June Gibbs B
Inspector Ge

WHO PAYS ?

YOU PAY.

Report Medicare Fraud.

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

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

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

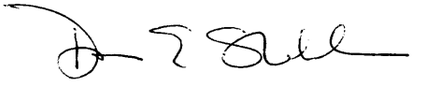
1-800-HHS-TIPS
(1-800-447-8477)

A MESSAGE FROM THE SECRETARY

The Department of Health and Human Services' (HHS') programs provide some of this Nation's most essential benefits. Fraud, waste and abuse threaten to undermine the effectiveness of those programs, cost taxpayers billions in lost and wasted dollars and deprive vulnerable beneficiaries of the care and support they need. To best serve the American people and make the most efficient use of our resources, we have worked for tougher laws and intensified our oversight, and we have reached out to enlist the cooperation of other agencies and organizations with similar goals, as well as the public and the health care industry.

The Inspector General has taken a leadership role in the Department's efforts, and the contributions of her office have been outstanding. The Office of Inspector General (OIG) has joined others within and outside the Department, notably the Health Care Financing

Overall, Fiscal Year 1999 has been a busy and productive time for OIG. I commend the Inspector General for the accomplishments of her office, including record savings to the Government and a record number of successful prosecutions. These are achievements to be proud of, and achievements to build on. As a Department, we have a lot of work ahead of us. With the Inspector General as an indispensable member of the HHS team, I have every confidence that we are equal to the task.



Donna E. Shalala

FOREWORD

This report covers the full range of the Office of Inspector General's (OIG's) activities for the 6-month period April 1, 1999 to September 30, 1999. During this time, OIG has continued to play a crucial role in helping the Department of Health and Human Services (HHS) carry out its critical mission. Recognizing the breadth and complexity of the challenges facing the Department, we have sought new and better ways to promote the efficacy of HHS programs and to identify and ferret out fraud, waste and abuse. To that end, we have initiated structural reforms, introduced new ways of thinking and created new partnerships.

Our efforts have been well rewarded. In Fiscal Year 1999, OIG reported record savings to the Government of over $12 billion, much of which resulted from passage of the Balanced Budget Act (BBA) of 1997. The BBA instituted what is commonly regarded as the most sweeping set of changes to Medicare since the program's inception. Many of these reforms were consistent with recommendations made by our office or were aimed at correcting program weaknesses and vulnerabilities identified by our work. We also reported 401 convictions of individuals or entities that engaged in crimes against departmental programs, a significant increase over previous years.

Key to our accomplishments are the many partnerships we have established with others who share our goals. For example, we have been working closely with State auditors to provide broader coverage of the Medicaid program, thus ensuring more effective use of scarce Federal and State audit resources. Recently, the Administration launched a new National Health Care Fraud and Abuse Task Force in which OIG, in collaboration with the Health Care Financing Administration, the Department of Justice and other Federal and State organizations, is formulating strategies to combat health care fraud and abuse and safeguard the well-being of Medicare and Medicaid beneficiaries. While the task force will focus on a wide range of health care fraud and abuse policy issues, particular attention will be devoted to fighting nursing home fraud and abuse and excluding dishonest and abusive providers from participation in Medicare, Medicaid and other Government-funded health care programs.

The OIG is also engaged in numerous proactive efforts designed to help prevent fraud and abuse and heighten the health care industry's compliance with Medicare rules. This includes issuing compliance program guidance; publishing fraud alerts; issuing advisory opinions regarding OIG-enforced sanction authorities; undertaking beneficiary outreach and education along with the Administration on Aging, the Health Care Financing Administration and the American Association of Retired Persons; and expanding the toll-free hotline for beneficiaries and providers to report suspected fraud.

For more than a decade, OIG has also been involved in efforts to improve enforcement in the area of child support through audits and evaluations dealing with such topics as paternity establishment, the review and adjustment of support orders, and medical support. More recently, our investigative capabilities have been brought to bear on this problem. Working with the HHS Office of Child Support Enforcement, we have established a multiagency, multijurisdictional task force to address the most egregious cases of nonsupport. Originally launched in the Midwest, this model has now been broadened to several additional geographical areas.

Another key issue facing the Department is the vulnerability of its computer-dependent systems to the Year 2000 (Y2K) problem. Successful delivery and payment for HHS-supported services also depend on the computer systems of HHS's partners. Accordingly, in addition to its reviews of departmental systems, OIG has published evaluations of the Y2K readiness of various Medicare provider groups and Medicare contractors.

As always, our office seeks to be responsive to the Congress and the Department, and much of our work is driven by concerns they raise. Moreover, our successes in large part have been the result of the cooperation and support they and others have provided us. I look forward to working with these partners in the new millennium to ensure the highest level of effectiveness, efficiency and integrity in the HHS programs that serve and protect the American people in such vital ways.

June Gibbs Brown
Inspector General

HIGHLIGHTS

Introduction

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

Statistical Accomplishments

For Fiscal Year (FY) 1999, OIG reported savings of $12.6 billion, comprised of $11.9 billion in implemented recommendations and other actions to put funds to better use, $251.5 million in audit disallowances and $407.7 million in investigative receivables. (See Appendix A and the sections entitled "Resolving Office of Inspector General Recommendations, A. Questioned Costs" and "Investigative Prosecutions and Receivables" in the General Oversight chapter in each of the two FY 1999 semiannual reports for details.)

In addition, for FY 1999, OIG reported 2,976 exclusions of individuals and entities for fraud or abuse of the Federal health care programs and/or their beneficiaries, 401 convictions of individuals or entities that engaged in crimes against departmental programs, and 541 civil actions. (See sections entitled "Fraud and Abuse Administrative Sanctions" in the Health Care Financing Administration [HCFA] chapter and "Investigative Prosecutions and Receivables" in the General Oversight chapter of the two FY 1999 semiannual reports.)

Following are some of OIG's most notable accomplishments for the 6-month period ending September 30, 1999.

Quality of Care

The OIG carried out several initiatives related to the quality of care provided to program beneficiaries.

☐ Hospital Oversight

A 2-year study by OIG found major deficiencies in the external oversight system intended to make sure the Nation's hospitals are safe. Four inspection reports assessed the key roles in hospital quality oversight played by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the State survey and certification agencies, and HCFA.

The OIG recommended that HCFA exert leadership in addressing the shortcomings identified; steer the external review process so that it represents a balance between the educationally-oriented approaches of JCAHO and the enforcement-oriented approaches of the State agencies; and undertake actions to hold both JCAHO and the States more fully accountable for their performance in reviewing hospitals. In addition, OIG urged that HCFA

determine the appropriate minimum cycle for conducting certification surveys of nonaccredited hospitals. (See page 2)

☐ **Nursing Homes**

In a series of inspection reports, OIG concluded that serious problems with quality of care continue to exist in nursing homes. The OIG proposed that an effective strategy to deal with these problems include actions to enhance the survey and certification process; strengthen the Ombudsman program with increased resources; improve nursing home staffing levels; and improve coordination between State survey agencies and Ombudsmen. In addition, further evaluation and performance measurement of the standards mandated by the Omnibus Budget Reconciliation Act of 1987 and the conditions in nursing homes would make an important contribution to efforts to improve nursing home care. (See page 16)

☐ **Organ Transplantation**

The OIG is continuing its work in the area of organ transplantation. In one report issued during this period, OIG found considerable variation in median waiting times for kidney and liver transplantations among the Organ Procurement and Transplantation Network regions. In a second report, OIG determined that the 117 liver transplant centers cluster in metropolitan areas, leaving large portions of the population at considerable distance from a transplant center. The OIG concluded that widespread access to liver transplant centers does not exist, and noted several factors other than allocation policy that affect this access. (See page 46)

Medicare Managed Care

Medicare managed care, with about 7 million enrolled beneficiaries, continues to be an important focal area. During this reporting period, OIG looked at the following issues:

☐ **Inpatient Services after Beneficiary Disenrollment**

The OIG found that Medicare paid hospitals $224 million for inpatient fee-for-service care furnished to beneficiaries who had disenrolled from six managed care plans. About $41 million of this amount was paid for beneficiaries who later reenrolled in managed care. Medicare would have paid $20 million in capitation payments to the plans had the beneficiaries not disenrolled. Based on this analysis, it appeared that plans could avoid significant payments for medical services by having sicker beneficiaries disenroll, obtain services under the fee-for-service program and then reenroll when they were healthier. (See page 3)

☐ **Payments for Institutionalized Beneficiaries**

Medicare pays health maintenance organizations (HMOs) a higher capitation rate for beneficiaries who are institutionalized. Based on a statistical sample, OIG estimated that Medicare overpaid $22.2 million for beneficiaries who were incorrectly classified as institutionalized. The report recommended that HCFA strengthen its onsite review procedures to better identify HMOs that inaccurately report the status of beneficiaries, and identify and recover the resulting overpayments. (See page 4)

☐ **Administrative Costs**

Through adjusted community rate proposals, managed care organizations present to HCFA their estimates of the costs needed to provide Medicare services to enrolled beneficiaries. The OIG continued to find that the administrative cost component of these proposals exceeded actual expenditures by millions of dollars and included such items as brokers' commissions and entertainment, which would not be allowable if regulations governing other parts of the Medicare program were applied to managed care organizations. The results of these audits, as well as others underway, are being provided to HCFA for its consideration of legislative changes. (See page 4)

☐ **Overlapping Inpatient Expenditures**

The OIG assisted the Department of Defense (DOD) OIG in reviewing claims for beneficiaries dually eligible under the DOD and Medicare health programs. The DOD spent about $45.2 million in FY 1997 for inpatient care of beneficiaries on whose behalf HCFA made per capita payments to HMOs for medical services, including inpatient treatment. The DOD OIG recommended -- and HHS OIG fully supported -- that DOD, HHS and the Office of Management and Budget develop a strategy to reduce or eliminate these overlapping Federal expenditures. (See page 5)

Significant Investigative Results

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

☐ **Health Services Corporation**

As the result of investigations by OIG in Georgia, Florida and New York, a major health services corporation and its subsidiary agreed to pay the Government $61 million in civil damages and criminal fines. The multimillion dollar global settlement resolves allegations that both companies engaged in schemes to defraud Medicare. As part of the civil settlement agreement, the corporation will pay $50.92 million to settle alleged False Claims Act violations. In addition, the subsidiary agreed to plead guilty to Federal criminal charges related to Medicare fraud in Florida and Georgia, and to pay $10.08 million in criminal fines. (See page 27)

☐ **Medical Care Company**

In Pennsylvania, the Government reached a $16.5 million settlement with a medical care company for the filing of false Medicare claims by various companies it acquired. The OIG investigated claims submitted for mobile diagnostic tests by a diagnostic laboratory purchased by one of the company's subsidiaries. The laboratory and this subsidiary marketed their tests through improper kickback arrangements with the ordering physicians. The settlement reached not only resolves this allegation of improper kickback activity, but also other allegations of misconduct by the related companies. (See page 34)

☐ **Former Medicare Contractors**

Two former Medicare contractors agreed to settle their criminal, civil and administrative liability for misrepresenting their performance to HCFA. In order to resolve allegations of manipulating certain computer files to obtain a better score on the Contractor Performance

Evaluation Program and concealing poor performance on provider audits, the companies pled guilty to felony charges and agreed to pay in excess of $12 million in criminal fines and civil penalties and to forgo contract claims totaling $3.1 million. Both corporations also entered into a 5-year corporate integrity agreement with OIG. Problems such as these, coupled with longstanding vulnerabilities in the Medicare contractors' internal control systems, prompted the recent establishment of a joint OIG/HCFA task force to develop preventative solutions. The task force is actively exploring various options to reduce the contractors' risk of errors, fraud and other illegal acts and to improve their controls over financial management and information systems security. (See page 28)

☐ **Home Health Care Company**

A complaint to the HHS Inspector General hotline initiated a major investigation and audit by OIG which culminated in a multimillion dollar settlement with the largest home health care company in Texas. The company agreed to pay the Government $10 million to settle allegations of Medicare fraud against its subsidiary, a provider of home health care and infusion therapy services. Among other allegations of wrongdoing, the Government alleged that the subsidiary improperly charged Medicare for unallowable costs which resulted in the submission of false claims to the program. (See page 33)

Child Support Enforcement

In addition to its audit and inspection work in this area, OIG has made the detection and prosecution of absent parents who fail to pay court-ordered child support a priority. The OIG has worked with the Office of Child Support Enforcement (OCSE) and other Federal, State and local partners to develop programmatic and operational procedures to expedite the collection of child support and to bring to justice those who willfully disregard their obligations. The OIG has opened 775 investigations of child support cases nationwide since 1995, which have resulted in 147 convictions and court-ordered restitution and settlements of over $10 million.

☐ **Investigative Task Forces**

In 1998, OIG and OCSE initiated multiagency, multijurisdictional investigative task forces consisting of enforcement units from different States in the Midwest and Mid-Atlantic regions. The task forces are designed to identify, investigate and prosecute criminal nonsupport cases both on the Federal and State levels through the coordination of law enforcement, criminal justice and child support office resources; their goal is to create streamlined systems of referral, investigation and prosecution that will bring to justice the most egregious offenders. Based on the initial success of this approach, similar units have been established in other geographical areas during FY 1999, including the Northeast, Southwest and Pacific Coast during this 6-month period. (See page 56)

☐ **New Hampshire's Collection Procedures**

The OIG reviewed New Hampshire's innovative requirement that businesses report not only newly hired employees but also newly hired independent contractors. By garnishing contractor earnings, the State increased child support collections from the self-employed, one of the most difficult groups from which to collect payments. The OIG recommended

that the Administration for Children and Families (ACF) consider encouraging other States to require businesses to report the hiring of independent contractors. As a result, ACF publicized OIG's report in its nationwide newsletter. (See page 60)

☐ **Review and Adjustment of Child Support Orders**

Under current law, periodic reviews of child support orders are no longer required. Child support agencies must notify parents every 3 years of their right to request a review of their child support orders, and must conduct a parent-requested review if none has been performed within the past 3 years. The OIG urged a reevaluation of Federal review and adjustment policies in light of the merits of periodic reviews as demonstrated by research by OIG and others. In addition, OIG suggested ways to improve the current processes. (See page 59)

☐ **Paternity Establishment**

The Congress requires that State child support agencies provide voluntary paternity acknowledgment services through in-hospital acknowledgment programs, the State agencies responsible for maintaining birth records and alternative sites. While OIG recognizes that States have made promising efforts to provide written and oral notification of rights and responsibilities to parents who voluntarily acknowledge paternity, some vital records agencies and other alternative sites are still unaware of this obligation. About half the States currently offer voluntary paternity acknowledgment services through some of their public assistance offices, but few States have yet expanded service to other sites. The OIG made a number of suggestions to improve the use of alternative sites by capitalizing on and refining effective practices now being used in some localities, and to ensure that agencies provide both written and oral notifications to all parents considering voluntary paternity acknowledgment. (See page 60)

Year 2000 System Compliance

As part of its oversight responsibilities for departmental activities, OIG continued to assess the Department's progress toward Year 2000 (Y2K) computer system readiness. As noted below, the Medicare program's systems, including those external systems that interact with HCFA, received particular attention.

