordingly, OIG recommended that HCFA direct the FIs to implement additional procedures and controls to ensure that all clinical laboratory tests performed by hospital outpatient department laboratories are appropriately grouped together and not duplicated for payment purposes, as well as recover the identified overpayments. Also, OIG proposed that HCFA consider eliminating separate reimbursement for additional hematology indices. The HCFA concurred and agreed to take corrective action. (CIN: A-01-96-00527)

Laboratory Fraud

During this reporting period, OIG successfully completed civil cases related to fraudulent billings to Medicare, Medicaid and other Federal health care programs on the part of independent laboratories and physicians. In addition to settlements reached as part of the Hospital Outpatient Laboratory Project discussed on page 5, convictions and settlements were also obtained for other types of fraudulent or abusive activities involving laboratories and these health care providers. The following case represents a significant example of laboratory fraud which resulted in a settlement during this period:

- In Florida, a laboratory and its president agreed to settle their civil liability under the False Claims Act for submitting false Medicare claims. The defendants agreed to be permanently excluded from participation in Federal health care programs and to release claim to approximately \$103,675 in funds administratively suspended by their Medicare carrier. Although the defendants documented an inability to pay the judgments against them, both the laboratory and its president agreed to the entry of judgments against them in the amounts of \$2.85 million and \$27,000 respectively. They further agreed that about \$215,300 in bank accounts frozen by the United States will be transferred to the Government. Over a 10-week period, this clinical laboratory submitted Medicare claims for specified diagnostic testing and received approximately \$952,000 in payments. Interviews of the referring physicians listed on the laboratory's Medicare claims, however, disclosed that they had not referred patients to the laboratory for testing. Moreover, most of the physicians had never seen the beneficiaries they supposedly referred.

Bad Debts Reported Under Medicare's End Stage Renal Disease Program

An OIG review disclosed that an end stage renal disease (ESRD) chain allocated approximately \$16.1 million in unallowable costs to its facilities in CY 1996. This resulted

in an overstatement of \$1.5 million for reimbursable Medicare bad debts claimed by these facilities. In addition to a financial adjustment of the \$1.5 million, OIG recommended that the chain establish additional procedures to exclude the unallowable costs identified from future cost reports. Both HCFA and the ESRD chain generally concurred with OIG's findings and recommendations. (CIN: A-01-98-00508)

Medicare Reimbursement for Hospital Beds in the Home

Medicare authorizes beneficiaries to obtain hospital beds for use in their homes. This is done on the basis of a rental schedule with an option to purchase the beds. Suppliers receive monthly reimbursement from the Medicare DME regional carriers based upon a fee schedule. In CY 1996, Medicare allowed charges of over \$272 million for the four categories of hospital beds included in this OIG study.

The OIG determined that Medicare's monthly rates for the four types of hospital beds studied, when considered with total rental payments during the 15 month extended rental period, exceeded the rates of other payers by more than 14 percent. The BBA provides HCFA with the necessary tools to immediately reduce rates if there is compelling evidence that their rates exceed those generally being paid in the marketplace. If this authority is exercised for the beds surveyed, OIG estimates that annual savings would total between \$32.7 to \$40.9 million; over 5 years, that would save Medicare about \$163 to \$204 million. Also, concluding that the payment method used by Medicare inappropriately overcompensates for rental use during the first 3 months of each rental period, OIG recommended that HCFA seek legislation to correct that aspect of the problem. The HCFA concurred with the intent of OIG's recommendations and is undertaking a comparison of hospital bed rates and a competitive bidding demonstration project as a prelude to making hospital bed rate changes. (OEI-07-96-00221; OEI-07-96-00222)

Ordering Medicare Equipment and Supplies

The OIG issued two related reports concerning the ordering of Medicare equipment and supplies, one on the physician-patient relationship and the other on physician perspectives. In the first report, OIG found that most medical equipment and supplies were prescribed by the treating physician, but in 6 percent of cases the physician reported not knowing the patient and 13 percent of physicians who said they knew the patient did not order the equipment or supplies. Fourteen percent of sample medical equipment and supplies was found to be either questionable or medically unnecessary. This conservatively represents \$414 million in inappropriate Medicare payments. Patients' medical records were more often questionable when the physicians reported not ordering the equipment or supplies, and were less likely to be questioned when there had been a recent encounter between the physician and patient. Several recommendations were made to strengthen the role of the physician in approving medical supplies and equipment.

In the second report on physician perspectives, OIG found that two-thirds of physicians were satisfied with the current process of ordering medical equipment and supplies. Physicians who were more informed about Medicare requirements for coverage and payment of medical equipment and supplies were more likely to be satisfied with the ordering process. In this report, OIG recommended that HCFA strengthen its efforts to educate physicians regarding their ordering of medical equipment and supplies. (OEI-02-97-00080, OEI-02-97-00081)

Fraud Involving Durable Medical Equipment Suppliers

The DME industry has consistently suffered from waves of fraudulent schemes in which Medicare or Medicaid is billed for equipment never delivered, higher-cost equipment than that actually delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State from that billed in order to obtain higher reimbursement. During this reporting period, OIG obtained settlements and convictions of unscrupulous suppliers for a variety of schemes as demonstrated by the following examples:

- The ring leader of a scheme to defraud Medicare was sentenced in Florida. Her sentence included 78 months imprisonment and 3 years supervised release for conspiracy to commit money laundering. She led a scheme involving four parenteral and enteral nutritional (PEN) therapy supply companies that obtained physician provider numbers and used them to bill Medicare for medically unnecessary and nonrendered services. She owned all these companies in whole or in part, hiding the true ownership of the PEN companies through nominee owners. The proceeds of the fraud were laundered by the company owners through check cashers, or "runners," causing a loss to the Medicare program of \$750,000. She represents the last of 11 defendants, including her husband, to be sentenced in this case.
- In California, a DME company owner was sentenced to 1 year incarceration and 5 years probation, and ordered to pay \$400,000 in restitution based on his earlier plea to grand theft. The DME company specialized in ventilators and disposable supplies. When orders came into the company and the product was shipped out, the owner would add items to the invoices before billing. As a result, supplies were billed each month that were never delivered. The owner participated in this scheme with his office manager, who also pled guilty to grand theft. The office manager was sentenced to 3 years probation and 500 hours community service, and ordered to pay \$152,880 in restitution.
- A Pennsylvania DME company and the company's Chief Operating Officer signed a settlement agreement with the Government, agreeing to pay

\$265,000 for submitting false claims to Medicare. The investigation disclosed that the company billed Medicare for body jackets but actually provided "E-Z Vests," a product which does not comply with Medicare's criteria for reimbursement. The agreement also called for permanent exclusion of the company and a 3-year exclusion of its Chief Operating Officer.

- In Illinois, a now defunct DME company and its owner reached an agreement with the Government settling allegations of Medicare fraud. Investigation uncovered that the owner submitted false claims to Medicare, billing the program for reimbursable female external urinary collection devices when he actually provided noncovered adult diapers. Although the Medicare single damages amount totaled \$373,704, the settlement amounted to \$188,897, based on an inability to pay. The owner also agreed to be permanently excluded from all Federal health care programs. He will be sentenced based on a related criminal charge at a later date.
- In New York, a DME company owner was sentenced to 3 years probation and ordered to pay \$232,402 in restitution for defrauding Medicare and private insurance companies. The owner submitted false Medicare claims and paid two physicians kickbacks to sign certificates of medical necessity for patients they never examined. He also defrauded six private insurance companies by filing false claims. In his private insurance scheme, he submitted claims for services not rendered. Insurance companies then sent reimbursement checks to a post office box rented to a DME company through him. Previously, he was convicted, sentenced and ordered to pay restitution of \$104,335 for submitting false claims to Medicaid.
- The former owner of a DME company with three offices in Arizona was sentenced to 15 months incarceration, followed by 3 years supervised release and 200 hours of community service. He was also ordered to pay \$120,413 in restitution. The owner had pled guilty to filing false claims and failure to pay taxes in relation to his DME company. He billed Medicare \$4,800 each for power wheelchairs but either failed to deliver them, or delivered less expensive chairs or scooters instead. He also failed to pay taxes withheld from employees.

Special Fraud Alert: Physician Certifications

During this reporting period, OIG issued a special fraud alert entitled "Physician Liability for Certifications in the Provision of Medical Equipment and Supplies and Home Health Services." It was published in the Federal Register on January 12, 1999. The special fraud alert was issued to educate and inform physicians of the significance of the certifications

they make in connection with the items and services they order for home health services and DME. Under the Medicare program, physicians prescribing home health care or DME, such as hospital beds, wheelchairs and oxygen delivery systems, must certify that the services are medically necessary and that the beneficiary meets the requirements to qualify for the benefit. This special fraud alert is an effort to assist providers in their compliance efforts by explaining in clear language the physicians' responsibilities in making certifications and the legal significance of the certifications.

Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs

The OIG concluded that Medicare and its beneficiaries could have saved \$1 billion in 1998 if the allowed amounts for 34 drugs were equal to prices obtained by the Department of Veterans Affairs (VA) under the Federal Supply Schedule. The Medicare allowance was greater than the VA acquisition cost for every drug reviewed. For 3 of the 34 drugs, Medicare allowed more than 16 times the VA acquisition cost. Eleven drugs had Medicare allowances that were between two and six times higher than the VA cost. For only two drugs was the difference between Medicare reimbursement and VA cost less than 25 percent.

The VA purchases drugs for its health care system directly from manufacturers or wholesalers, whereas Medicare reimburses doctors and suppliers for drugs which they administer or supply to beneficiaries. Previous OIG reports found that actual wholesale prices (AWPs) available to physicians and suppliers are often significantly lower than the Medicare allowed amounts. This report provides additional evidence that the published AWP used in determining the Medicare allowed amounts for certain prescription drugs can be many times greater than the actual acquisition costs available in the marketplace. The OIG reiterated its earlier recommendation that HCFA reexamine its Medicare drug reimbursement methodologies with the goal of reducing payments as appropriate. Until legislation can be enacted providing for such reform, HCFA should utilize the new inherent reasonableness or competitive bidding authorities provided in the BBA of 1997 to reduce Medicare's unreasonably high payments for drugs. The HCFA concurred and noted that it has made several efforts to reduce excessive reimbursement rates, including using an inherent reasonableness adjustment for albuterol sulfate. The OIG believes that HCFA should continue to use this approach to lower inappropriate payments for other drugs with excessive reimbursement rates. (OEI-03-97-00293)

Medical Necessity of Medicare Ambulance Services

This OIG inspection report assessed the medical necessity of a sample of Medicare ambulance services that did not result in hospital or nursing home admissions or emergency room care. Two-thirds of the 30 sampled cases were not medically necessary because alternative transportation would not have endangered the patient's health. Medicare allows approximately \$104 million each year for these medically unnecessary ambulance services.

The OIG recommended that HCFA develop a prepayment edit to verify the medical necessity of ambulance claims that are not associated with hospital or nursing home admissions or emergency room care. The HCFA concurred with the recommendation, but will not be able to implement it prior to the major overhaul of ambulance payment policies required by the Balanced Budget Act of 1997. The OIG suggested that HCFA take whatever action it can now, consistent with available resources, and also include the issue identified in this report to its agenda during negotiations on the ambulance fee schedule. (OEI-09-95-00412)

Transportation Fraud

A common Medicare fraud scheme associated with transportation and ambulance companies is the submission of claims for transportation of patients to a hospital when they are really taken somewhere else for which claims are nonreimbursable. Other schemes include billing singly for patients who were transported as a group and falsely claiming reimbursement for ambulatory patients. The following examples of cases involving transportation fraud were resolved during this reporting period:

- In New York, the largest ambulance services provider in the United States agreed to pay \$9.5 million to resolve allegations against it and its potential liability. Between 1990 and 1995, the company submitted false Medicare claims by using false diagnosis codes to impel Medicare to pay for otherwise nonreimbursable services. It also billed Medicare for ambulance services that were not medically necessary. As part of the settlement, the company entered into a comprehensive institutional compliance agreement which will be monitored and enforced by OIG for the next 5 years.
- A Mississippi ambulance company entered into a settlement agreement with the Government, agreeing to pay \$1 million for improperly billing the Medicare and Medicaid programs. A subsidiary of the company allegedly billed false claims for services not rendered. Since 1992, the subsidiary submitted false claims for transporting ambulatory patients they claimed were bed-confined and for upcoding the claims in order to meet Medicare coverage requirements. The former owners of the subsidiary have already been sentenced for their part in the scheme.
- In Pennsylvania, the corporate secretary of an ambulance company pled guilty to a charge that the corporation made material false statements to the Government. The corporation submitted claims to Medicare for providing beneficiaries with ambulance trips to area hospitals for services such as x-rays, chemotherapy and other types of therapy. In actuality, these beneficiaries were transported to physicians' offices for routine visits. As a

result of the corporation's improper transportation claims, it was sentenced to pay the maximum fine of \$500,000 and a special assessment of \$200.

- In Massachusetts, an ambulance company agreed to pay the Government \$120,000 to resolve allegations concerning improper billing practices. Between 1993 and 1996, the company billed for advanced life support services when it actually provided basic life support services reimbursed by Medicare at a lower rate. Investigation uncovered that during the time period in question, the company did not employ an emergency medical technician certified to perform these advanced life support services. As part of the settlement, the ambulance company also agreed to implement a compliance plan which includes performance of an annual audit of claims submitted to Medicare.

