



Department of Health
and Human Services

Office of Inspector General

Semiannual Report

April 1, 1997 - September 30, 1997



June Gibbs Brown
Inspector General

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

A MESSAGE FROM THE SECRETARY

Improving service to the American people in the areas covered by the Department of Health and Human Services' (HHS') programs is a formidable task. I am pleased at the considerable strides we have made this fiscal year and would like to recognize the vital leadership role played by the Office of Inspector General (OIG) in these efforts.

To meet the many challenges that face our Department, we have developed new and unique ways of approaching our mission. In keeping with this posture, we launched a 2-year demonstration project in 1995 under which OIG, the Health Care Financing Administration, the Administration on Aging and their several partners in the law enforcement and health care communities zeroed in on fraudulent practices within three growing sectors of the health care industry. Operation Restore Trust, a comprehensive, bold initiative which employed intergovernmental and interdisciplinary teamwork, proved a great success. We are now broadly and aggressively applying the knowledge and experience gained from this model in other areas.

Recognizing the profitability of this approach, the Congress enacted the Health Care Portability and Accountability Act of 1996. The Act envisions a fraud fighting program that coordinates the efforts of a broad array of law enforcement and health care agencies and provides a framework, new tools and resources for the struggle to improve the integrity of the Nation's health care system. With this new, reliable source of funding in effect, we have already achieved dramatic results, including OIG health care investigative receivables of approximately \$1.2 billion for Fiscal Year (FY) 1997, an amount five times greater than for FY 1996. Moreover, provisions of the recently enacted balanced budget law and the Administration's new three-part home health initiative, many of which build on OIG findings and recommendations, will allow us to further sharpen our attack on health care fraud and abuse.

In addition to commending the Inspector General and her staff for the critical contributions they have made in the health care area, I would like to note some of OIG's other significant accomplishments. Among them were the several reviews and investigations completed during this reporting period in the area of child support enforcement, another Administration priority, and the comprehensive audit of the Department's financial statements.

At HHS, we are working diligently toward our common goal of providing the finest service to our customers. I am proud of our progress and confident that OIG's commitment and dedication will enable us to sustain the momentum we have achieved in meeting the challenges that lie ahead.

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

Donna E. Shalala

FOREWORD

I am pleased to present this semiannual report highlighting the activities and accomplishments of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) for the 6-month period ending September 30, 1997.

Over the last few years, we have undergone a fundamental reevaluation of how best to carry out our mandate and radically altered our ways of doing business to achieve maximum impact. Through greater teamwork within OIG and heightened coordination with other governmental and outside agencies sharing common goals, we have greatly increased our efforts to combat fraud, waste and abuse in the Department's programs and operations. We believe that the success of this approach is well reflected in our accomplishments.

In 1995, the Administration launched Operation Restore Trust to target three particularly vulnerable sectors of the Medicare program. Under Secretary Shalala's leadership, OIG and its partners mounted an intensive attack against health care fraud and abuse. The soundness of this approach was clearly validated by the remarkable results it yielded. Building on the success of Operation Restore Trust, we are now institutionalizing its methodologies and expanding the project to cover more geographical areas and all aspects of the Medicare and Medicaid programs. We are also gratified that recent legislative changes in the health care area attest to the impact of our labors.

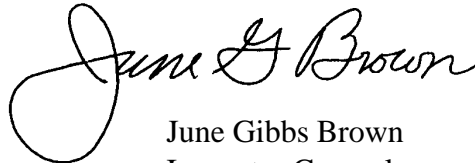
Other cooperative efforts have resulted in broader coverage of the Medicaid program through partnerships with State auditors and Medicaid agencies as well as the Health Care Financing Administration (HCFA), the working of more joint investigative cases with the Federal Bureau of Investigation, collaboration with the Department of Justice (DOJ) on various hospital initiatives, and the development with HCFA, DOJ and the health care industry of model compliance plans. These types of partnerships are critical as we continue to seek more efficient and effective ways of promoting better service to the American public.

The OIG's fraud fighting capabilities have been greatly enhanced by enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The fraud and abuse control program mandated by HIPAA provides much needed resources, stronger enforcement tools and a management structure to coordinate the work of numerous fraud fighting units of Federal, State and local governments. The Act also provides an innovative mechanism to fund these new antifraud efforts, which assures that needed resources will continue to be available. With this stable funding in place, OIG has achieved savings of \$7.6 billion in

Fiscal Year (FY) 1997, including an unprecedented \$1.2 billion in investigative receivables, as well as more than 2,700 exclusions of unsuitable health care providers. Other recent measures adopted by the Administration and the Congress will further strengthen our ability to combat fraud and abuse.

Another highlight of FY 1997 was completion of the HCFA financial statement audit conducted as part of OIG's review of the Department's financial statements under the Government Management Reform Act of 1994. This was the first time in the history of the Medicare program that a comprehensive, statistically valid sample of Medicare fee-for-service claims was undertaken to determine the correctness of payments. The results of OIG's claims testing corroborated past program findings that the Medicare program is inherently vulnerable to improper provider billing practices. The HCFA and the Department's Chief Financial Officer are aggressively working on a corrective action plan which addresses OIG's concerns.

Fostering improvement in HHS programs and operations is an ongoing, long-term process. While we recognize the need for continued innovation, we are pleased to be able to point to solid achievements during this fiscal year. We believe that our record establishes a firm foundation for the future and look forward to addressing with the Secretary the opportunities and challenges to come.



June Gibbs Brown
Inspector General

HIGHLIGHTS

Introduction

During the 6-month period ending September 30, 1997, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) continued to maximize its impact through a heightened emphasis on interdisciplinary teamwork within its own organization, and greater collaboration with other Federal and State agencies. The effectiveness of this partnership approach is amply demonstrated by the results of many of the initiatives described in this semiannual report. Highlights of OIG's accomplishments for this period follow.

Health Care Fraud and Abuse Control Program

The OIG has continued to steer its efforts toward rapid and effective implementation of the antifraud provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Title II of that Act directs the Attorney General and the Secretary of HHS (acting through the Inspector General) to establish a national Health Care Fraud and Abuse Control Program to accomplish a number of purposes, chief among them to coordinate Federal, State and local law enforcement activities with respect to health care fraud and abuse. Other important statutory goals are to facilitate enforcement of all applicable remedies for health care fraud; to provide industry guidance relating to fraudulent practices; to establish a national adverse actions data bank; and to conduct investigations, audits and other reviews relating to the provision of and payment for health care in the Nation.

During this reporting period, OIG, in close coordination with the Department of Justice (DOJ) and other components of HHS, took significant strides in implementing the ambitious Fraud and Abuse Control Program. Through expansion of its own investigative, audit and evaluation staffs, OIG has extended its coverage to geographical areas that were underserved in recent years and bolstered its ability to fulfill its responsibilities under the broadened antifraud and abuse program. Moreover, OIG has sought to maximize its effectiveness by joining forces with DOJ and other law enforcement and health care agencies to coordinate antifraud and abuse efforts nationwide.

Other accomplishments under HIPAA in this reporting period include providing funding (through grants and interagency agreements) for other Federal, State and local partners in health care enforcement and oversight; issuing the first formal advisory opinions in response to industry inquiries concerning the propriety of specific transactions or practices; and assisting in the development and design of the adverse actions data bank mandated by HIPAA.

For more information concerning the Health Care Fraud and Abuse Control Program, see page 2.

Federal Financial Accountability

This semiannual reporting period was distinguished by important advances in Federal Government financial accountability pursuant to the Government Management Reform Act of 1994. The Act required the preparation and audit of agencywide financial statements beginning with Fiscal Year (FY) 1996. Therefore, for the first time, HHS prepared, and OIG audited, the Departmentwide financial statements.

Financial statements provide accountability for taxpayer dollars by reporting how those dollars were spent and what agencies own and owe. The OIG's audits provide an objective evaluation of the reliability of those statements, including an evaluation of financial management processes, systems and internal controls.

The OIG's audit of the Health Care Financing Administration's (HCFA's) financial statements, for instance, found that several internal controls needed to be strengthened. By projecting the results of a statistical sample, OIG estimated that improper payments amounted to about \$23.2 billion nationwide, or about 14 percent of total Medicare fee-for-service payments. These improper payments could range from inadvertent mistakes to outright fraud. Insufficient documentation to support the amounts reported in HCFA's financial statements and in the combined statements of the Department as a whole was also noted. In addition, the Department lacked important internal controls over grants and had systemic weaknesses in several accounting controls.

Recognizing the benefits of audited financial statements, the Department has made a commitment to achieving financial discipline and to ensuring accountability for Federal dollars. The OIG believes that HHS has taken the important first steps in reaching those goals. (See pages 4, 46, 57, and 60)

Home Health Care

The problems associated with Medicare's home health benefit have been well documented and OIG has reported on these problems frequently over the last several years. Currently, OIG has a number of investigations underway of home health agencies across the country.

During this reporting period, OIG released two final reports on Medicare's home health benefit indicating significant waste, fraud and abuse in that program whose expenditures reached an estimated \$16.9 billion last year. In an audit in four of the Nation's most populated States, OIG found that 40 percent of home health visits should not have been reimbursed by Medicare. In an inspection conducted in the five largest States, OIG determined that about 25 percent of certified home health agencies fit the profile of "problem providers" as defined in the report. The study results were presented at a hearing

of the Senate Special Committee on Aging. In response to the OIG findings, the President had the Department issue a 6-month moratorium on certification of new home health agencies for participation in Medicare, during which time program safeguards will be introduced. Moreover, OIG is gratified to note that the recently enacted budget legislation contains several provisions which make fundamental changes in the way Medicare pays for home health in an effort to eliminate inappropriate expenditures. (See page 23)

Child Support Enforcement

Under the authority of the Child Support Recovery Act of 1992, OIG has initiated more than 200 investigations nationwide of parents who have refused to pay past due support. Thus far, these cases have resulted in some 45 arrests, 23 convictions and court-ordered restitution of close to \$15 million.

In an effort to further increase child support collections, OIG has reviewed various State processes for suspending the drivers' licenses of parents who are delinquent in child support payments. Noting that an administrative process used by some States appears to have been effective in tracking down delinquent parents, collecting payments and quickly suspending licenses, OIG suggested that information on this process, as well as the benefits it offers, be distributed to all States. Other reports identified HHS grantees that were delinquent in child support payments and noted effective in-hospital voluntary paternity acknowledgement programs. (See pages 50-52)

Hospital Projects

Two major OIG projects involving hospitals resulted in more than \$16 million in settlements. One project (Diagnosis Related Group Payment Window Project) concentrated on hospitals submitting claims for nonphysician outpatient services that had already been included in inpatient payments. The second (Project Bad Bundle) consisted of settlements with hospitals to recover improper claims and penalties resulting from their unbundling and double billing laboratory tests that had been processed as a group, to obtain a higher reimbursement. Other hospital projects are described in Chapter I in the section entitled "Major Hospital Initiatives." (See pages 7-10)

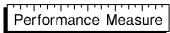
Statistical Accomplishments

Funding levels for FY 1997 enabled OIG to press the vigorous pursuit of its mission to protect the integrity of HHS programs and operations. The OIG is pleased to report savings for the fiscal year of \$7.6 billion, comprised of \$6,178 million in implemented recommendations and other actions to put funds to better use, \$125 million in disallowances from questioned costs and \$1,248 million in investigative receivables. (See Appendix A, and the sections entitled "Resolving Office of Inspector General Recommendations, A. Questioned Costs" and "Investigative Prosecutions and Receivables" in the General Oversight chapters of OIG's FY 1997 semiannual reports for details.)

One of OIG's most potent tools in its fight against fraud and abuse is the ability to exclude individuals and entities from payment under the Medicare, Medicaid, Maternal and Child Health Services Block Grant and Block Grants to States for Social Services programs for any services they furnish, order or prescribe. Some of the bases for exclusion are conviction for health care related fraud, revocation or surrender of a health care license and failure to repay health education assistance loans. Because of its significant impact, OIG has increased its resources in the exclusions area and has initiated a special project to improve the quantity and quality of information used for exclusion decisions. As a result, 2,719 exclusions were effectuated during the fiscal year, an increase of 93 percent over the previous fiscal year. (See page 13)

In addition, for FY 1997 OIG reported 215 convictions of individuals or entities that engaged in crimes against departmental programs, and 1,255 civil settlements. The State Medicaid fraud control units, which are the principal means by which OIG exercises oversight of the Medicaid program, reported 341 convictions in their most recent 6-month reporting period. (See pages 15, 38 and 69)

OIG Work in Performance Measurement

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

Internet Address

This semiannual report and other OIG materials may be accessed on the Internet at the following address:

<http://www.dhhs.gov/progorg/oig>

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**Health Care
Financing
Administration**

Chapter I

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

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

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

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

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

The OIG has documented excessive payments which led to statutory changes to reduce payments for hospital services, indirect medical education, DME and laboratory services. To ensure quality of patient care, OIG has assessed clinical and physiological laboratories; evaluated the medical necessity of medical equipment and of services provided by home health agencies; analyzed various State licensure and discipline issues; reviewed several

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

The OIG also audits HCFA's financial statements, which account for more than 82 percent of Department of Health and Human Services (HHS) outlays. In addition to issuing an opinion on the statements, OIG has assessed compliance with Medicare laws and regulations and the adequacy of internal controls.

Fraud and Abuse Control Program

During this reporting period, OIG took additional steps toward implementing its significant new responsibilities under Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Act establishes a comprehensive program to combat fraud committed against all health plans, both public and private. This legislation required the Departments of Justice (DOJ) and HHS to establish a Fraud and Abuse Control Program, no later than January 1, 1997. Under the joint direction of the Attorney General and the Secretary (acting through the HHS Inspector General), the Fraud and Abuse Control Program is to achieve certain statutory goals: coordinating Federal, State and local law enforcement efforts relating to health care fraud; conducting investigations, audits and evaluations relating to health care in the United States; facilitating enforcement of the civil, criminal and administrative statutes applicable to health care; providing industry guidance relating to fraudulent health care practices; and establishing a national data bank to report final adverse actions against health care providers.

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

During this reporting period, HHS and DOJ issued the first grants and interagency funding agreements for projects to foster antifraud and abuse efforts. Of the funds made available for Fiscal Year (FY) 1997, up to \$3.5 million was set aside for enforcement activities by Federal, State and local agencies (other than HHS and DOJ) that are currently involved in health care fraud and abuse control. On March 26, 1997, DOJ and HHS jointly published a Notice of Availability of Funds inviting qualifying Federal, State and local agencies to submit proposals to receive a portion of this money to fund projects or activities that

promote the objectives of the Fraud and Abuse Control Program. A total of 28 proposals were received and rated by a panel from HHS and DOJ. The panel recommended funding for 11 proposals (eight State governmental units, the District of Columbia, and two Federal agencies) totaling \$1.55 million. The Secretary and the Attorney General adopted the recommendations of the panel, and funds were issued in July. During future months, OIG will be monitoring these grants for effectiveness in furthering the goals of the Fraud and Abuse Control Program.

The OIG continues to provide policy direction, technical assistance and advice regarding the creation of the final adverse actions data bank mandated by HIPAA, now named the Healthcare Integrity and Protection Data Bank (HIPDB). On April 4, 1997, OIG signed a Memorandum of Understanding with the Health Resources and Services Administration (HRSA), through which OIG agreed that HRSA will design, implement and operate HIPDB. The OIG chairs the Executive Steering Council, which includes representatives from DOJ, HCFA and HHS's Assistant Secretary for Management and Budget (ASMB). These representatives participate in the oversight of HIPDB. The OIG also acts as liaison to involve other Federal and State law enforcement agencies in both reporting to and querying HIPDB.

As part of the Fraud and Abuse Control Program, OIG has expanded its hotline operation. During this period, the automated menu system was modified to allow all callers the opportunity to talk with an investigative technician. In addition, OIG is automating its complaint resolution process and increasing its analytical capabilities by linking an analysis of the complaint activity with other available data in the Department.

Other activities implementing HIPAA are also underway. The processes for providing industry guidance, including formal advisory opinions, safe harbors and special fraud alerts relating to fraudulent health care practices are in place, and OIG issued its first advisory opinions during this reporting period. These four opinions and future advisory opinions are available to the public on the Internet at <http://www.dhhs.gov/progorg/oig>. The OIG has also initiated a negotiated rulemaking process to establish standards relating to the new statutory exception to the anti-kickback statute for certain risk-sharing arrangements. More than 20 government, industry and consumer representatives are participating in this rulemaking process. The OIG continues to add staff to accomplish the office's responsibilities under the expanded antifraud and abuse program.

Implementation of HIPAA has been a cooperative effort. The OIG has and will continue to work closely with other components of HHS, chiefly HCFA and ASMB.

Audit of Health Care Financing Administration's Financial Statements

Performance Measure

While portions of HCFA's financial statements were audited in previous years, OIG undertook its first comprehensive audit of HCFA's FY 1996 financial statements. The OIG was unable to express an opinion on the statements because documentation was not adequate or was not available to support the reported amounts.

As part of the audit, and for the first time in the Medicare program, a comprehensive, statistically valid sample of fee-for-service claims was taken to determine the correctness of payments. The results of OIG's sample underscored the Medicare program's inherent vulnerability to incorrect provider billing practices. The OIG estimated that improper payments totaled about \$23.2 billion nationwide, or about 14 percent of total Medicare fee-for-service benefit payments in FY 1996. Most of the improper payments were attributable to insufficient or no documentation, lack of medical necessity, incorrect coding, and noncovered or unallowable services. Reviews of submitted documentation by OIG, in conjunction with HCFA contractor medical personnel, detected virtually all of the improper payments. When these claims were submitted for payment to Medicare contractors, they contained no visible errors, and contractors processed these claims based on the submitted documentation which was correct 99 percent of the time.

The OIG made a number of recommendations to ensure provider compliance with Medicare reimbursement rules and regulations and to preserve the solvency of the Medicare trust funds. The HCFA agreed with the recommendations and has developed a corrective action plan. (CIN: A-17-95-00096)

Beneficiary Awareness of Health Care Financing Administration Publications in 1995

Performance Measure

As part of its survey to determine beneficiary satisfaction with Medicare, OIG asked beneficiaries about their awareness of the Medicare Handbook and eight other HCFA publications. As illustrated in the following chart, OIG found that while about three-fourths of the beneficiaries surveyed were aware of the Handbook in 1993 through 1995, the number of beneficiaries using it declined significantly in 1995.

BENEFICIARY AWARENESS AND USE OF THE MEDICARE HANDBOOK			
	1993	1994	1995
Percent of Beneficiaries Aware of the Medicare Handbook	76%	76%	75%
Percent of Beneficiaries Aware of the Handbook Who Used It in Past Year	55%	58%	38%

The OIG also found that few beneficiaries were aware of other selected HCFA publications. For example, only 7 percent of respondents were aware of HCFA's Guide to Choosing a Nursing Home and 26 percent were aware of HCFA's Guide to Health Insurance for People with Medicare Coverage. Moreover, 75 percent of beneficiaries did not know how to obtain the free publications.

While OIG recognizes that awareness of HCFA's publications may depend on beneficiaries' specific needs, they cannot benefit from HCFA's guidance if they do not know the information is available. Accordingly, OIG recommended that HCFA continue current efforts and experiment with new methods to develop an effective strategy to increase beneficiary awareness of its publications. Further, OIG proposed that HCFA reinstate the listing of HCFA publications in the Medicare Handbook and include instructions on how to obtain the publications. (OEI-04-93-00152)

Beneficiary Satisfaction and Understanding of Home Health Services in 1995

Performance Measure

Based on its prior survey in 1994, OIG had recommended that HCFA consider ways to improve existing explanations of the home health benefit to beneficiaries and pursue new methods to increase understanding of the benefit. Since that time, HCFA published a beneficiary pamphlet and videotape presentation which explain home health benefits in simple terms. Further, HCFA developed a home health equivalent of the Explanation of Medicare Benefits, called a Notice of Utilization intended to inform beneficiaries what home health services Medicare has paid for.

As part of its 1995 survey to determine beneficiary satisfaction with Medicare, OIG asked beneficiaries about their experiences with home health services. Of the 942 respondents to the survey, 139 said they had received home health services. The OIG determined that Medicare beneficiaries continued to be satisfied with home health care. Ninety-five percent said home health agency personnel did an adequate job and 96 percent said they received the number of home health visits they thought they needed. In this survey, as in 1994, most beneficiaries believed their conditions improved as expected. However, 25 percent of

beneficiaries still did not understand what home health care is paid for by Medicare. Further, about 75 percent of beneficiaries were unaware of the hotlines run by the States for reporting complaints and fraud.

The OIG recommended that HCFA continue efforts to educate beneficiaries on Medicare-funded home health services. The HCFA should make every effort to ensure the broadest possible distribution of the pamphlet and videotape presentation, making use of such sources as home health agencies, hospital discharge planning units and other institutional sources of referrals for home health care. Also, HCFA should plan to evaluate the Notice of Utilization after it has been in use for 6 to 12 months to determine its impact on beneficiary understanding and on the regional home health intermediaries. The HCFA concurred with the recommendations. (OEI-04-93-00153)

Beneficiary Satisfaction with Services by Durable Medical Equipment Regional Carriers

Performance Measure

In October 1993, HCFA began processing medical equipment and supply claims through four regional carriers (DMERCs). The DMERCs were given specific responsibilities for educating Medicare beneficiaries and responding to their questions and concerns. The OIG has planned a study to ascertain whether the establishment of the DMERCs has met its intended objectives. To complement that larger study, OIG conducted a survey to determine the knowledge, experiences and satisfaction of Medicare beneficiaries who use DME, prosthetics, orthotics and supplies with services provided by the DMERCs.

The OIG found that most beneficiaries who have had contact with their DMERC were satisfied with the service received. However, overall satisfaction rates varied considerably among the four regions. Moreover, OIG determined that beneficiaries who used medical equipment and supplies had limited knowledge of their DMERC and few knew where to go for more information about their Medicare benefits. While 10 percent of beneficiaries who responded reported encountering possible fraud or abuse related to their medical equipment or supplies, many did not contact anyone about their suspicions. The OIG also found that all four DMERCs conducted beneficiary outreach, but only did so to a limited degree and reported difficulties in their efforts.