☐ **Medicare Providers and Managed Care Organizations**

The OIG conducted several inspections and follow-up studies to determine the relative readiness of Medicare providers and managed care organizations for Y2K. The studies showed that only about half the provider organizations and only about 22 percent of managed care organizations were ready. The OIG is following up these studies to provide up-to-date information to the Department as the year closes. (See page 13 and 14)

☐ **Medicare Contractors**

The Medicare contractors are responsible for processing and paying about $180 billion in fee-for-service claims each year. The ability of their computer systems to operate effectively by Y2K and beyond is therefore of critical importance. In preparation for that date, HCFA increased its Medicare contractors' funding by over $100 million during FY 1998. At

HCFA's request, OIG reviewed the administrative costs reported by four contractors and found that about $650,000, or 11.4 percent of the $5.7 million reported, did not qualify as charges to the Y2K project. The OIG also maintained its active monitoring of the contractors' progress in renovating their systems through frequent site visits (about 360 to date) in conjunction with HCFA staff. The results of the visits were provided to HCFA's Chief Information Officer. (See page 15)

☐ Other Departmental Systems

An OIG review determined that seven of the Program Support Center's (PSC's) mission-critical systems were Y2K compliant as of April 1, 1999. The remaining system, the Payment Management System, was months behind its estimated Y2K compliance date of December 31, 1998. This system serves over 20,000 grantees and disburses more than $165 billion annually. On June 30, 1999, PSC advised that the system had been certified as Y2K compliant. (See page 69)

Internet Address

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

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Health Care Financing Administration

Chapter I

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

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

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

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

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

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

The OIG also audits HCFA's financial statements, which account for more than 84 percent of Department of Health and Human Services (HHS) outlays. In addition to issuing an opinion on the statements, OIG has assessed compliance with Medicare laws and regulations and the adequacy of internal controls.

External Review of Hospital Quality

Performance Measure

In four related final inspection reports, OIG assessed the key roles in hospital quality oversight played by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the State survey and certification agencies and HCFA. Overall, OIG concluded that while the system of oversight that HCFA relies upon has some strengths, it also has deficiencies that warrant serious attention. The HCFA, OIG documented, does little at present to hold either JCAHO or the State survey agencies accountable for their performance.

The OIG called for HCFA to exert leadership in addressing the shortcomings. First, as a guiding principle, OIG urged HCFA to steer the external review process so that it represents a balance between the educationally oriented approaches of JCAHO and the enforcement oriented approaches of the State agencies. In addition, OIG suggested a number of steps HCFA should take to hold both JCAHO and the States more fully accountable for their performance in reviewing hospitals. Also, OIG called for HCFA to determine the appropriate minimum cycle for conducting certification surveys of nonaccredited hospitals.

The HCFA responded positively to OIG's reports by presenting a detailed hospital oversight plan that incorporates OIG's recommendations and an accompanying strategy for hospital performance measurement. (OEI-01-97-00050; OEI-01-97-00051; OEI-01-97-00052; OEI-01-97-00053)

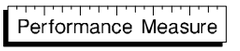
Hospital Readmissions under the Medicare Prospective Payment System

In this review, OIG sought to determine the validity of Medicare PPS claims in which a beneficiary was discharged and subsequently readmitted on the same day to the same PPS hospital. In Calendar Year (CY) 1996, PPS hospitals nationwide submitted over 17,000 claims, valued at over $112 million, for the second inpatient hospital stay.

For 100 readmissions selected from the 18 States with the greatest number of second inpatient hospitalizations, the peer review organizations (PROs) identified 29 readmissions valued at $178,741 that were inappropriately paid to PPS hospital providers in CY 1996 for the second inpatient stay. The OIG estimated that the overpayments due to inappropriate hospital readmissions in the 18 States totaled approximately $22 million in CY 1996. The review found that the largest number of errors was attributable to premature discharges. The OIG believes this is a serious quality of care issue which needs to be closely monitored.

The HCFA should join OIG in additional work on hospital readmissions to identify additional overpayments; monitor quality of hospital care; and profile aberrant hospital providers, ensuring that corrective action plans are instituted and referrals to OIG are made as appropriate. Further, HCFA should reinstate hospital readmission reviews and monitor the fiscal intermediaries' (FIs') recovery of the improper Medicare payments identified in OIG's sample. In response to the draft report, HCFA concurred with the recommendations. (CIN: A-01-98-00504)

Inpatient Services Performed on Beneficiaries after Disenrolling from Medicare Managed Care



This review was undertaken as part of OIG's ongoing work to assess whether Medicare risk plans are selectively enrolling healthier beneficiaries and encouraging sicker beneficiaries to disenroll. Six managed care firms were selected for this initial audit. In a review of beneficiaries who disenrolled from these plans from 1991 to 1996, OIG found that Medicare paid hospitals $224 million for inpatient services furnished to the beneficiaries within 3 months of their disenrollment; Medicare would have paid $20 million in capitation payments to these six firms had these beneficiaries not disenrolled; and about 18 percent of the expenditures ($41 million) were paid for beneficiaries who reenrolled in Medicare managed care after receiving the inpatient care under the Medicare fee-for-service program. It thus appeared that risk plans could avoid significant payments for medical services by having sicker beneficiaries disenroll, obtain services under the Medicare fee-for-service program and then reenroll.

The OIG is currently undertaking specific audit and investigative work related to enrollment and disenrollment actions at some of the managed care plans. As its analysis continues, OIG believes that the process it followed could be useful to HCFA in evaluating health

maintenance organization (HMO) performance. Accordingly, OIG recommended that, in addition to conducting studies and other efforts in this area, HCFA assess patients' health status both before and after disenrollment as part of its monitoring system. (CIN: A-07-98-01256)

Managed Care Payments for Beneficiaries with Institutional Status

Under risk-based contracts, HMOs receive payment on a prospective per capita basis. A higher capitation rate is paid for risk-based HMO enrollees who are institutionalized.

Based on the combined results of audits at eight HMOs located throughout the country, OIG estimated that risk-based HMOs received Medicare overpayments of $22.2 million for beneficiaries incorrectly classified as institutionalized. Of 800 beneficiaries sampled, 137 did not meet institutional status requirements. The majority of the 137 Medicare overpayments resulted from inadequate internal controls at the audited HMOs.

The OIG issued individual reports to the HMOs, which included recommendations to correct deficiencies, where necessary, and to refund overpayments to HCFA. Also, OIG recommended that HCFA strengthen its onsite review procedures to better identify risk-based HMOs that are unable to accurately verify and report the institutional status of enrolled beneficiaries. Further, OIG proposed that HCFA use the strengthened procedures on the next round of site visits to identify HMOs that have been incorrectly reporting beneficiaries as institutionalized, and conduct detailed audits to identify and recover the Medicare overpayments. The HCFA generally concurred with the recommendations and is taking action to address OIG's concerns. (CIN: A-05-98-00046)

Adjusted Community Rate Proposals for Risk-Based Managed Care Organizations

The adjusted community rate (ACR) process is designed for managed care organizations (MCOs) to present to HCFA their estimates of the funds needed to cover the costs (both medical and administrative) of providing the Medicare package of services to enrolled beneficiaries. In a previous audit, OIG concluded that the methodology allowing MCOs to apportion administrative costs to Medicare was flawed and that Medicare covered a disproportionate amount of these costs. As part of its continuing reviews of this area, OIG reported on the administrative costs included in the 1997 ACR proposals of three MCOs during this period.

The administrative cost component of a California MCO's proposal exceeded actual Medicare administrative expenditures by about $20.1 million. Additionally, the administrative cost component of a Missouri MCO's proposal exceeded the actual administrative expenses for the organization's entire operations by about $21 million, or 200

percent. At all three MCOs, OIG also noted costs for such items as brokers' commissions, entertainment, charitable donations and lobbying that would not be allowable if existing regulations for other parts of the Medicare program were applied to risk-based MCOs.

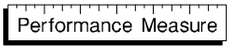
Including costs in the ACR proposal that exceed actual costs or that would be unallowable under Medicare's reimbursement principle of reasonableness serves to reduce any potential savings from the Medicare payments and the amount available to Medicare beneficiaries for additional benefits or reduced premiums. Since there is no statutory or regulatory authority governing the allowability of costs in the ACR process, no recommendations were addressed to the MCOs. The OIG believes, however, that the results of these audits and others previously issued highlight a significant problem. Preliminary findings from additional audits underway support this view. The results of these audits will be shared with HCFA so that appropriate legislative changes may be considered. (CIN: A-09-98-00093; CIN: A-07-99-01275; CIN: A-04-98-01188)

Overlapping Inpatient Treatment Expenditures for Defense Department Beneficiaries Enrolled in Medicare Health Maintenance Organizations

As part of OIG's partnership initiatives to expand audit coverage of the Medicare and Medicaid programs, OIG assisted the Department of Defense (DOD) OIG in its review of inpatient hospital claims for beneficiaries dually eligible under the DOD and Medicare health programs. Many military retirees and dependents aged 65 and older are eligible to receive health care benefits under both programs. Such beneficiaries can opt for benefits from either program depending on availability, expense, personal convenience and their perception of quality of care.

The DOD OIG determined that military treatment facilities provided inpatient services to beneficiaries who were also enrolled in Medicare risk-based HMOs. As a result, DOD spent about $45.2 million in FY 1997 for inpatient care of beneficiaries on whose behalf HCFA made per capita payments to HMOs for covered medical services, including inpatient treatment. The DOD OIG recommended that DOD consult with HHS and the Office of Management and Budget to develop a strategy, including possible legislative action, to reduce or eliminate these overlapping Federal expenditures. The HHS OIG fully supported this recommendation and encouraged HCFA to work with DOD on this matter. (CIN: A-14-99-00208)

Public Health and Managed Care: Opportunities for Collaboration



State and local public health agencies carry out a fundamental government responsibility to protect the health of the population by tracking disease, intervening in communities to control exposures that threaten the population and responding to changes in communities'

health needs. Increasing portions of privately and publicly insured populations are enrolled in managed care plans. As organized systems of care that are increasingly data driven, managed care plans offer public health agencies opportunities to track disease and health trends and to mount effective interventions.

In this report, OIG assessed how public health agencies are taking advantage of opportunities for collaboration with managed care plans to further population-based health activities. The OIG found that States are giving increased attention to fostering collaborations between public health departments and MCOs. However, the collaborations focus predominantly on delivering services, rather than on population-based public health activities.

The OIG concluded that collaborations that address public health population-based strategies have barely begun. Moreover, the current environment may mean that opportunities for realizing the potential of collaboration are fading. In the highly competitive MCO market, performing a broad-based community function reaching beyond the enrolled population is unlikely. The OIG identified ways in which departmental programs can support movement toward greater collaboration. (OEI-01-98-00170)

Medicare Reimbursement under Diagnosis Related Group System

The OIG maintains an active role in monitoring the diagnosis related group (DRG) system that Medicare uses to pay for hospital care. During this reporting period, OIG issued four reports in this area.

A. Basis for Errors among Diagnosis Related Groups with Highest Upcoding Rates

In an earlier review (OEI-01-98-00420), OIG used data from a validation of DRG coding to illustrate that the DRG system is vulnerable to abuse by providers through upcoding, particularly so within certain DRGS. Medical reviewers found that 10 DRGS accounted for over 50 percent of the upcoding in OIG's sample. Taken together, these DRGs represented 10 percent of Medicare's annual hospital discharges. The data are published in this current report, in response to numerous requests. (OEI-01-98-00421)

B. DRG 416: Septicemia

The results of the OIG validation described above indicated that approximately 20 percent of the sample DRG 416 discharges were improperly coded. Analyzing the Medicare Provider Analysis and Review file for fiscal years (FYs) 1993-1996, OIG found that a relatively small number of hospitals (120 out of 4,701) had abnormally high DRG 416 discharges compared to national figures. The OIG determined that the inappropriate billing of DRG 416 could have a major financial impact, with potential overpayments as high as $16.6 million. The true upcoding error rate can only be determined by undertaking a detailed claims review at each hospital.

The OIG recommended that HCFA institute a system to identify hospitals with atypically high billings for those DRGs identified as vulnerable to upcoding and review the discharges. The HCFA concurred. The OIG offered these findings for HCFA's consideration in its efforts to reduce upcoding. (OEI-03-98-00370)

C. DRG 296: Nutritional and Miscellaneous Metabolic Disorders

In a review of the Medicare Provider Analysis and Review file for FYs 1993-1996, OIG also found that 60 hospitals (out of 4,894) had abnormally high DRG 296 discharges. The OIG estimated that potential overpayments could be as high as $1.2 million or 8 percent of the $14.4 million paid these hospitals for DRG 296 in 1996. Again, OIG offered these findings for HCFA's consideration in its efforts to reduce upcoding. (OEI-03-98-00490)

D. DRG 014: Specific Cerebrovascular Disorders Except Transient Ischemic Attack

A small number of hospitals (35) were identified as having atypically high Medicare billings for DRG 014. The OIG estimated that potential overpayments in these hospitals for DRG 014 could be as high as $2.4 million. Again, OIG offered these findings for HCFA's consideration in its efforts to reduce upcoding. (OEI-03-99-00240)

Major Hospital Initiatives

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

A. Physicians at Teaching Hospitals

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

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

The fundamental tenet of the PATH initiative is that in order to receive reimbursement from Medicare Part B for a service rendered to a patient, the teaching physician must have

personally provided that service or have been present when the resident furnished the care. Physicians claiming reimbursement for services performed by the resident alone are making a duplicate claim -- one that has already been paid for under Part A through the GME and IME payments.