Chiropractic Care

The BBA of 1997 required HCFA to establish new utilization guidelines for Medicare chiropractic care by January 1, 2000. It also eliminated the need for an X-ray to document treatment necessity. In addition, New York State recently enacted legislation requiring private insurers to include chiropractic coverage in its benefits packages. The OIG conducted an inspection to better understand the impact of these changes on the Medicare and Medicaid programs and learn more about utilization controls.

In one report, OIG described the controls used by Medicare, Medicaid and other payers for chiropractic benefits. Utilization caps were the most widely used control mechanism. However, neither the utilization caps nor any of the other controls detected and prevented reimbursements for unauthorized Medicare chiropractic maintenance treatments. Accordingly, OIG recommended that HCFA develop system edits to detect and prevent such payments by requiring chiropractic physicians to use modifiers to distinguish the categories of the spinal joint problems, and requiring all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy. The HCFA agreed with OIG's recommendations. (OEI-04-97-00480)

The second report examined current and expected chiropractic care benefits under State Medicaid programs. While thirty States offer some form of coverage for chiropractic care under their Medicaid fee-for-service plans, States reported that utilization data showed no discernable trends suggesting explosive growth in Medicaid expenditures. Also, no State reported legislative or regulatory plans to expand their Medicaid chiropractic benefit beyond current coverage. (OEI-04-97-00490)

Noting that some State Medicaid programs allowed chiropractors to be reimbursed for services other than manual manipulation of the spine and X-rays, the only chiropractic

services authorized for Federal matching funds, OIG also issued a vulnerability alert regarding the potential for overpayments. (OEI-04-97-00493)

Chiropractic Services Covered by Medicare Managed Care Organizations

Performance Measure

In this inspection, OIG looked at the policies and practices for providing chiropractic services to Medicare beneficiaries in seven managed care organizations (MCOs). The study also compared chiropractic utilization in four MCOs with that of fee-for-service organizations.

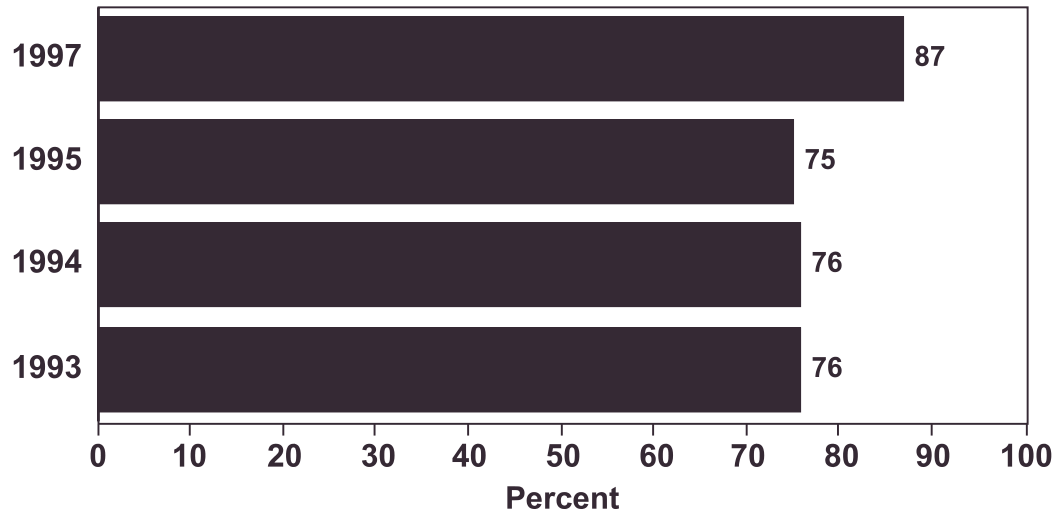
The OIG found that policies and practices for allowing chiropractic services varied among the seven MCOs. All seven MCOs covered manual manipulation of the spine as required by HCFA. However, four required a physician referral, and three allowed direct access. Six of the seven required a copayment, and five conducted utilization or post payment reviews to assure appropriateness of claims. One MCO referred chiropractors to the Federal Bureau of Investigation for fraudulent activities. On average, MCO beneficiaries who obtained chiropractic care received 12 treatments per year in 1996, whereas fee-for-service beneficiaries received 9 treatments. However, the percentage of MCO beneficiaries receiving chiropractic services was lower -- 1.5 percent as compared to 4 percent in fee-for-service plans. (OEI-04-97-00494)

Beneficiary Awareness of Health Care Financing Administration Publications in 1997

Performance Measure

As part of its 1997 survey to determine beneficiary satisfaction with Medicare, OIG asked beneficiaries about their awareness of the Medicare handbook and seven other HCFA publications. Eighty-seven percent of those surveyed reported that they knew about the handbook, a significant increase from the 1995 survey, as illustrated below.

BENEFICIARY AWARENESS OF THE MEDICARE HANDBOOK



While only 38 percent of the beneficiaries aware of the handbook reported using it in 1997, about the same as in 1995, 95 percent who used it found it helpful. Few beneficiaries were aware of HCFA's other free publications, however, and most did not know how to obtain them.

The HCFA's publications provide important information that Medicare beneficiaries and their families may use to make informed health care decisions. Since awareness of publications other than the handbook has not increased, new methods of informing the public need to be developed. As a result of the Balanced Budget Act of 1997, HCFA will likely update several of its publications. This presents a good opportunity for HCFA to intensify efforts to make beneficiaries aware of the availability of all its publications. (OEI-04-97-00033)

Federal and State Partnership: Joint Audits of Medicaid

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

To date, partnerships have been developed in 22 States. Extensive sharing of audit ideas, approaches and objectives has taken place between Federal and State auditors. Completed

reports have resulted in recovered and/or identified overpayments and potential program savings of \$145 million in Federal and State government funds. During this reporting period, the following joint audits were completed:

A. New York

Medicaid payments for Medicare beneficiaries (dually eligible beneficiaries) in New York were the subject of two co-issued reports covering CYs 1994 and 1995. The office of the New York State Comptroller (OSC) found that the State did not have sufficient controls in place to ensure that Medicare Part A benefits were used before allowing a Medicaid benefit payment to be made. In addition, OSC found that providers billed both Medicare and Medicaid for the same services without informing Medicaid that a Medicare payment was received.

The OSC recommended that the State investigate and recoup overpayments totaling \$14.9 million (\$7.45 million Federal share); determine the feasibility of implementing a mandatory statewide crossover system; consider developing a system that tracks Medicare lifetime reserve day balances to ensure that these benefits are exhausted before a Medicaid payment is made; and take action to educate providers about the proper use of lifetime reserve days. (CIN: A-02-98-01015)

B. New Jersey

The New Jersey Office of the State Auditor assessed whether financial transactions related to selected Medicaid program areas were reasonable and properly recorded in the accounting system for the period July 1, 1995 to July 31, 1997. While the transactions tested were proper, the State auditor noted certain procedural and reimbursement issues that merited management attention.

For example, a test of invalid coach transportation costs showed that half the claims did not have a related claim for a medical procedure during the travel time. The State auditor was able to match a portion of these claims to prescription drug claims, which indicated that Medicaid recipients had used the invalid transportation to pick up prescriptions. Further testing showed that 84 percent of the pharmacies that filled these prescriptions offered free delivery.

The State auditor made a number of recommendations, including implementing prepayment review processes to ensure that services are appropriate and improving prepayment edits. The OIG plans to follow up on the actions taken and to keep HCFA informed of the results. (CIN: A-02-99-01001)

Follow-Up to Detoxification Services for Medicaid Beneficiaries

Performance Measure

The OIG conducted a study to assess whether Medicaid and other State programs provide linkages for patient services between substance abuse detoxification programs and follow-up treatment. In surveying the Medicaid State agencies, OIG determined that 15 States have formal processes providing transition from substance abuse detoxification to treatment, and 32 have informal processes. The States tailor substance abuse programs to complement their own service delivery systems, using a variety of treatment settings and staff to ensure that integrated systems of care exist for Medicaid beneficiaries in their States. The OIG found that States vary in their capturing of quality and performance data, and concluded that States which do not capture information on continuum of care linkages have little basis to assess whether beneficiaries are receiving timely treatment services. Only one-third of States conduct performance monitoring of substance abuse programs.

The OIG recommended that HCFA and the Substance Abuse and Mental Health Services Administration (SAMHSA) work with State agencies to develop appropriate performance measures. Both HCFA and SAMHSA expressed a willingness to work with States in these efforts, though they cannot ensure that States meet goals and provide treatment and outcome data. (OEI-07-97-00270)

Medicaid's Use of External Quality Review Organizations

The BBA of 1997 increased States' authority to establish Medicaid managed care programs without obtaining Federal approval. In exchange for this flexibility, the Act required that the States contract with a qualified outside entity to conduct an annual review of managed care plans. The HCFA is working with its own contractors to define the types of external organizations qualified as External Quality Review Organizations (EQROs) and to determine the functions these organizations will carry out.

The seven State Medicaid agencies in OIG's sample charged the EQRO with one or more of the following activities: focused studies, encounter data validation, Health Plan Employer Data and Information Set validation, individual case review, technical assistance, evaluation of health plans' internal quality of care studies and administration of satisfaction surveys. The OIG found in its review that the experienced Medicaid agencies have come to approach quality oversight as a patchwork of complementary strategies including focused studies, consumer surveys or interviews, and data analysis. These agencies have learned to see value in engaging the services of a variety of contractors with a variety of skill sets, including, but not limited to, the Medicare peer review organizations.

The OIG also cautioned HCFA regarding the possibility that enhanced Federal funding for EQROs may create an unintended incentive to overuse external contractors at the expense of developing and maintaining necessary internal expertise. (OEI-01-98-00210)

Medicaid Fraud

At present, 47 States have Medicaid fraud control units (MFCUs). Three States, Nebraska, North Dakota and Idaho, have received waivers from establishing MFCUs as required by the Omnibus Budget Reconciliation Act of 1993. The MFCUs conduct investigations and prosecute providers charged with defrauding the Medicaid program or persons charged with patient abuse and neglect.

During FY 1998, OIG provided oversight and administered approximately \$85.8 million in funds granted by HCFA to the MFCUs to facilitate their mission.

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

- In Florida, a hospital health care corporation agreed to pay the Government \$469,000 to resolve its liability under the False Claims Act and entered into a corporate integrity agreement with OIG. This agreement settles allegations concerning Medicaid claims submitted by one of its component facilities between 1995 and 1997. The claims at issue were submitted to the Florida Medicaid program, by one of the corporation's hospitals, for services rendered to patients in the adolescent psychiatric unit. Allegedly, the hospital billed for services not rendered or not provided in accordance with Medicaid requirements; and, the defendants failed to adequately document the length and nature of the services provided.
- A psychologist in Georgia is serving a 2-year prison sentence for defrauding the Medicaid program of approximately \$209,000. Working with the owner of a day care center, the psychologist submitted false billings to Medicaid for services that were not medically necessary and services in excess of the number actually provided. In addition to imprisonment, the doctor was ordered to pay restitution in the amount of \$209,000 and was excluded for 15 years.
- An alcoholism clinic in New York was excluded for a period of 10 years for felony larceny. The two owner/operators of the clinic were involved in a scheme to defraud Medicaid, which lasted over 5 years. They submitted false claims which resulted in overpayments totaling approximately \$113,000. Both owners were ordered to pay restitution in the aforementioned amount and were each excluded for 10 years.

- The OIG excluded a dentist because he surrendered his license to practice dentistry in California while a formal disciplinary hearing regarding his professional competency was taking place. After surrendering his license and being excluded by OIG, the dentist moved to Oregon. While in Oregon, he applied for a license to practice dentistry with the appropriate licensing board and then for a provider number to bill Oregon's Medicaid program. In researching the dentist's current practices, OIG determined that he had not been truthful about his exclusion status and that the Medicaid agency had an investigation in progress regarding his current billing practices. The dentist was subsequently convicted of Medicaid fraud and falsifying business records. He has been excluded again for an additional 10 years.

**Public Health Service
Operating Divisions**

Chapter II

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Overview of Program Area and Office of Inspector General Activities

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

The Office of Inspector General (OIG) has concentrated on a variety of public health programs and issues such as biomedical research funding, substance abuse, 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 operating divisions. The OIG continues to examine policies and procedures throughout the agencies to determine whether proper controls are in place to guard against fraud, waste and abuse. These activities include preaward and recipient capability audits. This oversight work has

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

Settlement of Allegations of Grant Fraud and Sale of Unlicensed Experimental Drug

The University of Minnesota agreed to pay \$32 million to resolve its civil liability for the sale of an unlicensed, experimental drug over a period of more than 20 years. The lawsuit, brought under the qui tam provisions of the civil False Claims Act and common law theory of disgorgement of profits, sought recovery of profits and damages for violating FDA regulations prohibiting the commercial sale of unlicensed drugs as well as Department regulations requiring grantees to report, and properly account for, program income earned with Federal grant funds. The settlement also resolved disputes involving 29 Federal grants, most of which were administered by the Department, which the Court found were fraudulently billed by the University. Several Medicare-related counts against the University were earlier dismissed by the Court. The case, which settled on the scheduled date of trial, was litigated by the Civil Division of the Department of Justice. In addition to OIG, contributing to development of the case were NIH, FDA, the Office of the General Counsel, and the Assistant Secretary for Management and Budget. The Federal Bureau of Investigation worked with OIG in an initial criminal investigation of the matter. One important outcome of the case was a decision by the 8th Circuit Court of Appeals clarifying that the False Claims Act may be applied against State institutions.