The OIG recommended that HCFA take additional steps to improve the education and service to Medicare beneficiaries who use medical equipment and supplies. Specifically, HCFA should: evaluate ways to increase beneficiary satisfaction with the one DMERC region with the lowest overall satisfaction rating; instruct the DMERCs to emphasize the importance of courteous staff and timeliness in responding to beneficiary inquiries since these two variables seemed to be strongly related to overall beneficiary satisfaction; and look more carefully at effective ways to educate beneficiaries on what constitutes fraud and abuse and what to do if they suspect that one or the other has occurred. In response to the draft report, HCFA concurred with OIG's recommendations. (OEI-02-96-00200)

Major Hospital Initiatives

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

A. Physicians at Teaching Hospitals

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

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

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

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 systems' vulnerability to upcoding is a longstanding concern at OIG. The PATH reviews are designed to detect patterns or practices of upcoding, resulting in an unwarranted loss to the Medicare Trust Fund.

The PATH initiative has been undertaken as a result of OIG's extensive audit and investigative work in this area. To date, two institutions have entered into settlement with the Federal Government to resolve their Civil False Claims Act liability for overpayments related to improper claims submitted in the teaching setting and to upcoding, i.e., charging for a higher level of service than was actually delivered. These settlements have resulted in the Government's recovery of more than \$42 million in overpayments and penalties. As a condition of settlement, these institutions have also implemented corporate integrity programs to prevent and detect future erroneous claims. An audit completed at a third

institution disclosed no major problems with either billings in the teaching setting or upcoding, demonstrating that providers can and do bill the Medicare program correctly.

To determine whether, and to what extent, problems similar to those noted above were present at other teaching institutions throughout the country, the PATH project was expanded into a national initiative. In addition to conducting focused audits of these providers' medical billing records, the providers are given the opportunity to conduct a self-audit with Government oversight and to report their findings to OIG.

The PATH initiative has received a great deal of attention from the medical community, trade associations, the Congress and the media. The OIG has conducted a comprehensive review of the policy issues related to Medicare reimbursement for teaching physicians and has prepared an extensive overview paper on the PATH initiative, which is available upon request. It describes in detail OIG's position and plans on its teaching physician reviews.

B. Diagnosis Related Group Payment Window Project

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

This national project identified 4,660 hospitals that submitted improper billings for outpatient services. These hospitals will receive notification from the U.S. Attorney's Office concerning OIG's identification of erroneous claims and the facility's potential exposure under the Federal Civil False Claims Act. The hospitals are given the opportunity to enter into a settlement with the Government under which the financial exposure of the institution is substantially less than if litigated under the Act. Compliance measures to prevent and detect erroneous billing are also required under the terms of the settlement. The project is primarily coordinated by the U. S. Attorney's Office - Middle District of Pennsylvania. As of the end of the reporting period, settlements had been executed with approximately 380 hospitals and nearly \$46.7 million had been recovered.

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

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

C. Project Bad Bundle

The OIG, DOJ and multiple States have joined forces to combat Medicare and Medicaid fraud in hospital outpatient laboratory billing practices. A project begun in Ohio by OIG, DOJ and the Medicare carrier showed such promise, it was extended nationwide as Project Bad Bundle. This project seeks to recover improper claims plus penalties related to erroneous or excessive claims submitted for hematology and automated blood chemistry tests by hospital outpatient laboratories. These abusive practices stem from the unbundling and double billing of laboratory tests and the billing for certain medically unnecessary tests, which have been found to be widely practiced abuses.

Laboratory services are particularly vulnerable to this practice because of the multiple number of tests ordered at one time and the capability of automated equipment to run several tests from one sample. The reimbursement for tests bundled into a panel is less than that for each test run separately, and hospitals are required to bill certain groupings of blood tests using a "bundled" code.

The OIG and DOJ are working together on the national project to provide 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, including compliance measures, which was disseminated to all participating districts throughout the United States.

Project Bad Bundle targets hospital outpatient laboratories using an ongoing computer-based audit of claims submitted for outpatient laboratory services. A letter from the United States Attorney's Office is then sent to each hospital identifying the scope of the abusive practice at that facility and its potential exposure under the Federal Civil False Claims Act. In many jurisdictions, the hospitals are invited to participate in a self-audit program, the results of which are separately verified. In recognition of their participation in this self-audit process, the hospitals generally receive the benefit of double rather than triple damages for settlement purposes. In other jurisdictions, the hospitals may not be asked to do a self-audit, in which case treble damages are generally sought. In these cases, however, the hospital may request the opportunity to do a self-audit in exchange for the benefit of double damages. The terms of all of the settlements require implementation of compliance measures to correct the identified misconduct and to prevent future similar misconduct. To date, OIG has recorded settlements with over 40 hospitals as a result of Project Bad Bundle and its predecessor pilot, and recovered more than \$10.7 million.

D. Patient Transfers

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

Since 1986, however, OIG has found that some 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 \$165 million. Currently, OIG is working with the U.S. Attorney in the Middle District of Pennsylvania to address this continuing problem.

Hospital Fraud

The following cases are examples of those arising from major national projects (see page 7) related to hospitals' overbilling of Medicare:

- More than 100 hospitals in five New England States agreed to pay a total of \$3.4 million to settle allegations of improper Medicare billing practices. These recoveries from hospitals in Vermont, New Hampshire, Maine, Connecticut and Rhode Island are in addition to \$3.5 million recovered earlier from 83 hospitals in Massachusetts. All had submitted claims or bills for preadmission outpatient services (such as laboratory, radiology, CT scans, MRIs and pulmonary function tests) for which Medicare had already reimbursed under a flat rate paid in subsequent inpatient admissions. The hospitals agreed to implement measures to ensure future compliance and to reimburse copayments or deductibles to patients that may have been overbilled.
- Eight hospitals agreed to settle liability for improper claims for hospital outpatient laboratory tests, for a total of more than \$2.2 million. The settlements were for improper unbundling of claims related to automated blood chemistry, hematology and urinalysis tests. Medicare and Medicaid require that these tests be billed as a group; unbundled, they pay a higher rate of reimbursement. A critical component of the project is voluntary disclosure.
- A hospital in Indiana agreed to pay the Government \$700,000 to settle civil liability for defrauding the Medicare program. This agreement was also signed to settle civil liability for unbundling clinical laboratory tests to

increase their Medicare reimbursement. The settlement agreement included corporate integrity requirements. The consultants devised a billing scheme in which a computer program automatically produced fraudulent Medicare claims for laboratory services at hospitals.

- A hospital in Pennsylvania agreed to pay \$120,000, also to settle civil liability for unbundling clinical laboratory tests and overbilling Medicare for the tests. As part of the settlement this hospital also agreed to implement a corporate integrity program.
- A hospital in Massachusetts agreed to pay \$1.3 million to resolve civil liability for double-billing Medicare. The hospital contracted with an independent physiological and clinical laboratory for radiology services such as vascular ultrasounds. Between February 1988 and August 1994, the laboratory billed for services requested by hospital physicians which had already been reimbursed as inpatient laboratory services under Medicare Part A. As a result, Medicare overpaid \$580,000. The hospital agreed to adopt a comprehensive compliance plan to prevent improper billings.

Other significant cases were resolved during this period which also involved hospitals but were not part of the special projects:

- A hospital in Maryland agreed to pay \$564,000 to resolve civil liability for fraudulent ambulance billings. The hospital arranged with an ambulance company to pay \$55 for each round trip transporting a patient from the hospital to a radiation clinic on the hospital's grounds. The patients were actually transported by gurney from the hospital emergency room across a drive to the clinic -- a distance of 47 feet. The hospital then billed Medicare \$210 for each "ambulance" round trip. Between 1992 until 1995, it received a total of about \$188,000.
- A hospital in Delaware agreed to pay \$472,490 to settle allegations of billing Medicare for unbundled services, upcoding, billing for services not documented and billing for unnecessary services. Investigation showed that the hospital's billing lacked proper controls and was in disarray. The hospital has since merged with another medical center and its billing department was incorporated into the new owner's system. The hospital also agreed to implement a compliance plan.
- A hospital in Ohio agreed to pay \$400,000 to resolve its civil liability for billing Medicare for services not rendered. The hospital had contracted with the operator of an outpatient program to provide psychotherapy services to

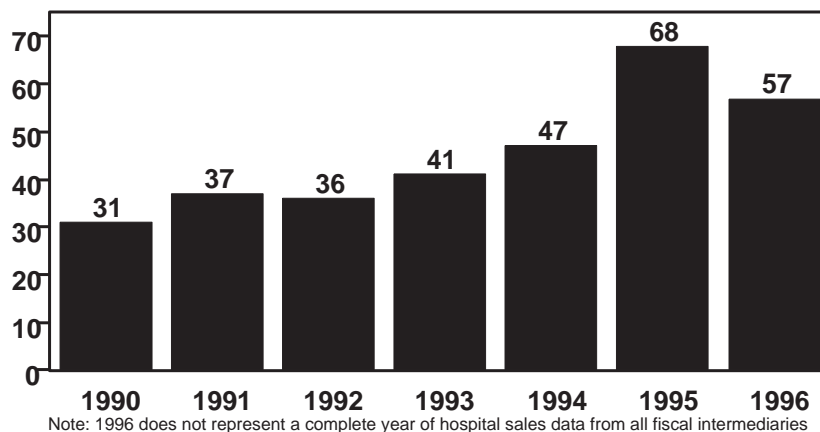
Medicare patients. The hospital submitted claims for psychotherapy services that were never performed or were for patients who, because of deteriorated mental conditions, could never have benefited. The resulting overpayment was approximately \$184,000. As part of the settlement, the hospital also entered into a corporate integrity agreement to prevent a recurrence of the improper billing.

Medicare Losses on Hospital Sales

At the inception of the Medicare program, hospitals were allowed to include the depreciation of assets as an allowable capital-related cost in their annual Medicare cost reports. When a hospital undergoes change of ownership for reimbursement purposes, Medicare guidelines specify that the hospital can receive an adjustment to the facility's final allowable or reimbursable costs based on the gain or loss on depreciated assets at the time of sale. Recent increases in hospital sales have raised concerns about Medicare's liability for depreciation adjustments.

The OIG determined that Medicare lost \$223 million and stands to lose another \$289 million in depreciation adjustments for hospitals sold between 1990 and 1996, and the program could lose an estimated \$53 million in depreciation adjustments for hospital sales expected in 1997. The following chart provides a breakdown of hospital sales for years 1990 through 1996.

**HOSPITAL SALES WITH DEPRECIATION ADJUSTMENTS
FISCAL YEARS 1990 THROUGH 1996**



The OIG concluded that substantial amounts of money are being and will continue to be paid in the coming years for an accounting procedure established in the early years of the

program. At the beginning of the 1980s, Medicare moved from cost-based reimbursement to a prospective payment system. The OIG believes that the policy allowing depreciation adjustments on hospital sales is an unnecessary holdover from the old cost-based reimbursement system that should be discontinued. Accordingly, OIG recommended that HCFA propose legislation to eliminate the requirement that Medicare make adjustments for gains or losses when hospitals undergo changes of ownership; propose a similar elimination of depreciation adjustments on hospital sales in the Medicaid program; and examine options for recalculating capital transition payments to hospitals undergoing changes of ownership for reimbursement purposes. The HCFA concurred with the recommendations, and the Balanced Budget Act of 1997 modified the Medicare statute to eliminate these adjustments. (OEI-03-96-00170)

Medicare Contractor Pension Costs

Since its inception, Medicare has paid a portion of the annual contributions made by contractors to their pension plans. Medicare contracts specify how to identify the Medicare segments of an organization and require the separate identification of each segment's pension assets.

The OIG found that Rocky Mountain Health Care Corporation correctly identified Medicare segment pension assets of almost \$3 million as of 1986. However, a 1986-1995 update understated these assets by about \$2.7 million. This understatement occurred primarily because the company omitted certain benefit payments and misidentified plan participants. The OIG recommended that the company increase the Medicare segment by \$2.7 million, and HCFA agreed. (CIN: A-07-96-01185)

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 2,621 sanctions, in the form of exclusions or civil actions, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. Over two-thirds of the exclusions were based on conviction of program-related crimes, conviction for the illegal manufacture or distribution of controlled substances, conviction related to patient abuse or loss of license to practice health care. Monetary penalties can be assessed under several CMP authorities which have been delegated to OIG.

A. Program Exclusions

Title XI of the Social Security Act provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health Services Block Grant and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, distribution of a controlled substance, revocation or surrender of a health care license, or failure to repay health education assistance loans (HEALs). Exclusion is

mandatory for those convicted of program-related crimes, crimes related to patient abuse, felony convictions for defrauding other health care programs and felony convictions for the illegal manufacture or distribution of controlled substances. A significant number of OIG exclusions involve failure to repay HEALs, as discussed in more detail in the chapter on the Public Health Service operating divisions.

Among OIG's exclusion authorities is the authority to exclude those individuals or entities that fail to provide immediate access to authorized agents of OIG and the Medicaid Fraud Control Units (MFCUs) to inspect documents. This powerful investigative tool is being used more frequently by MFCUs. During this reporting period, OIG authorized MFCUs to use this authority in six instances. In each instance the individual or entity complied with the request, and no exclusion was imposed.

In July 1996, OIG initiated Project Weed, for the purpose of increasing the number and quality of referrals to OIG that are processed for exclusions. To that end, documents and information relating to offenses requiring mandatory exclusions were to be given highest priority. Next in priority come all convictions of which OIG is aware that do not require mandatory exclusion but that may be subject to conviction-related discretionary exclusions. A final step is to obtain and review licensing board and Federal/State actions that are not related to convictions but that might call for discretionary exclusions. Project Weed has been instrumental in greatly increasing the number of exclusions imposed from 1,408 in FY 1996 to 2,719 in FY 1997.

During this reporting period, OIG imposed exclusions on 1,375 individuals and entities in all. The following are examples of some of the exclusions that were imposed during this reporting period:

- A licensed social worker was convicted of defrauding the New York State Medicaid program. The fraud associated with this criminal activity amounted to over \$200,000. Following this conviction, the social worker was excluded from program participation for a minimum of 15 years.
- A Rhode Island nurse's aide was excluded for a minimum of 10 years after being convicted of patient abuse. She had left a profoundly retarded and handicapped patient alone in a bathtub for several minutes and the patient died.
- An exclusion for a minimum of 10 years was imposed on a Texas physician. The physician was convicted of submitting false claims to Medicare and the Civilian Health and Medical Plan of the Uniformed Services (CHAMPUS). He participated in a scheme in which Medicare and CHAMPUS were billed

for services provided to patients who responded to advertisements for "free" cholesterol checks and blood circulation tests.

- An indefinite exclusion was imposed on a Connecticut surgeon as a result of his voluntary agreement not to practice medicine before his license expired and not to request renewal of his license. The agreement was entered into during formal proceedings by the licensing board which were initiated after a patient won a malpractice suit against the surgeon. In the malpractice case, it was found that the surgeon delayed surgery for 9 hours, as a result of which the patient's small intestine and half his large intestine had to be removed. The patient cannot digest food and must be fed intravenously for the rest of his life.
- The owner and operator of a nonemergency medical transport company was convicted of defrauding the Medicaid program. She had instructed her employees to falsify trip records and to bill multiple times for a single service provided. Following her conviction, she was sentenced to 15 months incarceration and ordered to make restitution of over \$32,000. This conviction resulted in a 10-year exclusion from the programs.
- A 10-year exclusion was imposed on a Texas transportation company owner and his company. He had defrauded the Louisiana Medicaid program of over \$200,000. As part of his scheme, he billed for miles not traveled.
- An individual who provided medical supplies was convicted of defrauding the Ohio Medicaid program of over \$200,000. He billed for providing medical supplies which were never delivered. Subsequent to his conviction, he was excluded for a minimum of 10 years.
- The part-owner of an Ohio mobile x-ray company was excluded from program participation for a minimum of 10 years. He was paid over \$430,000 by the Medicare and Medicaid programs for x-ray services he claimed had been performed by his company but which were never provided as claimed.

B. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law allows recoupment of monies lost through illegitimate claims as well as the imposition of additional penalties, and it also protects health care providers by affording them due process rights. The OIG also assists DOJ in bringing cases against wrongdoers under the Federal Civil False Claims Act. Many

providers elect to settle their cases prior to litigation. As part of resolving these cases, OIG frequently imposes corporate integrity programs on entities as a condition for being allowed to remain as a provider in the Medicare program. These integrity programs are designed to prevent a recurrence of the fraudulent activities which gave rise to the case at issue. The Government, with the assistance of OIG, recouped about \$100 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 for northern California agreed to pay \$12 million to resolve its civil liability for covering up claims processing errors. Employees altered or discarded documents that would have disclosed Medicare claims processing errors, substituted backdated and altered documents for original documents that contained errors and rigged purportedly random samples of files to trick HCFA auditors into believing its performance was better than it actually was. Damages to the Medicare program were estimated to be approximately \$6 million. The company pled guilty in May 1996 to conspiracy and obstruction of a Federal audit and was fined \$1.5 million, and is no longer a Medicare carrier.
- The co-owner of a Florida clinic agreed to pay more than \$1 million to settle civil liability for improperly billing Medicare. The clinic billed for unnecessary services and for services never rendered to "professional" beneficiaries (those who received inducements to travel from clinic to clinic for services). The individual, his wife and the clinic agreed to permanent exclusion from the Medicare program. The individual also pled guilty to conspiracy to file false claims for diagnostic tests.
- An anesthetist group at a New York hospital agreed to pay \$800,000 to settle allegations it submitted inflated Medicare claims. The group claimed one-on-one patient services when more than one patient was being treated at a time.
- A counseling center in Massachusetts agreed to pay \$608,000 to settle civil liability. The center established a geriatric program in 1991 to furnish mental health services to beneficiaries in nursing homes. Between 1992 and 1996, it billed for numerous services as performed by physicians when they were actually performed by clinicians such as clinical social workers or clinical psychologists.
- An outpatient alcohol and drug treatment facility in Oregon signed an agreement to pay \$400,000 to resolve liability for submitting Medicare claims for group therapy services that were not covered or had not been

properly documented. The facility included costs for nonallowable items such as room and board in its charges for group therapy.

- A Pennsylvania osteopath agreed to pay \$100,000 to settle civil liability for filing claims for chelation therapy, which is not covered by Medicare except in limited circumstances. The osteopath performed the therapy, then billed for certain components which are covered by Medicare, such as venipuncture, saline intravenous and intravenous therapy.
- A New Jersey internal medicine group practice agreed to pay \$30,000 to settle civil liability for filing improper Medicare claims. A laboratory that provided ultrasound and nuclear imaging diagnostic tests induced the group to bill improperly for interpretations of certain diagnostic tests. The laboratory billed Medicare for the technical component of the test, and the group billed for the professional component of the test. The group paid a low flat rate, then billed Medicare for the professional component of the test to obtain the difference -- which ranged from \$25 to \$75 per test.
- Another Pennsylvania osteopath agreed to settle his civil liability by paying \$13,000. The osteopath was excluded from Medicare and Medicaid in 1992 for failing to supply payment information, but he continued to file claims for reimbursement. His exclusion continues.

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

C. Compliance Activities

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

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

Further, in partnership with various hospital and medical associations such as the American Hospital Association, the American Medical Association, the Federation of American Health Systems and the American Association of Medical Colleges, OIG is currently developing a model hospital corporate compliance plan. This hospital corporate compliance plan is

intended to assist the hospital community by providing guidance regarding the development of internal controls and processes to monitor their own compliance with applicable laws and regulations.

In addition to developing model corporate compliance plans, OIG also monitors and verifies the completion of corporate integrity obligations that have been and are being established as a result of settlement negotiations following an OIG investigation or audit. Currently, OIG is monitoring 122 Government-imposed corporate integrity plans. These plans cover the range of providers from small physician offices to large laboratory corporations. Most corporate integrity plans are for 5 years and require a major effort by the provider to ensure that the company is operating within HCFA regulations and the parameters established by the corporate integrity plan. Failure to adhere to the corporate integrity agreement within the agreed time limit could result in exclusion of the provider.

Kickbacks

Many businesses engage in referrals to meet the needs of customers or clients for expertise, services or items which are not part of their own regular operations or products. The medical profession relies heavily upon referrals because of the myriad specialties and technologies associated with health care. If referrals of Medicare or Medicaid patients are made in exchange for anything of value, however, both the giver and receiver may violate the Medicare/Medicaid anti-kickback statute.

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

- referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Medicare or Medicaid programs; or
- purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service or item payable under the Medicare or Medicaid programs.

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

- The medical director of several Ohio nursing homes and his son were sentenced to 6 months home confinement and 3 years probation for their part in a kickback scheme. They were fined \$20,000 and agreed to make

restitution of \$126,500 as well as the cost of home monitoring. The son had contracted with a laboratory to rent space for a phlebotomist drawing station in the father's office. The laboratory also paid the father \$200 a month as a "remote consultant" and his son \$700 a month for "stand-by oxygen," although neither could explain what services they provided. The father also used his influence to get the nursing homes to switch their contracts to the laboratory.

- A Pennsylvania physician and the owners of two diagnostic companies agreed to settle civil liability for a kickback scheme. The company owners paid \$11,000 in kickbacks through a sham lease agreement with the physician and another doctor now deceased. The remaining physician assisted in the prosecution which resulted in the company owners' guilty pleas. The two owners agreed to pay a total of \$61,000, and both are permanently excluded from program participation. The physician agreed to pay \$18,000 to settle civil liability.