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

In sum, the PATH initiative has been undertaken as a result of OIG's extensive audit and investigative work in this area. To date, six institutions have entered into settlements with the Federal Government to resolve potential False Claims Act liability related to improper claims for Part B physician services submitted in the teaching setting. These settlements have resulted in the Government's recovery of over $75.1 million. As a condition of settlement, these institutions have also implemented compliance programs to prevent and detect future improper claims. Reviews completed at four other institutions disclosed no major problems with either billings in the teaching setting or upcoding, demonstrating that providers can and do bill the Medicare program correctly, and a review at one institution resulted in an administrative overpayment settlement with the carrier.

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

B. Diagnosis Related Group Three-Day Window Project

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

reports to HCFA identifying approximately $115.1 million in Medicare overpayments to hospitals caused by these improper billings.

This national project identified 4,660 hospitals that submitted improper billings for outpatient services. The project is primarily coordinated by the U.S. Attorney's Office - Middle District of Pennsylvania. As of the end of the reporting period, settlements had been executed with 2,660 hospitals and about $71 million had been recovered.

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

C. Hospital Outpatient Laboratory Project

The OIG, DOJ and multiple States have joined forces to target false or fraudulent Medicare and Medicaid claims in hospital outpatient laboratories. A project begun in Ohio by OIG, DOJ, the State of Ohio and the Medicare FI proved so successful, United States Attorneys' Offices in other States began their own investigations as part of an expanded effort. This project involves the recovery of multiple damages, when appropriate, for improper and excessive claims submitted for hematology and automated blood chemistry tests by hospital outpatient laboratories. These abuses stem from the improper unbundling and double billing of laboratory tests, and, in certain cases, the billing for certain medically unnecessary tests. The investigations have also shown numerous instances of billing for hematology complete blood count (CBC) additional indices that were not ordered by physicians and were not medically necessary.

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

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

Thus far, 233 hospitals have entered settlements in the Hospital Outpatient Laboratory Project, with settlements totaling more than $53.5 million. More hospitals are expected to settle in the near future.

D. PPS Patient Transfer Project

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

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

E. Pneumonia Upcoding Project

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

The OIG is currently investigating the coding for pneumonia upcoding at over 100 hospitals. To date, eight hospitals have settled their liability for such coding by paying over $15 million and agreeing to corporate integrity requirements.

Other Hospital Investigations

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

- A Maryland hospital agreed to pay the Government $2.1 million to resolve its civil liability for allegedly committing fraud against the Medicare and TRICARE programs. The hospital improperly billed both programs for outpatient clinic infusion therapy when the patients, or their relatives, actually self-administered the therapy in their homes. Between 1993 and 1996, the medical center submitted over 350 false claims to Medicare. As part of the settlement, the center entered into a comprehensive, 5-year corporate integrity agreement requiring new policies, training and annual independent audits.

- A hospital group headquartered in Massachusetts agreed to pay the Government $395,065 and entered into a 3-year corporate integrity agreement to resolve issues related to improper billing practices by one of its three hospitals. In September 1997, the hospital's counsel disclosed to the U.S. Attorney's Office that it had discovered a billing error in the hospital's oncology clinic. The hospital disclosed that between 1992 and 1997, it had billed Medicare Part B for a higher level of evaluation and management services provided to clinic patients than actually performed. The hospital attributed this problem to a programming error in its billing -- the overpayment was determined to be $263,376.

- In New York, a medical center agreed to pay the Government $360,000 to resolve its liability under the False Claims Act and to enter into a 3-year corporate integrity agreement. The medical center allegedly billed the Medicare program for unallowable pharmacy items. Between 1989 and 1993, the facility billed Medicare Part B for certain pharmacy supplies which were not covered under Medicare Part B. Medicare Part B drug coverage is limited to a small number of drugs, primarily immunological drugs. As a result of billing for these noncovered drugs, the medical center was overpaid approximately $180,000.

- A hospital in Ohio agreed to pay the Government $290,000 to settle allegations it improperly billed self-administered drugs (SADs) provided in an outpatient setting. Medicare laws and regulations state explicitly that, with certain specified exceptions, Medicare Part B pays for hospital services and supplies incident to a physician's services to outpatients, including drugs and biologicals which are not self-administered. As a result, Medicare generally does not pay for SADs provided to outpatients. In this case, the hospital self-disclosed the matter and then performed a self-audit to establish damages. It also provided the Government with substantial cooperation and information regarding this issue. As part of the settlement,

OIG also negotiated a comprehensive 3-year corporate integrity agreement with the hospital.

- A nonprofit hospital in California agreed to pay $51,000 to resolve its liability under the False Claims Act and civil monetary penalty (CMP) law. The hospital was named in a qui tam suit alleging that it paid kickbacks in the form of marketing costs to obtain referrals from a physician. The hospital has had financial difficulties for several years but agreed to pay almost double the amount of the alleged kickback. The hospital also entered into a 3-year corporate integrity agreement.

- In Maryland, a hospital agreed to pay the Government $10,000 to resolve its liability under the CMP law for knowingly placing a prior False Claims Act settlement amount on a Medicare cost report. In 1997, the hospital entered into a settlement with the Government for $564,000 and subsequently claimed the amount as legal fees on its Medicare Part A cost report for the fiscal year. Under the agreement made in 1997, the hospital was prohibited from submitting the settlement amount as a cost for reimbursement by any Federal health care program. In addition to receiving the maximum CMP, the hospital agreed to a new settlement agreement with certain corporate integrity provisions to address corrective action specifically tailored to the misconduct at issue.

Industry Guidance

The OIG has continued to issue advisory opinions, fraud alerts and other guidance as part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry. For the period from April 1, 1999 through September 30, 1999, OIG accepted 22 advisory opinion requests and issued 5 advisory opinions. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), OIG has enlisted the help of the provider and beneficiary communities to prevent impropriety by soliciting proposals (via Federal Register notice) for modifying existing safe harbors to the anti-kickback statute. The OIG received seven timely-filed responses to the 1998 notice. A more detailed description of these proposals is set forth in Appendix G. Where appropriate, OIG issues more general guidance in the form of special fraud alerts describing practices that OIG has investigated and believes are fraudulent, and special advisory bulletins articulating OIG's views on emerging practices or arrangements that potentially implicate fraud and abuse authorities. One significant special advisory bulletin issued during the period concerned gainsharing arrangements.

In the last year, several hospitals requested advisory opinions concerning the legality of "gainsharing" arrangements with physicians on the hospitals' staffs. These gainsharing arrangements involved the hospital giving physicians a percentage share of any reduction in

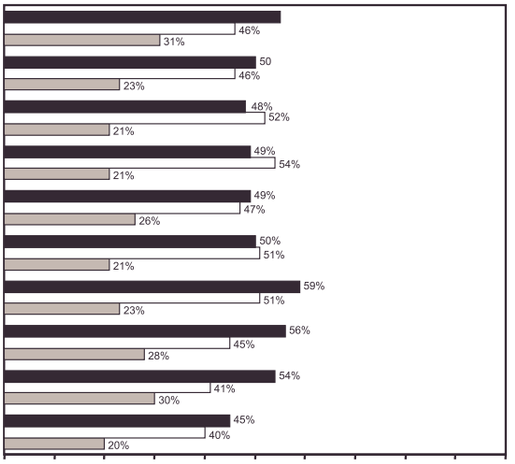
the hospital's costs for patient care attributable in part to the physicians' clinical efforts. In most arrangements, in order to receive any payment, clinical care must not have been adversely affected as measured by selected quality and performance measures.

In July 1999, OIG issued a special advisory bulletin concluding that gainsharing arrangements violate section 1128A(b)(1) of the Social Security Act, which prohibits a hospital from making a payment, directly or indirectly, to induce a physician to reduce or limit services to Medicare or Medicaid beneficiaries under the physician's direct care. Hospitals and physicians may be liable for CMPs of up to $2,000 per patient covered by the payments. The OIG stated that it will take into consideration whether a gainsharing arrangement was terminated expeditiously in determining whether to prosecute the arrangement.

Year 2000 Readiness of Medicare Providers

The OIG surveyed Medicare health care providers regarding their readiness for the Year 2000 (Y2K). In addition to Medicare's 100 mission-critical computer systems, HCFA must also be concerned with the compliance of individual systems used by Medicare claims-processing contractors and health care providers. This is especially important since the majority of Medicare claims are now sent electronically to the contractors for processing and payment.

Replies were accepted through February 1999. Respondents to OIG's survey included hospitals, nursing facilities, HHAs, DME suppliers and physicians. About half of them reported that their billing and medical records systems were Y2K ready. However, providers seemed less confident in the Y2K readiness of their biomedical equipment.



Less than half the respondents had developed a contingency plan in preparation for possible Y2K-related failures and less than half had received certification or guarantees that vendor systems were Y2K compliant. In addition, few respondents had actually tested data exchange with external vendors. Less than 60 percent of respondents reported that their Medicare contractor had sent them information or offered assistance on Y2K, and even fewer were aware that Medicare contractors offered free Y2K-ready software.

The OIG recognizes that HCFA has taken significant steps to address Medicare provider readiness. This report was designed to provide HCFA and health care provider associations with immediate access to OIG's survey results and to assist HCFA in its ongoing Y2K outreach and education efforts. (OEI-03-98-00250)

At HCFA's request, OIG further analyzed the Y2K survey results to determine if other variables had an impact on Y2K readiness. Overall, OIG found very few statistically significant relationships between these variables and the survey questions. (OEI-03-98-00252)

Year 2000 Readiness of Managed Care Organizations

Effective January 1, 1999, the Balanced Budget Act of 1997 established a new Medicare + Choice program that expanded the health insurance options available to Medicare beneficiaries. In a survey of Medicare + Choice contractors, OIG found that only 22 percent of them were Y2K ready. Of the remaining 78 percent, nearly two-thirds reported that all

their computer systems would be Y2K ready by December 31, 1999. While the majority of MCO respondents reportedly discussed possible millennium risks with their medical providers and subcontractors, most were unsure of their Y2K readiness; less than one quarter reported testing data exchanges with two-thirds or more of their medical providers and subcontractors.

The HCFA is conducting an outreach effort to address the preparedness of MCOs and is monitoring the MCO's business continuity and contingency planning efforts. The HCFA has also awarded a contract to an independent verification and validation firm to provide assistance in conducing onsite visits to numerous MCOs to assess their Y2K readiness. (OEI-05-98-00590)

Contractors' Administrative Costs for Year 2000 Remediation of Medicare Systems

During FY 1998, HCFA increased funding to its Medicare contractors by over $100 million for renovation of their computer systems in preparation for the Year 2000. At HCFA's request, OIG reviewed the administrative costs reported by four Medicare contractors to determine whether they were allowable, i.e., qualified as charges to the Year 2000 project. The OIG found that about $650,000, or 11.4 percent, of the $5.7 million in costs reported by the contractors was unallowable for reimbursement. Some of the unallowable costs were unsupported or based on estimates, while others were attributable to accounting errors. In addition to recommending financial adjustments for the unallowable costs, OIG recommended that HCFA clarify its written guidance to contractors regarding the allowability of certain cost items. In response to the draft report, HCFA generally concurred. (CIN: A-05-99-00008)

Year 2000 Contractor System Compliance

The OIG has sustained its active monitoring of the progress being made by the Medicare contractors to remediate their mission-critical computer systems in preparation for the Year 2000. To date, OIG staff have participated in approximately 360 visits to the contractors, along with staff from HCFA and HCFA's independent verification and validation contractor. These visits focused on the shared system maintainers and data processing centers used by multiple contractors to process Medicare claims. Their purpose was not only to evaluate progress in meeting HCFA's various deadlines and in resolving previously reported issues, but also to discuss concerns on the part of all parties present. Such concerns included inadequate contingency plans to deal with possible system failures, the need for additional guidance from HCFA on testing requirements and the need to conduct workload assessments to identify the time and resources necessary for meeting HCFA's compliance requirements. The results of the visits were provided in memorandums to HCFA's Chief Information Officer.

Quality of Care in Nursing Homes

Performance Measure

In a series of reports, OIG assessed the quality of care in nursing homes. While real improvements have been made in nursing home care since passage of the Omnibus Budget Reconciliation Act (OBRA) of 1987, OIG found persistent problems in nursing home conditions and systems. The OIG commended HCFA for its extensive nursing home initiative which addresses many of these areas. Also, the Administration on Aging (AoA) has taken steps to enhance the Ombudsman program.

The OIG noted that the problems identified in these reports will require continuing attention, possibly for several years. The broad outline of an effective strategy would include actions to enhance the survey and certification process; strengthen the Ombudsman program with increased resources; improve nursing home staffing levels; and improve coordination between State survey agencies and ombudsmen. Also, OIG believes that further evaluation and progress measurement would make an important contribution to efforts to advance nursing home care, specifically a systematic assessment of OBRA 1987 and the creation of a periodic report card on conditions in nursing homes.

The OIG has incorporated action items from HCFA, AoA and current OIG work into one comprehensive, long term agenda to continue improvements in nursing home care. This agenda consists of a three stage approach of immediate action, research and evaluation, and continued progress measurement. (OEI-02-98-00331; OEI-02-98-00330; OEI-02-98-00350; OEI-02-98-00351; OEI-06-98-00280; OEI-02-99-00060)

Fraud Involving Nursing Homes

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

- In Pennsylvania, a nursing home company agreed to pay the Government $3 million to settle allegations that it submitted false claims to Medicare. The improper claims were for saline dressings which were not reimbursable because they were used for cleaning purposes and not for wounds. The ongoing criminal investigation in this case has resulted in six criminal convictions, including the company owner, four salesmen and a physician for their roles in defrauding the Government and for illegal kickback activity.