Low-Volume Institutional Review Boards

Performance Measure

In a follow-up to its June 1998 report on the problems facing institutional review boards (IRBs), OIG noted that there are some unique challenges facing hospital-based IRBs outside of the academic health centers. These IRBs tend to oversee considerably fewer research protocols than those at the large research centers and are referred to as "low-volume" in this report.

The OIG inspection results indicate that low-volume IRBs, like others, face significant threats to their effectiveness; they review too much, too quickly, with too little expertise, and conduct minimal review of approved research. In addition, they face conflicts that threaten their independence, provide little training for investigators and board members, and devote little attention to evaluating IRB effectiveness. Finally, they face major changes in the research environment.

The OIG concluded that the same recommendations set forth in its prior 1998 report apply to low-volume IRBs. In implementing these recommendations, OIG suggests that oversight agencies pay special attention to the particular needs of low-volume IRBs. Specifically, OIG proposes that the Office of Protection from Research Risks and FDA address

low-volume IRBs' relative isolation from the rest of the IRB community by fostering collaborations between them and others. (OEI-01-97-00194)

Food and Drug Administration Warning Letters

The OIG issued two related studies on FDA's warning letter process -- one on trends and perspectives, the other on timeliness and effectiveness. The OIG found that the warning letter process is an effective tool in achieving industry compliance with Federal laws and regulations. The FDA completed appropriate follow-up in 97 percent of the cases. However, FDA frequently failed to meet its own timeliness guidelines. Another concern is that the Office of Regulatory Affairs/Office of Enforcement's warning letter data base does not match district records of warning letters issued. The size of a district, the type of firms it regulates, and the experience and attitudes of its staff contributed to the wide variation among districts in the number of warning letters issued. The nationwide decrease in the number of warning letters issued annually primarily resulted from changes in FDA policies and practices, as well as from better industry compliance. The OIG recommended that FDA improve both its timeliness and the accuracy of its warning letter data base and that it continue to improve its relations and communication with industry. (OEI-09-97-00380; OEI-09-97-00381)

Centers for Disease Control and Prevention's Year 2000 Remediation

The OIG's ongoing review of CDC's Year 2000 (Y2K) computer system remediation has covered, to date, CDC's inventory of major systems, Y2K test methodologies, independent verification and validation, and testing in Y2K certified environment. The OIG's recommendations in each of these areas follow.

With respect to the inventory of major information systems, OIG recommended that CDC use consistent terminology for reporting Y2K system status and review compliance data included in the inventory to ensure its accuracy. Also, OIG proposed that CDC develop a standardized test plan using guidelines established by the General Accounting Office for Y2K test methodologies.

The OIG believes that it will be difficult for CDC's Y2K independent verification and validation (IV&V) contractor to be totally independent and thus ensure a true IV & V process because of the contractor's major involvement in non-Y2K work at CDC. Accordingly, OIG recommended that CDC reevaluate whether it can rely on the current IV & V process and include additional testing in 1999 to ensure that its systems operate as intended. Further, OIG recommended that, to the extent possible, CDC retest in 1999 its major information systems in environments that have been certified as Y2K compliant to ensure that they operate as intended. The CDC generally agreed with OIG's findings and recommendations. (CIN: A-04-98-05006)

Disclosure Statements of Major Research Universities

In May 1996, OMB Circular A-21 was revised to require that universities receiving \$25 million or more annually in Federal research funds describe their accounting practices in a disclosure statement prescribed by the Federal Cost Accounting Standards Board. The objective of the disclosure statement is to ensure that universities have policies and practices in place that result in charges to Federal research projects that are accurate, allowable and properly allocated to institutional activities. The university is required to submit its statement to the cognizant Federal agency, the Department of Health and Human Services (HHS) in most cases, for a determination that its cost accounting practices are adequately disclosed and that they comply with cost accounting standards and cost principles set forth in the Circular.

The OIG is determining the adequacy and compliance of approximately 140 disclosure statements submitted to the Department for approval. As of December 31, 1998, OIG had reviewed 23 such statements and expects to complete another 32 reviews by the end of FY 1999. As appropriate, OIG recommended that universities establish new, or revise existing, policies and procedures or that they revise those practices that are inconsistent with cost accounting standards or cost principles. These recommendations will help strengthen financial controls and ensure the integrity of the billions of Federal research dollars to be awarded to major universities in future years. (Various CINs)

Superfund Financial Activities

The Hazardous Substance Response Fund, commonly known as the Superfund, is used to respond to emergency environmental hazards and to pay for removing toxic substances. Through agreements with the Environmental Protection Agency, certain HHS agencies receive Superfund money to carry out health-related activities mandated by law. During this reporting period, OIG audited FY 1997 Superfund financial activities at the following agencies:

A. Agency for Toxic Substances and Disease Registry

The ATSDR obligated about \$63.9 million and disbursed about \$58.8 million of Superfund money. The OIG found that these funds were generally administered in accordance with applicable laws and regulations; however, management controls needed to be strengthened. The ATSDR agreed with most of OIG's recommendations. (CIN: A-04-98-04220)

B. National Institute of Environmental Health Sciences

The National Institute of Environmental Health Sciences' (NIEHS') obligations totaled about \$53.9 million and disbursements totaled about \$60.5 million of funds obligated during and prior to FY 1997. The OIG determined that NIEHS generally administered the fund according to Superfund legislation. (CIN: A-04-98-04221)

Medicare Pricing for Indian Health Service's Contract Health Services Program

The IHS provides or funds comprehensive health services for American Indians and Alaska Natives. When IHS cannot provide needed health care in its own facilities, its Contract Health Services (CHS) program contracts with private providers. While other Federal purchasers of health care can require that services be offered at favorable Medicare rates, IHS does not have this legislative advantage. Instead it must rely on a hospital's willingness to offer Medicare rates.

The OIG determined that in FY 1995 IHS paid \$8.2 million more than the Medicare rates for contracted services. Savings from enactment of the legislative change sought by IHS to require hospital acceptance of Medicare prices could be used to provide additional health care. The OIG anticipates that IHS and the Department will use this report in the legislative development process. (CIN: A-15-97-50001)

Indian Health Service: Program Integrity and Ethics Functions

Performance Measure

In response to a request by the IHS director, OIG evaluated the effectiveness of the operation of the IHS program integrity and ethics function by comparing these operations to those of four other organizations. The program integrity and ethics staff have three major responsibilities: to investigate complaints and allegations about IHS and tribal employees, perform ethics activities and coordinate personnel suitability investigations.

The OIG determined that staff at headquarters seemed to understand the mission, policies and procedures of the program integrity and ethics functions, but over half the staff at area offices found them unclear. Moreover, the current organizational structure obscures the function's visibility and prominence, and fragments responsibility for personnel suitability. The OIG found that staffing may be inadequate; the ratio of staff to agency employees was less than that of any of the other agencies studied.

The OIG made specific recommendations to assist IHS in improving administration of the program integrity and ethics function by clarifying responsibilities, and enhancing visibility and prominence within the organization. (OEI-04-97-00060)

Mental Health Clinical Training Program

Under the Mental Health Clinical Training Program, SAMHSA awards grants to provide funding to individuals for graduate training or development in psychology, psychiatry, nursing or social work. Trainees are generally required to repay each month of financial support through an equal period of service to underserved mentally ill populations in public

facilities. If trainees fail to satisfy this service obligation, they must repay the Government three times the cost of the traineeship plus interest.

The SAMHSA's Center for Mental Health Services contracts with a private corporation to monitor and track the appointments and payback activities of trainees. However, in OIG's opinion, the contractor did not adequately fulfill this responsibility. The contractor did not identify and refer for debt collection the trainees who did not satisfy their service payback obligations, nor did it audit and report on the service payback status of trainees in debt collection. The OIG recommended that SAMHSA ensure that the contractor complies with contract requirements and audits the status of all trainees' service payback activities, and implement procedures to refer trainees who default on their payback obligations to OIG for exclusion from participation in the Medicare and Medicaid programs. In commenting on the draft report, SAMHSA generally agreed with these recommendations. (CIN: A-15-97-80001)

Youth Use of Cigars

The OIG produced two related inspection reports on youth use of cigars -- one concerning Federal/State regulation and enforcement, and the other on patterns of use and perceptions of risk. The OIG found that 19 percent of teens in its focus groups had smoked a cigar in the last 30 days, and one-half the smokers said they still expected to be using cigars 5 years from now. Teens in the focus groups said their peers use cigars as "blunts" for smoking marijuana. Cigars are not subject to the same oversight at the Federal and State levels as cigarettes and spit tobacco.

In this oversight review of the Department's implementation of rules relating to tobacco use by minors, OIG recommended that the Office of the Assistant Secretary for Health take immediate action to inform the public about the health risks associated with cigar smoking and pursue a collaborative strategy with the Federal Trade Commission and the Congress to initiate a Surgeon General's warning label for cigars. In the longer run, the Department should address the need for additional research on cigars, including prevalence, patterns of use, health effects, the addictive potential of cigars and the practice of "blunting." (OEI-06-98-00020; OEI-06-98-00030)

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. The Department's Program Support Center (PSC) takes all steps that it can to ensure repayment. However, some loan recipients ignore their indebtedness.

After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Once the individual has been declared in default, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid and all Federal health care programs for nonpayment of these loans. During this 6-month period, 231 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.

At the conclusion of this reporting period, 123 individuals had taken advantage of the opportunity and entered into settlement agreements or completely repaid their HEALs. The amount of money being repaid, through settlement agreements or through complete repayment, totals over \$69 million. The following are examples of some of these settlements:

- After being notified that he was excluded as a result of his failure to repay his HEAL debt, a New York physician entered into a settlement agreement to repay almost \$400,000 in student loans.
- A settlement agreement was signed by a Connecticut physician to repay his HEAL debt of almost \$280,000.
- A doctor of osteopathy in Michigan entered into a settlement agreement to repay his \$192,000 HEAL debt.
- In California, a podiatrist entered into a settlement agreement to repay his HEAL debt of over \$157,000.

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

Chapter III

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. The major programs 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 program implementation among the Federal, State and local governments.

In 1993, the Congress passed the Government Performance and Results Act mandating Federal agencies to establish strategic planning and to prepare annual performance plans, beginning with a plan for FY 1999. The annual performance plan sets out measurable goals that define what will be accomplished during a fiscal year. The OIG has initiated a review of selected data sources and information collection systems supporting ACF's 1999 performance plan.

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.

Child Support Enforcement

The United States Attorney General has placed enforcement of the Child Support Recovery Act of 1992 as a top Department of Justice (DOJ) priority. The Act made it a Federal misdemeanor crime for a parent in one State to refuse to pay past due support for a child in another State, when the support has been owed for more than 1 year or exceeds \$5,000. Any subsequent offense is a felony violation. A recent amendment to this Act has 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 the Office of Child Support Enforcement (OCSE) are the sponsors of a multiagency, multijurisdictional investigative task force headquartered in Columbus, Ohio, whose mission is to identify, investigate and prosecute the most egregious violators of the Federal and State child support laws in the Midwest -- with special emphasis on the States of Illinois, Michigan and Ohio. The task force is comprised of personnel from the OIG Office of Investigations, U.S. Marshals Service, U.S. Attorneys Offices, the Department of Justice, 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 force is 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 three investigative units -- one each in Illinois, Michigan and Ohio -- 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 force is a screening unit in Columbus, Ohio which is manned by analysts and auditors from both OIG and OCSE. This unit receives the child support cases from the States, conducts preinvestigative analyses of these cases through the use of information data bases and then forwards 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 actively investigated over 315 cases at the Federal and State levels with over 100 cases still being evaluated at the screening unit. Currently, 31 Federal arrests have been executed and 18 individuals already

sentenced. The total arrearage amount related to the Federal convictions is \$467,000. There have been 163 arrests on the State level.

Based on the success of this initial task force, plans have been made to start four more in other areas of the country by the end of this fiscal year. The first of these additional task forces has already been established in Baltimore, Maryland, and it will cover the States of Maryland, Virginia, Delaware and Pennsylvania as well as the District of Columbia.

The Federal arrests, convictions and sentencings resulting from the task force approach, during this reporting period, include the following:

- An Ohio man was sentenced after pleading guilty to failing to pay past due child support of \$42,000. Since 1985, the man had paid little child support for his three children who are now 25, 22 and 21. He was sentenced to 5 years probation with electronic monitoring and ordered to pay total restitution. One of his children is president of the Ohio chapter of the Association for Children for Enforcement of Support.
- In Iowa, a man was sentenced for failure to pay a legal child support obligation. He was approximately \$43,000 in arrears on his child support payments. He was sentenced to 5 years probation and ordered to make restitution of \$36,250.
- A Michigan man pled guilty to failure to pay child support and was sentenced to 4 years probation and ordered to pay \$40,436 in restitution. He was arrested in May 1998, after voluntarily surrendering to OIG agents in Massachusetts for failing to meet child support obligations in Michigan. He works as the Chief Executive Officer for a technical education firm.
- In Minnesota, an individual was sentenced for failure to pay a legal child support obligation. His sentence included 5 years probation and an order to pay \$29,447 in restitution, the amount of his child support arrearage.