Criminal Fraud

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

- In Ohio, an individual was sentenced to up to 15 years in prison and ordered to repay her former physician employer \$500,000 she had embezzled while working for him. The woman had deposited a number of Medicare checks and other funds in accounts she controlled, and she was not discovered until the physician hired a new accounting firm. She was also sentenced to serve concurrently four consecutive 1-year sentences for forgery of documents and theft of funds from a nursing home that employed her after the physician fired her.
- A chiropractor was sentenced in Iowa after pleading guilty to mail fraud related to filing false Medicare and Medicaid claims. The chiropractor had employees alter and falsify office records to make it appear patients received spinal manipulations or physical therapy when the service included only the sale of placebos, vitamins or nonreimbursable items and services. She was sentenced to a year and a day in prison and ordered to pay restitution of \$27,270 to private insurance companies she defrauded. She also signed a civil agreement to pay \$60,000 to Medicare and Medicaid. She is subject to a 5-year exclusion from Medicare and Medicaid.

- A practicing psychiatrist in Pennsylvania was sentenced for his part in submitting Medicare and Medicaid claims for services never performed. As part of the investigation six search warrants were executed, during which the physician was observed loading patient records into his vehicle to either remove or destroy them. He pled guilty and was sentenced to 3 months home confinement and 3 years probation, and was fined \$10,000. In line with a civil settlement entered earlier, he paid \$500,000.
- A physician assistant was sentenced in Florida to 3 years supervised release and was fined \$100 for submitting false Medicare claims for psychological services which he never performed. Others also have been implicated for billing Medicare and Medicaid for psychiatric and psychotherapeutic services never provided. The total Medicare overpayment was more than \$2.3 million. The physician assistant received a minimal sentence and agreed to cooperate in the investigation of others involved.

Hospice Eligibility

To be eligible for Medicare hospice benefits, an individual must initially be certified by a physician as terminally ill with a life expectancy of 6 months or less. Election to the palliative care offered by this program requires beneficiaries to voluntarily relinquish their right to curative care for their terminal condition under the Medicare program.

In reviewing one California hospice provider, OIG found that Medicare paid \$2.1 million for 37 ineligible beneficiaries and another \$1.35 million for 19 beneficiaries whose eligibility could not be determined based on the medical evidence in their files. The OIG review, which included reviews by physicians of the hospice's eligibility determinations, covered 78 beneficiaries who had been in hospice care for more than 210 days.

In addition to proposing financial adjustments, OIG recommended that the Medicare intermediary coordinate with HCFA in providing training to hospice providers and physicians on eligibility requirements for hospice beneficiaries and conduct periodic reviews of hospice claims to ensure the hospices are obtaining sufficient medical information to make valid eligibility determinations. (CIN: A-09-96-00064)

Enhanced Medicare Payments for Beneficiaries Classified as Having End Stage Renal Disease

Several OIG reviews have focused on the enhanced payments made to health maintenance organizations (HMOs) on behalf of Medicare beneficiaries classified as having end stage renal disease (ESRD). Monthly payment rates for such beneficiaries are about 7 to 10 times greater than the regular non-ESRD rates. In a previous review, OIG identified a systems problem with payments to HMOs for beneficiaries who were no longer ESRD-eligible. The

HCFA was to correct the systems problem and identify and collect any overpayments made to HMOs.

A. End Stage Renal Disease Misclassifications

To examine the extent of the systems problem and the amount of overpayments, OIG reviewed the payments made to Group Health Cooperative of Puget Sound in Washington State for beneficiaries no longer classified as having ESRD. The OIG identified 40 beneficiaries enrolled with Group Health between March 1992 and April 1996 who were inappropriately classified as having ESRD status. As a result, Group Health received Medicare overpayments of nearly \$2.8 million for that period. Although Group Health was providing timely notification to HCFA when the ESRD status of beneficiaries changed, the designation was not changed because of a HCFA computer deficiency and the enhanced payments continued.

The HCFA reported that it began implementing system enhancements to address the problem of incorrect ESRD status in August 1996. The OIG recommended that Group Health refund the \$2.8 million in Medicare overpayments, review the ESRD status of Medicare enrollees subsequent to the period covered by the audit and refund any additional overpayments. Group Health acknowledged that overpayments were received but disagreed on the beginning date that overpayments should be refunded. (CIN: A-10-96-00001)

B. Recovery of Overpayments

In this review, OIG found that HCFA's systems had been modified to maintain a more complete history of ESRD information, and, effective October 1996, HCFA implemented systems changes to adjust payments to HMOs when a beneficiary's ESRD entitlement ends. The OIG estimates that systems enhancements will prevent approximately \$15 million in future overpayments.

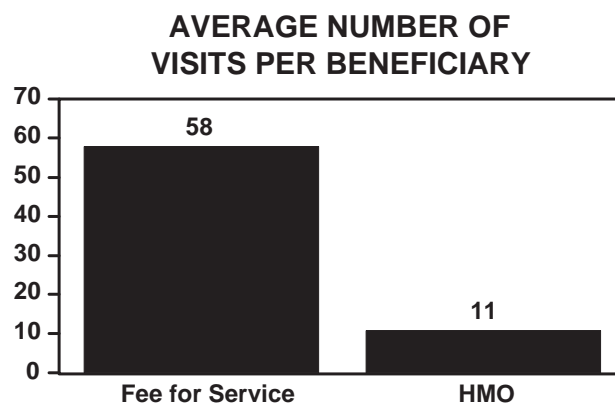
However, OIG also found that HCFA is unnecessarily limiting the time period for recovery of the overpayments from HMOs made on behalf of beneficiaries whose ESRD entitlement had ended. The OIG identified \$20.5 million in overpayments which HCFA does not plan to collect because of these time limits. These overpayments, made to HMOs between January 1992 and February 1995, were in addition to the overpayments identified in OIG's prior reports. In response to the draft report, HCFA disagreed with OIG's recommendation to recover all overpayments back to 1992 but agreed with OIG's other recommendations. (CIN: A-14-96-00203)

Health Maintenance Organizations' Management of Home Health Services

Over the past 5 years, Medicare expenditures for home health services have increased more than fourfold to an estimated \$16.9 billion in 1996 and expenditures have varied

significantly among the Nation's home health agencies. The rapidly escalating costs and wide variation among providers have raised concerns about differences in how home health care is managed by various providers. In view of the reputation of Medicare risk HMOs for controlling costs, OIG examined how those HMOs managed home health services.

The OIG found that most HMOs closely managed home health services. Eighty-nine percent of the HMOs surveyed contracted for all the home health services they provided beneficiaries and most paid contractors on a fee-for-service basis. Virtually all the HMOs used case managers to approve, coordinate and monitor home health visits. The OIG determined that HMOs tightly controlled costs and the number of visits. Based on data from those HMOs that provided information on the volume and cost of home health visits, OIG found that, on average, HMOs authorized fewer visits per beneficiary in 1994 than did fee-for-service providers, as illustrated below.



Almost half the HMOs surveyed provided home health care for about one-fourth the cost under the fee-for-service system.

Home health contractor opinions were mixed on the adequacy of care provided. Whereas 56 percent of the home health contractors surveyed said that the number of visits authorized by HMOs was adequate, 42 percent expressed concern about the number of authorized visits. Moreover, while 30 percent thought HMO beneficiaries were advantaged in terms of overall home health care when compared to fee-for-service beneficiaries, 51 percent thought they were disadvantaged. (OEI-04-95-00080)

Home Health Services in California, Illinois, New York and Texas

Performance Measure

In reviewing a sample of home health agency (HHA) claims in four States, OIG found that 40 percent of the services did not meet Medicare reimbursement requirements. The services were not reasonable or necessary, were provided to beneficiaries who were not homebound, did not have valid physician orders or were not adequately documented. As a result, OIG estimated that for the 15 months ended March 31, 1996, Medicare intermediaries approved unallowable HHA claims totaling about \$2.6 billion of the \$6.7 billion claimed in the four States reviewed. This problem occurred primarily because physicians did not always review or actively participate in developing plans of care, beneficiaries were not provided with a notice of benefits claimed in their behalf and medical reviews of HHA claims by intermediaries were not effective in curbing abuses.

The OIG recommended that HCFA consider alternatives in restructuring the home health reimbursement methodology and revise Medicare guidance and regulations for physicians and intermediaries. The HCFA generally concurred with OIG's recommendations. (CIN: A-04-96-02121)

Home Health: Problem Providers and Their Impact on Medicare

For purposes of this inspection, OIG analyzed the activities of a sample of "problem" home health agencies as defined in the report. The OIG identified one-quarter of the home health agencies in the five Operation Restore Trust States as problem providers. These agencies receive almost 45 percent of all Medicare expenditures for home health services in the five States.

The OIG determined that many of these agencies share ownership and operational characteristics that can undermine HCFA's ability to recover overpayments or levy sanctions against their owners. Most problem home health agencies are closely-held proprietary corporations whose owners are involved in related organizations and complex business relationships. Because HCFA has few available preventative measures, the owners of problem agencies can continue to receive Medicare money even after the agency is closed. In addition, the expansion of the home health benefit, coupled with few restrictions on certification, have led to ever-increasing administrative problems. Further, lenient cost report submission requirements and limited resources hamper fiscal intermediaries' ability to provide adequate oversight.

The OIG's recommendations address the Medicare certification process and other measures that would protect the Medicare trust fund, and prevent questionable providers and individuals from taking advantage of the program. In response to the report findings and testimony before the Congress, the President had the Department issue a 6-month

moratorium on certification of new home health agencies for participation in Medicare, during which time program safeguards will be introduced. (OEI-09-96-00110)

Home Health Agency Fraud

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

- In Arizona, two individuals were sentenced to 3 years probation and each fined \$15,000 for their fraudulent schemes. The two operated a home health agency (HHA) in Nevada and attempted to open one in Arizona. They approached an Arizona physician and offered to pay in cash or equipment for referrals of Medicare patients. They also filed false information when applying for Medicare certifications in Arizona.
- The former general manager and bookkeeper of an Ohio home health agency was sentenced to 15 months in prison and 3 years supervised release, and ordered to make restitution of \$115,155. She embezzled the money from the agency, which provided services under Medicare. She created fictitious employees, caused issuance of duplicate checks in the names of other employees, created phony refund checks to insurers, reimbursed fictitious office expenses and stole checks made out in her name.

Imaging Services for Nursing Home Patients: Medical Necessity

This inspection on the medical necessity of imaging services provided to residents of nursing homes and paid by Medicare is the first of three related reports on imaging services for nursing home residents. The OIG found that less than 2 percent of chest x-rays provided to nursing home patients in 1994 were medically unnecessary or undocumented. In contrast, OIG determined that 25 percent of electrocardiograms (EKGs) provided to nursing home patients in 1994 were medically unnecessary or undocumented. High volume physicians and suppliers were particularly likely to provide medically unnecessary or undocumented EKGs.

The OIG recommended that HCFA require Medicare contractors to profile high volume EKG suppliers and physicians to determine if they routinely bill for medically unnecessary and undocumented EKGs. (OEI-09-95-00092)

Nursing Home Fraud

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

- A rehabilitation company and its owners were sentenced in Pennsylvania for billing Medicare for services to nursing home patients who had no need or could not benefit from these services. The company altered, forged and destroyed documentation to obtain Medicare reimbursement, requiring onsite therapists to rewrite notes showing beneficiaries as qualified or making progress when neither was the case. The company was sentenced to 2 years probation and was ordered to pay a \$25,000 fine. One owner was sentenced to 3 years probation and fined \$10,000. The other was sentenced to 6 months home detention and 3 years probation, and fined \$15,000. The loss to Medicare was \$192,000.
- The operator of an Illinois chain of nursing homes agreed to pay \$768,510 to settle civil liability for Medicare overpayments. In 1990, the corporation entered an arrangement with a billing company to review its records and bill Medicare for "lost charges" (medical supplies for which the company had failed to submit claims). Most of these claims had already been paid as part of patients' per diem costs. The two owners of the billing company were criminally prosecuted and sentenced to prison earlier. This was the thirteenth settlement with nursing homes involved with the billing company, resulting in total recoveries of \$4.4 million.
- The owner of a physicians' group, a physical therapists' corporation and billing company agreed to pay \$3.1 million to resolve liability for submitting false claims to Medicare. He also agreed to an exclusion of his corporation. He employed physical therapists to serve residents in seven nursing homes in Maryland, Virginia and the District of Columbia under contract with his corporation, as well as retired physicians to supervise the therapy. Through the billing company, claims were submitted as though the therapy was incident to professional services of the supervising physicians. The physicians, however, provided no professional services, and were only present part of the day. They documented no professional services in the medical files and were found to be reading newspapers and involved in other non-medical activities.

Enteral Nutrition Therapy Equipment and Supplies in Nursing Homes

This report describes the extent of Medicare Part B payments and potential vulnerabilities related to enteral nutrition therapy equipment and supplies for nursing facility payments and discusses possible alternative Medicare payment policies. The OIG found that costs for such equipment and supplies, including such items as intravenous poles, infusion pumps, feeding kits and tubing, totaled approximately \$260 million in 1995. Although Medicare pays for DME when used in patients' homes, it does not make separate payments for them in nursing facilities; these items are considered standard equipment for nursing facility operations and are covered as part of the daily rate that Medicare or Medicaid pays for the stay. However, Medicare does pay separately for equipment used in connection with enteral feeding in nursing facilities, even if the same equipment would not otherwise be covered.

The OIG found that equipment used for enteral nutrition therapy costs more than identical equipment billed under the DME fee schedule. Further, OIG concluded that current Medicare payment policy in this area fails to capitalize on market forces and efficiencies available to nursing facilities. Approaches to solve vulnerabilities and wasteful spending associated with enteral nutrition therapy payment policies range from resolving specific areas of identified excesses to restructuring the global payment mechanism for Medicare services provided to nursing facility patients. While several options are presented in this report, OIG believes restructuring Medicare's payment mechanism for Part B services to patients of nursing facilities is most responsive to its overall concerns. Enteral nutrition therapy is but one example of the possible benefits from changes to current policy which will ensure that Medicare is paying the most reasonable cost. The HCFA concurred with the recommendations made in the report. The Balanced Budget Act of 1997 made significant amendments to the Medicare payment method for nursing home residents receiving this service. (OEI-06-92-00866)

Enteral Nutrition Therapy: Medical Necessity

In this inspection, one of a series on the issue of enteral nutrition, OIG found that most beneficiaries who filed Medicare Part B enteral nutrition claims in 1995 had a general medical need for the therapy. However, the study identified vulnerabilities in the areas of special enteral formulas and the pump delivery method. Ten percent of beneficiaries who used a special formula did not meet guidelines for the special formula, and 9 percent of beneficiaries who used the pump delivery method did not meet criteria for that delivery method. Further, medical reviewers from the Public Health Service's Health Resources and Services Administration found that the slow administration rate criterion for the pump delivery method is vulnerable to abuse.

The OIG estimated that questionable Medicare allowances in 1995 were \$2.9 million for beneficiaries who did not meet special formula criteria and \$7.5 million for beneficiaries

who did not meet Medicare guidelines for the pump delivery method. If the slow administration rate had not been a Medicare criterion, Medicare might have saved \$28 million. The OIG recommended that claims for special formulas and the pump delivery method be considered for focused medical reviews, and that when beneficiaries are in nursing facilities, the formula, equipment and supplies be covered under the nursing facility daily rate instead of under Part B. Both HCFA and the Assistant Secretary for Planning and Evaluation concurred with the recommendations. The Balanced Budget Act of 1997 amended Medicare payment methods along the lines recommended by OIG. (OEI-03-94-00022)

Medicare Reimbursement for Parenteral Nutrition

The OIG compared Medicare's reimbursement for the four parenteral nutrition codes with the highest allowances in 1995 with that of State Medicaid agencies, a sample of Medicare risk-contract HMOs and manufacturers' contract prices. The OIG found that Medicare reimbursement for the four parenteral nutrition codes is an average of 45 percent higher than lower-paying Medicaid agencies and 78 percent higher than lower-paying Medicare HMOs. In addition, Medicare reimbursement for the four selected codes is between 9 and 12 times higher than the contracted price charged by three manufacturers to a low-volume supplier of parenteral nutrition.

The OIG recommended that HCFA examine other payment methods that could lead to more cost-effective reimbursement for parenteral nutrition solutions. Options that could be explored include basing prices on "inherent reasonableness," acquisition cost or competitive bidding. The HCFA concurred with the recommendation. The Balanced Budget Act of 1997 froze payment levels for 3 years. (OEI-03-96-00230)

Laboratory Fraud

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

During the course of this initiative, OIG found numerous problems in the ways that most independent clinical laboratories were charging Medicare for clinical tests. In turn, industry awareness of the initiative spawned a series of qui tam lawsuits against laboratories. Under the qui tam provisions of the Civil False Claims Act, a private party may sue on behalf of the Government to recover damages and penalties flowing from the submission of false claims to the Government. The Act requires the party to file the action under seal and to disclose all material evidence to DOJ, which conducts an investigation to determine whether the Government should intervene. In its investigation, DOJ works closely with the Federal

agency allegedly victimized. The private party initiating the suit is awarded a portion of any damages or penalties assessed.

These qui tam cases, as well as audits and investigations of smaller laboratories, are significant not only because of the recovery of Medicare funds but also because they highlight vulnerabilities that continue to put Medicare at risk, as shown in the following examples:

- In Florida, a laboratory owner and a clinic owner were sentenced to 30 months and 4 months, respectively, for Medicare fraud. The lab owner was ordered to make restitution of \$500,000 and a special assessment of \$900, while the clinic owner had to make restitution of \$50,000 and pay a \$500 assessment. Together with a cardiologist who contributed his signature and provider number, they defrauded Medicare of approximately \$4 million over a 3-year period by billing for lab tests and medical treatment that were either never performed or medically unnecessary. The cardiologist was sentenced to 6 months in prison and ordered to pay restitution of \$410,000.
- The owner of another Florida diagnostic company agreed to settle charges that she filed claims for services which were not provided or were not medically necessary. The owner agreed to transfer to the Government \$137,850 which had been withheld, as well as medical, diagnostic and other equipment valued at \$29,800. (The equipment was later donated by the Government to nonprofit medical facilities in South Florida.) She also had to list all her assets, with the provision that if any assets were not disclosed a judgment of \$1.58 million will be entered. She agreed to permanent exclusion from Medicare and other Government health programs.
- The owners of a Boston-based independent clinical and physiology laboratory agreed to pay \$1.3 million for improperly billing Medicare for certain radiology services. The laboratory overbilled Medicare for blood specimen transportation fees, misrepresented services to obtain higher reimbursement, and unbundled urine analysis tests. It also double-billed Medicare for radiology services requested by hospital physicians which had already been reimbursed as inpatient laboratory services under Medicare Part A. The laboratory agreed to permanent exclusion from the Medicare program, and the two owners were excluded from participating in the program for 2 years. The hospital also had agreed to a \$1.3 million civil settlement for its part in the scheme.
- A third Florida laboratory agreed to pay \$700,000 to settle allegations that it submitted false claims to Medicare. Over a 5-year period, the laboratory

exaggerated mileage traveled by phlebotomists to induce improper Medicare reimbursement. The laboratory also agreed to pay \$24,500 in attorney's fees for relators of the qui tam that gave rise to this case.

Medicare Allowances for Incontinence Supplies

In December 1994, OIG issued a report which identified over \$100 million in questionable allowances for incontinence supplies. Since its initial study began, there have been aggressive efforts by HCFA, the DMERCs and OIG to prevent such questionable allowances. Both the DMERCs and OIG have issued fraud alerts concerning inappropriate billings for incontinence supplies. In October 1994, the DMERCs issued a draft policy clarifying coverage and frequency parameters for incontinence supplies; the final version was issued in October 1995.

In its current review, OIG determined that abusive practices for incontinence supplies have all but disappeared, declining by over 75 percent since 1994. Total Medicare allowances for incontinence supplies have declined for the first time since 1991. Allowances decreased by over 40 percent from \$260 million in 1994 to \$150 million in 1995. In addition, more than \$50 million has been recovered through seizures and restitutions from abusive incontinence suppliers.

Concerted efforts by HCFA, OIG and other law enforcement agencies, in the form of changes in payment and coverage policy, fraud alerts, reports and prosecutions have contributed to the declines in Medicare allowances documented in this report. Based on OIG's analysis, OIG estimates that declines in questionable billings saved the Medicare program \$85 million in 1995. By the fourth quarter of the year, most of the abusive billings had disappeared, resulting in estimated savings in 1996 of \$104 million. If the current trend continues, OIG estimates that Medicare will save \$542 million between 1996 and 2000. (OEI-03-94-00773)

Medicare Payments for Pressure Reducing Support Surfaces

Pressure reducing support surfaces are a kind of DME used for care of pressure sores. Support surfaces are coded under one of 16 different HCFA common procedure coding system codes and categorized into three groups. In an effort to clarify and improve existing support surface medical policies, new DMERC guidelines became effective January 1, 1996. These new guidelines no longer allowed reimbursement for alternating pressure mattresses if used for preventive treatment and no longer required certificates of medical necessity for support surface equipment, except for air-fluidized beds.

In a review to assess the effect of these new policies, OIG found that they are having a positive impact on controlling Medicare costs for support surfaces, but that inappropriate payments are still being made. Moreover, OIG noted a variety of other problems related to

Medicare support surface reimbursement, but these were due to a lack of adherence to existing DMERC guidelines. For example, some beneficiaries reported using group 2 support surface equipment before first trying a less expensive support surface from group 1. Of the beneficiaries surveyed who had been appropriately reimbursed for support surface equipment, most reported that their pressure sores had healed completely or improved.