- In Kansas, a nursing home therapy service provider agreed to pay the Government $688,996 to settle allegations of improper conduct with respect to providing therapy services to nursing home patients. The allegations included the following: billing for therapy that was excessive in duration, providing medically unnecessary therapy, billing for time for staff education purposes under inappropriate circumstances, excessively billing for application of splints and positioning of patients, and billing for certain aspects of wound therapy which did not require the skills of a therapist. As part of the settlement, the defendant agreed to adhere to a 3-year comprehensive corporate integrity agreement.

- In California, a diagnostics company and its owners paid the Government $400,000 to settle allegations that the company submitted, and the owners caused it to submit, false Medicare claims. Evidence showed that the company maintained two places of business so it could bill through two different Medicare carriers. Company technicians would travel to nursing homes and provide respiratory therapy and diagnostic treatment to patients, often at a frequency exceeding what was considered medically necessary by Medicare standards. The company billed a portion of the treatments through one carrier and the other portion through the other carrier so that each carrier would not know the true number of treatments provided to each patient. The Government also alleged that, on occasion, the company would bill both carriers for the same treatment. Under the terms of the agreement, the company and one of its owners agreed to a 15-year exclusion from participation in Federal health care programs. The co-owner entered into a comprehensive corporate integrity agreement covering her conduct and any entity in which she has an ownership or management interest, including the DME company she currently owns.

- A psychological services practice agreed to settle allegations of billing Medicare for mental health services not rendered to nursing home residents. The practice allegedly engaged in a broad-based scheme in the Maryland/Virginia/Washington, D.C. area of billing a comprehensive diagnostic mental health evaluation every time one of their therapists saw a nursing home patient. Over a 4-year period, their alleged submission of false claims resulted in a loss to Medicare of approximately $2 million. By the time of the settlement, the corporation had no assets and agreed to permanent exclusion and closure of its business. Two corporate officers signed separate settlements, agreeing to pay the Government $50,000 and $102,000, respectively, and to be permanently excluded. A third officer did not agree to settle, and a civil trial is pending.

- A Texas podiatrist was sentenced to 3 years probation and 4 months home confinement, and was ordered to pay restitution of $26,402 for her role in a scheme to defraud Medicare of $357,000. The podiatrist submitted forms to her billing clerk indicating she rendered a higher level of service to nursing home residents than the routine foot care she actually provided. The clerk, who admitted she submitted false claims to Medicare when she knew the podiatrist provided a lesser service, was previously sentenced to 2 years probation.

Abuse Complaints of Nursing Home Patients

The original purpose of this OIG study was to ascertain what could be learned about the extent and nature of abuse of nursing home patients based on data available from the abuse complaint systems of 11 large States.

The OIG obtained data about complaints made, but not necessarily substantiated. While OIG could not determine the extent to which nursing home patients were in jeopardy, it was able to conclude that what was being reported by patients was serious. The OIG found a consistent reporting of abuse and neglect from each of the States. More important, OIG found that each State was reporting an increase in neglect complaints. These types of complaints related directly to quality of patient care in an environment which should ensure each patient's well-being.

Due to the lack of uniform data systems and definitions across States, OIG also could not determine whether States with higher reported abuse complaint levels actually had more abuse occurring, had more aggressive abuse reporting systems, or had some other outside influencing factors.

Given HCFA's plans to strengthen the complaint process and its recent letter to the State survey agencies clarifying expectations for the collection, review, investigation and reporting of complaints, OIG will wait to conduct a further study on patient abuse complaint systems until the improved complaint process is implemented. (OEI-06-98-00340)

Glucose Monitoring in Nursing Homes

In this memorandum, OIG recommended that HCFA institute a national policy stipulating that daily routine glucose testing services provided by nursing homes are routine services covered under the per diem rate and not billable separately to Medicare.

Medicare policy does not specifically address glucose testing performed by nursing homes. Historically, nursing homes have not billed Medicare for these services. However, based on a consultant's advice, some nursing facilities have begun billing for glucose tests performed

on their patients. The HCFA has left the decision as to whether to cover these tests to individual FIs.

In 1996, Medicare nursing homes billed about $70,000 for glucose testing; in 1998, that figure rose to nearly $452,000. By contrast, a single Medicare intermediary received over 9,000 claims for nursing home glucose testing in late 1998 and early 1999. This intermediary has chosen not to pay these claims, which could cost Medicare between $3 million and $4 million. However, another FI is processing and will pay many of the 2,000 claims for glucose testing submitted by nursing homes at $100 to $300 per claim.

The OIG believes that a national policy prohibiting separate billing for glucose testing would be consistent with Medicare and Medicaid efforts to prevent unbundling of services and to establish prospective payment rates. Permitting nursing homes to bill for blood glucose tests invites abuse and risks substantial program losses. (OEI-05-99-00380)

Skilled Nursing Facilities

Performance Measure

The OIG produced three reports on the early effects of the PPS on access to skilled nursing facilities (SNFs), and the appropriateness of Medicare payments for physical and occupational therapy in SNFs. The studies found that, so far, there are no serious problems in placing Medicare beneficiaries in nursing homes. However, nursing homes are changing their admission practices in response to the new PPS; one-fifth of the hospital discharge planners say that, as a result, it has become more difficult to place patients who require extensive services, while it has become easier to place patients who need rehabilitation services. The OIG also found that most nursing home patients were appropriate candidates for and benefitted from the physical and occupational therapy they received. However, almost 13 percent of the therapy was billed improperly to Medicare because it was not medically necessary and/or the therapy was provided by staff who did not have the appropriate skill.

The OIG recommended that HCFA instruct Medicare fiscal intermediaries to provide more training to facility and therapy staff on Medicare coverage criteria and guidelines, local medical review policies and monitoring procedures for therapy; work collaboratively with the national therapy and nursing home associations to assure that they provide accurate and comprehensive information to their members; and adequately fund Medicare contractors to perform medical reviews of therapy. The HCFA agreed with the recommendations. (OEI-02-99-00400; OEI-09-97-00121; OEI-09-97-00122)

Criminal Fraud

One of the most common types of fraud perpetrated against Medicare, Medicaid and other Federal health care programs involves the filing of false claims or statements. Such false claims may be pursued civilly under the False Claims Act (see, for example, the hospital

initiatives described on pages 7-10, above). In appropriate cases, false claims may also be prosecuted criminally as Federal offenses such as mail fraud, wire fraud, false statements and various health care fraud offenses. Following are descriptions of criminal prosecutions successfully concluded during the reporting period:

- A North Carolina podiatrist was sentenced to 1 year and 1 day imprisonment, 2 years supervised probation, payment of $4,335 in restitution and a special assessment of $14,100. In addition, a settlement calls for him to pay the Government $400,000 and for his permanent exclusion. In parallel criminal and civil proceedings, the Government alleged that over a 5-year period, the podiatrist submitted false claims to Medicare and Medicaid. Specifically, he sought payment for nonroutine surgical procedures when he actually performed routine services, such as the cutting and trimming of toenails, and the removal of corns and calluses. Through this scheme, he received approximately $142,000 from Medicare and Medicaid. He previously pled guilty to 52 counts of mail fraud, wire fraud, false statements and health care fraud. He also pled guilty to 12 counts of false statements with regard to fraud committed against the Medicaid program.

- In Florida, a licensed acupuncturist was sentenced to 33 months imprisonment, 3 years supervised release and payment of $50,000 in restitution for conspiracy to defraud Medicare. The acupuncturist and his former wife operated six acupuncture clinics. They conspired with physicians in a scheme to circumvent and defraud the Medicare program for nonreimbursable acupuncture and related treatments. The investigation involved the first known extradition of a fugitive from a foreign country based on Medicare fraud charges. In 1994, the acupuncturist fled the United States to Taiwan via Hong Kong after being charged with Medicare-related violations, as well as unrelated sexual battery charges filed by the State.

- A Pennsylvania man was sentenced for his role in the improper billing practices of his employer, a physician. He was sentenced to 6 months home detention, 3 years probation and a $4,000 fine for mail fraud. As a billing manager for the physician, he participated in the submission of false claims for services not rendered to Medicare and private pay patients. The fraudulent activity resulted in an estimated loss of over $600,000. Finally, the physician was sentenced for racketeering and sale of prescription drug samples to 3 years imprisonment, 5 years supervised released, payment of $650,000 in restitution, forfeiture of $105,000 to the Government and a $25,000 fine. The physician inappropriately prescribed certain controlled

substances to patients who were, in fact, drug abusers and improperly billed for services not rendered to Medicare and private pay patients.

- Another Pennsylvania man was sentenced to 37 months incarceration, 3 years supervised release and payment of $21,616 in restitution for using a fictitious medical license, illegally distributing controlled substances and mail fraud. Posing as a physician specializing in psychiatry and licensed in Pennsylvania, the man entered into a physician-patient relationship with more than 500 patients to whom he provided psychiatric treatment and care. In so doing, he often prescribed controlled substances to patients, including powerful prescription medications. He was neither licensed to practice medicine in Pennsylvania, nor authorized to prescribe drugs or render other psychiatric services.

- A Virginia physician was sentenced to 6 months house arrest, 2 years probation and payment of a $20,000 fine. The physician previously pled guilty in November 1998 to mail fraud in connection with defrauding the Medicare and Medicaid programs. As part of his criminal plea, he agreed to surrender his medical license for life and to pay $26,112 in criminal restitution. A psychiatrist in practice for the past 30 years, he falsely represented that he treated patients when a licensed professional counselor actually provided the services. He also engaged in improper billing practices related to the treatment of his patients during hospitalization; for example, he submitted claims to Medicare for individual psychotherapy services and psychiatric evaluations not rendered. In addition, the investigation uncovered allegations that the psychiatrist used treatment of an unconventional and sexually inappropriate nature.

- In Florida, a laboratory owner was sentenced for conspiracy to submit false claims to 3 years probation, with a special condition that he serve 4 months in a special treatment center, followed by 8 months home confinement. The man paid kickbacks to local doctors and clinic owners in return for their referring clinical laboratory services to his laboratory. Moreover, he actively solicited clinics and encouraged them to order certain tests, with a higher Medicare reimbursement rate, for which he could bill the program. In order to have the cash necessary to pay these kickbacks, the laboratory owner engaged in an elaborate money laundering scheme. Two other codefendants, who participated in the money laundering scheme by cashing checks under the $10,000 Internal Revenue Service reporting requirement, were sentenced as well. One was sentenced to 60 days home confinement, 2 years probation and participation in an approved outpatient mental health program. The other was sentenced to 3 months home confinement and 4

years probation, with a special condition that he serve 4 months in a special treatment center.

Kickbacks

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

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

- referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Medicare or Medicaid programs; or

- purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service or item payable under the Medicare or Medicaid programs.

Violators are subject to criminal penalties, or exclusion from participation in the Medicare or Medicaid program, or both. They may also be subject to CMPs. The following cases are some of the examples of the sentences for this crime:

- In Florida, the employee of a mobile diagnostic laboratory was sentenced to 3 years probation and payment of $349,000 in restitution for conspiracy to defraud the United States Government through illegal kickback activity. The man paid kickbacks in exchange for Medicare patient referrals. In addition to his sentencing, two other case-related subjects entered into a pre-trial diversion program. Both former owners of impotence clinics, these individuals committed offenses against the Medicare and Civilian Health and Medical Plan of the Uniformed Services (CHAMPUS) programs, now known as TRICARE. This investigation was opened after receiving allegations that numerous impotence clinics in Florida were billing Medicare and CHAMPUS for services and DME not medically necessary or not ordered by physicians.

- A New York man was sentenced to 5 months imprisonment, 5 months home confinement and 2 years supervised release for his role in illegal kickback activity. His scheme involved paying kickbacks to doctors in return for patient referrals to a magnetic resonance imaging (MRI) company where he served as a "medical consultant." As part of the scheme, the man received checks from the MRI company's owners made payable to his own business. He then deposited the checks into his business account and paid the referring doctors in cash. As part of his sentence, he was ordered to file an amended tax return to account for unclaimed kickback monies he received through this scheme.

- In New York, a man was sentenced to 3 years probation, 4 months home detention and a $1,000 fine for conspiracy to commit mail fraud and illegal kickback activity. He engaged in these improper activities while working as the office manager for a physician. From 1990 through 1994, the two conspired to solicit and obtain kickbacks from specific medical facilities in return for Medicare patient referrals to those facilities for diagnostic services. They then split the kickbacks received. For his part in the scheme, the physician was arrested for mail fraud and sentenced to 2 years probation, 6 months home detention and a $30,000 fine.

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 1,943 administrative sanctions, in the form of program exclusions or civil actions, on individuals and entities for engaging in fraud or abuse or other activities deemed to be a risk to Federal health care programs and/or their beneficiaries.

A. Program Exclusions

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

During this reporting period, OIG imposed exclusions on 1,689 individuals and entities. The following are examples of some of the exclusions that were imposed:

- A registered nurse in Colorado was excluded from participating in Medicare, Medicaid and all Federal health care programs for a period of 10 years following his conviction in district court of second degree assault against two hospital patients. The registered nurse was sentenced to 6 years imprisonment (suspended), placed on 4 years probation, and required to register as a sex offender.

- In Alabama, a man posing as a licensed professional counselor and clinical psychologist was excluded from program participation for 10 years. For over 8 years, the subject used the mail to defraud the FEHBP, TRICARE, private insurance companies and approximately 450 individual patients by submitting false claims. He was sentenced to 18 months in prison and ordered to pay restitution of over $300,000.

- A certified nursing assistant in Tennessee was excluded for 20 years after being convicted of raping a resident of a rehabilitation center. The man pled guilty to two counts of rape and was sentenced to 16 years in prison. Further, local police received allegations of sexual assaults by the man against his own children, and he was charged with 15 additional counts of rape of a child. In this instance, the man pled guilty to one count of rape and was sentenced to 8 years imprisonment, to be served concurrently.