The OIG's enforcement work also continues in cases of interstate nonpayment of child support occurring in States outside the task force area, as shown by the following examples:

- In Missouri, a man was sentenced for failure to pay child support and for failure to file a Federal income tax return. He had previously pled guilty for failing to meet his child support obligation for his developmentally disabled son, and his arrearage exceeded \$49,000. Efforts to attach his property and to garnish his wages were largely frustrated because he placed his assets in the names of friends and relatives, incorporated his business into another

company and failed to file income tax returns. The man was sentenced to 5 years probation and ordered to pay \$425 per month in child support against his arrearage. A civil penalty and fine for his tax liability will be determined at a later date.

- In Virginia, a man was sentenced for failure to pay child support. Prior to his sentencing, the custodial parent indicated the child feared his father and had emotional and learning disabilities. The father was sentenced to 5 years probation and was ordered to make restitution of \$42,975, the amount owed in past due support. He was also ordered to pay \$438.75 each month against his arrearage. It was further ordered that he could not see his son until the appropriate court approved visitation. The man was extradited to Virginia from Oklahoma after resolving State charges of drug possession.
- In Texas, a man was sentenced for failure to pay child support in the State of Nevada. His sentence included 5 years probation and an order to pay full restitution of \$26,337. This represents the first conviction involving child support enforcement in the District of Nevada.
- A man was sentenced to 30 days in jail and 1 year probation, and ordered to pay \$20,368 for failure to pay child support. To avoid meeting his child support obligation in Oklahoma, he moved from Oklahoma to Florida, changing residences frequently. He has a previous conviction for assault and battery on a police officer.
- In Oregon, a man was sentenced for failure to pay child support. His sentence included payment of his child support arrearage of \$15,060 (in increments of \$300 per month) and 5 years probation. Since OIG received this case, the man had moved from Hawaii to Nevada, where he was arrested; to Oregon, where he pled guilty; and back to Nevada. Through a cooperative effort with Nevada, California and Hawaii child support enforcement authorities, OIG played a role in raising his monthly child support obligation from \$100 to \$585.

To date, OIG has investigated 559 child support cases nationwide. During this period, these cases resulted in 36 convictions and court-ordered restitution of over \$1.2 million. Prosecutions in this area are unique in that sentences ordered by a judge take into account the need for the defendant to continue to be able to pay. Therefore, alternative sentencing options -- such as work release, home detention and probation where nonpayment is a violation -- are ordered.

Child Support Enforcement Annual Report to Congress

Performance Measure

The Congress requires that OCSE submit an annual report describing program activities over the prior year. While the law specifies much of the data to be included in the report, it contains a considerable amount of information in addition to what is mandated. The OCSE compiles the annual report based on States' reports of their child support activities.

In a survey of 36 individual users, OIG found that, overall, users are satisfied with and rely on the report. However, most cited the lack of a clearly defined message, timeliness and data integrity as the report's main weaknesses; many identified opportunities for strengthening the report to have it better meet their needs.

Based on this feedback, OIG recommended that, in the future, the annual report focus primarily on performance. It should highlight program successes, strengths and weaknesses; emphasize performance data which demonstrates how well the program is meeting its goals; and adequately describe program accomplishments that, when used to compare different program strategies, may be valuable to Federal policymakers and State programs. Further, OCSE should review the report's production and distribution processes and identify ways to improve the report's timeliness. The ACF agreed to implement OIG's recommendations. (OEI-02-98-00070)

Interstate Compact on the Placement of Children

At ACF's request, OIG examined States' implementation of the Interstate Compact on the Placement of Children. The Compact is an agreement among States intended to ensure that children placed across State lines receive adequate protection and services.

The OIG determined that States have Compact policies and procedures that are generally uniform and comprehensive. However, States are sometimes unaware that children have been placed in their jurisdiction; this can happen when children have been placed through the Compact but the receiving State does not know that the placements have been finalized or when there are placements that ignore the Compact. Half the States did not know how many children they had placed through the Compact in 1997. The OIG determined that the two main reasons for poor quality and inconsistent State data were the differing standards among the States and ineffective tracking techniques.

Although the Compact is a promising and viable way for States to fulfill their obligations to the children they place across State lines, weaknesses in the Compact's structure may leave some children vulnerable. Accordingly, OIG encouraged States to abide by the principles of the Compact and proposed that ACF be prepared where necessary to provide technical assistance on how to more effectively implement the Compact, especially in regard to placement notification and uniform data collection. The OIG will continue its work in this

area and will analyze in greater detail how well this system is being implemented. (OEI-02-95-00041)

Foster Care Eligibility in California: Follow-On Review

A previous OIG review estimated that California was incorrectly paid \$51.7 million (Federal share) for title IV-E Foster Care for the 3-year period ending September 30, 1991. However, OIG did not recommend that ACF recover this amount as a moratorium on such recoveries had been effected by the Omnibus Budget Reconciliation Act of 1993. Once the moratorium expired, ACF initiated recovery action. The State then submitted additional documentation to ACF to contest many of the questionable payments previously identified. Based on ACF's review of the documentation and an OIG follow-on review made at ACF's request, it was determined that the State was paid \$38.9 million (Federal share) in ineligible foster care payments for the 3-year period. The OIG recommended recovery of this amount. (CIN: A-09-98-00075)

Misuse of Grant Funds

Resolution of charges of misusing Department of Health and Human Services (HHS) grant funds occurred in the following case involving foster care services:

- The City and State of New York agreed to pay HHS \$49 million to settle a civil lawsuit initiated by an employee of the city's child welfare agency. Over a 4-year period, the city agency allegedly misused \$39 million in HHS grants by not providing required foster care services. The defendants failed to formulate case plans for foster children and to conduct case reviews for children in foster care every 6 months. As part of the settlement, certain compliance and monitoring provisions were imposed to ensure the city and State provide mandated foster care services in the future.

Tribal Child Care

Federal Child Care and Development Fund (CCDF) grants enable Tribes to provide child care subsidies to low-income American Indian and Alaska Native families so they can work, attend training or return to school. More than 17,000 American Indian and Alaska Native children currently receive child care services funded wholly, or in part, by CCDF Tribal grants. State CCDF programs also serve American Indian and Alaska Native children, as the law permits American Indians and Alaska Natives to access the CCDF program through Tribes or the States. Tribes in 31 States receive CCDF grants directly from the Federal Government.

For this inspection, OIG visited 29 Tribal CCDF programs in 7 States where more than 60 percent of the Tribal CCDF grantees are located. The OIG found that Tribal CCDF grants

provide American Indian and Alaska Native children greater access to affordable child care by using more expansive eligibility criteria and offering culturally sensitive services. However, Tribes and States lack knowledge about each others' programs, thus limiting access to child care services. Moreover, OIG identified impediments in the coordination of Head Start and child care programs, and found that child care plans, payment systems and reporting are uneven.

The OIG made specific recommendations to improve access to child care, improve coordination between Head Start and CCDF, address vulnerabilities in Tribal reporting and payments, and make the most of resources provided by the technical assistance contractor and regional ACF staff. The ACF concurred with OIG's findings and recommendations and highlighted their ongoing efforts in these areas. (OEI-05-98-00010)

Early Efforts by States to Monitor Outcomes of Welfare Reform

Performance Measure

In a final report on States' early efforts toward monitoring the impact of welfare reform, OIG found that two-thirds of States are beginning to use administrative data to track the short-term outcomes of former welfare clients. In addition, almost all States are planning or beginning to conduct evaluations; however, these evaluations vary widely in scope and methodological rigor with few results currently available. Only a few States believe that their current efforts to monitor outcomes of welfare reform are sufficient.

While the report made no recommendations, it raised issues for further consideration. These included: exploring the capacity of States to track outcome measures using their administrative data; validating the data used for outcome measures; reviewing the quality and scope of States' evaluations; and assessing the breadth and depth of a State's overall efforts to measure outcomes of welfare reform. (OEI-05-98-00130)

Dual Payment of Welfare Costs

The TANF block grant legislation inadvertently created a dual payment to the States for certain common administrative costs for the former Aid to Families with Dependent Children, Medicaid and Food Stamp programs. To correct this, the Agricultural Research, Extension and Education Reform Act of 1998 required the Secretary of HHS to determine the amounts that were now included in States' TANF block grants that could be allocated to Food Stamps and Medicaid.

The Assistant Secretary for Management and Budget (ASMB) was responsible for developing the methodology to be used by the States in calculating the amounts for adjustment. At ASMB's request, OIG assisted in evaluating the methodology and was available for onsite validations. Onsite validations were conducted in three States -- Ohio, Virginia and Texas -- and the results were reported to ASMB.

The Secretary issued letters to the 50 States and the District of Columbia identifying the appropriate adjustments for their Food Stamp and Medicaid programs. Annual adjustments to the Food Stamp and Medicaid programs for the next 4 years total \$227 million and \$295 million, respectively. It is expected that many States will appeal this decision.

Discretionary Grants Awarded to Alleviate Poverty Performance Measure

The ACF's Office of Community Services (OCS) awards discretionary grants to help alleviate the causes of poverty in distressed communities. The OIG reviewed two awards to determine whether grant objectives were achieved and funds properly expended.

A. California Grant

A nonprofit grantee was awarded \$500,000, \$340,000 of which was to be invested (as a stock purchase) in a for-profit company that would use the funds to expand its business and create 40 full-time permanent jobs for low-income persons. The remaining \$160,000 was retained by the grantee to cover its costs for administering the project. The OIG found that the equity investment resulted in neither the intended business expansion nor the expected new job creation. The only expansion that occurred was purchase of new equipment. The number of new employees on the payroll ranged from 7 in January 1997, shortly after the initial stock purchase, to 10 in August 1997 and down to 6 as of November 1997.

Also, the company did not account for or accurately report to the grantee the use of the \$340,000. The OIG determined that \$86,000 was used for the intended purposes of the project with the balance either unaccounted for or used for other purposes.

The OIG concluded that the grantee did not have the management capability or the experience for managing an economic development project of this size. The for-profit company did not have the management systems, physical plant or business acumen to achieve the intended purposes of the grant. The OIG recommended the grantee obtain a complete accounting from the company on how the \$340,000 investment of Federal funds were used and seek instructions from OCS transferring fiduciary responsibility to an entity more capable of protecting the Federal investment. (CIN: A-09-98-00065)

B. Oregon Grant

The OIG reviewed a \$250,000 grant awarded to an Oregon nonprofit organization to create 18 permanent full-time jobs through a business development venture. However, only four full-time jobs were created during the grant period and none existed by the end of the grant. The review also identified unexpended program income and unallowable charges totaling \$27,000. In addition to a financial adjustment, OIG recommended that before any future awards are made, the grantee has performance measurements in place and control deficiencies corrected. (CIN: A-10-98-00008)

Atlanta Empowerment Zone Corporation

The OIG examined whether the Atlanta Empowerment Zone Corporation (AEZC) had the systems and controls needed to manage its Empowerment Zone (EZ) grant. The Empowerment Zone program is a major Federal initiative to revitalize economically distressed areas of the country. The program encourages job creation while preparing disadvantaged residents to fill those jobs with a comprehensive range of services. In December 1994, Atlanta was designated as a Federal Empowerment Zone and the State of Georgia was awarded \$100 million over the next 10 years. As fiscal intermediary, the State provides funds to the City with as few restrictions as possible.

While OIG found AEZC's written accounting and management policies and procedures adequate, their effective implementation was questionable as AEZC was undergoing a reorganization as a result of numerous problems identified by the Georgia Department of Consumer Affairs. The OIG recommended that the City of Atlanta, which assumed control of AEZC, expeditiously determine if and how it will continue to implement the EZ strategic plan through AEZC; assure that adequate policies and procedures are followed and resources and staff are in place; and diligently monitor the EZ activities. City officials agreed with OIG's findings and recommendations. (CIN: A-04-98-00121)

Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program: First Year Outcomes

Performance Measure

Performance data reported by AoA's community volunteer projects show that the projects recruited and trained volunteers, educated Medicare beneficiaries and identified instances of potential fraud, waste and abuse. The 12 projects recruited and trained 3,682 trainers who educated nearly 41,800 Medicare beneficiaries to detect and report suspected cases of health care fraud and abuse. The projects received a total of 657 allegations of fraud, abuse or waste and 88 were identified as potential overpayments. The projects estimated that as much as \$1.16 million in Medicare funds may be recouped. The OIG believes that before a new round of grants is awarded, it is important to identify and describe implementation problems, curricula for training trainers, best practices for tracking trainers' activities and fraud allegations, and efforts to document outcomes. In addition, OIG believes that AoA needs to clarify guidance to projects about trainees and community education activities. (OEI-02-97-00522)

General Oversight

Chapter IV

GENERAL OVERSIGHT

Introduction

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

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

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133, under which HHS is cognizant agency to audit the majority of the Federal funds awarded to major research schools, State and local government cost allocation plans, and separate indirect cost plans of State agencies and local governments. Also, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG 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.