The OIG recommended that HCFA establish the requirement for periodic review and renewal of the medical necessity for beneficiaries' use of group 2 support surface equipment. The OIG believes that this will help eliminate problems identified in this report and save as much as \$12 million annually. In response to the draft report, HCFA did not agree that such review was necessary in light of new coding procedures it had established. (OEI-02-95-00370)

Fraud Involving Durable Medical Equipment Suppliers

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

- A DME provider and his daughter were sentenced in Michigan for pleading guilty to a charge of violating the Racketeer Influenced and Corrupt Organization Act. The two individuals participated in a scheme that defrauded the Medicare program of \$25 million. They billed Medicare for unnecessary incontinence care supplies and for both bundled and unbundled catheter care kits, resulting in duplicate and inflated claims for thousands of patients in hundreds of nursing homes nationwide. They were sentenced to 57 months incarceration, followed by 3 years supervised release. In addition, the DME provider will forfeit \$12 million and his daughter \$100,000 to the Government. A civil complaint was filed earlier against the provider, nine other persons and several companies, seeking reparation for the Medicare overpayments. Several other family members and friends who participated in the scheme are to be sentenced shortly.
- In Florida, an oxygen and medical equipment company agreed to pay \$612,500 to settle civil liability for falsifying information to obtain Medicare payment for oximetry tests, oxygen and DME. The company's

own employees performed tests on Medicare patients to which it sold equipment, violating HCFA rules.

- In Massachusetts, a DME company agreed to pay \$490,500 to resolve civil liability for improper Medicare claims. The company submitted claims for skin barrier products under improper codes and provided these products to nursing home patients far in excess of legitimate medical needs. As a result, the company was overpaid \$297,000. This case is part of a national project targeting suppliers of incontinence care products who fraudulently bill Medicare.
- The former co-owner of a Pennsylvania DME company was sentenced to 6 months home confinement and 2 years probation for destroying records during an investigation into alleged Medicare fraud by OIG. He was also fined \$10,000. The sentence and fine were light because it was his first offense and because earlier he and the other former co-owner had paid more than \$4 million in settlement of civil charges.
- In Texas, a DME supply company and its owner agreed to pay \$1.35 million to settle allegations of billing Medicare for lymphedema pumps at grossly inflated prices. From 1992 through 1994, the company billed under the highest reimbursement code for the pumps and received as much as \$5,000 for each from Medicare. It was entitled to only \$600 for a pump, for which the company had paid \$495. As part of the settlement, the company agreed to implement a corporate compliance program. The pump manufacturer agreed earlier to pay \$4.9 million for its marketing of the pump. Several other DME suppliers across the country have also entered settlement agreements for overbilling for the pumps, resulting in recoveries of \$15 million to date.

Questionable Practices Involving Nebulizer Drug Therapy

This report identifies questionable practices relating to nebulizer drug therapy provided to beneficiaries under Medicare Part B. As the report notes, DMERC C (Palmetto Benefits) identified problems and laid the groundwork for the OIG inspection. The OIG concluded that Medicare paid for multiple inhalation drugs that may be harmful when used together and identified other questionable drug provision practices that may compromise beneficiaries' care. For example, OIG found that Medicare beneficiaries received units of albuterol sulfate that differed from amounts prescribed by their physicians and that prescribed dosage levels for some beneficiaries exceeded medical guidelines. Further, OIG determined that questionable billing practices contributed to improper Medicare payments for nebulizer therapy.

The OIG recommended that HCFA develop a strategy to eliminate the questionable and abusive billings identified and ensure that beneficiaries requiring nebulizer therapy receive treatments that are appropriate. As part of this strategy, OIG urged HCFA to implement a comprehensive coverage and medical review policy focusing on nebulizer equipment and inhalation drugs. The OIG estimated that if its recommendations had been in place during the time period of its review, Medicare could have saved up to \$40 million in payments for questionable nebulizer equipment and drugs.

The OIG is planning a multidisciplinary review to determine the magnitude of inappropriate multiple nebulizer drug use as well as the identification of suppliers employing fraudulent or abusive practices in their Medicare billings. The HCFA concurred with OIG's recommendations and has already taken steps to institute corrective actions. (OEI-03-94-00391)

Experiences of Health Maintenance Organizations with Pharmacy Benefit Management Companies

The OIG examined the experiences of HMOs, particularly those participating with Medicare or Medicaid, in contracting with pharmacy benefit management (PBM) companies. These companies have emerged as significant players that can help payers and health plans control rising costs and improve drug therapy of their providers and to their patients. The HMOs, among others, can contract with PBMs for services ranging from claims processing to disease management programs involving patients, pharmacists and physicians.

The OIG found that the number of HMOs using PBMs has nearly tripled since 1993. Seventy-four percent of these HMOs serve Medicare and/or Medicaid beneficiaries. Nearly all HMOs use PBMs for services that affect patients' use of prescription drugs; in the future, many HMOs will use PBMs in ways that influence patient care even more directly. The HMOs biggest concern about PBMs is the potential for bias resulting from the PBMs' alliances with drug manufacturers. Other concerns include confidentiality of data, disclosure of information to patients and the HMOs' own oversight of the PBMs' performance.

The OIG found that there was minimal oversight of PBMs' performance by HCFA and the State Medicaid agencies. Accordingly, OIG recommended that HCFA and the State Medicaid agencies take steps to ensure that its Medicare HMOs are sufficiently accountable for the quality of the services their PBMs provide to beneficiaries. Further, HCFA, the Food and Drug Administration (FDA) and the Health Resources and Services Administration (HRSA), working together with external organizations, should build on existing efforts to develop quality measures for pharmacy practice that can be used in managed care settings. The HCFA, FDA and HRSA agreed with the recommendations. (OEI-01-95-00110)

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 were really taken somewhere else for which claims are nonreimbursable. Other schemes include billing singly for patients who were transported as a group and simply creating false claims. The following cases are examples of some of those settled during this reporting period.

- An ambulance company settled a civil case for \$1.475 million. The company billed Medicare and Medicaid for round trips to physicians' offices as if the destinations were hospitals. It also billed for round trips to hospitals for dates on which no other medical service was billed. The company was paid \$400,000 in 1990 for routinely billing individually for several people who were transported at one time to dialysis centers.
- A district court in Texas granted a civil judgment against the president of an ambulance company and its subsidiaries. The president and the companies were ordered to pay \$304,050 in damages, fines and penalties for submitting false Medicare claims. Between 1988 and 1990, they submitted 100 false claims for ambulance service for patients who were transported to dialysis centers rather than hospitals.

Federal and State Partnership: Joint Audits of Medicaid

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

To date, partnerships have been developed with 19 State auditors, 11 State Medicaid agencies and 2 State internal audit groups. Extensive sharing of audit ideas, approaches and objectives has taken place between Federal and State auditors. Completed reports have involved a financial impact of over \$100 million affecting both Federal and State Government funds.

Medicaid Reimbursement for Clinical Laboratory Tests

In an eight-State review, OIG concluded that the States did not have adequate controls to detect and prevent inappropriate payments for laboratory tests. Contrary to applicable laws and guidelines, the States paid medical providers more for clinical laboratory services processed by physicians' offices, independent laboratories and hospital laboratories for their outpatients than the amounts Medicare recognizes for the same services. As a result, the eight States potentially overpaid laboratory providers an estimated \$6.5 million (\$3.7

million Federal share) for chemistry, hematology and urinalysis tests during the 2-year audit period. Further, OIG estimated that \$3.2 million (\$1.9 million Federal share) in additional annual savings is available if the eight State agencies implement the report recommendations and if providers continue to bill for clinical laboratory tests using the same methodology used during the audit period.

The OIG recommended that the States install system edits and controls to detect and prevent the types of errors disclosed, recover the Medicaid overpayments for clinical laboratory services identified and reimburse the Federal Government for its share of any recoveries made by the State agency. Six States generally agreed with reported findings and recommendations, while two did not.

The HCFA issued a State Medicaid Director letter clarifying Medicaid policy on the bundling of laboratory tests and the upper limit of payments for such tests. (CIN: A-01-96-00004)

Cost Containment for Medicaid Disability Programs

Between 1993 and 1995, the total number of disabled Medicaid beneficiaries grew from 5.0 to 5.85 million, while expenditures for this population increased from \$38.6 to \$49.2 billion. The OIG determined that most cost containment initiatives currently underway affect relatively small groups of disabled beneficiaries and their impact on cost containment is not clear. In fact, none of the sample States have focused strategically on containing Medicaid costs for disabled beneficiaries as a group. Initiatives to reduce costs for hospital inpatient and intermediate care facilities-mentally retarded services, which account for the largest proportions of expenditures for the disabled, are few.

The OIG recommended that HCFA and the Office of the Assistant Secretary for Planning and Evaluation jointly develop a research agenda at the Federal, State and local levels that is aimed at controlling costs while assuring quality care for disabled Medicaid beneficiaries. (OEI-05-95-00400)

Medicaid Managed Care

State Medicaid agencies have turned to managed care to rein in escalating health care costs while ensuring health care access for Medicaid enrollees. The Federal Government encourages the switch to managed care by approving Medicaid experiments in some States which require that Medicaid recipients enroll in managed care plans.

A. Retooling State Medicaid Agencies for Managed Care

This inspection focused on 10 States strongly committed to Medicaid managed care. The OIG found that as State Medicaid agencies increase their commitment to managed care, they face five major organizational challenges: establishing core development teams, acquiring

necessary knowledge and skills, instilling a new mission and culture, redeploying fee-for-service staff and avoiding a fee-for-service meltdown. Most of the States have addressed the first two, with some degree of success. However, they have barely begun to address the last three.

The OIG recommended that HCFA provide forums to help State Medicaid agency managers share best practices and common pitfalls. Also, OIG recommended that HCFA devote more attention to oversight and monitoring of how State Medicaid agencies handle the organizational challenge of building a new managed care system without undermining fee-for-service cost control functions. The HCFA concurred with the thrust of OIG's recommendations. (OEI-01-95-00260)

B. Early and Periodic Screening, Diagnosis and Treatment Program

Performance Measure

Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, State Medicaid agencies must provide eligible children services that include comprehensive, periodic health assessments beginning at birth and continuing through age 20. All medically appropriate immunizations are required. Age appropriate assessments, known as screens, must be provided at intervals following defined periodicity schedules. In order to rein in escalating health care costs, State Medicaid agencies have turned to managed care. This inspection examined the extent to which Medicaid managed care providers delivered EPSDT to Medicaid children.

As illustrated in the following chart, OIG found that fewer than one in three Medicaid children enrolled in managed care plans received timely EPSDT services. Six of ten received none at all. The OIG noted that older adolescents enrolled in Medicaid managed care received significantly fewer required EPSDT services than other children.

RECEIPT OF EPSDT SERVICES			
Age of Child	Receive All EPSDT	Receive Some EPSDT	Receive No EPSDT
birth - age 5	30%	22%	48%
ages 6 - 14	32%	1%	67%
ages 15 - 20	14%	0	86%
all ages	28%	12%	60%

Further, OIG determined that children received significantly more EPSDT services from Medicaid managed care plans when States informed the plans which children were due for services.

The OIG recommended that HCFA revise its EPSDT reporting requirements and data collection to emphasize the number of children who receive all of their EPSDT screens in a timely fashion. The HCFA should encourage States to actively notify managed care plans of enrollees due for EPSDT exams and follow up if EPSDT services are not rendered shortly thereafter; work with States to ensure timely managed care EPSDT reporting to determine whether States are meeting their participation goals; and emphasize to States the need to define and clarify EPSDT requirements in their Medicaid contracts with managed care plans. The HCFA agreed with OIG's recommendations. (OEI-05-93-00290)

C. Use of Surveys as Beneficiary Protection Tool

State Medicaid agencies are increasingly enrolling their beneficiaries in full-risk managed care plans. Beneficiary surveys are among the tools available to them as a beneficiary protection. These surveys can be of value in allowing agencies to gain insights on plan performance and helping beneficiaries make informed enrollment decisions.

In its review, OIG found that these surveys were of limited use as a beneficiary protection. Agency leadership found their survey results largely confirmed what they knew from other sources and were of questionable value with regard to the technical quality of care. These surveys have yet to provide beneficiaries with information to help them choose a plan. The intermittent nature of Medicaid eligibility and low response rates have made such surveys expensive to conduct in a credible fashion. Nevertheless, some agencies reported success in using more narrowly focused surveys and plans have found surveys useful in identifying issues of importance to their memberships.

The OIG recommended that HCFA either establish a work group or technical advisory group on Medicaid beneficiary surveys or add surveys to the agenda of an existing group. Either group should provide policy-level guidance on how to make cost-effective use of beneficiary surveys. Moreover, HCFA should devote greater attention to how the Medicaid agencies are using beneficiary surveys. It should revise its written guides for reviewing and monitoring Medicaid managed care initiatives to call attention to the importance of using beneficiary surveys in more focused strategic ways. The HCFA generally concurred with the recommendations and efforts are already underway between HCFA and the Agency for Health Care Policy and Research to address them. (OEI-01-95-00280)

Pharmacy Acquisition Costs for Drugs Reimbursed under Medicaid

Most States reimburse pharmacies for Medicaid prescription drug costs using a formula which discounts the average wholesale price (AWP). While this discount is most commonly about 10 percent nationally, it has been recognized as insufficient to ensure that a reasonable price is paid for drugs. At HCFA's request, OIG conducted two reviews to develop a

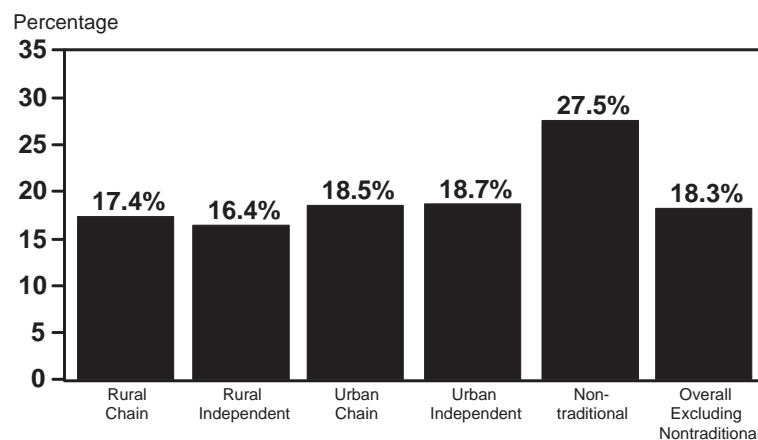
nationwide estimate of the discount below AWP at which pharmacies purchase drugs--both brand name and generic.

Based on these reviews, OIG recommended that HCFA ensure that States reimburse the ingredient portion of Medicaid drugs in a manner more consistent with OIG's findings and study any other factors (e.g., dispensing fees) that it believes could significantly affect pharmacy reimbursement. In response to the draft reports, HCFA agreed with the findings and recommendations.

A. Brand-Name Drugs

Based on pricing information from 315 pharmacies in 11 States, OIG estimated that the actual acquisition cost for brand-name drugs was a national average of 18.3 percent below AWP. As illustrated below, this combined the results for four categories of pharmacies; it excluded the results obtained from nontraditional pharmacies, such as nursing homes or hospital pharmacies, which would have inappropriately inflated percentages.

ESTIMATED PRICE DIFFERENCE FOR BRAND NAME DRUGS



Had reimbursement been based on OIG's findings, as much as \$225 million could have been saved for 100 brand-name drugs with the greatest amount of Medicaid reimbursement in Calendar Year (CY) 1994. (CIN: A-06-96-00030)

B. Generic Drugs

For generic drugs sold to Medicaid beneficiaries, OIG estimated that pharmacies pay an average of 42.5 percent below AWP. This estimate was based on pricing information from 314 pharmacies in 11 States. Unlike reimbursement for brand-name drugs, reimbursement for generic drugs can be limited by Federal upper limits established by HCFA. Considering

these upper limits, OIG calculated that if reimbursement had been based on its findings, as much as \$145.5 million could have been saved for 200 generic drugs with the greatest amount of Medicaid reimbursement in CYs 1994 and 1995. (CIN: A-06-97-00011)

Controlling Medicaid Nonemergency Transportation Costs

The HCFA estimates that nonemergency transportation expenditures total one percent of all Medicaid program costs, or about \$1 billion in 1995. The HCFA also estimates that, nationally, nonemergency transportation costs increased 10 percent per year from 1990 to 1995. Some individual States report that their nonemergency transportation costs increased substantially more.

Each of the four State programs studied by OIG reported significant savings from efforts to control nonemergency transportation costs. The case study programs focused their control efforts on the kinds of fraud and abuse which were most likely to occur: to beneficiaries using Medicaid transportation who had other means of transportation; beneficiaries making unnecessary trips; and providers billing Medicaid for more miles than they actually provided or for trips they did not provide. These programs also reduced nonemergency transportation costs by adhering strictly to the requirement that States use the least costly means of transportation when multiple methods exist. Further, the case study programs used brokers as intermediaries to assure that transportation was necessary; such brokers have a contractual incentive to control costs.

The OIG recommended that HCFA advise States of opportunities to establish controls to reduce costs for nonemergency transportation. Most States could adopt practices similar to those used by the case study programs described in this report. The HCFA concurred with OIG's recommendations. (OEI-04-95-00140)

Medicaid Fraud

The MFCUs are responsible for investigating fraud in more than 98 percent of all Medicaid health care provider payments. Forty-seven States now have units and are receiving funds and technical assistance from OIG. Three States have received waivers from establishing MFCUs as required by the Omnibus Budget Reconciliation Act of 1993. The MFCUs conduct investigations, and bring to prosecution persons charged with defrauding the Medicaid program or with patient abuse and neglect.

During FY 1997, OIG administered approximately \$80.5 million in grants to the MFCUs. The MFCUs reported 341 convictions and \$15.5 million in fines, restitutions and overpayments collected for the period January 1, 1997 through June 30, 1997.

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

- In Tennessee, two men were sentenced to 7 months incarceration, 7 months home confinement and 2 years supervised release for defrauding Medicaid. One man's father was sentenced to 1 day incarceration and 18 months supervised release. The three submitted fraudulent crossover claims to Medicaid, including submitting false expenses on cost reports and failing to report related parties. The father was incarcerated earlier in a related case involving his brother and several nursing homes.
- In Colorado, a family practice physician pled guilty to a State charge of violating the State's medical practice laws and pled for his corporation to a charge of offering a false instrument for recording. The physician had his own laboratory in his office and performed unnecessary tests in order to pay for the equipment. He was sentenced to 1 year probation and 100 hours of community service. He was ordered to pay \$129,665 in restitution for Medicare and Medicaid damages and OIG investigative costs. The case was the first prosecution in Colorado that was based on medical necessity alone.
- The executive director of an Illinois nursing home pled guilty to embezzlement and filing false income tax returns. He embezzled more than \$1.5 million from the nursing home through various schemes, including falsifying records from the nursing home construction account, receiving \$540,000 in overpayments and defrauding a 94-year-old Medicare patient of \$200,000. He was sentenced to 46 months in prison plus 36 months supervised release, and ordered to pay \$67,500 to the resident and \$1.5 million to the home. He used part of the money to buy hundreds of pornographic tapes.

**Public Health Service
Operating Divisions**

Chapter II

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Overview of Program Area and Office of Inspector General Activities

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

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

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

Drug Enforcement Administration Reporting to the National Practitioner Data Bank

Hospitals and other health care organizations use the national Practitioner Data Bank to help with employment background checks of health care practitioners. The Data Bank includes records of malpractice payments and adverse actions taken against health care practitioners. Under current policy, the Drug Enforcement Administration (DEA) is required to report to the Data Bank health care practitioners who have had their Controlled Substance Act registration number revoked or suspended because of violations of this law.

The OIG found that DEA was not reporting to the Data Bank practitioners who voluntarily gave up their registration numbers when confronted with a potential adverse action against them. According to DEA data, in 1994 and 1995 a total of 509 and 486 practitioners, respectively, voluntarily gave up their licenses rather than "show cause" why DEA should not revoke, suspend or deny their registration.

The OIG recommended that DEA and Data Bank officials work together to include "voluntary withdrawals" that are the result of misconduct as part of adverse action reporting to the Data Bank. The HRSA agreed. (OEI-12-96-00160)

Ryan White Comprehensive AIDS Resources Emergency Act: Connecticut

Performance Measure

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Title II, is intended to supplement State spending on the human immunodeficiency virus (HIV) epidemic and to improve services for HIV positive individuals and their families who would otherwise have no access to health care. The OIG found that, contrary to the Act's requirements, Connecticut could not provide assurances that it was maintaining the required level of effort for HIV-related activities. The State's reports on such expenditures were not based on reliable information and were not accurate or complete.

Also, although the State is required to use Ryan White funds only as the payer of last resort, it used \$995,000 in such funds for drug assistance to low-income individuals when State funds were available. Further, the State used Ryan White funds, rather than State funds, for services to inmates. The HRSA agreed with OIG's recommendations for improving guidance to States and for making the necessary policy and procedural changes to ensure States' adherence to the Act's requirements. (CIN: A-01-97-01500)

Exclusions for Health Education Assistance Loan Defaults

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

After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Once the individual has been declared in default, the Social Security Act permits and, in some instances, mandates exclusion from Medicare and State health care programs for nonpayment of these loans. During this 6-month period, 240 individuals were excluded as a result of PSC referral of their cases to OIG.

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

At the conclusion of this reporting period, 789 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 \$48 million. The following are examples of some of these settlements:

- After being excluded for 2 years, a dentist in California entered into a settlement agreement to repay his debt of over \$197,000.
- Soon after being notified of his exclusion, a podiatrist in New York signed a settlement agreement to repay his HEAL debt of over \$203,000.
- An osteopath in California entered into a settlement agreement to repay her HEAL debt of over \$270,000.
- Immediately after being notified he was being excluded for defaulting on his HEAL, a physician in Indiana completely repaid his debt of almost \$46,000.
- In order to stay his exclusion, a Georgia physician entered into a settlement agreement to repay his HEAL debt of \$180,000.

- Shortly after being notified of his exclusion, a Maryland podiatrist entered into a settlement agreement to repay his debt of over \$135,000.

Food and Drug Administration's Inspections of Plasma Fractionators

Performance Measure

The FDA is responsible for regulating blood products, some of which are made from plasma, and for inspecting licensed plasma fractionators at least once every 2 years. (The 26 fractionators worldwide separate the various active components of plasma.) The FDA's Center for Biologics Evaluation and Research (CBER) and Office of Regulatory Affairs (ORA) help carry out these responsibilities.