- After pleading guilty to four counts of violation of the Controlled Substance, Drug, Device, and Cosmetic Act, a Pennsylvania pharmacist was sentenced to serve 23 months incarceration and ordered to pay $12,000 in restitution. Over a 3-year period, the pharmacist illegally dispensed the medication Darvon to a customer without a doctor’s prescription. After overdosing on the medication, the customer reported the pharmacist’s illegal activities to the police. The pharmacist was excluded for 10 years.

- In Maryland, a physician who prescribed medication to Internet clients around the world, whom he admittedly never examined, was excluded indefinitely from program participation after surrendering his license to practice medicine in the State. The physician had sex with several of his patients and handed out medication indiscriminately. One patient died under his care from "drug intoxication," and another patient, under treatment for cocaine addiction, committed suicide.

- As part of a plea agreement, OIG consented to the permanent exclusion of an Ohio physician charged with obstructing a criminal investigation of health care offenses. The physician came under investigation by the FBI and other law enforcement agencies as a result of reported billing

irregularities and improprieties. His office housed its own laboratory where blood tests for his patients were conducted. Ordered to turn over a number of records via subpoena, the physician altered many of the patient cards, adding entries to make it appear that certain in-house laboratory blood tests had been ordered and performed when he knew they had not been. Also, test reports from other outside laboratories were removed from patient files so it would appear that these blood tests (which were billed by the physician to Medicare) had been performed in his office. The physician was ordered to pay restitution of almost $29,000 and a CMP of approximately $57,000.

- A clinic owner in Georgia was excluded from program participation for 20 years. The subject was indicted along with 11 others as part of a scheme to defraud Medicare. The scheme, which involved 6 clinics and diagnostic companies, utilized patient recruiters and unlicensed physicians assistants. Medicare was then billed for medically unnecessary and nonrendered services, and the proceeds were laundered by the clinic owners and employees. The total loss to the Medicare program was in excess of $6 million dollars. For his part in the scheme, the clinic owner was sentenced to 21 months in jail, 3 years supervised release and a $50 special assessment. He was also ordered to pay full restitution in the amount of $696,000.

B. Civil Penalties for Patient Dumping

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

The OIG is authorized to impose CMPs of up to $25,000 against small hospitals (less than 100 beds) and up to $50,000 against larger hospitals (100 beds or more) for each instance

where the hospital negligently violated any of the section 1867 requirements. In addition, OIG may impose a CMP of up to $50,000 against a participating physician, including an on-call physician, for each negligent violation of any of the section 1867 requirements.

Between April 1, 1999 and September 30, 1999, OIG collected $1.7 million in CMPs from 61 hospitals and physicians. The following is a sampling of the alleged violations involved in the FY 1999 Patient Anti-Dumping Statute settlements from this reporting period.

- A Tennessee emergency room physician agreed to pay $15,000 to resolve one dumping allegation. The incident involved the inappropriate transfer of a gunshot victim to a trauma center approximately 30 miles away. The patient was thought to be stabilized; however, immediately prior to transfer the patient began to bleed heavily. Nonetheless, the physician transferred the patient by ambulance but without blood, even though blood was available and the patient had been prepped to receive blood. Shortly after arriving at the trauma center, the patient died from blood loss and a heart attack.

- An Illinois hospital paid $50,000 to resolve dumping allegations that six patients did not receive appropriate medical screening examinations. In five of the cases, the hospital was denied prior payment authorization by the individuals' managed care organizations. Four of these patients, children aged 4-12, were triaged and advised to see a physician in the morning. The fifth was an 84-year old who was only triaged. In the sixth case, the emergency room physician instructed the patient to go to an urgent care center for treatment.

- A New York obstetrician/gynecologist (OB/GYN) agreed to pay $45,000 and attend and complete training on the requirements of, and the physician obligations under, the Patient Anti-Dumping Statute. This physician allegedly failed to come to the hospital, examine and treat a 19-year old uninsured pregnant patient in active labor. In addition, the OB/GYN refused to admit the patient and requested that the patient's boyfriend drive her to another hospital rather than arrange for an appropriate transfer.

- A hospital in Kansas paid $148,000 to resolve dumping allegations that involved four burn victims. In one incident, the hospital failed to provide an appropriate transfer for a patient. The remaining three incidents involved the hospital's failure to accept patients who needed the hospital's specialized capabilities or facilities. Three of the four patients had out-of-state Medicaid insurance coverage.

- A Maryland hospital resolved a dumping allegation by paying $35,000 because it failed to respond to a request made for treatment of a man who collapsed outside the hospital but on hospital grounds. The man had come to the hospital with family members but went outside because he was not feeling well. After the emergency room denied two requests for assistance made by hospital security guards, a security guard was able to obtain the assistance of a doctor and other hospital personnel. The man could not be resuscitated and died.

C. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers and others who submit false or improper claims to the Medicare and State health care programs. The OIG also assists DOJ in bringing (and settling) cases against wrongdoers under the False Claims Act. Many providers elect to settle their cases prior to litigation. As part of resolving these cases, OIG frequently imposes corporate integrity agreements on entities as a condition for being allowed to remain as a provider in the Medicare program. The integrity programs established by these agreements are designed to prevent a recurrence of the fraudulent activities that gave rise to the case at issue. The Government, with the assistance of OIG, recouped more than $160 million through both CMP and False Claims Act civil settlements related to the Medicare and Medicaid programs during this reporting period. Some examples of these cases include:

- A major home health services corporation and one of its subsidiaries entered into a global settlement totaling $61 million with the Government, including approximately $10 million in criminal fines. The settlement resolves the corporation's criminal, civil, and administrative liability arising from Medicare fraud investigations in Georgia, Florida, and New York. In Georgia and Florida, the investigation examined a series of transactions in which the home health services corporation paid another large health care corporation in order to secure the right to provide Medicare-reimbursable management services to the other corporation. The home health services corporation's payments took various forms, including selling its HHAs to the other corporation at below-market prices, and making cash contributions to the other corporation's purchase of HHAs from third parties. As a result of this investigation, the subsidiary pled guilty to conspiracy, mail fraud and violation of the Medicare anti-kickback statute. In New York, an independent investigation focused on allegations that the corporation submitted unallowable expenses on its Medicare cost reports, including personal expenses of executives, gifts and entertainment, and merger costs. In addition to paying $61 million, the corporation entered into a comprehensive corporate integrity agreement with OIG.

- Stemming from a qui tam complaint filed in New Mexico, two former Medicare contractors agreed to settle their False Claims Act, criminal and administrative liability for misrepresenting their performance to HCFA. In order to resolve allegations of manipulating certain computer files to obtain a better score on the Contractor Performance Evaluation Program, one of the corporations agreed to pay the Government $6.84 million. On or after May 1, 2001, the United States may, at its sole discretion, demand that the other corporation pay the Government $5.86 million, after considering the corporation's financial condition, for attempting to conceal evidence of poor performance on their audits of Medicare Part A providers. In addition, both corporations will forgo contract claims totaling $3.1 million. Both corporations also entered into a 5-year corporate integrity agreement with OIG. In addition, as part of the global settlement, the former contractors pled guilty to obstruction of a Federal audit and conspiracy to obstruct a Federal audit. A third corporation, co-owned by the contractors to provide them with management services, pled guilty to conspiring to obstruct a Federal audit as well. The three companies agreed to pay a total of $1.5 million in criminal fines which will be applied to their civil liability. The United States should ultimately receive $15.8 million in criminal fines, the civil settlement and the contract claims.

- A psychiatric hospital with a partial hospitalization program (PHP) in the Chicago, Illinois area agreed to pay the Government $4 million to resolve allegations of improper billing practices. The settlement covers Medicare claims the hospital submitted for partial hospitalization services rendered to patients for over a 3-year period. Through its PHP, the hospital submitted claims to Medicare for services which were not medically necessary, reasonable or appropriate. As part of the settlement, the hospital also agreed to a 5-year corporate integrity agreement that specifically addresses the billing of PHP services and applies to its affiliates, including therapeutic day schools and outpatient clinics. In order to fund the settlement payment, the owner sold the hospital, and the buyer has agreed to comply with the relevant provisions of the corporate integrity agreement.

- A physician and his oncology clinic jointly agreed to pay the Government $963,736 to resolve their civil liability for submitting false claims, and entered into a corporate integrity agreement with OIG. Between 1992 and 1997, the physician and his clinic allegedly submitted improper claims to Medicare and the Mississippi Medicaid program for services rendered at the clinic by nonphysicians without a physician's supervision or presence. The corporate integrity agreement applies to all entities in which the physician has an ownership or management interest and that submit claims for

reimbursement to any Federal health care program. The physician currently owns two rural oncology clinics, one in Mississippi and the other in Illinois.

- A Pennsylvania physician agreed to pay the Government $225,000 to settle allegations that his practice upcoded office visits and angioplasty consultations. This settlement figure represents approximately treble damages. The physician also agreed to enter into a 3-year corporate integrity agreement.

- A health care services corporation agreed to pay the Government $195,000 to resolve its liability for submitting claims for poor quality services at one of its nursing facilities. The case stems from a 1996 HCFA survey of several residents' records that uncovered inadequate nutrition care, wound care, incontinence care and supervision at a nursing facility in Pennsylvania. The poor quality of care alleged was attributed primarily to an inability to control high staff turnover. In addition to the amount paid in damages, the settlement calls for comprehensive compliance provisions that include implementation of a specific quality of care protocol, training and the appointment of an independent consultant for 1 year to monitor and ensure provision of quality care.

- A New York physician agreed to pay the Government $23,041 to settle allegations related to improper billing practices. Between August 1991 and December 1996, the physician allegedly billed Medicare for certain arthroscopy surgical procedures as if they were more complex surgical procedures than those actually performed. As a result, he received an approximate overpayment of $14,127. As part of the settlement, the now retired physician agreed to permanent exclusion from Medicare, Medicaid and other Federal health care programs.

Under the CMP law (CMPL), OIG has authority to proceed administratively against persons or entities who submit false claims for payment under the Medicare and Medicaid programs. Under CMPL, the Inspector General may impose a civil penalty of "not more than $10,000 for each item or service" falsely claimed, and "an assessment of not more than three times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim." (42 U.S.C. 1320a-7a). Among the cases successfully pursued under the CMPL authority were:

- In Maine, a small town agreed to pay $50,000 to resolve allegations that the town submitted false claims to Medicare for the use of the fire department's ambulance service in circumstances where there was no medical necessity. Ambulances were being used as a taxi service to transport the town's

residents to the hospital because the town was afraid of liability should it not pick up someone who called.

- A Colorado pharmacist, his wife and the irrevocable trust for which his wife is a trustee agreed to pay $120,267 to resolve alleged violations of billing while excluded. After being excluded from participating in Medicare and State health care programs, the pharmacist caused Medicaid to improperly pay for more than 2,000 claims that were submitted for prescriptions he filled. His wife and the trust were parties to the agreement because some of the pharmacies involved were owned by the irrevocable trust.

- Queries into the National Practitioner Data Bank (NPDB) are restricted by statute to hospitals, other health care entities, State licensing boards and professional societies. Authorized agents may only query with the specific authorization of an eligible entity for specifically designated and limited purposes. An Arizona corporation agreed to pay $42,500 to resolve allegations of unauthorized queries into the NPDB. The corporation allegedly queried the NPDB on behalf of an eligible entity without due authorization. The OIG deemed that the queries violated NPDB confidentiality provisions, which include improper disclosure, use or access to NPDB information. This was the first time the Inspector General imposed a CMP for alleged violations of NPDB confidentiality provisions.

D. Compliance Activities

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

The OIG continues in its efforts to promote voluntarily developed and implemented compliance programs by providing guidance for the various parts of the health care industry. To this end, OIG has developed and released compliance program guidance for clinical laboratories, hospitals, HHAs, third-party billing companies, DME, prosthetics and orthotics suppliers, and hospices. The OIG is currently working on guidance for other sectors of the industry, including Medicare+Choice organizations that offer coordinated care plans and nursing homes. The seven fundamental elements of an effective compliance program are: implementing written policies, procedures and standards of conduct; designating a compliance officer and compliance committee; conducting effective training and education; developing effective lines of communication; enforcing standards through well-publicized disciplinary guidelines; conducting internal monitoring and auditing; and responding promptly to detected offenses and developing corrective action initiatives.

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

In addition to developing compliance program guidance, OIG monitors corporate integrity obligations imposed on health care providers as part of global settlements of OIG investigations and audits. Presently, OIG is monitoring 418 Government-imposed corporate integrity agreements. These agreements cover the range of providers from small physician offices to large hospitals and laboratory corporations. The duration of most corporate integrity agreements is 5 years and these agreements require a substantial effort by the provider to ensure that the organization is operating within HCFA rules and regulations and the parameters established by the corporate integrity agreement. Failure to adhere to the corporate integrity agreement could result in exclusion of the provider in addition to other penalties.

For the first time, OIG and the health care industry, in conjunction with the Health Care Compliance Association, conducted a joint roundtable on health care compliance to gain new insights into the challenges of creating effective compliance programs. A summary report on this meeting was issued on April 13, 1999, and is available on OIG's website. The March 22 Washington, D.C. event was a direct result of OIG's desire to engage in constructive discussions with the health care compliance industry about various practices and policies related to compliance programs, including how to deal with compliance recommendations advanced by OIG. Over 125 compliance officers, health care compliance consultants and Government representatives attended the day-long event. The participants represented a wide spectrum of institutional and individual provider organizations.

Beneficiary and Provider Outreach Activities

Since the February kick-off of the national initiative against waste, fraud, and abuse in the Medicare program, OIG has continued its collaborative partnership with HCFA, the Administration on Aging (AoA), the American Association of Retired Persons (AARP) and DOJ, including the Federal Bureau of Investigation. Since the event, the OIG hotline (1-800-HHS-TIPS) has served as an educational and reporting resource to approximately 300,000 callers. The hotline has also experienced a spike in calls from Puerto Rico and has established an active monitoring and evaluation system to ensure that concerns of the Hispanic community are addressed.