Year 2000 System Compliance

The OIG has taken an active role in monitoring the progress being made by the Health Care Financing Administration (HCFA) and other HHS agencies to remediate their mission critical computer systems. The Office has an ongoing presence at agencies' central offices, to oversee the progress on their internal systems. The OIG has also focused its monitoring efforts on the Medicare contractors, where OIG staff have participated in over 200 site visits with HCFA staff and HCFA's Independent Verification and Validation (IV&V) contractor. During this reporting period, OIG issued a status report to the HHS Chief Information Officer (CIO), a number of alerts to the HCFA CIO and issued a statement for the record for a Year 2000 hearing held by the House Ways and Means Committee.

A. Interim Report

In its second interim report to the HHS CIO, OIG noted some new issues, along with previously identified issues which continue to present obstacles to Year 2000 compliance. Overall, OIG reported that the operating divisions are expending significant time and resources to address the year 2000 challenge and have made progress since OIG's initial report in May 1998.

The OIG's work continued to focus on HCFA because the Department's Tier I status, indicating insufficient evidence of adequate progress, is a direct result of OMB's concerns about HCFA's ability to bring its external systems into timely compliance. The success or failure of HCFA's overall millennium effort is inseparably linked to the Medicare contractor systems. During this reporting period, OIG observed problems relating to two of the systems shared by contractors. In addition, the Department had not established a formal policy on what is required to self-certify mission-critical systems, when recertification is required or what documentation should be retained. Also, OIG found persistent problems with contingency planning. The OIG made recommendations to deal with these issues and continues to monitor the Department's progress. (CIN: A-17-98-00044)

B. Statement

The OIG issued a statement for the record on HHS Readiness for the Year 2000 for the February 24, 1999 hearing held by the House Ways and Means Committee. Consistent with the focus of the hearing, OIG's statement principally discussed the remediation efforts at HCFA and ACF. The OIG pointed out the significant progress made by these operating divisions but also noted areas of concern. For example, OIG noted that the operating divisions generally met the Department's December 31, 1998 due date for system compliance, but that for HCFA to meet this date it had to accept self-certifications with "except for" statements from its Medicare contractors. On the surface some of these exceptions were significant; however, HCFA expected to have them resolved before the March 31, 1999 due date set by OMB. The OIG's statement detailed other problems found and concluded by saying that OIG would now focus its monitoring effort on testing system compliance, including "end-to-end" testing of system interfaces with one another.

Financial Statement Audit of the Department for Fiscal Year 1998

Performance Measure

As required by the Government Management Reform Act of 1994, OIG audited the departmentwide consolidated financial statements for FY 1998, which include the newly prepared statements of budgetary resource and financing, and custodial activity. This audit encompassed individual audits of eight operating divisions' financial statements.

The audit report, which appears in the Department's Accountability Report for FY 1998, indicates a qualified opinion on the FY 1998 statements. Although the Department has made progress since the FY 1997 audit, documentation problems continue and compliance with the reporting requirements of the new combined statements is an emerging issue. Medicare contractors, for instance, did not maintain adequate documentation to support \$23 billion in reported accounts receivable activity during the year. This amount resulted in gross accounts receivable of about \$5.8 billion, or about \$3.3 billion net, at fiscal year end. Also, a number of operating divisions did not have available all the accounting information needed for audit of the statements of budgetary resources, financing, and custodial activity.

In addition, the report noted material internal control weaknesses, problems that are systemic across a number of operating divisions, as well as significant dollar issues affecting only one division. The OIG again reported that the Department and its operating divisions still do not have a fully functioning, integrated financial reporting system capable of producing complete and reliable financial statements in a timely manner. In some instances, statement adjustments were still being made in January 1999, about 2 months late. Also reported was the need for significant improvements in HCFA's methodology for estimating Medicare accounts receivable and in the electronic data processing controls at the HCFA central office and HCFA contractors.

The Department generally agreed with OIG's recommended improvements. (CIN: A-17-98-00015)

Results Act Review Plan

Performance Measure

In 1993, the Congress passed the Government Performance and Results Act (GPRA) mandating Federal agencies to establish strategic planning and to prepare annual performance plans, beginning with a plan for FY 1999. The annual performance plan sets out measurable goals that define what will be accomplished during a fiscal year. The GPRA also requires that a program performance report comparing actual performance with performance goals be submitted no later than March 31 of each year following submission of the plan. The first program performance report, for FY 1999, is due March 31, 2000.

Since FY 1999 marks the initial implementation of performance measurement, OIG's work during this fiscal year focuses on assessing data collection methods and controls over the

HHS systems that produce performance data. For subsequent years, OIG is developing a cyclical review plan directed toward those measures that are related to mission-critical issues and high risk areas (fraud, waste and abuse).

At the Administration for Children and Families (ACF), OIG will focus on two of the operating division's data collection systems: the Adoption and Foster Care Analysis and Reporting System and the National Child Abuse and Neglect Data System. Both were used to establish baseline data for selected performance measures contained in the FY 1999 ACF Performance Plan. The OIG will evaluate ACF's and selected States' systems for collecting, recording and verifying the performance data reported.

At the Food and Drug Administration and the Centers for Disease Control and Prevention, two of the Nation's principal public health agencies, OIG will evaluate the accuracy of information reported for those measures that relate to mission-critical issues and high risk areas.

At the Health Care Financing Administration, OIG's continuing financial statement audit work is directly applicable to assessment of HCFA-generated, financially-related performance data. For example, in FY 1997, OIG tested over 20,000 claims from the Medicare National Claims History File which contains individually identifiable data on beneficiary eligibility and all Medicare services used. The HCFA is using data from this system in its FY 1999 performance plan. In addition, HCFA cites other OIG work in its FY 1999 performance plan. For example, using OIG's work as its basis, HCFA established such performance goals as reducing the percentage of improper payments in both the Medicare fee-for-service and the home health programs.

It should be noted, however, that it has long been OIG's role to conduct audits, inspections and investigations that 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 itemized in appendix F.

Nonfederal Audits

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

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the first half of FY 1999, OIG's National External Audit Review Center (located in Kansas City) reviewed

about 1,200 reports that covered over \$687 billion in audited costs. Federal dollars covered by these audits totaled \$208 billion, about \$97 billion of which was HHS money.

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

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

A. Office of Inspector General's Proactive Role

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

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

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 1,153 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,055
Reports issued with major changes	21
Reports with significant inadequacies	<u>77</u>
Total audit reports processed	1,153

The 1,153 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling \$9.9 million as well as 2,746 recommendations for improving management operations. In addition, these audit reports provided information for 30 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 the Inspector General Act Amendments of 1988. These costs are separate from the amount ordered or returned as a result of OIG investigations (see page 69).

	<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	399	\$367,370,000	\$81,715,000
B. Which were issued during the reporting period	<u>84</u>	<u>\$117,707,000</u>	<u>\$5,479,000</u>
Subtotals (A + B)	483	\$485,077,000	\$87,194,000
Less:			
C. For which a management decision was made during the reporting period ² :	126	\$145,854,000	\$21,039,000
(i) dollar value of disallowed costs ^{3,4}		\$140,482,000	\$19,478,000
(ii) dollar value of costs not disallowed		\$5,372,000	\$1,561,000
D. For which no management decision had been made by the end of the reporting period	357	\$339,223,000	\$66,155,000
E. For which no management decision was made within 6 months of issuance ⁵	280	\$247,261,000	\$46,200,000
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	45	\$1,257,606,000
B. Which were issued during the reporting period	<u>15</u>	<u>\$ 220,985,000</u>
Subtotals (A + B)	60	\$1,478,591,000
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	21	\$226,562,000
(b) based on proposed legislative action	<u>0</u>	<u>0</u>
Subtotals (a+b)	21	\$226,562,000
(ii) dollar value of recommendations that were not agreed to by management	<u>2</u>	<u>\$ 167,000</u>
Subtotals (i + ii)	23	\$226,729,000
D. For which no management decision had been made by the end of the reporting period ³	37	\$1,251,862,000

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 advisory opinions and safe harbor regulations related to the anti-kickback statute. Among the regulatory initiatives promulgated during the reporting period were:

- Final Rulemaking on Revised OIG Exclusion Authorities Resulting From Public Law 104-191 (RIN 0991-AA87) - The rule addresses revisions to OIG's administrative sanction authorities to comport with sections 211, 212 and 213 of the Health Insurance Portability and Accountability Act (HIPAA). The regulatory provisions serve to expand the scope of certain basic fraud authorities, and revise and strengthen the current legal authorities pertaining to exclusions from Medicare, Medicaid and all other Federal health care programs.
- Proposed Rulemaking on Revised OIG Sanction Authorities Resulting From Public Law 105-33 (RIN 0991-AA95) - This rule proposes revisions to OIG's exclusion and CMP authorities resulting from the Balanced Budget Act of 1997. The rule is intended to protect and strengthen Medicare and State health care programs by increasing OIG's anti-fraud and abuse authority through new or revised exclusion and CMP provisions.
- Proposed Rulemaking on the Health Care Fraud and Abuse Data Collection Program and the Reporting of Final Adverse Actions (RIN 0991-AA98) - In accordance with section 221(a) of HIPAA, this rule will establish a national health care fraud and abuse data collection program for the reporting and disclosing of certain final adverse actions taken against health care providers, suppliers and practitioners.

In addition, during this period, OIG developed and published a number of Federal Register notices that addressed development of OIG compliance program guidances, special fraud alerts and special advisory bulletins in a number of areas. These included:

- Solicitation notices on the development of OIG compliance program guidance for certain Medicare+Choice organizations, the nursing home industry and the hospice industry, and a Federal Register solicitation notice on the development of new safe harbor provisions and special fraud alerts.
- The publication of final OIG compliance program guidance for third-party medical billing companies and OIG's provider self-disclosure protocol; as well as draft compliance guidance for the durable medical equipment, prosthetics, orthotics and supply industry.
- Publication of the OIG special fraud alert on Physician Liability for Certifications in the Provision of Medical Equipment and Supplies and Home Health Services, and the draft special advisory bulletin on the Patient Anti-Dumping Statute.

C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process. For example, OIG testified at five hearings and made one statement for the record 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.

Employee Fraud and Misconduct

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

- A former food inspector with the Food and Drug Administration (FDA) was sentenced in California to 3 years probation, 6 months home confinement, 250 hours community service and payment of a \$20,000 fine. The FDA employee previously pled guilty to bribery for allowing uninspected food into the United States. He admitted to accepting bribes from an importer in return for "looking the other way" when shipments, including adulterated food, entered the country. In light of the former inspector's voluntary efforts to identify similar schemes and advice on ways to correct the system he took advantage of, prosecutors asked for leniency in his sentencing. His

cooperation also included testifying before a U.S. Senate subcommittee investigating corrupt importers.

- In Georgia, a former employee of the Centers for Disease Control and Prevention (CDC) was sentenced after pleading guilty to embezzlement. His sentence included 6 months in a halfway house, 3 years probation, 500 hours community service, and an order to pay a \$3,000 fine and \$450 in restitution. He worked as a Safety and Occupational Health Specialist in the Radiation Protection Section of CDC. One of his responsibilities included purchasing the equipment necessary to ensure safe and proper handling of radioactive materials at CDC facilities. Over a 2-year period, the employee submitted 249 false vouchers for equipment he never purchased. He provided the cashier's office with forged receipts to document these vouchers, and he listed companies on the receipts that did not exist. His false voucher scheme resulted in a total reimbursement of \$105,360 from the Cash Imprest Fund.
- In Maryland, two former employees of the National Institutes of Health (NIH) were sentenced for their part in a scheme to defraud the Government of more than \$14,360. One of the employees, a timekeeper at NIH, submitted false and inflated time cards on behalf of another NIH employee. The timekeeper was paid by this other employee to submit time cards for him for overtime compensation hours he did not work. Both employees were sentenced to 3 years supervised probation and ordered to perform 100 hours and 50 hours community service, respectively. In addition, the employee who received improper overtime compensation was ordered to pay restitution of \$6,640. The timekeeper was terminated from his job for failing to perform his assigned duties, and the other employee retired from Government service.

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 179 successful criminal actions. Also during this period, 620 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 279 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, nearly \$175.8 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.

Appendices

APPENDIX A

Savings Achieved Through Policy and Procedural Changes Resulting from Office of Inspector General Audits, Investigations and Inspections October 1998 through March 1999

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. 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 \$6,446.1 million for this period.