In response to a congressional request, OIG found that inspections in which ORA was involved resulted in more reported conditions and more enforcement actions against plasma fractionators than inspections made solely by CBER. The ORA has since been assigned the lead inspection role.

The OIG also reviewed FDA's handling of a recall of a plasma product and found it generally appropriate. However, OIG pointed out the need to ensure that MedWatch reports of adverse events were used to target plasma fractionators and/or products for inspection. In addition, CBER did not consistently deal with problems of plasma collection devices found to be involved with saline contamination. The FDA generally agreed with and has begun implementing OIG's recommendations. Most important, FDA has developed a plan to regulate all biologic products and to redefine the working relationship between CBER and ORA. (CIN: A-03-97-00350)

Food and Drug Administration's Handling of Issues Related to Conjugated Estrogens

In response to a congressional request, OIG examined several issues related to FDA's handling of the drug Premarin (conjugated estrogens). The OIG found no unapproved formulations of the drug. However, FDA did not have evidence demonstrating that the currently marketed formulation of Premarin was bioequivalent to the version tested for osteoporosis in the late 1970's. While current regulations require drug manufacturers to show that any reformulations are bioequivalent to the approved product, this requirement was not in effect for conjugated estrogens at that time. Scientific literature, however, has shown that the current version of Premarin is effective in preventing and managing osteoporosis.

The congressional inquiry also questioned whether the approval of the drug Prempro, a combination drug that uses a reformulation of the drug Premarin, was appropriate. The OIG found that although the Premarin tablet formulation used in Prempro differed slightly from the marketed Premarin, the drug manufacturer submitted "in vivo" (in the living body)

bioequivalence data to demonstrate that the new and currently marketed formulations were bioequivalent. Finally, OIG did not find that FDA gave preferential treatment to the Premarin manufacturer over generic drug sponsors.

Beyond the specific issues in the congressional request, OIG identified concerns with the citizen petition process, including the excessive length of the process in one petition case and the lack of policies and procedures governing such an important process. The report makes no recommendations. (CIN: A-15-96-50002)

State Pharmacy Boards' Oversight of Patient Counseling Laws

Although State pharmacy boards have played an active role in explaining and urging compliance with State patient counseling laws, their enforcement of the laws has been minimal. Boards identified a lack of resources for enforcement, the economics of pharmacy practice and limited patient demand as major obstacles to successful implementation of the laws. Patient counseling by pharmacists serves as the last line of defense against adverse drug reactions and against the misuse of prescription drugs, which adds as much as \$100 billion a year to health care costs.

The OIG recommended that FDA collaborate with State pharmacy boards by collecting data about the usefulness of written information offered to patients. The OIG also proposed that the Health Care Financing Administration (HCFA) facilitate State efforts to enforce Medicaid patient counseling requirements by working with States to assess progress toward a counseling performance objective and by developing guidelines on State oversight of counseling requirements. Both FDA and HCFA concurred with OIG's recommendations. (OEI-01-97-00040)

American Stop Smoking Intervention Study

The American Stop Smoking Intervention Study (ASSIST), administered by NIH's National Cancer Institute (NCI), is part of the Department's overall commitment to reduce smoking. Between FYs 1991 and 1996, the program awarded \$104 million to 17 State health agencies and a coordinating center for public awareness campaigns.

An FY 1996 congressional appropriations conference report requested that OIG review the ASSIST program for possible lobbying violations. Responding to that request, OIG examined activities in eight States that raised questions about the use of ASSIST funds for lobbying purposes. The OIG identified one instance of nonreimbursable lobbying activities. As for the program's overall effectiveness, OIG agrees with NCI that more analysis is needed. (CIN: A-15-97-60004)

National Institutes of Health Progress in Implementing General Accounting Office Recommendations

In a November 1991 report entitled "Major NIH Computer System--Poor Management Resulted in Unmet Scientists' Needs and Wasted Millions" (GAO/IMTEC-92-55), the General Accounting Office (GAO) recommended several corrective actions. To determine NIH's progress in implementing these recommendations, OIG conducted a follow-up review.

The OIG's review noted that NIH had successfully implemented most of GAO's recommendations. However, NIH had excluded one of its mainframe computers from capacity reports to the Department and had not established the adequacy of purchasing mechanisms to enable scientists to acquire computing needs promptly and efficiently. The NIH agreed with most of OIG's recommendations in these areas. (CIN: A-15-95-40001)

Grant and Contract Fraud

A major New York university medical center agreed to pay the Federal Government \$15.5 million to resolve civil liabilities arising from the over-recovery of Federal funds for indirect costs associated with research grants and contracts. The center was charged with submitting false information to the Department's indirect cost negotiators for FYs 1984 through 1993. The Government investigation, which resulted in the largest payback ever by a university medical center for overcharges of indirect costs, began when a former center employee filed a qui tam complaint under the Federal False Claims Act. The employee had noted that false financial information had been submitted to indirect cost negotiators to purposely inflate the indirect cost rate. The settlement followed a lengthy analysis by OIG, which reviewed the whistleblower complaint and recommended that the Government join in the qui tam suit.

Chief Financial Officers Act Audits of the Public Health Service for Fiscal Year 1996

Performance Measure

As required by the Government Management Reform Act of 1994, OIG reviewed--through contracts with independent accounting firms--the financial statements and/or operations of the PHS component agencies. This work was undertaken as part of OIG's audit of the combined HHS-wide financial statements discussed on page 60.

A. Food and Drug Administration Financial Statements

The accounting firm qualified its opinion on FDA's FY 1996 financial statements because it could not be satisfied as to the amounts shown for property, plant, and equipment (\$366.8 million), accumulated depreciation (\$152 million), and depreciation expense (\$11 million). The FDA agreed with most of the findings and recommendations in the report. (CIN: A-17-96-00003)

B. National Institutes of Health Financial Operations

In assessing NIH's internal controls and operations, the accounting firm noted a number of conditions that, if uncorrected, will affect the audit opinion on the FY 1997 financial statements. For instance, grant oversight and grant accrual were deficient, and NIH lacked a system to ensure audit scrutiny of grant recipients. The NIH generally agreed with the recommendations for corrective action. (CIN: A-17-96-00008)

C. Centers for Disease Control and Prevention Financial Operations

As in the case of NIH, CDC had a number of conditions that, if uncorrected, will affect the audit opinion on the FY 1997 financial statements. These conditions included weaknesses in grant oversight and accrual, as well as in audit scrutiny of grant recipients. The CDC generally agreed with the accounting firm's recommendations. (CIN: A-17-96-00007)

D. Health Resources and Services Administration Financial Statements

The accounting firm qualified its opinion on HRSA's FY 1996 statements, primarily because of the Departmentwide method used to charge grant advances. Also, HRSA did not maintain adequate documentation to support the accounts showing the consumption and status of appropriated funds. In response, HRSA concurred with the recommendations, and the Department has developed a better system for charging grant advances. (CIN: A-17-96-00005)

E. Substance Abuse and Mental Health Services Administration Financial Statements

A qualified opinion was also issued on SAMHSA's financial statements, essentially for the same reasons as noted above for HRSA. The SAMHSA management agreed with the accounting firm's recommendations. (CIN: A-17-96-00006)

F. Indian Health Service Financial Statements

The accounting firm qualified its opinion on the IHS financial statements due to the reasons noted above for HRSA and due to extensive problems with accounting for property carrying a book value of \$413 million. The IHS concurred with the recommendations to correct the problems noted. (CIN: A-17-96-00004)

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 Superfund financial activities at the following agencies:

A. Agency for Toxic Substances and Disease Registry

In FY 1995, ATSDR obligated about \$68.4 million and disbursed about \$62.1 million of Superfund money. The OIG found that these funds were generally administered in accordance with Superfund legislation; however, management controls needed to be strengthened. The ATSDR agreed with most of OIG's recommendations. (CIN: A-04-96-04575)

B. National Institute of Environmental Health Sciences

Similarly, in FY 1996, the National Institute of Environmental Health Sciences administered Superfund resources--including obligations of \$52.3 million and disbursements of \$44.5 million--according to statutory requirements. The OIG's report therefore made no recommendations. (CIN: A-04-97-04598)

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

Chapter III

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

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

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

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

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

services; expand available financial resources; upgrade data collection and reporting; and enhance program oversight.

Implementation of State Child Support Certified Data Systems

Performance Measure

The Family Support Act of 1988 required each State to develop a statewide automated data system capable of controlling, accounting for and monitoring all processes for determining paternity and collecting child support. The Act also set October 1, 1995 as the deadline for States to implement the required certified automated data system. Because only one State met this deadline, the Congress authorized a 2-year extension of the deadline.

The OIG found that most States and territories were well positioned to have certified automated child support data systems in place by the revised October 1, 1997 deadline. At the time of OIG's review, five additional States had developed certified systems. And, as illustrated in the following table, two-thirds of the 48 remaining States/territories were in the implementation and operational phases at this time.

STATE PROGRESS IN DEVELOPING AUTOMATED DATA SYSTEMS	
CURRENT PHASE	NUMBER OF STATES IN PHASE
Design	2
Programming	3
Testing	9
Conversion	2
Implementation	9
Pilot in several counties, but enhancing	1
Operational statewide, but enhancing	12
Operational statewide, but transferring new system	1
Level 1 Certification Review	2
Level 2 Certification Review	7
Certified	6
TOTAL STATES/TERRITORIES	54

The States, ACF and the contractors generally attributed implementation delays to three elements: the requirement to share technology, short timeframes for developing and

implementing the systems, and ineffective State/contractor working relationships. The OIG found that most States considered the quality of Federal technical assistance and guidance in these areas to be good to excellent. The OIG recommended some additional steps that ACF should take to ensure that all States developed a certified automated child support data system by October 1, 1997. Further, since the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires States to develop several additional child support data systems by October 1, 2000, OIG will issue a report on lessons learned by the States in their current efforts which ACF may apply to these new systems. (OEI-04-96-00010)

State Drivers' License Suspension Processes

Performance Measure

To increase child support collections, some States have passed laws that provide for the suspension of drivers', occupational, or professional licenses of noncustodial parents delinquent in child support payments. Some States use primarily an administrative process to suspend licenses, while others use primarily a judicial process.

Although OIG was not able to obtain conclusive evidence on the effectiveness of these processes from all eight States reviewed, the administrative process generally targeted more eligible cases, had more collections and took less time to suspend licenses. For example, in Maine, which uses the administrative process, the threat of license suspension has helped the State collect more than \$23 million since August 1993. The technique was so successful that only 41 licenses were actually revoked.

The OIG recommended that ACF disseminate to the States the favorable results of the administrative processes reviewed and the best practices used by all eight States. The ACF agreed that such information would be useful to the States. (CIN: A-01-96-02502)

Grantees and Providers Delinquent in Child Support

The OIG identified 1,184 Medicare physicians, National Health Service Corps health care providers, and NIH principal research investigators who were in arrears on their child support payments. These delinquent absent parents owed \$21.5 million. At least two thirds of these, in a sample drawn for further analysis, were not current in meeting their child support obligations. The OIG found that computerized matching of program and child support enforcement information could help in recovering delinquent support payments, but the amounts are relatively small and there are presently limits in this approach.

The OIG recommended several alternative approaches. The ACF generally concurred with OIG's recommendations, pointing out several initiatives it has undertaken. The HRSA, NIH and HCFA were generally supportive but raised some concerns about the practicality of taking action. This report offers some suggestions to deal with these problems. (OEI-07-95-00390)

In-Hospital Voluntary Paternity Acknowledgment Programs

Four inspection reports summarized the results of an OIG study of in-hospital voluntary paternity acknowledgment programs. The study found that all States have established in-hospital programs for voluntary paternity acknowledgment. Child support agencies, vital records bureaus and birthing hospitals all support these efforts and report largely effective interaction with each other. Child support and vital records agencies also rate birthing hospitals capable and willing to assist in the voluntary acknowledgment process. However, both agency and hospital respondents report confusion over their respective roles. As acknowledgment programs mature, their growth and success will rely on enhanced hospital assistance, effective outreach and interagency collaboration.

To forge partnerships between child support and vital records agencies, OIG recommended that the Office of Child Support Enforcement (OCSE) help to more clearly define respective agency roles and inform child support agencies regarding the appropriate use of Federal child support enforcement funds to pay vital records agencies for their program involvement. To promote birthing hospital participation, OIG recommended that OCSE monitor statewide implementation, assuring that all States conduct hospital assessments, encouraging State agency assistance to hospitals, and clarifying the appropriate role of hospital staff in communicating with unmarried parents. (OEI-06-95-00160; OEI-06-95-00161; OEI-06-95-00162; OEI-06-95-00163)

Child Support Enforcement

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

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

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

To date, OIG has initiated over 200 child support cases nationwide. These cases have resulted in approximately 45 arrests, 23 convictions, and court-ordered restitution of close to \$15 million. Prosecutions in this area are unique in that sentences ordered by a judge take into account the need for the defendant to continue to be able to pay. Therefore, alternative sentencing options -- such as work release, home detention and probation where nonpayment is a violation -- are ordered.

In several Federal districts, the U.S. Attorney's office has been aggressive in pursuing child support enforcement cases. One of the first was the Eastern District of Virginia, which has dubbed its operation "Longarm," and cooperates with OIG in prosecuting nonpaying parents OIG turns up. In the past 6 months, four of the men on Virginia's list of "Top Ten Deadbeat Dads" have been found and prosecuted. At the same time, the Eastern District of California has successfully prosecuted three persons that OIG located and had arrested. All the Texas Federal districts are actively involved, and activity is beginning to show success in at least four other States. In all, 23 child support cases were resolved during this reporting period. The following examples illustrate some of the circumstances involved in these cases:

- A man was sentenced in Missouri to 5 years probation and ordered to pay \$105,990 in restitution for failing to pay child support obligations in California. He had owed child support since May 1981. After he was arrested in March 1996, he made two \$300 payments, but he has made no additional payments since June 1996. The man's former wife and son had to obtain funds from the Aid to Families with Dependent Children program to live. The man resided in a variety of locations, including several in California, Colorado, Massachusetts, Michigan, Oregon, New York, New Hampshire, New Jersey and New Mexico. In addition, he had been gainfully employed as a glazier in many of these locations. His arrearage totaled more than \$105,000 as of November 1, 1996.
- After pleading guilty to failure to pay child support, a man was sentenced in Virginia to 30 days in jail and 4 years probation, and was ordered to pay \$52,000 in restitution. He had moved to Florida with his mistress after leaving his wife, who had lost a leg to cancer, and his children to live off welfare.
- Also in Virginia, another man was sentenced to 10 days incarceration and 5 years probation, and ordered to pay more than \$66,000 in restitution for failing to pay child support. The man had taken everything from his family's apartment and the bank accounts, gone to Florida and remarried, even though he had not been divorced.

- In OIG's first Federal child support conviction in the District of Columbia, a man pled guilty to failure to pay support for two daughters. Born in the Ukraine and now living in France, the man was arrested at Dulles Airport. He was given a 5-year probationary sentence and directed to pay more than \$21,200 in restitution, plus \$625 a month during his probation.
- A Texas man was sentenced to 3 months in prison and ordered to pay more than \$36,190 in back child support. The man had not paid child support for his 7-year-old son, who lived in Michigan with his mother, since January 1992. The man was self-employed, selling pet hermit crabs to children. From June 1993 through September 1996, his gross income was more than \$123,000.

Foster Care

During this reporting period, OIG conducted several reviews to determine whether Federal funds were appropriately used in State foster care programs.

A. Payments Made to Foster Family Agencies in California

The OIG found the State inappropriately claimed \$31 million (Federal share \$15.5 million) for administrative costs allocable to social services. The OIG's review covered the 15 counties in California with the largest volume of payments to foster family agencies. These agencies are nonprofit organizations that contract with county welfare departments and provide services to the State's foster care program. They perform such functions as recruiting and training foster parents and providing social services to and on behalf of foster children. The agencies receive monthly payments which cover the amounts paid to the foster parents for the children's care, the costs of social services provided to the children and parents, and the agencies' costs of administering the program. Federal regulations specifically prohibit Federal foster care funds from being used to pay for the cost of social services. While the State agreed that administrative costs related to federally unallowable social services were inappropriately claimed, it disagreed with the method of calculating the amount to be refunded to the Federal Government. (CIN: A-09-96-00071)

B. Fees Retained by Private Child Placing Agencies in Indiana

The OIG found that certain private nonprofit child placing agencies in Indiana retained a portion of foster care maintenance payments, which, as defined by statute, are for food, clothing, and shelter required for the child's care. The retained funds were used to cover costs of operations and case management, as well as costs of providing therapy, counseling, respite care, psychiatric care, and training. For the period of this review, other Federal program funding sources for these types of services were generally exhausted. The OIG also found that the State contracted with a for-profit child placing agency. Payments to a

for-profit institution on behalf of a foster care child were not allowable at the time of OIG's review.

The OIG recommended that the State make a financial adjustment of \$3.7 million (Federal share \$2.3 million) for the funds retained by the child placing agencies and about \$698,000 (Federal share \$442,000) paid to the for-profit agency. The OIG also recommended that the State take steps to improve its oversight activities. The State generally concurred with OIG's findings and recommendations. (CIN: A-05-96-00055)

C. Allocation Rates in Missouri

The OIG reviewed Missouri's allocation rates over a 5-year period for computing certain categories of costs for reimbursement under the title IV-E Foster Care program. In calculating the allocation rates used to claim administrative costs, the State included counts of children who were ineligible because their age exceeded foster care criteria. In addition, the State made direct payments on behalf of those ineligible children. The State concurred with OIG's recommendations for recovery of overcharges totaling \$650,000. (CIN: A-07-97-01027)

Head Start Grantees

The following reviews of Head Start grantees identified unallowable program charges and other financial management problems.

A. Georgia

As requested by ACF, OIG audited selected costs incurred by an Albany, Georgia, Head Start grantee. The OIG identified unallowable charges to Head Start of \$225,000, including unsupported and unallowable nonfederal matching (\$191,000), payments for unallowable compensatory time (\$30,000), and charges for undocumented and unallocable travel (\$4,000).

In addition, contrary to Federal regulations, the grantee drew down \$46,000 of Head Start funds in excess of immediate cash needs. Recommendations called for a refund to the Federal Government of \$271,000 as well as actions to strengthen the grantee's internal controls. (CIN: A-04-96-00107)

B. Idaho

Using contracted audit services, OIG reviewed the financial activities of an Idaho Head Start grantee. Findings included unreported earnings on Federal funds, inequitable distribution of fringe benefit costs and indirect costs, lack of supporting documentation for travel costs, participation in political activities, unimplemented cost-of-living salary increases and an inadequate purchase order system. Recommendations called for recovery of \$410,000. (CIN: A-10-96-00007)

Protection and Advocacy Grantees

The ACF's Administration on Developmental Disabilities funds protection and advocacy programs for persons with developmental disabilities. Grantees are to use these funds to pursue legal, administrative and other appropriate remedies to protect and advocate for the rights of the developmentally disabled under all applicable Federal and State laws. Any revenue earned (e.g., reimbursement of legal fees on a successful settlement) is to be used to expand program services. However, OIG reviews at two grantees identified over \$100,000 of unreported income in 1996. A review of the financial status reports submitted by the eight largest protection and advocacy grantees showed no program income reported for FYs 1995 or 1996. The OIG's recommendations call for appropriate expansion of program services by the grantees. In addition, OIG is providing ACF its audit guide for use in identifying the amount of unreported income at other sites. (CIN: A-03-97-00514; CIN: A-03-97-00515)

Community Services Block Grant Program: New Jersey

Performance Measure

The OIG identified two major programmatic weaknesses in New Jersey's administration of the Community Services Block Grant (CSBG) program. First, the current methodology of distributing awards to grantees was not consistent with program requirements that grant funds be directed to those programs that offer the greatest opportunity for addressing poverty needs in the communities. Second, once grant funds were awarded, the State did not have an effective monitoring program in place.

The OIG recommended that New Jersey establish a system that will fund only CSBG grantees who design programs with the most potential for reducing causes of poverty in communities being served and establish and implement formal policies to monitor and document the performance of grantees both through progress reports and through onsite monitoring visits.

The State concurred with OIG's findings and recommendations and has worked on strategies and systems to improve program monitoring and the effectiveness of services to clients and communities. (CIN: A-02-96-02003)

States' Allocation of Training Costs

The OIG's review of States' allocation of training costs charged to Federal programs covered procedures and practices used by four States--Michigan, Kansas, California and Washington. In each State reviewed, OIG identified problems with compliance with Federal reimbursement requirements to the extent that OIG is recommending that the States reimburse the Federal Government \$19.4 million in erroneous claims.

The OIG found that States charged training costs directly to the Federal programs instead of allocating portions of the cost to benefitting State programs; inappropriately claimed certain costs at the enhanced rate of 75 percent rather than the allowable rate of 50 percent; provided insufficient documentation to support those costs claimed at the enhanced rate; included two duplicate claims; used unallowable third-party contributions to meet matching requirements; claimed costs in excess of actual costs; and claimed unallowable costs for facilities, equipment and other miscellaneous items. In addition to Federal reimbursement, OIG recommended procedural changes to prevent recurrence of these inappropriate charges. (CIN: A-05-96-00043; CIN: A-07-97-01028; CIN A-09-96-00066; CIN: A-10-96-00004)

Financial Statement Audit of the Administration for Children and Families

Performance Measure

As part of its Departmentwide financial statement audit, OIG contracted for an audit of ACF's FY 1996 financial statements. The independent accounting firm qualified its opinion on the statements for several reasons. For instance, the fair presentation of grant receivables could not be determined because the range of possible audit disallowances reported in prior years, \$7.6 million to \$20.1 million, could affect the grant receivables balance. The firm also noted two material weaknesses: ACF does not reconcile grant advance records, which are maintained by the Department's Payment Management System, with its general ledger control account, and ACF does not accrue fourth quarter grant expenses.