All of the outreach partners listed above have individual and collaborative activities underway. The OIG continues to distribute hundreds of its Medicare fraud educational materials to beneficiaries through AoA grantees, the AoA network and AARP regional offices, and is pursuing endorsement from the American Library Association of its "Medicare Fraud is Money Down the Drain" poster for distribution to member libraries

nationwide. Efforts are also underway to develop a working relationship with Asian American and Hispanic organizations to translate and print Medicare fraud materials into Mandarin Chinese and distribute these materials and those already printed in Spanish, to Chinese Americans and Hispanics.

In addition to beneficiary outreach, OIG has made progress in working with provider groups. Specifically, OIG has coordinated discussion between the partners and the American Hospital Association, has had two productive meetings with the American College of Physicians/American Society of Internal Medicine and seeks to promote dialogue with other provider groups.

Mutually Exclusive Procedure Codes at Hospital Outpatient Departments

Mutually exclusive procedures represent medical services that cannot reasonably be furnished in the same session, to the same patient, and by the same provider. An OIG review found that while HCFA established edits to preclude payment for certain mutually exclusive services provided by doctors' offices and clinics, payment for the same type of services was not prevented when provided in hospital outpatient departments. The OIG recommended that HCFA instruct FIs to implement edits to preclude payment for Medicare Part B mutually exclusive procedure codes. Based on its review of payments for radiology and pathology/laboratory services made in 1996 and 1997 by FIs, OIG believes these edits would result in savings to Medicare of approximately $29.1 million over a 2-year period. Also, OIG recommended that HCFA notify hospital providers that Medicare Part B will no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services. The HCFA generally concurred with the recommendations. (CIN: A-01-98-00507)

Home Health Care Reimbursement

During this reporting period, OIG reviewed statistical samples of the home health care services claimed by three Florida providers to determine whether they met Medicare reimbursement guidelines.

In an audit of 100 claims filed by one provider, OIG found that 44 involved services that did not meet Medicare reimbursement requirements. The 100 claims involved 2,264 services, of which 759 were unallowable. The OIG estimated that between $2.2 million and $3.8 million of the $9.1 million claimed by the provider for the year ending December 31, 1996 did not meet reimbursement requirements.

In a second review, OIG determined that 42 of 100 claims involved services that did not meet Medicare reimbursement requirements. The 100 claims involved 2,294 services, of

which 577 were unallowable. The OIG estimated that between $1.9 million and $3.5 million of the $8.3 million claimed for 1996 did not meet the reimbursement guidelines.

In its third review, OIG found that 32 of 100 claims involved services that did not meet Medicare reimbursement guidelines. The 100 claims involved 1,930 services, of which 429 were unallowable. The resulting overpayment was estimated at between $2.3 million and $4.7 million of the $21.8 million claimed by the provider for 1996.

Although OIG found that the providers monitored their own employees and subcontractors, the monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement requirements; it did not properly address homebound status, the medical necessity of services or duplication of services. The OIG recommended that HCFA instruct the FI to recover the overpayments; require the FI to instruct the providers on their responsibilities to properly monitor their subcontractors for compliance with Medicare regulations; and monitor the FI and the providers to ensure that corrective actions are effectively implemented. The HCFA concurred with the recommendations. (CIN: A-04-97-01170; CIN: A-04-97-01169; CIN: A-04-97-01166)

Home Health Agency Fraud

Home health agencies are one of the fastest growing segments of the health care industry because they allow many patients to remain in their own homes at less expense than might be incurred at a hospital or other institution. The OIG has become aware of a number of fraudulent arrangements by which home health care providers, medical professionals and others associated with the operation of HHAs, inappropriately bill Medicare and Medicaid. The following cases represent some examples of improper activities related to the provision of home health care services:

- As the result of an OIG investigation and audit, a multimillion dollar settlement was reached with the largest home health care company in Texas. The company agreed to pay the Government $10 million to resolve allegations involving its subsidiary, a provider of home health care and infusion therapy services. Allegedly, the subsidiary improperly charged Medicare for unallowable costs including salaries, travel and legal fees. In addition, the subsidiary allegedly conspired with and caused SNFs to overcharge Medicare for infusion therapy drugs, supplies and nursing services. As part of the settlement, the subsidiary also entered into a comprehensive corporate integrity agreement with OIG.

- A Texas physician and his clinic agreed to pay the Government $1.7 million to settle allegations of violating the Federal physician self-referral prohibition and Federal health care program regulations. The physician allegedly participated in a scheme to circumvent prohibitions against the

referral of patients to an HHA in which the physician has a significant ownership interest. The physician violated these statutes by indirectly referring his patients to an HHA owned by his wife. In settling this case, the OIG waived its permissive exclusion authority and imposed a corporate integrity agreement requiring outside audits, reporting and other compliance measures over the next 5 years. One factor considered in OIG's decision to waive its permissive exclusion authority involved the essential specialized services the physician provides to indigent patients in an underserved area. This investigation arose out of a civil lawsuit involving allegations of cost report fraud against the physician's wife.

- In Arizona, a couple who owned and operated an HHA was sentenced for theft of public monies. The wife was sentenced to 1 year probation, restitution of $97,201 and a fine of $3,000. Her husband's sentence included 3 years probation and 140 hours of community service. It was alleged that the couple paid for patient referrals and that they operated a DME company and private staffing company, using the same staff as their Medicare-funded operation. During the execution of a search warrant, evidence of cost report fraud was obtained. As a result, the Medicare carrier suspended payments to the HHA, and the business closed shortly thereafter. The couple also agreed to permanent exclusions from the Medicare and Medi-Cal programs.

Laboratory Fraud

During this reporting period, OIG successfully resolved civil cases related to fraudulent billings to Medicare, Medicaid and other Federal health care programs on the part of laboratories, physicians and other providers of laboratory services. In addition to settlements reached as part of the Hospital Outpatient Laboratory Project discussed on page 9, convictions and settlements were also obtained for other types of fraudulent or abusive activities involving laboratories and these health care providers. The following cases represent significant examples of laboratory fraud which resulted in settlements during this period:

- In Pennsylvania, a medical care company agreed to pay the Government $16.5 million to resolve allegations regarding the filing of false Medicare claims by various companies it acquired. The claims arose from the sale of mobile diagnostic tests to the patients of independent physicians nationwide. These noninvasive tests were primarily marketed between 1992 and 1995 by a diagnostic laboratory purchased by one of the company's subsidiaries in 1994. The laboratory and this subsidiary marketed their mobile diagnostic tests by offering various kickbacks to doctors in exchange for ordering tests for their patients. This improper practice resulted in the

performance of thousands of medically unnecessary tests. Company salesmen also engaged in improper billing practices despite Medicare's prohibition against claiming services doctors do not personally provide. This settlement resolves three different qui tam suits brought against the laboratory, the subsidiary and/or related companies, alleging similar conduct.

- An independent clinical laboratory in Michigan agreed to pay the Government $500,000 to resolve its liability under the False Claims Act. The laboratory allegedly submitted improper Medicare Part B claims for additional hematological indices, calculations derived from CBC test results. The CBC testing machines were programmed to automatically calculate the results of additional indices for which the laboratory billed, even though the physicians did not order them. Since the additional indices were not medically necessary, they were not covered under Medicare guidelines. Corporate integrity provisions were not required as the laboratory is no longer in business.

- A Massachusetts hospital specializing in clinical laboratory services agreed to pay the Government $476,167 to resolve allegations of improper billing practices and to enter into a 3-year corporate integrity agreement. This settlement resulted from a voluntary disclosure by the hospital under OIG's Voluntary Disclosure Pilot Program. The investigation focused on improper billings for various pathology laboratory tests over a 6-year period. The disclosure and subsequent verification audit determined that various billing irregularities, primarily involving services claimed but not documented, and upcoded services, resulted in an approximate overpayment of $326,000 by Medicare and Medicaid.

Usage and Documentation of Home Oxygen Therapy

In an inspection of usage and documentation of home oxygen therapy, OIG found nearly one-quarter of oxygen certificates of medical necessity (CMNs) to be inaccurate or incomplete, and estimated that Medicare paid $263 million in 1996 for oxygen equipment covered by such CMNs. The OIG also found that 13 percent of beneficiaries reported never using their portable oxygen systems. In addition, some suppliers were unable to fully document the equipment services they reported providing to beneficiaries.

The OIG recommended that HCFA ensure that carriers' system edits identify incomplete CMNs, and delay payments for oxygen equipment claims until complete certificates are submitted. In addition, OIG proposed that HCFA target oxygen claims for focused medical review; quickly establish specific service standards for home oxygen suppliers; and continue to alert physicians to their critical role in determining medical need for and utilization of

medical equipment paid for by Medicare. The HCFA concurred with OIG's recommendations. (OEI-03-96-00090)

Fraud Involving Durable Medical Equipment Suppliers

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

- A Florida man was sentenced after previously pleading guilty to count one of a 23-count indictment charging him with conspiracy, mail fraud and money laundering. He was sentenced to 46 months imprisonment followed by 2 years supervised release. He was also ordered to pay restitution of over $14 million both jointly and severally. For over 4 years, he owned and operated numerous DME companies in Florida along with several other individuals. These companies billed Medicare for nutritional supplements for beneficiaries who did not require the product.

- In California, a DME company located in Missouri agreed to pay the Government $1.2 million to settle allegations that the company submitted false claims to Medicare. The company's misconduct was uncovered during an OIG investigation of a home health care corporation based in California. The company allegedly submitted claims to Medicare for DME after patients had died, had been admitted to a SNF and/or hospital, or after the DME had been returned to the company. The company also allegedly submitted Medicare claims for which CMNs and other claims documents were improperly altered, falsified or marked to facilitate payment. In addition, claims were submitted which lacked the required claims submission documents or were for noncovered items. As part of the settlement, the company entered into a 5-year corporate integrity agreement.

- In New York, four individuals were sentenced for their participation in a scheme to defraud Medicare. Along with others, these individuals owned and operated three DME companies that billed four DME regional carriers for upcoded services. Originally exposed by a local, consumer-related news program, their scheme involved the use of aggressive telephone marketing aimed at providing lower quality DME to Medicare beneficiaries than the higher quality items reflected in their Medicare billing. For his role in the scheme, one man was sentenced to 2 years probation and a $5,000 fine. Two others each received 2 years probation. These three, along with

another defendant, previously entered into, and paid, a civil settlement of $380,000 in connection with this investigation. Finally, the fourth individual, who acted as the chief owner/operator of the three DME companies, was sentenced for his role in the scheme to 5 years probation, 1,000 hours of community service and payment of $19,871 in restitution. All individuals and entities were sanctioned.

- In Florida, a DME company owner was sentenced to 30 months imprisonment and 3 years supervised release for conspiracy to defraud Medicare via mail fraud. Through his DME scheme, the man and his company caused a loss to the Medicare program of over $500,000. In order to generate claims for his company, he paid beneficiaries for the use of their names and Medicare numbers. He also paid cash to physicians for their signatures on oxygen-related DME prescriptions and to the owner of an oximetry company for false oxygen testing results.

- In New York, a man was sentenced to 3 years supervised release and ordered to make restitution of $40,000 based on violations of mail fraud and illegal kickback activity. A former DME company owner and supplier, the man paid kickbacks to a podiatrist, in return for Medicare patient names and their Medicare numbers. He then provided medically unnecessary lymphedema pumps to these patients.

Licensing Requirements for Prescription Drug Suppliers

Performance Measure

The OIG reviewed HCFA and National Supplier Clearinghouse (NSC) efforts to ensure that DME suppliers have valid pharmacy licenses to bill Medicare for prescription drugs. Only DME supply companies licensed to dispense prescription drugs may bill Medicare for these items when provided in conjunction with DME or prosthetic devices. The NSC is responsible for issuing Medicare supplier billing numbers and ensuring that suppliers meet prescribed standards for participation.

The OIG determined that NSC has taken several steps to determine that DME suppliers billing for drugs have valid pharmacy licenses and that few non-licensed suppliers continue to bill Medicare for drugs. Since HCFA and NSC appear to be taking appropriate action in this area, OIG issued this informational report to encourage collaborative efforts to recover incorrect payments and identify any remaining suppliers without required licensure. (OEI-07-98-00460)

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 the patients are really taken to other facilities for which claims are nonreimbursable. Other schemes include billing singly for patients who were transported as a group and falsely claiming reimbursement for ambulatory patients. The following examples of cases involving transportation fraud were resolved during this reporting period:

- Two Maryland ambulance company owners pled guilty to theft from the Medicare program and to Medicaid fraud. Together, they owned and operated three ambulance companies. From 1993 through 1998, the business partners and their companies defrauded Medicare and Medicaid by transporting ambulatory beneficiaries to doctors' offices and dialysis centers. When necessary, they also acted in the capacity of billers, drivers, dispatchers and emergency medical technicians. One of the owners was sentenced to 10 years incarceration, with all but 18 months suspended, placed on 5 years probation and ordered to pay $555,134 in restitution. The other owner involved in the scheme will be sentenced at a later date.

- In Delaware, two individuals were sentenced to 30 months incarceration, 3 years probation and an $800 special assessment for their roles in a scheme to defraud Medicare by submitting false claims for ambulance transportation. Their medical billing company, now a defunct corporation, was also ordered to pay a special assessment of $3,200. The scheme involved a conspiracy between an ambulance company and the defendants, acting as the ambulance company's billing service. The ambulance company transported as many as six people at a time in wheelchairs and passenger vans to free-standing dialysis centers for treatment. The ambulance company, its president and vice-president pled guilty in 1997 and were previously sentenced. During the 10-month relationship between the two companies, Medicare paid them over $1.2 million, of which approximately $900,000 was due to improper billings.

- In Pennsylvania, a transportation broker agreed to pay the Government $4,500 to settle allegations that he violated the anti-kickback provisions of section 1128B(b)(1) of the Social Security Act. Evidence showed that this individual received illegal remuneration from ambulance companies in exchange for referrals from nursing home providers that ordered ambulance services that were billed in whole or in part to the Medicare and Medicaid programs. Under the terms of the settlement agreement, the individual agreed to cooperate with any current or future OIG investigations related to

such ambulance services that were provided by any of the ambulance companies from which he allegedly received illegal remuneration.