OIG Recommendation	Implementing Action	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Medicare Secondary Payer Extensions: Establish a centralized database of information about private insurance coverage of Medicare beneficiaries. Extend the Medicare secondary payer (MSP) provision to include end stage renal disease (ESRD) beneficiaries as long as the individual has employer based coverage available. (OEI-07-90-00760; OEI-03-90-00763; CIN: A-10-86-62016; CIN: A-09-89-00100; CIN: A-09-91-00103; CIN: A-14-94-00391; CIN: A-14-94-00392)	The database capacity was achieved through the authorization of a data exchange between the Social Security Administration (SSA) and the Health Care Financing Administration (HCFA) and between the Internal Revenue Service (IRS) and HCFA. Section 4631 of the Balanced Budget Act (BBA) of 1997 permanently extended current MSP policies for beneficiaries who are disabled and have ESRD. For ESRD beneficiaries, the statute also increased the time period Medicare is secondary payer from 18 to 30 months.	\$1,700

OIG Recommendation	Implementing Action	Savings in Millions
<p>Medicare Part A Payments for Skilled Nursing Facilities: Services should be bundled into Medicare and Medicaid's payments to nursing homes; Part B payments for services normally included in the extended care benefit should continue to be examined for appropriateness; and a legislative recommendation should be developed to prohibit entities other than the skilled nursing facility (SNF) from seeking coverage on behalf of persons in Part A covered SNF stays for enteral nutrition, incontinence care, and surgical dressings, and limit Medicare coverage of these services to Part A. In 1997 congressional testimony, OIG supported establishing a prospective payment system (PPS) and consolidated billing. (OEI-03-94-00790; OEI-06-92-00863; OEI-06-92-00864; CIN: A-17-95-00096; CIN: A-14-98-00350)</p>	<p>Section 4432 of the BBA of 1997 phased in a PPS for SNF care. Covered services include Part A SNF benefits and all services for which payment may be made under Part B (except physician and certain other professional services) during the period when the beneficiary is provided covered SNF care.</p>	<p>\$1,250</p>
<p>Capital-Related Costs of Hospital Services: Extend congressionally mandated reductions in hospital costs. The HCFA should seek legislative authority to continue mandated reductions in capital payments; excess capacity was not considered in the capital cost policy. (CIN: A-09-91-00070; CIN: A-07-95-01127)</p>	<p>Section 4402 of the BBA of 1997 provided for rebasing of capital payment rates for an additional reduction in the rate of 2.1 percent.</p>	<p>1,100</p>
<p>Reforming Medicaid Disproportionate Share Payments: Disproportionate share payments to hospitals should be related to costs incurred in treating Medicaid and indigent patients to correct the inequities and abuses in current payment methodologies. (CIN: A-06-90-00073; CIN: A-04-92-01025)</p>	<p>Section 4721 of the BBA of 1997 reformed disproportionate share payments under State Medicaid programs by placing limitations on Federal financial participation.</p>	<p>980</p>
<p>Medicare Payments for Oxygen: The HCFA should reduce Medicare payments for oxygen concentrators and ensure that beneficiaries receive necessary care and support in connection with their oxygen therapy. (OEI-03-91-00711, OEI-03-91-001710)</p>	<p>Section 4552(a) of the BBA reduced Medicare reimbursement for oxygen 25 percent until 1999 and by 30 percent for each subsequent year; section 4552(c) mandated that the Secretary develop service standards for oxygen provided in the home.</p>	<p>400</p>

OIG Recommendation	Implementing Action	Savings in Millions
<p>Medicare Laboratory Reimbursements: In July 1989, OIG recommended that HCFA take advantage of economies of scale present in the laboratory industry by considering competitive bidding or making reductions to the fee schedule amounts. In January 1990, OIG recommended that HCFA seek legislation to allow across the board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices which laboratories charge physicians in a competitive marketplace. In a January 1996 follow-up, OIG found that Medicare continued to pay more to clinical laboratories than physicians for the same tests. Although the Omnibus Budget Reconciliation Act (OBRA) of 1993 reduced the fee schedule to 76 percent of the average in 1996, OIG recommended that HCFA periodically evaluate the national fee schedule to ensure that it is in line with the prices physicians pay for the same clinical laboratory services. (OAI-02-89-01910; CIN: A-09-89-00031; CIN: A-09-93-00056)</p>	<p>Section 4553 of the BBA of 1997 provided for reducing fee schedule payments by lowering the cap to 74 percent of median for payment amounts, with no inflation update for 1998 through 2002.</p>	<p>\$300</p>
<p>Medicare Home Health Care Services: The HCFA should revise Medicare regulations to require that the treating physician establish the plan of care and specifically prescribe the type and frequency of home health services needed. (CIN: A-04-94-02087)</p>	<p>Effective February 1995, Medicare regulations require that a beneficiary be under the care of a physician who establishes the plan of care and that the physician's orders for services in the plan of care specify the medical treatments to be furnished, the discipline to furnish the services and their frequency.</p>	<p>199.2</p>
<p>Medicare Payments for Prescription Drugs: The HCFA should reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. (OEI-03-95-00420; OEI-03-94-00390; OEI-03-97-00290)</p>	<p>Section 4556 of the BBA of 1997 reduced Medicare payments for drugs, which are paid based on the average wholesale price, by 5 percent.</p>	<p>110</p>
<p>Payments for Durable Medical Equipment: Excessive Medicare Part B payments for enteral and parenteral nutrition, equipment and supplies should be reduced, or competitive acquisition strategies should be employed. (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230; OEI-06-92-00861)</p>	<p>Section 4551 of the BBA of 1997 froze Medicare payments for enteral and parenteral nutrition and supplies for 1998 through 2002, and simplified the process used to reduce inherently unreasonable prices by 15 percent.</p>	<p>100</p>
<p>Medicare Payments to Hospitals for Bad Debt: The HCFA should seek legislative authority to modify the bad debt payment policy. (CIN: A-14-90-00039)</p>	<p>Section 4451 of the BBA reduced bad debt payment to providers to 75 percent during FY 1998, 60 percent during FY 1999 and 55 percent in later years.</p>	<p>90</p>

OIG Recommendation	Implementing Action	Savings in Millions
<p>Medicare Payments for Unnecessary and Poor Quality Endoscopies: The HCFA should reduce the incidence of payments for unnecessary and poor quality gastrointestinal endoscopies. (OEI-09-88-01006)</p>	<p>The OIG accepted the peer review organizations Fourth Scope of Work as an acceptable corrective action plan for HCFA to address OIG’s recommendation and reduce payments for unnecessary and poor quality endoscopies.</p>	\$54.8

<p>Short/Doyle Medicaid Payment Rates: The State of California should ensure that Short/Doyle payments are limited in accordance with the State’s Medicaid plan and Federal requirements. (CIN: A-09-91-00076; CIN: A-09-92-00094)</p>	<p>The HCFA approved a California State plan amendment that modified and clarified the States’s reimbursement policy for Short/Doyle Medicaid mental health services.</p>	5.7
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ADMINISTRATION FOR CHILDREN AND FAMILIES

<p>\$50 Child Support Disregard in the Child Support Enforcement Program: The \$50 disregard provision, which allowed the first \$50 collected from absent parents to be turned over to the family and not counted against Aid to Families with Dependent Children (AFDC) benefits, did not provide the AFDC family with any incentive to cooperate more fully with child support officials in locating the absent parent and should be eliminated. (CIN: A-02-86-72606)</p>	<p>Section 302 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 eliminated the authority which allowed the recipient to keep the first \$50 of child support collected in a month.</p>	121
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Other	Implementing Action	Savings in Millions
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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>	35.4
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APPENDIX B

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

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

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Modify Formula for Costs Charged to the Medicaid Program:		
The Health Care Financing Administration (HCFA) should consult with the Congress on modification of the Federal medical assistance percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per capita income relationships. (CIN: A-06-89-00041)	The HCFA did not agree with the recommendation, and no legislative proposal was included in the President's current budget.	\$4,100
Laboratory Roll-In:		
Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)	The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.	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)	Although HCFA included a proposal to mandate Medicare coverage for all State and local government employees in the FY 1990 budget submission, no legislative proposal was included in the President's current budget. Also, HCFA did not agree with the recommendation to make Medicare the secondary payer.	1,559
Clinical Laboratory Tests:		
Develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CIN: A-09-89-00031; CIN: A-09-93-00056)	The HCFA agreed with the first recommendation but not the second. The Balanced Budget Act of 1997 reduces Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002. The President's current budget proposes to reduce the fee schedule ceiling from 74 to 72 percent.	1,130*

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

OIG Recommendation	Status	Savings in Millions
<p>Reduce Hospital Capital Costs: Determine the extent that capital reductions are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070; CIN: A-14-93-00380)</p>	<p>The HCFA did not agree with the recommendation. Although the Balanced Budget Act of 1997 reduces capital payments, it does not include the effect of excess bed capacity and other elements included in the base year historical costs.</p>	\$820
<p>Medicaid Payments to Institutions for Mentally Retarded: The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)</p>	<p>The HCFA nonconcurred with OIG's recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA and OIG negotiated an agreement for HCFA to send the report to all State Medicaid directors. This action has been taken. However, pursuant to section 4711 of the Balanced Budget Act of 1997, the Secretary shall conduct a study on the effect on access to, and the quality of services provided to beneficiaries of the rate-setting methods used by States.</p>	683
<p>Flexible Benefit Plans: The value of flexible benefit plans should be included in the definition of wages for the hospital insurance portion of the Federal Insurance Contributions Act. (CIN: A-05-93-00066)</p>	<p>While HCFA agreed with the recommendation and has submitted a legislative proposal to subject flexible benefit plans to the hospital insurance tax, the proposal was not included in the President's budget.</p>	291
<p>Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality. (CIN: A-05-89-00055; CIN: A-05-92-00006)</p>	<p>The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's current budget.</p>	210
<p>Graduate Medical Education: Revise the regulations to remove from a hospital's allowable graduate medical education (GME) base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020)</p>	<p>The HCFA did not concur with the recommendations. Although the Balanced Budget Act of 1997 contains provisions to slow the growth in Medicare spending on GME, OIG believes that its recommendations should be implemented and that further savings can be achieved.</p>	157.3

OIG Recommendation	Status	Savings in Millions
<p>Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 tests identified by the OIG audit. (CIN: A-01-93-00521)</p>	<p>The HCFA agreed with 8 of the 10 tests recommended for addition to the list and added 6 of these tests to its carrier manual. The HCFA will periodically review applicable tests and related equipment. Also, although a legislative proposal to add further tests was included in the President's FY 1997 budget, the Congress decided (through the Balanced Budget Act of 1997) to achieve savings through other means, including freezing laboratory payments through 2002 and reducing the national payment cap to 74 percent of the median of all fee schedules.</p>	\$130
<p>Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing 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 physician status, 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 current budget proposes to allow an assessment of a \$1 fee on any claim not submitted electronically.</p>	126
<p>Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (CIN: A-06-94-00039)</p>	<p>The OIG is continuing to monitor the Medicaid drug rebate program.</p>	123

OIG Recommendation	Status	Savings in Millions
<p>Medicaid Cost Sharing: The HCFA should promote the development of effective cost sharing programs by: allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services; allowing for higher beneficiary cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800)</p>	<p>The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. However, HCFA has no current plans for providing information on States' cost-sharing experiences.</p>	\$122
<p>Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The HCFA should propose legislation to expand the diagnosis related group (DRG) payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)</p>	<p>The HCFA agreed to recover the improper Medicare billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and OIG. The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's current budget.</p>	83.5
<p>Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)</p>	<p>The HCFA considered a proposal recommending that the Medicare 190-day lifetime limit for psychiatric admissions be extended to general hospitals; however, such a proposal was not included as part of the President's current budget.</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 is in the process of issuing a final regulation which addresses the coverage of ambulance services and vehicle and staff requirements. The agency intends to address advanced and basic life support services as part of the negotiated rulemaking process on the ambulance fee schedule which is set to begin in January 1999.</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 is examining payment allowances and methodologies at other payers and is reviewing data to determine if Medicare payments are excessive.</p>	40

OIG Recommendation	Status	Savings in Millions
<p>Reduce End Stage Renal Disease Payment Rates: The HCFA should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)</p>	<p>The HCFA agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing these rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatment. A March 1996 study by ProPAC recommended an increase to the current rates, but HCFA did not believe an across-the-board increase was warranted and intended to monitor facilities' costs and other factors to determine if a rate increase would be appropriate. Toward this end, the Balanced Budget Act of 1997 requires the Secretary to audit the cost reports of each renal dialysis provider at least once every 3 years. The HCFA said it plans to begin these audits in FY 1999.</p>	\$22*
<p>Collect Overpayments from Health Maintenance Organizations for Misclassified End Stage Renal Disease Beneficiaries: The HCFA should issue clear guidelines for the recovery of overpayments from health maintenance organizations (HMOs) and recover all overpayments occurring at least since 1992 that were made to HMOs on behalf of misclassified end-stage renal disease (ESRD) beneficiaries. (CIN: A-14-96-00203)</p>	<p>The HCFA agreed to clarify its policies for collecting overpayments from HMOs. However, it collected overpayments retroactively only to March 1995 for the majority of misclassified beneficiaries and retroactively to October 1993 for the remaining beneficiaries who were misclassified as having ESRD before enrollment in the HMO. Due to this limited recovery schedule, HCFA has not collected \$20.5 million in overpayments which occurred since 1992. The HCFA disagreed with the OIG recommendation to collect the overpayments retroactively to 1992.</p>	20.5