Since the audit, the Department has developed a better system for charging grant advances. In addition, ACF has agreed to implement the recommendations for corrective action. (CIN: A-17-96-00002)

General Oversight

Chapter IV

GENERAL OVERSIGHT

Introduction

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

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

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from the Office of Management and Budget's (OMB's) designation of HHS as cognizant agency to audit the majority of the Federal funds awarded to major research schools, 104 State and local government cost allocation plans, and separate indirect cost plans of about 1,000 State agencies and local governments. Also, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG is responsible for auditing the Department's financial statements beginning with the FY 1996 statements.

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

Financial Statement Audit of the Department for Fiscal Year 1996

Performance Measure

As required by law, OIG made its first audit of the Departmentwide financial statements for FY 1996. This audit combined the results of individual audits of the operating agencies' financial statements and/or operations, which were summarized in previous chapters. Based on these results, OIG issued a disclaimer of opinion, which means that it was unable to express an opinion on the financial statements, primarily because documentation was not adequate or available to support the reported amounts. However, OIG did find a material instance of noncompliance; that is, an estimated 14 percent of Medicare fee-for-service payments did not comply with Medicare laws and regulations due to such errors as insufficient provider documentation, lack of medical necessity, incorrect coding, and noncovered or unallowable services. In addition, OIG noted the following material internal control weaknesses:

- The HCFA does not have a method for estimating the national error rate of improper Medicare fee-for-service payments.
- The Department lacks internal controls over grant accounting, including year-end grant accrual, reconciliation of grant advances, and a formal process to ensure all required single audits are timely submitted.
- Systemic weaknesses exist in controls for processing transactions affecting accounts payable and accounts receivable.
- The Department has systemic weaknesses in controls for processing transactions affecting the net position accounts.
- Controls for electronic data processing procedures contain systemic weaknesses.

Material weaknesses are those problems that are systemic across a number of operating agencies, as well as significant dollar issues affecting only one agency.

In response to OIG's recommendations for improving internal controls, the Department has developed a comprehensive corrective action plan to ensure financial discipline. The OIG believes that with the individual agencies' support, the Department can achieve the level of accuracy and reliability needed to make unqualified opinions a reality in future audits. (CIN: A-17-96-00001)

Reviews of Departmental Service Organizations

Performance Measure

Five HHS service organizations provide common accounting and administrative services to the individual operating agencies. During this reporting period, OIG contracted with independent accounting firms to review these organizations' internal controls, as discussed below. The results of these reviews were considered in OIG's audit of the HHS-wide financial statements.

A. Departmentwide Payroll System

This assessment determined that adequate controls were in place to ensure the reliability of financial information provided by the payroll system to the various HHS operating agencies. The HHS Program Support Center generally concurred with this conclusion, as well as with the recommendations. (CIN: A-17-96-00010)

B. Division of Computer Research and Technology

The National Institutes of Health's (NIH's) Division of Computer Research and Technology provides a variety of data processing services on a fee-for-service basis to NIH and other HHS agencies. The accounting firm concluded that the control structure policies and procedures were suitably designed and operating effectively but noted some deficiencies in physical security controls. (CIN: A-17-96-00013)

C. Division of Financial Operations

In addition to evaluating internal controls, the firm reviewed general computer application controls, program change controls, and security controls. The Division agreed with the recommendations for corrective action on four weaknesses that were noted. (CIN: A-17-96-00009)

D. Division of Payment Management

The Division of Payment Management in the Program Support Center serves as the fiscal intermediary between HHS agencies and their grant and contract recipients. The Division's Payment Management System processes about \$160 billion in payments to recipients each year. The accounting firm found that the control policies and procedures for this system were suitably designed and operating effectively. (CIN: A-17-96-00011)

E. Information Technology Services

Until July 1997, Information Technology Services (ITS) processed financial transactions for the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration and the Indian Health Service. In reviewing general computer controls and program change controls at ITS, the accounting firm noted four conditions that needed to be improved. The ITS generally agreed with the recommendations. (CIN: A-17-96-00012)

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 second half of FY 1997, OIG's National External Audit Review Center (located in Kansas City) reviewed over 2,000 reports that covered almost \$1.1 trillion in audited costs. Federal dollars covered by these audits totaled \$250.2 billion, about \$133.3 billion of which was HHS money.

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

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

A. Office of Inspector General's Proactive Role

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

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

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number (800-732-0679) and through training. During the past 6 months, 394 individuals were provided with technical assistance through OIG's toll free number. In addition, formal training was provided to certified public accountant societies and State auditor staff on issues related to Circular A-133.
- The OIG is also very much involved with OMB and the American Institute of Certified Public Accountants in developing authoritative guidance for nonfederal auditors.

B. Quality Control

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

Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 2,031 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,792
Reports issued with major changes	6
Reports with significant inadequacies	<u>233</u>
Total audit reports processed	2,031

The 2,031 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling \$43.2 million as well as 4,184 recommendations for improving management operations. In addition, these audit reports provided information for 76 special memoranda which identified concerns for increased monitoring by departmental management.

Resolving Office of Inspector General Recommendations

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

A. Questioned Costs

The following chart summarizes the Department's responses to OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs which are challenged because of a violation of law, regulation, grant, etc. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and the Inspector General Act Amendments of 1988. These costs are separate from the amount ordered or returned as a result of OIG investigations (see page 69).

**TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS**

	<u>Number</u>	<u>Dollar Value</u>	
		<u>Questioned</u>	<u>Unsupported</u>
A. For which no management decision had been made by the commencement of the reporting period ¹	396	\$317,719,000	\$26,537,000
B. Which were issued during the reporting period	<u>164</u>	<u>\$123,076,000</u>	<u>\$11,250,000</u>
Subtotals (A + B)	560	\$440,795,000	\$37,787,000
Less:			
C. For which a management decision was made during the reporting period ² :	208	\$74,522,000	\$13,233,000
(i) dollar value of disallowed costs		\$62,407,000	\$6,570,000
(ii) dollar value of costs not disallowed		\$12,115,000	\$6,663,000
D. For which no management decision had been made by the end of the reporting period	352	\$366,273,000	\$24,554,000
E. For which no management decision was made within 6 months of issuance ³	193	\$142,976,000	\$13,307,000

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	28	\$147,210,000
B. Which were issued during the reporting period	<u>23</u>	<u>\$3,154,660,000</u>
Subtotals (A + B)	51	\$3,301,870,000
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management		
(a) based on proposed management action	19	\$3,269,749,000
(b) based on proposed legislative action		
Subtotals (a+b)	19	\$3,269,749,000
(ii) dollar value of recommendations that were not agreed to by management	<u>1</u>	<u>\$64,000</u>
Subtotals (i + ii)	20	\$3,269,813,000
D. For which no management decision had been made by the end of the reporting period ²	31	\$32,057,000

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. Legislative and Regulatory Development Functions

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

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

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

The OIG promulgated interim final regulations (61 FR 7350) establishing a new 42 CFR part 1008 to address the OIG advisory opinion process. In accordance with section 205 of HIPAA, these final regulations set forth the specific procedural aspects under which OIG receives and responds to advisory opinion requests from outside parties and, in consultation with the Department of Justice, will issue advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to the Medicare and State health care programs. The OIG is currently developing a revised final rule on the advisory process that will respond to all relevant public comments received in response to the interim final rule.

■ OIG Final Rule: Revised Peer Review Organization Sanctions for Failing to Meet Statutory Obligations

Final regulations were also promulgated in accordance with sections 214 and 231(f) of HIPAA on revised peer review organization (PRO) sanctions for failing to meet statutory obligations (62 FR 23140). The final regulations addressed revised OIG procedures governing the imposition and adjudication of program sanctions based on recommendations from a State PRO. Specifically, these regulations revised 42 CFR part 1004 with regard to: the determination of "unwillingness or inability" of a practitioner or other person who fails to comply with statutory obligations, the establishment of a minimum period of exclusion,

and a revised monetary penalty amount that may be imposed for each instance of medically improper or unnecessary services provided.

■ Additional Regulatory Activity

In addition, through Secretarial charter, OIG published a Federal Register notice (62 FR 28410) establishing a negotiated rulemaking committee designed to address the shared risk exception in accordance with section 216 of HIPAA. The Department's interests on the committee are represented directly by OIG; other committee members consist of representatives of outside interests that are likely to be significantly affected by the interim rule. The committee's purpose is to negotiate the development of interim final regulations addressing the shared risk exception to the Federal health care programs' anti-kickback provisions.

Further, OIG continues to develop proposed regulations in accordance with HIPAA provisions designed to broaden the scope and basic fraud authorities that strengthen OIG's exclusion and civil money penalty authorities in a number of areas.

C. Congressional Testimony and Hearings

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

Nationwide Audit of Training Contract and Administrative Costs

This report provides a summary of the results of OIG's nationwide audit of training contract and administrative costs charged to HHS supported programs in the States of New York, Illinois, California, Missouri, Oklahoma, Florida and New Jersey. Collectively, these States claimed approximately \$310 million in training costs during the audit periods.

The primary objective of the audits performed in the States, other than New York, was to determine if some or all of the conditions found during OIG's earlier reviews of training practices in New York also existed in other States. Overall, OIG found that improper practices for identifying and charging training and administrative costs existed to some extent in all seven States reviewed. As a result, OIG recommended financial adjustments totaling over \$58 million (nearly \$37 million Federal share), \$37 million of which related to New York State.

In responding to the draft report, ASMB substantially agreed with OIG's findings and offered comments and corrective actions it anticipated taking in the future. Moreover, ASMB concurred with OIG's recommendations and indicated that it would take appropriate action to not only notify operating agencies of the report findings but also coordinate efforts to periodically review future training expenditures. (CIN: A-02-95-02002)

Governmental Accounting

Each year, State and local government entities receive about \$200 billion for administration of Federal grants and associated activities. As part of its Governmentwide cognizance responsibilities as defined in OMB Circular A-87 to ensure that administrative costs are being charged in accordance with the appropriate statewide cost allocation plans, OIG has continued its efforts to identify cost containment areas and/or areas where costs are being inappropriately charged.

A. Impact of Change in Reporting Criteria on State Pension Plans

The OIG, during its review of the Delaware public employee retirement pension plan, noted that the change in the allowed method of reporting pension costs had a significant impact on the financial position of the State's plan. Delaware's use of the recently authorized Government Accounting Standards Board (GASB) Statements 25 and 26 resulted in its pension plan showing an underfunding of \$17 million as of June 30, 1996. However, OIG notes, had the State applied the previous reporting criteria (GASB Statement 5), the Delaware plan would have shown an overfunding of \$712 million for the same time period. This "swing" of \$729 million has a significant impact on the Federal Government since it is the source of about 20 percent of funding of States' pension plans.

The OIG reported these findings to ASMB. The Department has reported these findings to the Office of Management and Budget. (CIN: A-03-97-00455)

B. Illinois Pension Costs

The OIG's review of Illinois' pension contributions charged to Federal programs identified overcharges of almost \$1.1 million over a 2-year period. The State's pension funds were appropriated at a rate lower than needed to meet the actuarially determined contribution rate. As a result, funding available to meet the State's pension costs for some agencies was exhausted prior to the end of the fiscal year. Once the appropriated funds were exhausted, the agencies stopped remitting the State's share of pension costs to its retirement system, while the Federal share was remitted and claimed for reimbursement. This is contrary to Federal requirements that pension costs be uniformly charged to both federally assisted and other activities. In addition, OIG identified undercharges to State programs by two State agencies totaling over \$516,000. Recommendations call for the State to either refund the net overcharges or eliminate the net shortfall by obtaining additional funding. (CIN: A-05-96-00056)

Financial Management of University Recharge Centers

Recharge centers at universities typically include such facilities as motor pools, computer centers or supply stores. They provide goods and services to users, including federally sponsored agreement holders, and then charge the costs to the users. The costs charged to Federal grants and contracts by the recharge centers must meet the requirements of Office of Management and Budget (OMB) Circular A-21.

In assessing the centers' financial management at 15 universities, OIG found that inadequate policies and controls had resulted in \$1.9 million in overcharges to the Federal Government. These overcharges related to 21 of the 87 centers reviewed. Specifically, the centers accumulated surplus fund balances and deficits that were not used in computing subsequent billing rates; overstated billing rates and inequitably billed users; and used fund balances inappropriately to calculate facilities and administrative cost rates. Because unclear guidance in OMB Circular A-21 may have contributed to some of these problems, OIG believes that the circular should be revised to include criteria on developing and reviewing billing rates and on accounting for and applying surplus deficit balances. The Department agreed with this recommendation, as did the Council on Government Relations, which comprises 140 research-intensive universities. (CIN: A-09-96-04003)

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 102 successful criminal actions. Also during this period, 793 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 156 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over \$147 million was ordered or returned as a result of OIG investigations during this semiannual period. Civil settlements from investigations resulting from audit findings are included in this figure.

Program Fraud Civil Remedies Act

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

reporting at the end of each fiscal year on investigations completed under PFCRA and referred for administrative action.

During FY 1997, no settlements were made under PFCRA. While all cases are routinely analyzed for potential action under PFCRA, the availability of OIG's CMP authorities in health care matters often renders PFCRA unnecessary. Also, PFCRA cannot be applied to many of the grants administered by HHS, since these grants often exceed the financial limits of PFCRA.

Appendices

APPENDIX A

Savings Achieved As a Result of Office of Inspector General Audits, Investigations and Inspections April 1997 through September 1997

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

Legislative savings are annualized amounts based on Congressional Budget Office estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected or for multiple years, if applicable. Total savings from these sources amount to \$3,857.1 million for this period.

OIG Recommendation	Implementing Action	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Medicare Laboratory Reimbursements: The Medicare fee schedule allowances for clinical laboratory tests should be brought in line with the prices physicians are paying for tests purchased from independent laboratories. (OAI-02-89-01910; CIN: A-09-89-00031)	Section 13551 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 reduced the national cap to 76 percent of the median of all fee schedules, and froze the annual update for 1994 and 1995.	\$919
Medicare Secondary Payer - Blue Cross and Blue Shield Association: The HCFA should negotiate a reasonable settlement to recover the sums improperly paid by HCFA contractors for which Medicare should have been the secondary payer. (CIN: A-02-93-01006)	The Blue Cross and Blue Shield Association agreed to a global settlement with the Department of Justice and HCFA to settle disputes over Medicare secondary payer (MSP) claims. In addition to the \$115 million the Blue Cross Association immediately refunded HCFA, as part of the settlement, the Association implemented a 3-year data exchange agreement with HCFA that is expected to result in savings of \$720 million in Fiscal Year 1997 for a 3-year total savings of \$920 million.	720

OIG Recommendation	Implementing Action	Savings in Millions
<p>Disproportionate Share Hospitals: Disproportionate share payments to hospitals should be related to costs incurred in treating Medicaid and indigent patients to correct the inequities and abuses in current payment methodologies. (CIN: A-06-90-00073)</p>	<p>Section 13621 of OBRA 1993 prohibited designation of a hospital as a disproportionate share hospital (DSH) for purposes of Medicaid reimbursement unless the hospital has a Medicaid inpatient utilization rate of at least one percent. It also limited DSH payment adjustments to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients less payments received from Medicaid (other than DSH payment adjustments) and uninsured patients.</p>	<p>\$650</p>
<p>Capital-Related Costs of Inpatient Hospital Services: Extend congressionally mandated reductions in hospital costs. (CIN: A-09-91-00070)</p>	<p>Section 13501(a)(3) of OBRA 1993 mandated reduction of 7.4 percent for inpatient capital costs.</p>	<p>486</p>
<p>Medicare Secondary Payer - Initial Enrollment Questionnaire: The Health Care Financing Administration (HCFA) should take steps to collect primary insurance information in a more timely and accurate manner, requiring beneficiaries to disclose other health insurance information, and should revise all Medicare claims forms to require spousal information before claims can be paid. (CIN: A-09-89-00100; OEI-07-90-00760)</p>	<p>Since 1995, all Medicare beneficiaries are being asked to complete the Initial Enrollment Questionnaire and list any other health insurance they have. The HCFA has reported that two-thirds of all new beneficiaries are voluntarily completing the questionnaire and this has helped HCFA document 110,000 cases each year in which new beneficiaries have other coverage.</p>	<p>425</p>
<p>Medicaid Transfer of Assets: Strengthen the transfer of asset rules so that people cannot give away property to qualify for Medicaid. Assets and income from special needs trusts should be counted for Medicaid qualifying purposes and be subject to third party liability recovery. (OAI-09-86-00078; CIN: A-09-93-00072)</p>	<p>Section 13611 of OBRA 1993 provided for a delay in Medicaid eligibility for institutionalized individuals or their spouses who dispose of assets for less than fair market value on or after a specified look-back date; set forth rules under which funds and other assets of an individual placed in trust by or on behalf of an individual or the spouse are treated, for purposes of Medicaid eligibility, as resources available to the individual, and under which payments from the trust are to be considered assets disposed of by the individual; and specified that, for purposes of applying the transfer of asset prohibitions, the look-back period with respect to trusts is 60 months.</p>	<p>200</p>
<p>Capital-Related Costs of Outpatient Hospital Services: Extend congressionally mandated reductions in hospital costs. (CIN: A-09-91-00070)</p>	<p>Section 13521 of OBRA 1993 mandated reduction of 10 percent for outpatient hospital costs.</p>	<p>150</p>

OIG Recommendation	Implementing Action	Savings in Millions
<p>Medicare Secondary Payer - Data Match: Extend MSP data match beyond the OBRA 1989's sunset date. (OEI-07-90-00760; CIN: A-09-89-00100)</p>	<p>Section 13561(a) of OBRA 1993 extended the MSP data match through 1998.</p>	<p>\$120</p>
<p>Ambulance Services for Medicare End Stage Renal Disease Beneficiaries: The HCFA should ensure fairer payment for services rendered, and ensure that claims meet Medicare coverage guidelines. (OEI-03-90-02130; OEI-03-90-02131)</p>	<p>A set of proposed national codes for use by carriers was developed in January 1994, and a program memorandum was finalized and distributed a year later for January 1995 implementation.</p>	<p>55.4</p>
<p>Ultrasound: The HCFA should prohibit payment for tests conducted with pocket dopplers, and advocate revisions in procedure codes and reimbursement rates to reflect the different levels of sophistication and quality of the diagnostic information provided. (OEI-03-88-01401; OEI-03-91-00460; OEI-03-90-00461)</p>	<p>The HCFA issued an instruction prohibiting separate payments for tests conducted with pocket dopplers and revised the Physician's Procedural Coding handbook to revise imaging codes for hand-held ultrasound devices.</p>	<p>5.9</p>
<p>Medicare Payments for Home Blood Glucose Monitors: The HCFA should ensure that Medicare payments for monitors are net of any available rebates. (CIN: A-09-92-00034)</p>	<p>The HCFA issued final regulations on the fee schedule for home blood glucose monitors. These regulations refer to the OIG report for support of fee schedule changes.</p>	<p>5</p>
GENERAL OVERSIGHT		
<p>Preaward Audits: The OIG reviewed contract proposals and contract extensions and provided contracting officials at HCFA and the Public Health Service with reports documenting questioned costs and unsupported costs. (Various CINs)</p>	<p>Contracting officials used OIG recommendations to negotiate contracts at significantly lower rates than originally proposed.</p>	<p>12.8</p>

Special Initiatives	Implementing Action	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		

Incontinence Supplies:

Information from OIG inspections indicated that suppliers engaged in questionable marketing practices and that beneficiaries were receiving unnecessary or noncovered incontinence supplies. A joint OIG/HCFA effort to address this problem resulted in the initiation of an OIG review of this area and a national investigation examining potentially fraudulent practices by specific suppliers. In addition to issuing reports, OIG dramatized the problem in speeches and congressional testimony. The OIG issued fraud alerts on this topic in December 1994 and August 1995. As a result of OIG investigations, approximately \$50.2 million was recovered through seizures and restitutions from abusive providers, further highlighting the intensity of the OIG/HCFA initiative. In these ways, OIG supported ongoing activity in HCFA and the durable medical equipment regional carriers (DMERCs) to control Medicare outlays for these supplies and equipment. (OEI-03-94-00770; OEI-03-94-00772; OEI-03-94-00773)

The DMERCs issued single national coverage guidelines in October 1995 and educated providers about proper billing. Since the initiative began in 1994, Medicare payments dropped by \$110 million a year, of which \$104 million in 1996 was directly attributable to the problems discussed in the OIG reports.