Bad Debts Reported by Medical Corporation

A medical corporation headquartered in Massachusetts provided renal dialysis treatment at 647 facilities in CY 1996. Each facility had a Medicare provider number and prepared a separate cost report. The corporation allocated indirect home office costs to the facilities and controlled certain direct charges that were also included in each facility's cost report. The OIG determined that the corporation allocated about $16.1 million in unallowable costs to 320 facilities claiming reimbursable bad debts in CY 1996. As a result, reimbursable bad debts were overstated by $1.5 million.

While the corporation has taken actions over the years to remove significant unallowable costs from its facilities' cost reports, corrective action is still needed to address the unallowable costs identified in this report. Accordingly, OIG recommended that the corporation establish additional procedures to exclude these unallowable costs from future cost reports. Further, OIG recommended that HCFA instruct the FIs to apply the cost adjustments and make the appropriate adjustments to reimbursable bad debt amounts claimed on the CY 1996 cost reports, and recover all overpayments. The corporation agreed with most of OIG's recommendations. (CIN: A-01-98-00508)

Pension Plan Audit

The OIG identified about $7.6 million in excess pension assets at Blue Shield of California which should be remitted to Medicare because of the closing of the Medicare segment of the contractor's pension plan. Blue Shield of California was a Medicare Part B contractor until its contract was terminated in 1996, and, as such, claimed Medicare reimbursement for Medicare employees' pension costs. Regulations and the Medicare contract provide, however, that pension gains attributable to the Medicare segment of a terminated contractor's pension plan be credited to the Medicare program. Accordingly, OIG recommended that the contractor remit the $7.6 million in excess pension assets to the Medicare program. The contractor agreed with the finding and recommendation. (CIN: A-07-98-02522)

Pension Costs Claimed for Medicare Reimbursement

In a review of pension costs claimed by Blue Shield of California, OIG identified about $2.4 million in unallowable pension costs which should be refunded to Medicare. While the Medicare contract provides for either an allocation or separate calculation of qualified plan pension costs for the Medicare segment of a contractor's business, the separate calculation method must be used if there is a material difference between the two methods. For FYs 1991 though 1997, Blue Shield of California based its claim for reimbursement of pension costs on an allocation of total company pension costs, even though those costs were

materially higher than the pension costs computed under the separate calculation method. Accordingly, OIG recommended that Blue Shield of California revise its claims to eliminate about $2.4 million in unallowable pension costs. The contractor agreed with the finding and recommendation. (CIN: A-07-98-02523)

Children's Health Insurance Program

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP), which provides $24 billion over 5 years to develop health insurance programs for low-income children. States have the option to expand their existing Medicaid programs, design new children's health insurance programs or develop programs that combine these strategies.

The OIG conducted a study involving 19 States to identify promising practices, barriers and issues related to the CHIP application and enrollment procedures. Based on its results, OIG recommended that HCFA work with States to improve the "readability" of CHIP applications and proposed specific ways in which HCFA could encourage States to simplify their application and enrollment processes for CHIP and Medicaid. Also, OIG recommended that HCFA work with the Immigration and Naturalization Service (INS) to encourage INS's development of clear guidance and policy statements on how applications for CHIP and Medicaid will impact noncitizens. Further, OIG urged that an interagency task force be formed to address conflicting public benefit application requirements. This interagency work group should develop uniform policies for verifying income using the eligibility verification system, determining household/family composition, defining countable income, counting child support and disclosing information. (OEI-05-98-00310)

Federal and State Partnership: Joint Audits of Medicaid

One of OIG's major initiatives has been to work more closely with State auditors in reviewing the Medicaid program. To foster the creation of these joint review efforts and to provide broader coverage of the Medicaid program, the Partnership Plan was developed. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors. To date, partnerships have been developed in 22 States. Extensive sharing of audit ideas, approaches and objectives has taken place between Federal and State auditors. Completed reports have resulted in identifying potential program savings of $145 million and over $39 million in overpayment recoveries of Federal and State government funds.

During this reporting period, two partnership reports on drug reimbursement in Utah were issued. Under Medicaid regulations, generic drugs are reimbursed at the lower of the pharmacist's usual and customary charge to the general public or an upper limit set by HCFA plus a dispensing fee. For brand name drugs or generics for which an upper limit has

not been established, reimbursement is the lower of the pharmacist's usual and customary charge to the general public or the estimated acquisition cost plus dispensing fee.

Like most States, Utah reimburses pharmacies for the ingredient cost of Medicaid prescription drugs using a formula which discounts the average wholesale price (AWP). The Utah Division of Health Care Financing (UHCF) conducted reviews to develop a statewide estimate of the discount below AWP at which pharmacies purchase brand name and generic drugs. Both reviews found that pharmacies pay less than AWP to acquire drugs: 18.4 percent below AWP for brand name drugs and 60.1 percent below AWP for generics.

The UHCF recommended that the State reimburse the ingredient portion of Medicaid drugs, brand name and generic, in a manner more consistent with the findings of their reports. The OIG continues to believe that the ingredient portion of Medicaid drug reimbursement should be consistent with what pharmacies actually pay for brand name and generic drugs, noting that the cost of Medicaid prescription drugs grew from $6.9 billion in FY 1992 to $12.4 billion in FY 1997. (CIN: A-06-99-00035; CIN: A-06-99-00036)

Medicaid Fraud

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

During FY 1999, OIG provided oversight and administered approximately $89.7 million in funds granted by HCFA to the MFCUs to facilitate their mission.

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

- In North Carolina, a provider of adaptive behavioral training to residents of therapeutic group homes agreed to pay the Government $240,000 to settle allegations of knowingly submitting false claims to the Medicaid program. The provider billed the Medicaid program for more therapeutic hours than were actually worked by its direct care aides in group homes. As part of the settlement agreement, the provider is required to adhere to certain mandatory integrity provisions.

- A Kansas nursing facility reached a settlement with the Government totaling $175,000 to resolve two qui tam suits alleging False Claims Act violations

due to substandard quality of care. The relators alleged that the nursing facility failed to provide adequate nutrition, proper supervision and sanitary living conditions, and submitted false claims to Medicaid. The OIG is not requiring any corporate integrity provisions because the nursing facility closed down several years ago.

- In Connecticut, a man was sentenced to 4 months incarceration, 4 months home confinement, 2 years probation and payment of $85,810 in restitution for mail fraud and failure to file income tax returns. The man participated in a scheme involving his DME company. Investigation revealed that he received Medicaid reimbursement for custom-fitted support stockings when he actually supplied less expensive, more generic support stockings. He received approximately $85,810 in profits as a result of this scheme.

Medicaid Managed Care Fraud and Abuse

The OIG examined fraud and abuse detection and referral activities in Medicaid managed care organizations, Medicaid State agencies and MFCUs. The OIG found that two States, Arizona and Tennessee, have active programs which result in detection and referral of fraud and abuse, while other States do not. Also, there is no general agreement about roles and requirements to detect and refer fraud and abuse cases. Medicaid State agencies and fraud units differed in the intensity and nature of oversight of managed care organizations, and all parties involved indicated that there was a need for tools to address fraud and abuse in managed care, including guidelines and training. (OEI-07-96-00250)

Public Health Service Operating Divisions

Chapter II

PUBLIC HEALTH SERVICE OPERATING DIVISIONS

Overview of Program Area and Office of Inspector General Activities

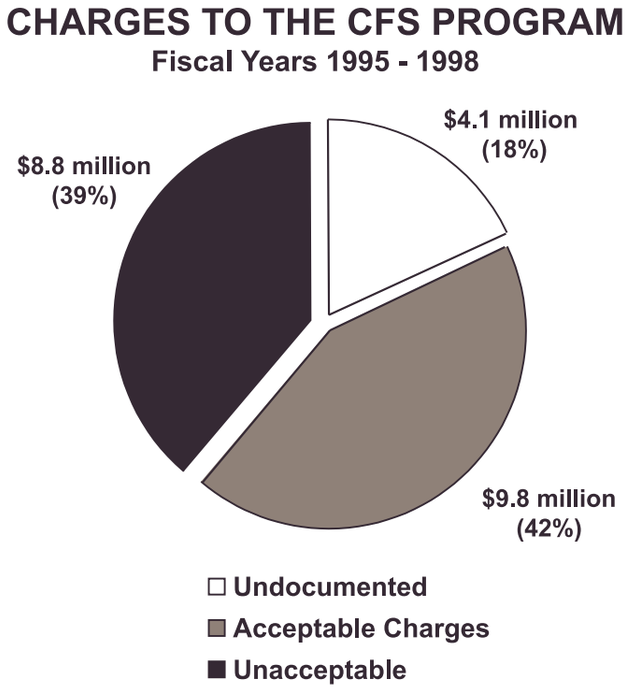
The activities conducted and supported by the Public Health Service (PHS) operating divisions represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health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

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

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

Costs Charged to the Chronic Fatigue Syndrome Program

At CDC's request, OIG conducted a review to determine whether costs charged to the Chronic Fatigue Syndrome (CFS) program during FYs 1995 though 1998 were actually incurred for that program in accordance with applicable laws, regulations and accounting standards. The OIG determined that CDC spent significant portions of CFS funds on the costs of other programs and activities unrelated to CFS, and failed to adequately document the relevance of other costs charged to the CFS program, as illustrated below.



Although CDC is not statutorily prohibited from spending funds budgeted for CFS on other programs, it is clear that the Congress expected the agency to spend the amount it budgeted for CFS only on CFS. The questionable charges identified by OIG resulted from deficiencies in CDC's internal control system regarding the handling of direct and indirect costs. As a result of these inappropriate charges, CDC provided inaccurate information to the Congress regarding the use of CFS funds and has not supported the CFS program to the extent intended by the Congress.

The OIG proposed that CDC implement a training and certification program for managers and staff responsible for budget and accounting functions within all organizational components. This proposal would ensure that appropriate officials are aware of

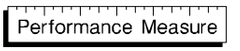
requirements applicable to the use of Federal funds and understand how to properly use CDC's accounting system. The OIG also proposed that CDC establish an internal quality assurance capacity within their Financial Management Office to carry out regular assessments of CDC's policies, procedures, practices and controls related to budget and accounting functions. Third, OIG recommended that CDC continue development of systems to properly identify and allocate organizationwide indirect costs at the CDC level and begin development of similar systems to identify and allocate indirect costs at its component units based on the relative benefits provided. The CDC generally concurred with OIG's findings and has taken action to implement the recommendations. (CIN: A-04-98-04226)

The Ryan White CARE Act: Implementation of the Spousal Notification Requirement

This report, from a series on the Ryan White CARE Act, concerned States' implementation of Section 8 (spousal notification requirement) of the Act. The OIG conducted this inspection in response to a congressional request.

The CDC has certified that all 50 States have plans reflecting a "good faith effort" to notify spouses about the HIV infection of their partners. The eleven States studied had taken actions to implement their CDC-approved plans. These States' notification programs are responding to common barriers, and several have taken actions which appear particularly useful or successful in easing these barriers. However, none of these sampled States collect data specifically on spousal notification. The OIG recommended that CDC promote education campaigns, encourage provider training and facilitate local collaboration between State and local public health departments and private providers. Further, OIG recommended that CDC encourage the development and use of data collection systems to monitor State spouse and partner elicitation and notification efforts. (OEI-05-98-00391)

Ryan White Evaluation Systems



Three OIG inspection reports examined the mechanisms that Ryan White grantees use to monitor subgrantee compliance, assess program outcomes and evaluate their effectiveness in meeting population needs. The OIG found that the State and metropolitan area grantees and AIDS drug assistance program administrators had monitoring mechanisms in place. However, few grantees or administrators were measuring program outcomes, although many grantees were planning to do so. While these grantees were assessing the needs of persons already in HIV/AIDS care, they were not meeting the requirement to obtain information about the needs of infected persons not currently receiving care. The AIDS drug assistance programs were conducting minimal assessments of whether they were reaching populations in need.

The OIG recommended that HRSA further strengthen routine monitoring mechanisms by supporting the development of system-wide databases; assist grantees to better measure program outcomes; and offer grantees technical assistance regarding gathering needs information from HIV-infected persons outside of HIV/AIDS care. (OEI-05-98-00390; OEI-05-98-00392; OEI-05-98-00393)

Patient Access to Transplantation

Performance Measure

Over the past decade, OIG has maintained an active interest in the Nation's organ allocation system. In 1991, OIG found that access of patients to donated kidneys fell short of expectations in some important respects, noting a wide variation in waiting times among racial groups, transplant centers and geographic regions. In a 1998 update to that report, OIG determined that racial and geographic disparities in waiting time still existed and, in some cases, seemed to be growing.

In the current reports, part of a series designed to shed light on the reasons for and implications of inequitable access to organ transplantation, OIG analyzed the most recent available data on median waiting times from the Organ Procurement and Transplantation Network (OPTN).

The OIG found a considerable variation in median waiting times for kidney transplantation among the OPTN regions, and determined that patients in regions with longer waiting times were less likely to receive a transplant. There was little variation in regional death rates and a limited relationship with length of time on the waiting list, possibly due to the use of dialysis.

There was also a considerable variation in median waiting times for liver transplants among the OPTN regions, and an inverse relationship between the median waiting time and the percentage of patients who actually received a transplant. The OIG also identified a regional variation in death rates for persons awaiting a transplant, probably due to factors such as patient characteristics and listing practices. The OIG is continuing its work in this area. (OEI-01-99-00210; OEI-01-99-00211)

Fostering Equity in Patient Access to Transplantation: Local Access to Liver Transplantation

Performance Measure

In the debate over the Department's regulation on organ allocation, concerns were raised that the rule could hinder local access to liver transplantation. This OIG study did not assess the effect of the regulation, but examined the extent to which local access to liver transplant centers exists currently.