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

OIG Recommendation	Status	Savings in Millions
<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.</p>	\$17
<p>State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings that contain duplicate tests, recover overpayments and make adjustments for the Federal share of the amounts recovered. (CIN: A-01-95-00005; CIN: A-05-95-00035; CIN: A-01-96-00001; CIN: A-06-95-00078; CIN: A-06-95-00031; CIN: A-04-95-01108; CIN: A-04-95-01109; CIN: A-07-95-01139; CIN: A-07-95-01147; CIN: A-04-95-01113; CIN: A-07-95-01138; CIN: A-09-95-00072; CIN: A-05-96-00019; CIN: A-10-95-00002; CIN: A-01-95-00006; CIN: A-02-95-01009; CIN: A-03-96-00200; CIN: A-03-96-00202; CIN: A-03-96-00203; CIN: A-05-95-00062; CIN: A-06-96-00002; CIN: A-06-95-00100)</p>		
<p>Medicare Claims for Railroad Retirement Beneficiaries:</p>	<p>While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.</p>	9.1
<p>Discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)</p>		
<p>Medicare Orthotics:</p>	<p>The HCFA concurred with the recommendations and has revised its national codes to distinguish among categories of devices. The OIG is currently conducting a follow-up to this study.</p>	7.9
<p>Develop guidelines that better define orthotic devices; develop policies for orthotic codes; develop screens for billing many orthotic devices on the same day or within a short time frame; pay special attention to billing for orthotics in nursing facilities; work with the American Orthotic and Prosthetic Association to develop a table of devices that should not be used together, and consider stricter standards to determine who is allowed to bill for orthotics. (OEI-02-95-00380)</p>		

OIG Recommendation	Status	Savings in Millions
<p>Third Party Liability Settlements and Awards: The HCFA should develop legislative proposals to close the loopholes in the Omnibus Budget Reconciliation Act of 1993 that allow Medicaid beneficiaries, who receive settlements and awards from third parties as a result of accidents, to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. The HCFA should also develop guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties. (CIN: A-09-93-00033)</p>	<p>The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g., health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements. In June 1996, HCFA issued guidelines which set forth advice on ways in which States can better recover Medicaid expenditures from established third-party settlements, especially for the disabled population.</p>	\$3
<p>Indirect Medical Education: Reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (CIN: A-07-88-00111)</p>	<p>The HCFA agreed with the recommendation, and the Balanced Budget Act of 1997 reduces the IME adjustment factor from the current 7.7 percent in Fiscal Year (FY) 1997 to 5.5 percent in 2001 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.</p>	to be determined
<p>Medicare Secondary Payer - End Stage Renal Disease Time Limit: Extend the Medicare secondary payer (MSP) provisions to include 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 and included this proposal in an earlier budget submission. Although the Balanced Budget Act of 1997 extends MSP policies for individuals with ESRD to 30 months, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.</p>	to be determined

OIG Recommendation	Status	Savings in Millions
<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: A04-97-01169; CIN: A-04-97-01166; CIN: A-04-97-01170)</p>	<p>Although the Congress and the Administration included provisions to restructure home health benefits in the Balanced Budget Act of 1997, HCFA still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. While agreeing in principle, HCFA said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. The OIG will continue to do work in this area.</p>	<p>to be determined</p>
<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 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 Balanced Budget Act of 1997 provides for some reduction of bad debt payments to providers. The President's current 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>	<p>to be determined</p>
<p>Establish Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: The HCFA should seek legislation that would require participating drug manufacturers to pay Medicaid drug rebates based on average wholesale price (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>	<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>

OIG Recommendation	Status	Savings in Millions
PUBLIC HEALTH SERVICE OPERATING DIVISIONS		
Institute and Collect User Fees for Food and Drug Administration Regulations:	In the absence of specific authorizing legislation, the Food and Drug Administration (FDA) is precluded by statute from imposing user fees to cover additional functions. The FY 2000 President's budget request for FDA proposes that FDA be given new user fee authority to enhance premarket review activities for medical devices and food additive petitions.	\$189.3
Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)		
Medicare Rates for Indian Health Service Contracted Health Services:	The IHS concurred with OIG's recommendations and is revising its legislative proposal for submission in the FY 2000 legislative cycle, identifying elements to be developed in its implementing regulations and continuing its efforts to obtain discount rates throughout its service area.	8.2
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)		
Recharge Center Costs:	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.	1
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)		
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Medical Child Support:	The Administration for Children and Families and HCFA agreed with OIG's findings and recommendations. State officials will move to consider a legislative change and budget option to address the recommendation for the 1999 legislative session.	11.4
Increase the number of noncustodial parents providing medical support for their children and reduce Medicaid costs by either requiring noncustodial parents to pay for all or part of the Medicaid premiums or establishing a new comprehensive health insurance plan for children with premiums paid by noncustodial parents. (CIN: A-01-97-02506)		

OIG Recommendation	Status	Savings in Millions
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GENERAL OVERSIGHT

Simplify Administrative/Indirect Cost Allocation Systems:

The OMB should simplify the process for charging administrative/indirect costs to Federal programs through reform of the cost allocation plans. Options for reform include use of block grant awards, a flat percentage rate for administrative/indirect costs, and negotiation of a nonadjustable rate for a predetermined number of years. (CIN: A-12-92-00014)

Some of OIG's recommendations are cited in the National Performance Review report that calls for reform of the cost allocation process. The OMB's revision of Circular A-87 addressed those recommendations. However, further reform is needed to address the bulk of administrative/indirect costs charged to the Federal Government.

\$660

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

OIG Recommendation	Status
HEALTH CARE FINANCING ADMINISTRATION	
<p>Improve the Health Care Financing Administration's Implementation of the Federal Managers' Financial Integrity Act Program:</p> <p>The Health Care Financing Administration (HCFA) should reevaluate its review of the Common Working File to ensure that all functional responsibilities of the system are included in Federal Managers' Financial Integrity Act reviews. (CIN: A-14-93-03026)</p>	<p>The HCFA still does not agree with the need to expand financial management reviews to other systems, such as the Common Working File.</p>
<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 provide sufficient documentation to support reported accounts receivable. Because of insufficient documentation, OIG again was not able to satisfy itself as to the fair presentation of the Medicare accounts receivable balance (\$2.5 billion in FY 1997). (CIN: A-17-95-00096; CIN: A-17-97-00097)</p>	<p>The HCFA has established a Medicare accounts receivable team to visit several contractors to explore ways in which to strengthen controls and improve contractor reporting.</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>

OIG Recommendation	Status
<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>
<p>Properly Account for Medicare Secondary Payer Overpayments:</p> <p>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. Also, the President's FY 1999 budget includes a legislative proposal to clarify MSP requirements.</p>
<p>Investigate Patient Dumping Complaints:</p> <p>The HCFA should improve its processes for investigating and resolving complaints involving potential violations of the Examination and Treatment for Emergency Medical Conditions and Workmen in Labor Act, commonly referred to as patient dumping. (CIN: A-06-93-00087)</p>	<p>The HCFA concurred with OIG's recommendations.</p>
<p>Medicare Beneficiary Satisfaction with Durable Medical Equipment Regional Carrier Services:</p> <p>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:</p> <p>The HCFA should establish the requirement for periodic review and renewal of the medical necessity for beneficiaries' use of group 2 support surface equipment. (OEI-02-95-00370)</p>	<p>The HCFA did not concur.</p>
<p>Excessive Medicare Payments for Prescription Drugs:</p> <p>The HCFA should examine its Medicare drug reimbursement methodologies. (OEI-03-97-00290)</p>	<p>The Balanced Budget Act of 1997 reduced Medicare payments by limiting them to 95 percent of the average wholesale price. Additional corrective action is warranted and called for in the President's 1999 and 2000 budget and legislative programs.</p>

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

Stronger oversight by HCFA is needed to provide reasonable assurance of detecting and preventing improper Medicare payments and to preserve the solvency of the Medicare Trust Funds. To ensure provider compliance with Medicare reimbursement rules and regulations, HCFA should develop a national error rate to objectively measure improper payments and performance in reducing such payments. (CIN: A-17-95-00096; CIN: A-17-97-00097)

The HCFA generally concurred and is increasing the level of claims review and the number of contractor medical directors, improving the use of technology and data, and developing and implementing a substantive testing program.

Medicaid Accounts Receivable and Accounts Payable:

The HCFA should send its annual State survey well in advance of the due date and include clear and complete instructions. Also, procedures should be implemented to address survey problems, and trend data should be developed. (CIN: A-17-95-00096; CIN: A-17-97-00097)

The HCFA sent the FY 1998 survey to the States well in advance of the due date.

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Require AIDS Drug Assistance Programs to Participate in the 340B Drug Pricing Program:

To ensure that eligible entities are accessing lower priced drugs, which enables them to provide additional services, the Health Resources and Services Administration (HRSA) should require State AIDS drug assistance programs to participate in the 340B drug pricing program. (CIN: A-01-97-01501)

The HRSA has issued a Federal Register notice requesting comments on a proposed condition of grant award that would require participation in the 340B Program for all eligible entities.

ADMINISTRATION FOR CHILDREN AND FAMILIES AND ADMINISTRATION ON AGING

Improve the Federal Foster Care Program:

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

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

Develop Effective Practices for Facility Purchases by Head Start Grantees:

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

The ACF agreed with OIG's recommendations.

OIG Recommendation	Status
GENERAL OVERSIGHT	
<p>Update Cost Principles for Federally Sponsored Research Activities:</p> <p>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>
<p>Guidelines to Reimburse Educational Institutions and Nonprofit Organizations:</p> <p>The Department should work with OMB to revise applicable cost principles to reflect the change in accounting for post retirement benefit (PRB) costs arising from implementation of Financial Accounting Standards Board Opinion 106. It should also advise negotiators for the Department’s Division of Cost Allocation to pay special attention to such costs when reviewing fringe benefit rates for schools and nonprofit organizations. (CIN: A-01-93-04000)</p>	<p>The OMB has revised Circular A-87 to limit PRB costs to the amount funded, but has no plans to revise Circular A-21. However, the Department has instructed negotiators that PRB costs claimed under Circulars A-21 and A-122 should be treated in the same manner as the provisions of Circular A-87.</p>

APPENDIX D

Notes to Tables I and II

Table I

¹ The opening balance was adjusted to reflect an upward revaluation of \$19.6 million.

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

CIN: A-04-89-05136	State of North Carolina: Grantee provided documentation in the amount of \$1,257,950.
CIN: A-04-96-40781	State of Alabama: Duplicate claim resolved with the grantee in the amount of \$170,819.
CIN: A-04-96-01133	Clinical Labs GA: Grantee settled with the Federal Government in the amount of \$162,217.

Not detailed are revisions to previously disallowed management decisions totaling \$676,444.

³ Included in management decisions to disallow is \$645,342 in costs attributable to audits performed by the Defense Contact Audit Agency.

⁴ Included in management decisions to disallow is \$12,714,000 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 managements 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-09-96-00054	Blue Cross of California Administrative Costs, August 1996, \$-1,653,079
CIN: A-09-94-01022	Intelligenetics #N01-GM-72110, October 1994, -\$12,400
CIN: A-06-97-00031	Review of AMP-Searle, Chicago, IL, October 1997, \$28,000,000
CIN: A-09-97-44626	State of California, April 1997, \$7,419,900
CIN: A-09-96-00066	CA Dept. Soc. Serv-Title IV-E Foster Care ADM Costs, September 1997, \$6,611,640
CIN: A-03-91-00552	Independent Living Program-National, March 1993, \$6,529,545 (Related recommendation of \$10,161,742 on Table II)
CIN: A-10-97-48849	State of Oregon, July 1997, \$6,379,395
CIN: A-07-92-00578	BC/BS of Texas Inc-Unfunded Pension Costs, October 1992, \$6,244,637
CIN: A-07-97-01213	Pension- Travelers Termination, February 1998, \$5,624,747
CIN: A-04-96-04575	Audit ATSDRS Superfund Finan. ACTS-FY95, ATSDR, June 1997, \$5,360,000
CIN: A-04-04-04599	Audit ATSDRS Superfund ACTs ATSDR/CDC, ATL, September 1997, \$4,800,000
CIN: A-01-97-46859	State of Massachusetts, May 1997, \$4,798,706

CIN: A-07-96-02001 Medicare Part B Admin Costs at BC/BS Colorado, December 1996, \$4,483,104

CIN: A-07-97-01234 Rocky Mountain Pension-Termination, May 1998, \$4,079,171

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

CIN: A-09-95-00056 Review of Training Activities-CA Dept. SOC. SVCS., August 1996, \$3,934,717

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

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

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

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

CIN: A-07-93-00633 Pension Segmentation-AETNA Life Insurance Co., October 1993, \$3,011,376

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-07-92-00585 Pension Segmentation BC/BS of California, January. 1994, \$2,973,504

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

CIN: A-04-98-02147 Health Management Network, Inc., January 1998, \$2,899,083

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

CIN: A-07-96-01185 BC/BS Rocky Mountain Pension Segmentation, June 1997, \$2,743,438

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

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

CIN: A-04-97-02138 Silver Springs Health Centers Part, January 1998, \$2,382,527

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

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

CIN: A-02-93-02001 Manpower Demonstration RES CORP HHS100890030, October 1994, \$2,024,444

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

CIN: A-04-96-00104 Review Refugee Cash & MCal Assistance PMTS IN FL, April 1998, \$1,867,382