\$108

APPENDIX B

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

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

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

OIG Recommendation	Status	Savings in Millions
<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 any adjustment factor is warranted for all teaching hospitals. (CIN: A-07-88-00111)</p>	<p>The Balanced Budget Act of 1997 reduces the IME adjustment factor from the current 7.7 percent in Fiscal Year (FY) 1997 down to 5.5 percent in 2001 and thereafter.</p>	\$900
<p>Reduce Hospital Capital Costs: Seek legislative authority to continue mandated reductions in capital payments beyond FY 1995. The HCFA should determine the extent of the capital reductions that are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070; CIN: A-14-93-00380)</p>	<p>Although the Balanced Budget Act of 1997 reduces capital payments, it does not include consideration of excess bed capacity.</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>Medicare Secondary Payer - End Stage Renal Disease Time Limit: Extend the Medicare secondary payer (MSP) provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016)</p>	<p>The Balanced Budget Act of 1997 contains a provision to extend MSP policies for individuals with ESRD to 30 months. Notwithstanding this provision, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until such time as the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.</p>	503

OIG Recommendation	Status	Savings in Millions
<p>Home Health Agencies: The HCFA should consider alternatives in restructuring the home health reimbursement methodology, emphasize the definition of homebound, revise Medicare regulations to require the physician to examine the patient before ordering home health services and require intermediaries to implement additional procedures for focused medical reviews. The HCFA also needs to develop and implement program safeguards to strengthen its ability to identify problem providers, prevent problem home health agencies from entering the program and prevent the Medicare trust fund from incurring further losses due to problem providers. In addition, HCFA should consider options to restructure the benefit to prevent fraud, waste and abuse. (CIN: A-04-95-01103; CIN: A-04-95-01104; CIN: A-04-95-01103; OEI-04-93-00262; OEI-04-93-00260; OEI-12-94-00180; OEI-02-94-00170, CIN: A-04-94-02087; CIN: A-04-94-02078; CIN: A-04-96-02121; OEI-09-96-00110)</p>	<p>The Balanced Budget Act of 1997 includes provisions to restructure home health benefits. Also, many provisions of the Administration's Medicare and Medicaid Fraud, Abuse and Waste Prevention Amendments of 1997 will strengthen HCFA's ability to address OIG concerns. However, to prevent abusive practices, HCFA needs to revise Medicare regulations to require the physicians to examine Medicare patients before ordering home health services and to re-educate physicians on home health eligibility requirements.</p>	<p>\$500</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 (PPS) hospitals which are profitable, and the inclusion of a bad debt factor in the diagnosis related group (DRG) rates. The HCFA should seek legislative authority to further modify bad debt policies. (CIN: A-14-90-00339)</p>	<p>The Balanced Budget Act of 1997 provides for some reduction of bad debt payments to providers. However, additional legislative changes are needed to implement the modifications that OIG recommended.</p>	<p>487.7</p>
<p>Flexible Benefit Plans: The value of flexible benefit plans, as defined by section 125 of the Internal Revenue Code, should be included in the hospital insurance portion of the Federal Insurance Contributions Act taxable wage base. (CIN: A-05-93-00066)</p>	<p>While HCFA agreed with the report findings related to revenue to the Hospital Insurance Trust Fund, a legislative proposal has not been included in the President's budgets.</p>	<p>420</p>
<p>Prospective Payment System's Capital Cost Rates: The HCFA should consider reducing payment rates by 7.5 percent to more accurately reflect costs of the base year used for the capital cost component of PPS, and continue to monitor the most current data and make any necessary further adjustments to the base rate. (CIN: A-07-95-01127)</p>	<p>The Balanced Budget Act of 1997 provides for a reduction in capital payments for 1998-2002. However, additional reductions may be warranted in the future.</p>	<p>249</p>

OIG Recommendation	Status	Savings in Millions
<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 OIG's follow-up report (CIN: A-05-92-00006) indicated that problems still exist with inappropriate admissions and that the volume of 1-day admissions on a national basis have increased approximately 150 percent over 1985 levels. The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's current budget.</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 Balanced Budget Act of 1997 contains provisions to slow the growth in Medicare spending in GME.</p>	157.3
<p>Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 chemistry 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. In November 1995, HCFA updated its carrier manual adding three of the tests recommended in the OIG report. A legislative proposal to add tests was not included in the President's FY 1998 Medicare savings package.</p>	130
<p>Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing and begin to plan now for the policy changes that will become necessary to achieve an almost completely paperless environment for processing Medicare claims. (CIN: A-05-94-00039; OEI-01-94-00230)</p>	<p>The HCFA concurred with OIG's recommendations. However, with respect to the policy options suggested, HCFA believes that mandating paperless claims is impractical.</p>	126
<p>Medicaid Drug Rebate Program: Best price calculation in the Medicaid drug rebate program should be indexed in a manner similar to the average wholesale price, which is indexed to the consumer price index-urban. (CIN: A-06-94-00039)</p>	<p>The OIG is continuing its review of the Medicaid drug rebate program.</p>	123

OIG Recommendation	Status	Savings in Millions
<p>Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The fiscal intermediaries should recover improper payments made to hospitals for nonphysician outpatient services (such as diagnostic tests and laboratory tests) rendered within 72 hours of the day of an inpatient admission, and refund the beneficiaries' coinsurance and deductible related to these payments. The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)</p>	<p>The HCFA agreed to recover the improper billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and OIG. The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's current budget.</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 190-day lifetime limit for psychiatric hospitals be extended to general hospitals; however, such a proposal was not included as part of the President's current budget.</p>	47.6
<p>Generic Drugs: The HCFA should identify and alert States to methods which would encourage the use of lower priced generic drug products in the Medicaid program. The HCFA should also take a more active role to encourage States to use generic drugs; provide stronger incentives for States to adopt policies that encourage use of generic drugs; monitor the States' efforts to encourage the use of lower priced drugs; and formally assess those activities. (CIN: A-06-93-00008)</p>	<p>The HCFA has provided a copy of the OIG report to States and encouraged them to use lower priced generic products. On February 2, 1996, States were requested to provide a description of any policies adopted that encourage use of equivalent generic drugs. This information is included in the 1995 State Drug Utilization Review Annual Report which was due to regional offices by June 30, 1996.</p>	46
<p>Medicaid Payments for Employer Group Health Insurance: The HCFA should continue to strongly support States implementing Section 1906 of the Social Security Act, and should propose legislation that allows States to pay employer group health plan (EGHP) deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules. (OEI-04-91-01050)</p>	<p>The HCFA concurred with the first recommendation and has been working in partnership with regional offices and States to promote full implementation. The HCFA deferred comment on the second recommendation.</p>	32
<p>Establish Medicaid Credit Balance Reporting : The HCFA should establish and monitor a national Medicaid credit balance reporting mechanism similar to the Medicare Part A credit balance reporting procedures. (CIN: A-05-93-00107; CIN: A-04-92-01023)</p>	<p>The HCFA agreed to establish a national reporting system; however a follow-up audit indicates that Medicaid credit balances continue to exist.</p>	25

OIG Recommendation	Status	Savings in Millions
<p>Reduce End Stage Renal Disease Rates: The HCFA should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)</p>	<p>The HCFA agreed that ESRD facilities have become more efficient in their operations and that the composite payment rate should reflect the costs of outpatient maintenance dialysis treatment in an efficiently operated facility. While the Omnibus Budget Reconciliation Act of 1990 prohibited HCFA from changing the ESRD composite rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatments. The study undertaken by ProPAC was presented to the Congress in March 1996 and recommended an increase to the current rates.</p>	\$22*
<p>Preclude Improper End Stage Renal Disease Payments to Health Maintenance Organizations: The HCFA should advise all risk-based health maintenance organizations (HMOs) and comprehensive medical plans that ESRD capitation rates are only effective for beneficiaries who currently are diagnosed as having ESRD; identify and recover all payments to HMOs and comprehensive medical plans for beneficiaries misclassified as having ESRD; and make systemic and procedural changes to prevent future overpayments. (CIN: A-04-94-01090; CIN: A-14-96-00203)</p>	<p>The HCFA agreed with OIG's findings and recommendations. The systems changes were implemented in August 1996. The HCFA continues to recoup improper payments.</p>	20.5
<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; and allowing for higher beneficiary cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800)</p>	<p>The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. It plans to solicit information from States implementing cost sharing and distribute it to States that do not impose it. Several States have submitted waiver applications to HCFA to develop demonstration projects which include experimental cost sharing provisions.</p>	19.8

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

OIG Recommendation	Status	Savings in Millions
<p>Minimize Incorrect Payments for Durable Medical Equipment Billed During Skilled Nursing Facility Stays</p> <p>The HCFA should minimize the opportunity for incorrect durable medical equipment (DME) payments by: improving the place of service coding system; improving the supplier knowledge of beneficiary location; reviewing the DME regional carriers' processes; and improving processes for identifying skilled nursing facilities for DME reimbursement purposes. (OEI-06-92-00860; OEI-06-92-00862; OEI-06-92-00865)</p>	<p>The HCFA has developed proposed regulations to address OIG's recommendations. They are currently undergoing departmental review and clearance.</p>	\$19
<p>Reduce Medicare Part B Payment for Enteral Nutrition at Home</p> <p>Reduce payments through competitive acquisition strategies for patients receiving enteral nutrition at home. (OEI-03-94-00021)</p>	<p>A plan for a DME competitive bid demonstration that includes enteral nutrition is underway. Section 4551(b) of the Balanced Budget Act of 1997 freezes Medicare payments for parenteral and enteral nutrition, equipment and supplies for 1998 through 2002.</p>	15
<p>Preclude Improper Medicaid Reimbursement for Clinical Laboratory Services:</p> <p>State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings which contain duplicate tests, recover overpayments and make adjustments for the Federal share of the amounts recovered. (CIN: A-01-95-00005; CIN: A-05-96-00031; CIN: A-01-96-00001; CIN: A-06-95-00078; CIN: A-04-95-01108; CIN: A-07-95-01139; CIN: A-07-95-01147; CIN: A-04-95-01113; CIN: A-07-95-01138; CIN: A-09-95-00072; CIN: A-05-96-00019; CIN: A-10-95-00002)</p>	<p>The HCFA is evaluating the OIG results.</p>	14
<p>Nonemergency Advanced Life Support Ambulance Services:</p> <p>The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513; CIN: A-01-94-00528)</p>	<p>The HCFA issued a proposed regulation in June 1997 that would shift the policy focus away from the type of vehicle used and towards the medical condition of the beneficiary.</p>	12.8

OIG Recommendation	Status	Savings in Millions
Medicare Payments for Orthotic Body Jackets:	The HCFA concurred and has instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices. However, payments continue at high levels. The OIG plans to revisit this issue as part of an ongoing study on orthotics.	\$10.4
Medicare Claims for Railroad Retirement Beneficiaries:	While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.	9.1
Limit Reimbursement for Hospital Beds:	The HCFA awarded a demonstration project on this subject in 1996. The project is expected to run in at least three sites for two cycles of 2 years each beginning in January 1997. The Balanced Budget Act of 1997 requires the Secretary to conduct a competition among individuals and entities supplying Part B items and services. However, only oxygen and oxygen equipment were specifically mentioned for one of the five demonstration projects.	6.2
Third Party Liability Settlements and Awards:	The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g. health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements.	3
Hospital General Administrative and Fringe Benefit Costs:	The HCFA has published changes to the PRM to clarify the allowability of several of the cost categories identified in OIG's report. The HCFA has not yet clarified the remaining cost categories noted in OIG's report.	to be determined

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 is precluded by statute from imposing user fees to cover additional functions.	\$44.4
Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)		
Medical Malpractice Coverage:	The HRSA has drafted a legislative proposal to amend the Federal Tort Claims Act to include the \$1 million limitation.	10
The Health Resources and Services Administration (HRSA) should consider seeking a legislative proposal to limit malpractice settlements or judgments involving community and migrant health centers to \$1 million. (CIN: A-04-95-05018)		
Recharge Center Costs:	The Assistant Secretary for Management and Budget concurred with the recommendations and has recommended to OMB that Circular A-21 be revised to provide more definitive guidance on the financial operations of recharge centers.	3.2
Universities should: improve their oversight of recharge centers; develop and implement policies and procedures for the operation of recharge centers that are consistent with Office of Management and Budget (OMB) Circular A-21; establish and maintain adequate accounting and recordkeeping procedures for recharge centers; and analyze and adjust billing rates to eliminate deficit and surplus funds. (CIN: A-09-92-04020)		
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Limit Federal Participation in States' Costs for Administering the Foster Care Program:	This proposal was not included in the President's current budget.	247
Limit Federal participation in foster care administrative costs through one of the following actions: limit future increases in administrative costs to no more than 10 percent per year; fund administrative activities via a single block grant with future increases based on the consumer price index; limit administrative costs to a percentage of maintenance payments; or restrict, through legislation, the filing period for retroactive claims, namely require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. (CIN: A-07-90-00274; OEI-05-91-01080)		

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 predetermined numbers of years. (CIN: A-12-92-00014)

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

\$660

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

OIG Recommendation

Status

HEALTH CARE FINANCING ADMINISTRATION

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

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

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

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

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

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

Medicare Trust Funds' Accounts Receivable Balances:

The HCFA and its Medicare contractors need an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information. Also, HCFA should retain proper documentation to support the reported balances and should strengthen internal controls on segregation of duties. (CIN: A-01-92-00516; CIN: A-01-94-00520; CIN: A-17-94-03032; CIN: A-17-95-00051; CIN: A-17-95-00096)

The HCFA agreed with the recommendations and is pursuing methods to substantiate the Medicare contractors' accounts receivable balances.

OIG Recommendation	Status
<p>Improve Financial Management Systems to Enhance Financial Reporting:</p> <p>The HCFA should develop and implement financial management systems and related accounting and administrative internal controls to ensure that all Medicare accounts payable and liabilities are reported to the HCFA general ledger at fiscal year end. (CIN: A-14-92-03015; CIN: A-14-93-03027; CIN: A-17-94-03032; CIN: A-17-95-00051; CIN: A-17-95-00096)</p>	<p>The HCFA is working with the contract actuaries to develop an improved methodology for estimating Medicare payables and a procedure for validating estimates. The HCFA is also asking the Medicare contractors to review their internal controls, particularly in the area of financial reporting. The long-term objective is implementation of a double entry accounting system, standardization of the reporting process and shared systems, and automation of the reporting process. On August 15, 1997, HCFA terminated the contract with the design contractor for development of the Medicare transaction system (MTS). The HCFA is assessing its future actions.</p>
<p>Consider Recommended Safeguards over Medicaid Managed Care Programs:</p> <p>The HCFA should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)</p>	<p>The HCFA generally concurred with OIG's recommendations but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.</p>
<p>Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program:</p> <p>The HCFA should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The HCFA should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)</p>	<p>The HCFA did not concur stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP but did not provide specific written methodology for computing AMP.</p>
<p>Physician Office Surgery:</p> <p>The PROs should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)</p>	<p>The HCFA continues to work with the PROs to refine a methodology for review of quality of care for ambulatory services. The implementation plan is to expand the review of ambulatory services to additional States, first on a pilot basis, then on an implementation basis in other States.</p>
<p>Patient Advance Directives - Early Implementation Experience:</p> <p>The HCFA should develop and issue specific regulatory guidelines clarifying acceptable documentation methods to assist providers in meeting the requirements of the Federal statute. The statute requires providers to inform individuals of any rights they have under State law regarding self-determination. (OEI-06-91-01130)</p>	<p>The HCFA did not concur with the recommendation, but is willing to provide assistance to States by issuing interpretive guidelines for survey and certification containing examples of what would constitute acceptable documentation of whether a patient has an advance directive.</p>
<p>Implementing the New Medicare Transaction System:</p> <p>The HCFA should take steps early to ensure that the new nationwide Medicare claims processing system, MTS, is designed to assure flexibility and adaptability to meeting future program requirements. (CIN: A-14-93-02543)</p>	<p>The HCFA concurred with OIG's recommendations. However, on August 15, 1997, HCFA terminated the contract with the design contractor for development of MTS. The HCFA is assessing its future actions.</p>

OIG Recommendation	Status
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Review Determinations of Graduate Medical Education Costs:

The HCFA should take steps to ensure that fiscal intermediaries audit teaching hospitals' full-time equivalent resident counts for the base year used in determining graduate medical education (GME) payments. (CIN: A-06-94-00059)

The HCFA concurred with the recommendation but noted that currently Medicare GME payments are not tied to reported costs, which may affect the accuracy of such costs.

Properly Account for Medicare Secondary Payer Overpayments:

Although agreement was reached to relieve Blue Cross and Blue Shield plans of past due Medicare secondary payer (MSP) overpayments, HCFA should continue to implement financial management systems to ensure that all overpayments (receivables) are accurately recorded. (CIN: A-09-89-00100; OEI-07-90-00763)

The HCFA is currently pursuing the recommended administrative action through improved information systems to guard against making improper Medicare payments to the Blue Cross and Blue Shield plans.

Investigate Patient Dumping Complaints:

The HCFA should improve its processes for investigating and resolving complaints involving potential violations of the Examination and Treatment for Emergency Medical Conditions and Workmen in Labor Act, commonly referred to as patient dumping. (CIN: A-06-93-00087)

The HCFA concurred with OIG's recommendations.

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Improve Blood Establishments' Errors and Accidents Reporting:

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

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

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.

Improve Oversight of Audits of Office of Community Service Grantees:

The ACF should track Office of Community Services grantees' implementation of recommendations made as a result of single audits, and follow up with grantees to ensure actions taken were effective. (CIN: A-12-92-00043)

The ACF agreed and will take steps to implement the recommendations within the limitation of current staffing resources.

OIG Recommendation	Status
<p>Strengthen State Practices Relating to Wage Withholding for Child Support Collections:</p> <p>The ACF, in consultation with State agencies, should request all U.S. jurisdictions to adopt standardized formats and language in court order forms used by State child support agencies. (CIN: A-09-12-91-00016)</p>	<p>The ACF is in the process of implementing this recommendation and has already implemented others.</p>
<p>Develop Effective Practices for Facility Purchases by Head Start Grantees:</p> <p>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)</p>	<p>The ACF agreed with OIG’s recommendations.</p>
<p>Colocating Intergenerational Programs:</p> <p>The Administration on Aging (AoA) and ACF should examine whether demonstrated successes in colocating programs and facilities in the private and public sector can be more broadly applied to departmental programs on a voluntary basis. (CIN: A-05-94-00009)</p>	<p>The AoA and the U.S. Department of Agriculture (USDA) generally agreed to address these issues through joint efforts; however, they pointed out the problems with colocation and the difficulties States experience with commodities. The AoA and USDA will coordinate in improving the administration of the program.</p>
<p>Improving Administration on Aging’s Nutrition Program for the Elderly:</p> <p>The AoA and the Department of Agriculture (USDA) should remove barriers to increase States’ use of commodities by fostering better communications and working relationships with State distribution agencies which handle USDA commodities; assuring a better variety of commodities; and improving dependability, quality and packaging of commodities. (CIN: A-01-93-02510)</p>	<p>The AoA and USDA generally agreed to address these issues through joint efforts.</p>
<p>Coordination of Specialized Transportation Services:</p> <p>The AoA needs to actively promote transportation consortiums, and provide the assistance needed by State agencies and local providers to promote improvements in coordinated transit systems. It should continue its work with other Department of Health and Human Services (HHS) agencies and Federal Departments to promote further development of coordinated transportation systems for the elderly, persons with disabilities and others in need of services. (CIN: A-05-95-00023)</p>	<p>The AoA concurred with the OIG recommended actions to increase implementation of coordinated transportation services nationwide. The AoA will work with the Joint Department of Transportation/HHS Coordinating Council to develop a strategic plan for improving transportation services.</p>
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 intends to begin work on revising hospital cost principles when the revisions of the Governmentwide cost principles for universities and State and local governments (OMB Circulars A-21 and A-87, respectively) are finalized by OMB.</p>

OIG Recommendation	Status
<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, and agreed that similar provisions should be incorporated in future modifications of circulars applicable to educational institutions and nonprofit organizations (OMB Circulars A-21 and A-122, respectively). In the interim, the Department has issued instructions to negotiators that PRB costs claimed under Circulars A-21 and A-122 should be treated in the same manner as the proposed provisions of Circular A-87.</p>
<p>Implement Random Moment Sampling Systems and Other Time Studies:</p> <p>The Department, in conjunction with OMB, should issue definitive, authoritative guidelines for States adopting random moment time studies. (CIN: A-07-93-00645)</p>	<p>The Department agreed with OIG’s conclusion and is working with OMB to develop guidelines related to the determination of administrative costs, including standards for using random moment time studies.</p>

APPENDIX D

Notes to Tables I and II

Table I

¹ The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of \$127.5 million.

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

CIN: A-02-87-05506	Virgin Island Commission on Aging: The Administration on Aging reduced the previously disallowed costs because additional documentation was provided for \$8,652,063
CIN: A-04-94-01090	End Stage Renal Disease Status Beneficiaries: HCFA determined that estimated overpayments were overstated by \$7,700,000
CIN: A-05-90-00010	Blue Cross/Blue Shield of Wisconsin: In depth analysis and negotiations determined that BC/BS owed an additional \$93,701

Not detailed are revisions to previously disallowed management decisions totaling \$191,081.

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

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

CIN: A-03-91-00552	Independent Living Program - National, March 1993, \$6,529,545 (Related recommendation of \$10,161,742 outstanding on Table II)
CIN: A-07-92-00578	Blue Cross/Blue Shield of Texas Incorporated - Unfunded Pension Costs, October 1992, \$6,244,637
CIN: A-03-89-00046	Maryland Blue Cross/Blue Shield Part B Administrative Costs for Fiscal Years 1985-1988, September 1991, \$5,996,278
CIN: A-05-96-00013	Illinois Department of Family Services Title IV-E Training Cost Allocation, August 1996, \$5,812,360
CIN: A-07-96-02001	Medicare Part B Administrative Costs at Blue Cross/Blue Shield of Colorado, December 1996, \$4,483,104
CIN: A-07-95-01010	Review of Missouri Title IV-E Claims, February 1996, \$4,246,295
CIN: A-05-94-00080	Associated Insurance Medicare Administrative Costs, July 1996, \$3,954,632
CIN: A-09-95-00056	Review of Training Activities - California Department of Social Services, August 1996, \$3,934,717
CIN: A-07-93-00633	Pension Segmentation- AETNA Life Insurance Co., October 1993, \$3,011,376
CIN: A-05-93-00013	Michigan Blue Cross/Blue Shield Contract Medicare Audit, April 1993, \$3,010,916
CIN: A-06-97-43135	State of Texas, February 1997, \$2,987,053
CIN: A-01-95-00504	Medicare Parts A&B Administrative Costs - AETNA, January 1996, \$2,938,223

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

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

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

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

CIN: A-03-90-02003 Blue Cross/Blue Shield of Western Pennsylvania of Western Pennsylvania Administrative Costs FYs 1986-1989, August 1993, \$2,218,528

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

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

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

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

CIN: A-06-96-00008 Arkansas Blue Cross/Blue Shield Administrative Costs - Contracted, September 1996, \$1,442,193

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

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

CIN: A-03-90-00051 Maryland Blue Cross/Blue Shield Part A Cost Audit, August 1991, \$1,438,414

CIN: A-07-92-00579 Blue Cross/Blue Shield of Michigan Inc. - Unfunded Pension Costs, October 1992, \$1,346,681

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

CIN: A-07-93-00700 Blue Cross/Blue Shield of Massachusetts - Unfunded Pension Cost Audit, May 1994, \$1,290,740

CIN: A-04-96-38688 State of Kentucky, April 1996, \$1,271,907

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

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

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

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

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

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

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

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

CIN: A-09-94-01010 Stratagene Close-out, March 1994, \$983,208

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

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

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

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

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

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

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

CIN: A-07-96-01178 Medicare Pension Costs Claimed Blue Cross/Blue Shield of Michigan, November 1996, \$631,248

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

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

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

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

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

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

CIN: A-03-97-43787 State of Virginia, February 1997, \$455,529

CIN: A-06-93-00042 Blue Cross/Blue Shield of West Virginia Termination, November 1992, \$434,134

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

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

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

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

CIN: A-04-96-01136 HCFA Survey Team of Savannah (Operation Restore Trust), December 1996, \$354,537

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

CIN: A-04-97-44101 State of Tennessee, February 1997, \$330,285

CIN: A-05-9-25697 West Central Wisconsin Community Action Agency Inc., August 1993, \$324,759

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

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

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

CIN: A-07-95-01151 Oregon Blue Cross/Blue Shield Unfunded Pension Costs, October 1995, \$260,335

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

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

CIN: A-04-96-40781 State of Alabama, May 1996, \$230,724

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

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

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

CIN: A-10-96-29857 University of Washington, January 1997, \$205,227

CIN: A-04-96-01131 HCFA Survey Team - Integrated Health Services - Operation Restore Trust, February 1997, \$202,780

CIN: A-06-96-00064 Skilled Nursing Facility Research at Methodist Hospital - Operation Restore Trust, January 1997, \$200,000

CIN: A-07-95-01150 Region Blue Cross/Blue Shield Pension Segmentation, October 1995, \$191,312

CIN: A-06-97-45299 Desire Narcotics Rehabilitation Center Inc., February 1997, \$181,523

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-03-94-26611 State of Delaware, December 1993, \$163,100

CIN: A-04-96-01124 HCFA Survey Team - Stafford Connecticut - Operation Restore Trust, February 1997, \$161,774

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

CIN: A-07-97-43584 State of Missouri, October 1996, \$139,314

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

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

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

CIN: A-01-96-38370 State of Rhode Island and Providence Plantations, May 1996, \$105,049

CIN: A-04-93-20785 State of Florida, June 1993, \$103,486

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

CIN: A-06-96-43307 Nueces County Community Action Agency, June 1996, \$92,969

CIN: A-07-95-01164 Medicare Administrative Costs - General American, December 1995, \$89,929 (Related recommendation of \$16,632 outstanding on Table II)

CIN: A-02-95-34278 Puerto Rico Department of Health, June 1995, \$86,064

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

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

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

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

CIN: A-04-96-01137 HCFA Survey Team - Daytona Nursing - Operation Restore Trust, December 1996, \$76,130

CIN: A-07-95-01166 Unfunded Pension Costs Nebraska Blue Cross/Blue Shield, January 1996, \$73,509

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

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

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

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

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

CIN: A-05-96-42077 City of Rockford Illinois, March 1996, \$59,283

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

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

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

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

CIN: A-04-96-01127 HCFA Survey Team - AMI Town Company Hospital, February 1997, \$47,147

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

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

CIN: A-03-93-03306 Survey Research Association, December 1993, \$48,779

CIN: A-03-97-44742 Association of Teachers of Prevention Medicine Inc., January 1997, \$45,000

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

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

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

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

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

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

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

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

CIN: A-07-97-01199 Blue Cross/Blue Shield New Mexico Unfunded Pension Costs, February 1997, \$31,372

CIN: A-05-97-44710 City of Chicago Illinois, November 1996, \$31,345

CIN: A-03-95-35319 Porter/Novelli, February 1995, \$31,332

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

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

CIN: A-05-95-36811 Independent School District No. 709 - Duluth, Minnesota, April 1995, \$30,000

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

CIN: A-10-96-41391 Klamath Family Head Start, April 1996, \$26,539

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

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

CIN: A-10-97-43797 State of Washington, January 1997, \$22,378

CIN: A-02-97-44455 Community Action Agency of Franklin County Incorporated, 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-05-96-43041 Hoosier Valley Economic Opportunity Corporation, June 1996, \$20,438

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

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

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

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

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

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

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

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

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

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

CIN: A-04-97-44623 Tuskegee University, February 1997, \$10,686

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

CIN: A-09-96-42238 San Pasqual Band of Mission Indians, May 1996, \$9,531

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

CIN: A-03-97-44971 Management Systems Applications Incorporated, November 1996, \$8,848

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

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

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

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

CIN: A-04-96-01128 HCFA Survey Team - Ed White Trans. Care - Operation Restore Trust, February 1997, \$7,244

CIN: A-08-96-43199 American Indian Health Care Association, Inc., July 1996, \$6,863

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 Oglaha Sioux Tribe, October 1996, \$6,494

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

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

CIN: A-04-96-43156 State of South Carolina, June 1996, \$5,996

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

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

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

CIN: A-02-97-44269 Puerto Rico Dept. of Anti-Addiction Services, October 1996, \$4,976

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

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

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

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

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

CIN: A-03-95-03318 Trans-Management Systems (Contract Close-out), May 1996, \$3,016

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

CIN: A-03-95-43716 West Virginia Medical Institute Inc., March 1995, \$2,688

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

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

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

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

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

CIN: A-08-96-43556 State of Utah, September 1996, \$2,134

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

CIN: A-09-94-01022 Itellegenetics, October 1994, \$-12,400

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

B. Reports in litigation:

- CIN: A-09-91-00155 Blackburn Care Home, November 1991, \$1,772,944 (Related recommendation of \$662,370 outstanding on Table II)
- CIN: A-03-92-00033 Blue Cross/Blue Shield of West Virginia Termination, November 1992, \$25,200
- CIN: A-09-96-39877 Amity Inc., November 1995, \$49,358

C. These audits are open pending resolution of the contractor's termination audit, related termination agreements and pending lawsuits:

- CIN: A-05-94-00064 Michigan Blue Cross/Blue Shield, Audit of Administrative Costs, June 1996, \$15,609,718
- CIN: A-07-96-01176 Medicare Excess Pension Assets - Blue Cross/Blue Shield of Michigan, November 1996, \$11,904,263

D. Report Awaiting Department Appeals Board Decision:

- CIN: A-03-92-16229 State of Pennsylvania, March 1992, \$468,217

Table II

¹ The opening balance was adjusted to reflect an upward adjustment of \$6.6 million.

² Management decisions have not been made within 6 months of issuance on 10 reports.

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

- CIN: A-06-91-00089 Audit of CN B Accounts to Determine the Status of Indian Health Service Cash On-Hand, April 1992, \$445,890
- CIN: A-09-96-00079 Health Care Management's Skilled Nursing Facilities Medical Supplies, January 1997, \$400,000
- CIN: A-06-96-43195 Muskegon-Oceana Community Action Against Poverty I, June 1996, \$130,993
- CIN: A-02-95-34946 City of Caguas Puerto Rico, March 1995, \$64,206
- CIN: A-04-97-46151 Tallatoona Economic Opportunity Authority Inc., February 1997, \$38,051
- CIN: A-06-96-43307 Nueces County Community Action Agency, June 1996, \$22,667
- CIN: A-07-97-45898 Salina Unified School District No. 305, January 1997, \$17,715
- CIN: A-06-97-45023 Caddo Community Action Agency Inc., November 1996, \$8,880
- CIN: A-05-95-37812 Northeast Michigan Community Service Agency Inc., August 1995, \$2,191

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

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

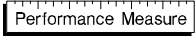
APPENDIX E

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

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

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	66
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	64
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	65
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, OIG has labeled some items throughout the semiannual report as performance measures with the symbol . Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program which is measured by the number of inoculations provided per dollar of cost. In OIG's opinion, the following audits, inspections and investigations finalized during this semiannual period offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals.

	Page
Audit of Health Care Financing Administration's Financial Statements	4
Beneficiary Awareness of Health Care Financing Administration Publications in 1995	4
Beneficiary Satisfaction and Understanding of Home Health Services in 1995	5
Beneficiary Satisfaction with Services by Durable Medical Equipment Regional Carriers	6
Home Health Services in California, Illinois, New York and Texas	23
Medicaid Managed Care	
B. Early and Periodic Screening, Diagnosis and Treatment Program	35
Ryan White Comprehensive AIDS Resources Emergency Act: Connecticut	42
Food and Drug Administration's Inspections of Plasma Fractionators	44
Chief Financial Officers Act Audits of the Public Health Service for Fiscal Year 1996	46
Implementation of State Child Support Certified Data Systems	50
State Drivers' License Suspension Processes	51
Community Services Block Grant Program: New Jersey	56
Financial Statement Audit of the Administration for Children and Families	57
Financial Statement Audit of the Department for Fiscal Year 1996	60
Reviews of Departmental Service Organizations	61

ACRONYMS

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

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

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

Office of Management and Budget Circulars:

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

General Accounting Office Government Auditing Standards

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

- Title 31, United States Code, section 3729 et seq., the Civil 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

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

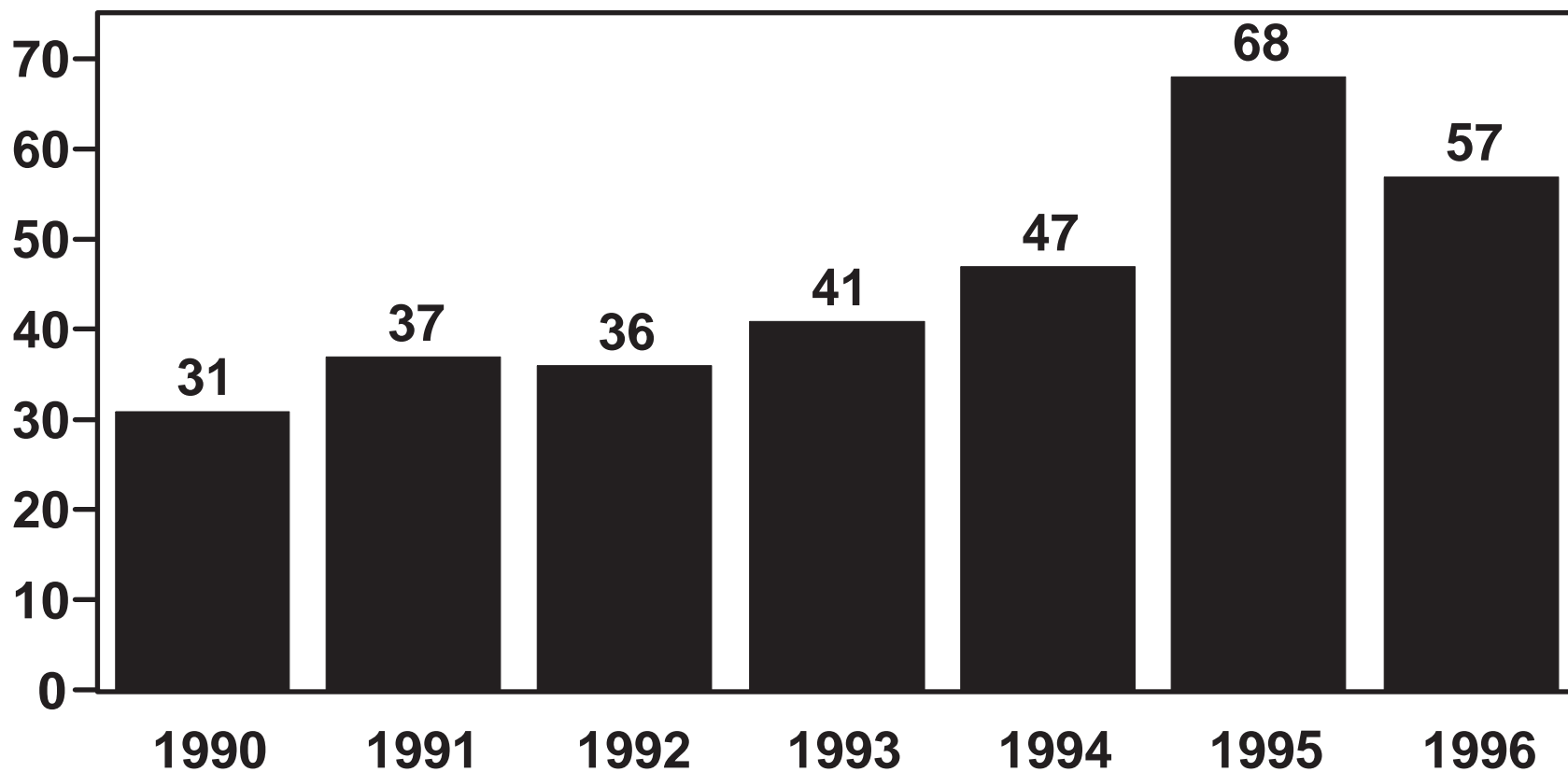
Office of Inspector General
330 Independence Avenue, S.W.
Washington, D.C. 20201

Internet Address
<http://www.dhhs.gov/progorg/oig>

BENEFICIARY AWARENESS AND USE OF THE MEDICARE HANDBOOK

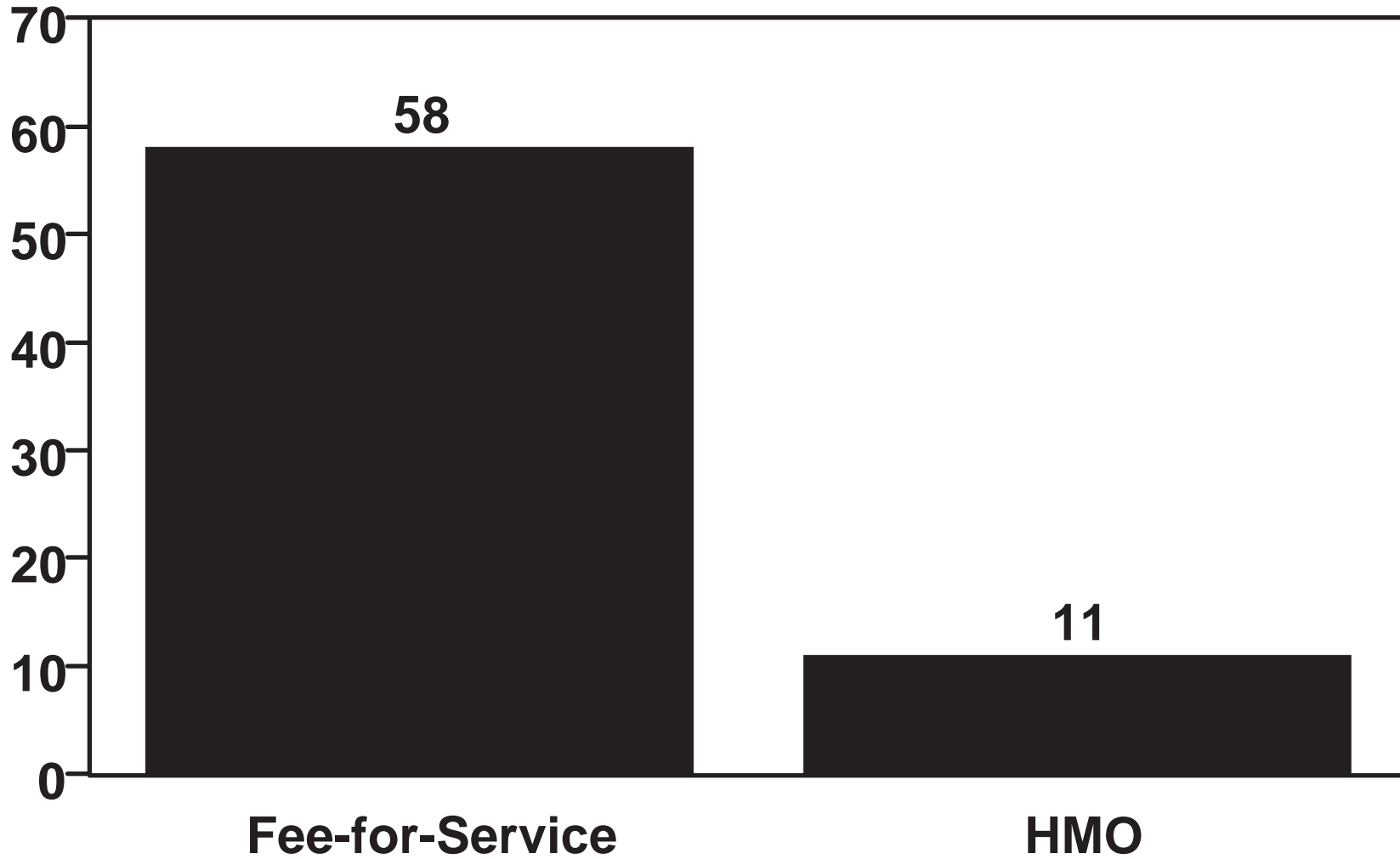
	1993	1994	1995
Percent of Beneficiaries Aware of the Medicare Handbook	76%	76%	75%
Percent of Beneficiaries Aware of the Handbook Who Used It in Past Year	55%	58%	38%

HOSPITAL SALES WITH DEPRECIATION ADJUSTMENTS FISCAL YEARS 1990 THROUGH 1996



Note: 1996 does not represent a complete year of hospital sales data from all fiscal intermediaries

AVERAGE NUMBER OF VISITS PER BENEFICIARY

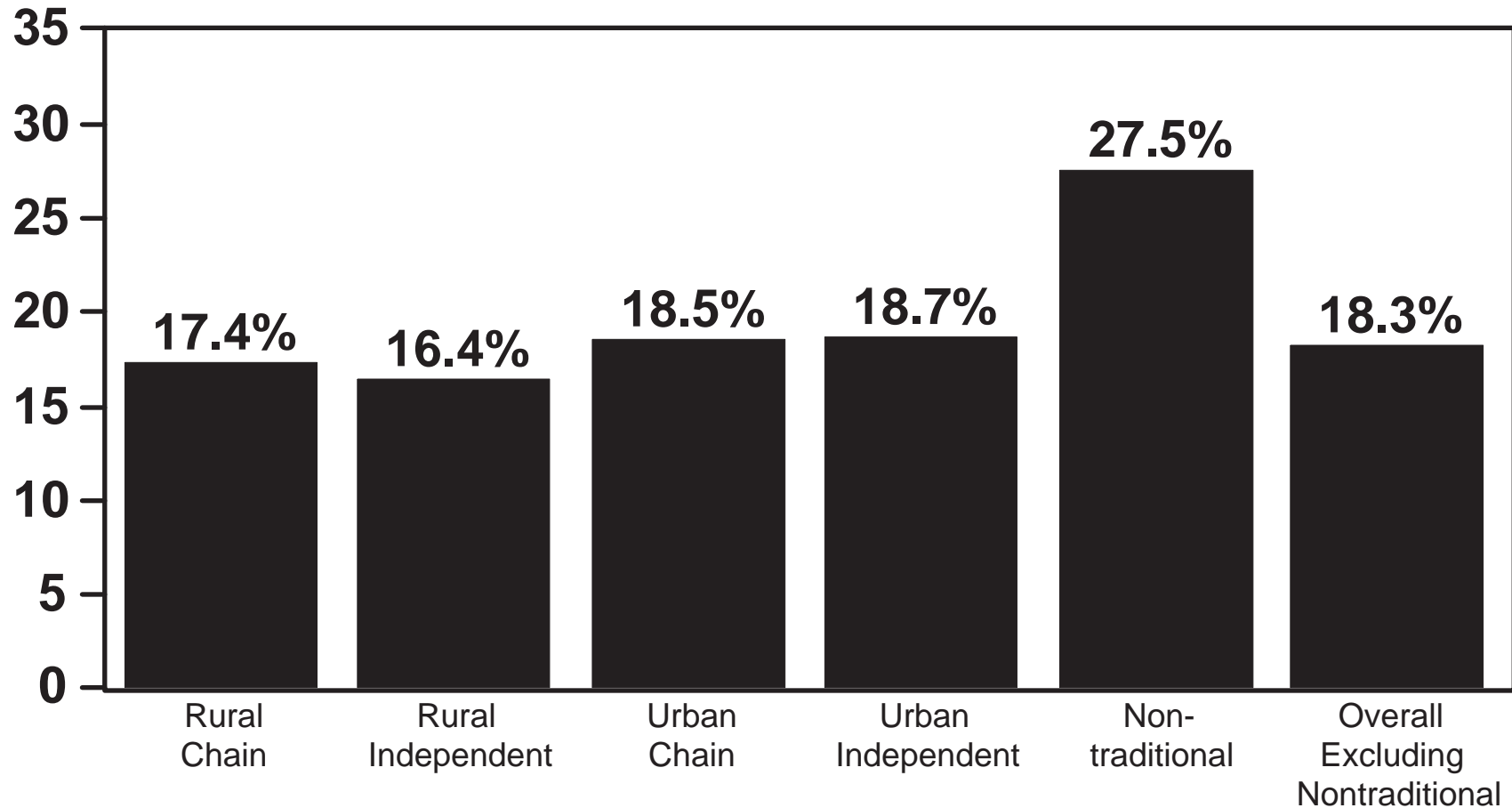


RECEIPT OF EPSDT SERVICES

Age of Child	Receive All EPSDT	Receive Some EPSDT	Receive No EPSDT
birth - age 5	30%	22%	48%
ages 6 - 14	32%	1%	67%
ages 15 - 20	14%	0	86%
all ages	28%	12%	60%

ESTIMATED PRICE DIFFERENCE BRAND NAME DRUGS

Percentage



STATE PROGRESS IN DEVELOPING AUTOMATED DATA SYSTEMS

CURRENT PHASE	NUMBER OF STATES IN PHASE
Design	2
Programming	3
Testing	9
Conversion	2
Implementation	9
Pilot in several counties, but enhancing	1
Operational statewide, but enhancing	12
Operational statewide, but transferring new system	1
Level 1 Certification Review	2
Level 2 Certification Review	7
Certified	6
TOTAL STATES/TERRITORIES	54