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-04-97-02130 Review FL Adult Care Center. CMHC Part. Hosp. Prog. , April 1998, \$1,709,245

CIN: A-03-97-00200 Virginia/Medicaid/Laboratory Fee Schedules, January 1998, \$1,629,750

CIN: A-02-94-01030 Hospice Eligibility Review in PR, June 1995, 1,598,837

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

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

CIN: A-04-96-00105 Rev. OCS Discretionary. Grants Awarded to Delta Foundation, December 1997, \$1,430,000

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

CIN: A-07-98-02506 AETNA Unfunded Pension Costs, August 1998, \$1,407,689

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

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

CIN: A-02-98-52102 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-07-93-00700 BC/BS of Mass-Unfunded Pension Cost Audit, May 1994, \$1,290,740

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

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

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

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

CIN: A-02-98-51817 Municipality of Ponce, Puerto Rico, Mar. 1998, \$1,155,022

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

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

CIN: A-07-98-01037 Task Order Report-Hannibal CAA Headstart, August 1998, \$1,050,349

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

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

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

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

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

CIN: A-09-98-49528 Hawaii Dept. Of Human Services, October 1997, \$952,016

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

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

CIN: A-02-94-01022 Blue Cross Shield NJ-Admin. Cost Medicare, September 1997, \$864,851

CIN: A-07-93-00701 BC/BS of Mass-Pension Costs Charged Audit, July 1994, \$839,740

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

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

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

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

CIN: A-04-98-02148 ORT - OAS/HCFI Behavioral Network, Inc., January. 1998, \$645,627

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

CIN: A-07-97-02503 Pension Kansas City BC/BS Termination, July 1998, \$635,984

CIN: A-07-96-01178 Medicare Pension Costs Claimed BC MICH, November 1996, \$631,248

CIN: A-04-94-01078 Monitoring Admin. Cost-Audit Medicare PB BC/BS of SC, July 1994, \$594,092

CIN: A-04-93-01069 Monitoring Admin. Cost Audit MCare Part A BC/BS of SC, July 1994, \$590,844

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

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

CIN: A-07-97-01207 Pension-Community Mutual Unfunded Pension, July 1997, \$571,413

CIN: A-03-97-00009 Peer Review Systems INC/CCAS/Ohio, March 1997, \$545,405

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

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

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

CIN: A-10-98-51043 Nooksack Indian Tribe, May 1998, \$433,539

CIN: A-07-96-01188 Pro Closeout-DOSHI CPA, August 1996, \$432,698 (Related recommendation of \$5,667 outstanding on Table II)

CIN: A-07-97-01235 DOSHI-Texas, June 1997, \$424,255 (Related recommendation of \$51,334 outstanding on Table II)

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

CIN: A-05-97-00013 Pacific Care of CA-HMO Institutional Status Project, April 1998, \$407,784

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

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

CIN: A-04-96-01136 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-05-93-25697 West Central Wisconsin Community Action Agency Inc., August 1993, \$324,759

CIN: A-04-98-54537 Morris Brown College, August 1998, \$319,751

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

CIN: A-07-98-02501 CT. BC/BS Unfunded Pension Costs, March 1998, \$292,152

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

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

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

CIN: A-05-96-00069 CPA Audit of Hooper Holmes HHA G&A-OI Case Open, February 1998, \$280,515 (Related recommendation of \$17,555 outstanding on Table II)

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

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

CIN: A-05-98-53935 Montgomery County Community Action Agency Inc., June 1998, \$257,702

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

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

CIN: A-04-96-01135 Partic. Part of HCFA Survey Washington Manor Nursing-ORT, February 1997, \$220,483

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

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

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

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

CIN: A-08-98-51825 Oglala Sioux Tribe South Dakota, May 1998, \$200,000

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

CIN: A-04-98-01181 Massachusetts Peer Review Organization, June 1998, \$183,074

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

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

CIN: A-04-98-49312 State of North Carolina, November 1997, \$164,792

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

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

CIN: A-06-98-51473 Chaves County Community Action Program Inc., March 1998, \$148,751

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

CIN: A-05-92-00048 WI Physician SVCS. Pension Medicare VS. ERISA, October 1992, \$130,577 (Related recommendation of \$2,068,964 outstanding on Table II)

CIN: A-07-97-25000 Pension Segmentation BC/BS Connecticut, Mar. 1998, \$122,548

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

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

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-09-97-00084 Audit of ADD at Children's Hospital, July 1998, \$108,177 (Related recommendation of \$90,528 outstanding related to Table II)

CIN: A-06-98-50301 Community Council of Reeves County, December 1997, \$107,609

CIN: A-03-98-03300 Raymond Maria Group-Contract Closeout, March 1998, \$102,476

CIN: A-02-98-53862 Municipality of Ponce, Puerto Rico, May 1998, \$101,325

CIN: A-09-98-00051 Colorado Foundation for Medical Care-Pro, January 1998, \$97,858

CIN: A-07-95-01159 NE BC/BS Pension Segmentation, January 1996, \$96,955

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

CIN: A-10-97-00003 BC 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 (Related recommendation of \$16,632 outstanding on Table II)

CIN: A-02-95-34278 Puerto Rico Dept. Of Health, June 1995, \$86,064

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

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

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

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

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

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

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

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

CIN: A-05-98-53935 Montgomery County Community Action Agency Inc., June 1998, \$70,193

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

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

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

CIN: A-08-97-44348 Three Affiliated Tribes, January 1997, \$68,468

CIN: A-06-97-43135 State of Texas, February 1997, \$67,644

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

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

CIN: A-09-98-52225 Nevada Indian Environmental Coalition, March 1998, \$61,645

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

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-04-96-01125 PARTIC-Part of HCFA Survey Team-Rosemont-ORT, February 1997, \$55,306

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

CIN: A-05-98-51855 Stark County Community Action Agency, March 1998, \$54,933

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

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

CIN: A-05-98-51302 Kootasca Community Action Inc., February 1998, \$52,000

CIN: A-09-95-00095 Health Services Advisory Group, Inc. (HSAG), December 1995, \$49,589 (Related recommendation of \$1,389,723 outstanding on Table II)

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

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

CIN: A-04-98-54538 NA-Morris Brown College, August 1998, \$43,985

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

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

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

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

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

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

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

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

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

CIN: A-05-97-00025 Health Care Plan-HMO Institutional Status Project, June 1998, \$27,201

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

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

CIN: A-09-98-50772 Institute for Black Parenting, April 1998, \$24,502

CIN: A-05-98-51567 State of Ohio, August 1998, \$24,000

CIN: A-09-94-27868 INYO MONO Advocates for Community Action, November 1993, \$22,875

CIN: A-09-98-51231 Tonto Apache Tribe, April 1998, \$22,836

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

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

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

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

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

CIN: A-04-97-01163 VIMI M'Care Pro. Contract Audit, September 1997, \$18,758

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

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

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

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

CIN: A-08-98-51825 Tonto Apache Tribe, May 1998, \$15,295

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

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

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

CIN: A-04-98-52413 Alcorn State University, April 1998, \$13,137

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-01-97-45487 ABT Associates Inc., January 1997, \$12,950

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

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

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

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

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

CIN: A-04-98-49581 Mid-South Foundation for Medical Care Inc., January 1998, \$8,938

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

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

CIN: A-06-97-47803 Cheyenne-Arapaho Tribes of Oklahoma, \$8,321

CIN: A-10-98-53162 People of Color against AIDS Network, April 1998, \$8,289

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

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

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

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

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

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

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

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

CIN: A-09-98-51231 Tonto Apache Tribe, April 1998, \$6,373

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

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

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

CIN: A-03-98-53352 Council for Early Childhood Professional Recognition, April 1998, \$5,965

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

CIN: A-06-98-52891 NA-Morton Comprehensive Health Service Inc., April 1998, \$5,842

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

CIN: A-10-98-50308 Coastal Community Action Program, December 1997, \$5,274

CIN: A-05-98-51316 Community Action Program Inc., of Western Indiana, February 1998, \$5,202

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

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

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

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

CIN: A-02-98-52833 Mental Health & Anti-Addiction Services Administration, April 1998, \$4,300

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

CIN: A-06-91-00034 Audit of Collection & Credit Activities at TDHS, January 1992, \$3,989

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

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

CIN: A-07-97-01233 Prowest-Doshi Idaho, June 1997, \$3,835

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

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

CIN: A-06-98-50840 St. Martin Iberia Lafayette Community Action Agency, February 1998, \$3,362

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

CIN: A-10-98-52321 Consejo Counseling & Referral Service & Consejo Ho, May 1998, \$3,088

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

CIN: A-06-98-53292 Arkansas Enterprise Group, May 1998, \$3,000

CIN: A-07-98-02502 CT. Blue Cross-Blue Shield Pension Cost 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-07-98-50741 Citizen Housing Information Council Inc., March 1998, \$2,678

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

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

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

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

CIN: A-06-98-53934 Osage Nation of Oklahoma, August 1998, \$2,368

CIN: A-09-98-53728 Tohono O Odham Nation, August 1998, \$2,198

CIN: A-01-97-47552 State of New Hampshire, May 1997, \$2,184

CIN: A-09-98-53899 Stanford University, June 1998, \$2,058

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

CIN: A-04-96-01161 MRNC M' Care Pro Contract Audit - State of SC, July 1997, \$1,294

CIN: A-06-96-43825 Cheyenne-Arapaho Tribes of Oklahoma, September 1996, \$892

B. The following audit is in litigation:

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

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

CIN: A-05-94-00064 MI Blue Cross/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-05-96-00058 Close-Out Audit of Medicare Contract-BCBS-MI, December 1997, \$5,226,443

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

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

Table II

¹ The opening balance was adjusted to reflect an upward revaluation of \$12.9 million.

² Included in the total recommendations agreed to by management is \$304,575 resulting from Defense Contract Audit Agency recommendations.

³ Management decisions have not been made within 6 months of issuance on 14 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-04-97-00109 Emergency Assistance Claims-NC, July 1998, \$13,000,000

CIN: A-01-97-02506 Review of the Avail. of Medical Coverage/CSE Support, June 1998, \$5,704,585

CIN: A-09-98-00068 Partnership Plan Report-California Medicaid, March 1998, \$1,600,000

CIN: A-06-97-00052 Study of Medicaid Drug Rebates Based on AWP, May 1998, \$1,150,000

CIN: A-05-95-00055 Medicare Pro Bid Proposal-RFP-HCFA-95-058/BH, September 1995, \$700,982

CIN: A-07-97-01230 OFMO-Doshi Oklahoma, June 1997, \$203,510

CIN: A-05-96-43154 Muskegon-Oceana Community Action Against Poverty I, June 1996, \$130,993

CIN: A-06-96-43307 Nueces County Community Action Agency, June 1996, \$22,667

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-03-98-51565 Mingo County Economic Opportunity Commission Inc., March 1998, \$5,434

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

CIN: A-01-98-00506 Psychiatric Outpatient at Newton-Wellesley Hospital, March 1998, \$1,120

B. The following audit is in litigation:

CIN: A-07-96-01177 Medicare Post Retirement Claim BC Mich., November 1996, \$8,978,998

APPENDIX E

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

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

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	67
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	69
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	65
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	66
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 Measure**. Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program which is measured by the number of inoculations provided per dollar of cost. In OIG’s opinion, the following audits, inspections and investigations finalized during this semiannual period offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals.

	Page
Improper Fiscal Year 1998 Medicare Fee-for-Service Payments	2
Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1998	3
Medicare Beneficiary Interest in Health Maintenance Organizations in 1997	8
Partial Hospitalization Services Provided through Community Mental Health Centers	11
Chiropractic Services Covered by Medicare Managed Care Organizations	35
Beneficiary Awareness of Health Care Financing Administration Publications in 1997	35
Follow-Up to Detoxification Services for Medicaid Beneficiaries	38
Low-Volume Institutional Review Boards	42
Indian Health Service: Program Integrity and Ethics Function	45
Child Support Enforcement Annual Report to the Congress	53
Early Efforts by States to Monitor Outcomes of Welfare Reform	55
Discretionary Grants Awarded to Alleviate Poverty	56
Health Care Anti-Fraud, Waste and Abuse Community Volunteer Program: First Year Outcomes	57
Financial Statement Audit of the Department for Fiscal Year 1998	61
Results Act Review Plan	61

ACRONYMS

ACF	Administration for Children and Families
AHCPR	Agency for Health Care Policy and Research
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
CCDF	Child Care and Development Fund
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMHC	community mental health center
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
FI	fiscal intermediary
FY	fiscal year
GME	graduate medical education
GPRA	Government Performance and Results Act of 1993
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHA	home health agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
ICF/MR	intermediate care facility for the mentally retarded
IHS	Indian Health Service
IME	indirect medical education
IRB	institutional review board
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
PATH	physicians at teaching hospitals
PHS	Public Health Service
PPS	prospective payment system
PRM	provider review manual
PRO	peer review organization
PSC	Program Support Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SNF	skilled nursing facility
TANF	Temporary Assistance for Needy Families

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 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(1), 274e, 290dd-2, 300w-8, 300x-8, 707, 1320a-7b, the Social Security and Public Health Service Acts

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

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