The OIG found that the 117 liver transplant centers cluster in metropolitan areas, leaving large portions of the population at considerable distance from a transplant center. More than 80 percent of liver transplants were performed in just 35 cities. Fifteen States have no liver transplant center and 45 percent of the population lives outside of metropolitan areas with liver transplant centers. Further, most new liver transplant centers have opened in areas where a liver transplant center already operates.

The OIG concluded that there is no widespread local access to liver transplant centers. Basic factors other than allocation policy affect this access, including the shortage of organs, the relationship between the number of transplants and patient outcomes, the high costs of running a transplant center and the housing of liver transplant programs in urban academic medical centers. (OEI-01-99-00470)

Legislative Recommendation to Improve Hospital Reporting to the National Practitioner Data Bank

Performance Measure

This memorandum report analyzed hospital reporting data and summarized studies relating to hospital compliance with the National Practitioner Data Bank reporting requirements. The OIG found that hospitals were apparently not reporting adverse actions taken against doctors. The report recommended that HRSA initiate a legislative proposal that would establish a civil monetary penalty of up to $10,000 for each instance of a hospital's failure to report. The HRSA concurred and is preparing a legislative proposal to impose a civil monetary penalty. The HRSA intends that the proposal apply more broadly to health care provider organizations and is considering recommending a monetary penalty level above that recommended by OIG. (OEI-12-99-00250)

Exclusions for Health Education Assistance Loan Defaults

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

After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Once the individual has been declared in default, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid and all Federal health care programs for nonpayment of these loans. During this 6-month period, 164 individuals were excluded as a result of PSC referral of their cases to OIG.

Individuals who have been excluded as a result of their default may enter into settlement agreements whereby the exclusion is stayed while they pay specified amounts each month to satisfy their debt. If they default on these settlement agreements, they can then be excluded

until their entire debt is repaid, and they cannot appeal these exclusions. Some health professionals, upon being notified of their exclusion, immediately repay their HEAL debt.

After being excluded for nonpayment of their HEAL debts, a total of 1,152 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debt. This figure includes the 80 individuals who have entered into such a settlement agreement or completely repaid their debt during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals over $76.7 million. Of that amount, $7 million is attributable to this reporting period. The following are examples of some of these settlements:

- After being notified that he was excluded as a result of his failure to repay his HEAL debt, a Michigan osteopath entered into a settlement agreement to repay over $123,000 in student loans.

- A settlement agreement was signed by a New York physician to repay his HEAL debt of almost $200,000.

- A podiatrist in New York entered into a settlement agreement to repay his $168,000 HEAL debt.

- In New Jersey, a physician entered into a settlement agreement to repay his HEAL debt of over $286,000.

Arkansas Regional Laboratory Construction Project

The OIG initiated this review to determine why costs related to FDA's construction of the Arkansas Regional Laboratory had increased. Total project costs are currently estimated at $37.9 million -- $10.4 million, or 38 percent, higher than the original estimate of $27.5 million.

The OIG found that the project's budget exceeded its estimate because $3.4 million in project costs were not included in the estimate used as the basis for the budget request; the architect and engineering (A&E) firm revised its estimate upward by $2.1 million; and $4.9 million in additional costs were attributable to a combination of factors, including inflation, the A&E firm's unfamiliarity with the Arkansas area and cursory assessment of market conditions, the effects of a building boom in Arkansas and the inexact nature of construction estimates. The OIG also identified several management control weaknesses in FDA's oversight of the project.

The OIG recommended that FDA establish clear lines of responsibility for future construction projects; implement a system for tracking estimated project costs throughout

the budget development stages; institute a policy to closely review budgets to ensure their completeness and accuracy; obtain second estimates for large construction projects; and institute general policies on developing a construction project budget. In response to the draft report, FDA generally concurred with OIG's recommendations and stated that it had been implementing actions consistent with the recommendations. (CIN: A-15-98-50002)

National Institutes of Health Printing Program

Performance Measure

The Director of each National Research Institute at NIH has authority to use sources outside the Government Printing Office (GPO) to publish, or arrange for the publication of, NIH materials. The NIH is responsible for ensuring that GPO receives an adequate number of copies of publications for distribution to Federal depository libraries as well as one copy for GPO's use in cataloging and indexing. Also, NIH must report to GPO all publications that it has published in the previous month.

The OIG identified numerous deficiencies in the operation of NIH's printing program and made specific recommendations to ensure corrective action. The NIH fully concurred with the OIG findings and recommendations, and stated that its goal is to be in complete compliance with Federal printing rules and procedures as dissemination of information is of vital importance to NIH's mission. (CIN: A-15-98-80001)

Contract/Grant Fraud

Resolution of charges of misusing PHS grant funds occurred in the following four cases:

- A prominent AIDS research scientist and the head of the retrovirology laboratory at a Florida medical center was sentenced to 15 months imprisonment, 2 years supervised release and a $10,700 fine for engaging in a scheme to defraud area research institutions. His laboratory received millions of dollars in AIDS and HIV-related research subcontracts from hospitals and universities, including one NIH grantee. In 1989, he established a fictional laboratory company which he misrepresented to fellow researchers as a functional AIDS research laboratory. Over a 6-year period, the man fraudulently billed both the university/NIH grantee and other institutions for AIDS research supposedly conducted by his company. The research was actually performed by his employees at the medical center. Further, between 1993 and 1996, the researcher, also a practicing dermatologist, allegedly submitted false Medicare claims for dermatology services, including claims for services not provided as billed and for medically unnecessary services. As a result of this subsequent investigation, the researcher agreed to pay the Government $784,500, to release any claims to $600,000 held in administrative suspension by the carrier and to accept a 5-year exclusion.

- A California nonprofit institution involved in public health research and educational activities agreed to pay the Government $306,000 to resolve its liability under the False Claims Act. This case arose from an OIG audit regarding the relationship between the institution and professors at a California university. Under the arrangement, the institution applied for and administered grants in which the principal investigators were actually professors performing the grant work on the university campus. Since these grants were run through the institution rather than directly from the university, NIH paid for salaries of principal investigators and consultants who were professors. The OIG found that almost $2 million in salary payments and an additional $450,000 in overhead payments would not have been made to the institution if NIH had known the true nature of the relationship between it and the university professors. The institution also agreed not to apply for any more grants from Federal Government sources.

- A major medical research facility in Massachusetts agreed to pay the Government $920,000 to settle its alleged misapplication of grant funds awarded by PHS. The allegation involved a doctor, formerly employed at the facility, who applied to NIH for a research grant to study gene mutations in mice at the medical center. The application stated that the research doctor would devote at least 50 percent of his time to the project. Prior to the initial award being made, the doctor moved out of the country. In 1995 and 1996, the medical facility submitted applications to NIH to continue the grant, even though the doctor resided in Holland. The OIG found that the doctor did not spend 50 percent of his time on the project as required by the grant award, and that the facility knowingly accepted the grant funds and applied a substantial portion of them to support other research projects. In all, the facility received approximately $368,000 in unentitled grant funds. As part of the settlement, the facility agreed to enter into a compliance agreement to ensure that similar problems do not recur.

- In New York, an HHS grantee agreed to pay the Government $350,000 to settle allegations concerning the propriety of certain costs charged to Department grants and contracts. The OIG performed an audit of five grants and contracts awarded to the organization between 1992 and 1997. The awarding agencies included CDC, the Office of Minority Health and HRSA. The OIG identified $717,924 in costs claimed by the organization that were unreasonable, unallowable or improperly documented. Based on an inability to pay, the case was settled for $350,000. As a result of the settlement, the organization and its owner will be subject to increased scrutiny in the performance of duties under present or future HHS contracts or grants.

Fiscal Year 1998 Financial Statement Audits of Public Health Service Agencies

Performance Measure

In support of its audit of the consolidated HHS-wide financial statements for FY 1998, OIG audited, through contracts with independent public accounting firms, the financial statements of the major PHS agencies. Improvements were noted at many of the agencies since the previous year.

A. Food and Drug Administration

The accounting firm issued an unqualified opinion on FDA's FY 1998 financial statements and noted no material weaknesses in the system of internal controls. Agreeing with the recommendations, FDA is in the process of further strengthening internal controls. (CIN: A-17-98-00014)

B. National Institutes of Health

The NIH received an unqualified opinion on the FY 1998 balance sheet and the statements of net costs, custodial activities, budgetary resources and changes in net position. However, the accounting firm disclaimed an opinion on the statement of financing because NIH was unable to reconcile net costs to budgetary obligations. The NIH concurred in the recommendations to continue to strengthen internal controls. (CIN: A-17-98-00008)

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

The accounting firm issued an unqualified opinion on the CDC and ATSDR FY 1998 financial statements and noted no material weaknesses in the agencies' systems of internal controls. Agency officials agreed with the firm's findings and recommendations. (CIN: A-17-98-00007)

D. Health Resources and Services Administration

The HRSA received a qualified opinion on its FY 1998 balance sheet and the statements of net cost and changes in net position, primarily because the agency was unable to completely reconcile the "Fund Balance with U.S. Treasury" general ledger account to the balance reported by the Department of the Treasury at the year's end. The firm also disclaimed an opinion on the statements of budgetary resources, financing and custodial activity, which could not be reconciled to the general ledger. The HRSA concurred and is taking corrective action. (CIN: A-17-98-00005)

E. Substance Abuse and Mental Health Services Administration

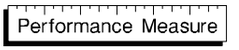
The accounting firm issued an unqualified opinion on SAMHSA's FY 1998 balance sheet and the statements of net cost and changes in net position. However, the firm was unable to reconcile the statements of budgetary resources, financing and custodial activity to amounts reflected in the general ledger for the year ended September 30, 1998. As a result, the firm

disclaimed an opinion on these financial statements. Agency officials are taking corrective action on the recommendations. (CIN: A-17-98-00006)

F. Indian Health Service

The IHS received a qualified opinion on its FY 1998 balance sheet and the statements of net cost and changes in net position, primarily because the balances for the net position accounts were in error. The firm also disclaimed on the statements of budgetary resources, financing and custodial activity because it could not reconcile these statements to the IHS general ledger. Again, the agency agreed with the audit findings and has begun to implement the recommendations. (CIN: A-17-98-00004)

Federal Occupational Health Billing Operations



The HRSA's Federal Occupational Health (FOH) provides occupational health services to approximately 160 Federal agencies through interagency agreements. The OIG contracted with an independent public accounting firm to perform agreed-upon procedures to assist FOH in evaluating the billing operations in place during FY 1998. The firm noted minor exceptions in billing operations and made recommendations for improvements. (CIN: A-17-99-00019)

Year 2000 Computer Compliance Activities

Reviews were conducted at two PHS agencies as part of OIG's overall initiative to monitor the Department's efforts to address Year 2000 (Y2K) compliance issues. All Federal agencies must ensure that their computer systems are Y2K compliant well before December 31, 1999, to avoid the risk of widespread system failures.

A. Centers for Disease Control and Prevention

Assessments of CDC's efforts in achieving Y2K compliance for five of its mission-critical systems were provided in a series of four memorandums. The OIG reported on such areas as the accuracy of CDC's system status inventory, internal testing and independent verification and validation of major information systems, and testing in a non-Y2K certified environment. The issues identified have since been addressed by CDC. (CIN: A-04-98-05006)

B. National Institutes of Health

The OIG's review of NIH's actions to address Y2K compliance focused on contracts for information technology (IT) acquisitions that will perform data processing beyond December 31, 1999. The NIH is taking steps to ensure that IT acquisitions are Y2K compliant; contracting officials provided documentation showing that 23 of the 30 contracts reviewed were in compliance. As a result of OIG's review, NIH officials incorporated Y2K compliance clauses into the seven contracts that were not in compliance. These clauses

carry out the Federal Acquisition Regulation compliance requirements. (CIN: A-15-98-80002)

Administration for Children and Families, and Administration on Aging

Chapter III

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

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

With respect to TANF, OIG will continue to ensure program integrity, identify opportunities for program improvement, and provide Federal and State management with useful information regarding the goal of moving individuals and families from welfare dependency to self-sufficiency.

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

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

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

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

Child Support Enforcement: Investigations

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

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

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

Central to the task forces are the screening units located in each task force region which are staffed by analysts and auditors from both OIG and OCSE. These units receive the child support cases from the States, conduct preinvestigative analyses of these cases through the use of information databases and then forward the cases to the investigative task force units where they are assigned and investigated. This streamlines the process by which the cases best suited for criminal prosecution are identified, investigated and brought to fruition. As the task forces bring in more law enforcement partners on the State level, the number of cases adjudicated will rise dramatically. At this point, the task force units have received over 1,200 cases from the States. As a result of the work of the task forces, 51 Federal arrests have been executed and 32 individuals already sentenced. The total recovered amount related to Federal investigations is $1.2 million. There have been 222 arrests on the State level and 181 convictions or civil adjudications to date.

Two of the five task forces were initiated prior to this reporting period. Headquartered in Columbus, Ohio and Baltimore, Maryland, these task forces are in the Midwest and Mid-Atlantic regions -- with special emphasis on the States of Illinois, Michigan, Ohio, Maryland, Virginia, Pennsylvania, Delaware and the District of Columbia. Based on the success of these two initial task forces, three more have recently become operational in other areas of the country in this fiscal year, including the Northeast, Southwest and the Pacific Coast. In the Northeastern task force area, investigative efforts are headquartered in New York City, with special emphasis on the States of New York and New Jersey. For the Southwestern area, headquartered in Dallas, Texas, efforts focus especially on the States of Texas, Louisiana and Oklahoma. Efforts of the Pacific Coast task force area are directed at the States of California, Oregon, Washington and Arizona, with headquarters located in Sacramento, California.

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

- One of Virginia's top 10 deadbeat parents received the first sentence given in the country under the Deadbeat Parents Punishment Act as the result of a trial conviction. After finding the man guilty of failure to pay child support at a bench trial, the judge sentenced him to 20 months imprisonment. He also ordered the man to pay his arrearage of $106,144 in restitution, of which $72,000 represents the amount of public assistance benefits the custodial parent relied upon in lieu of the man's support. Over the past several years, the man absconded twice in attempting to avoid his court-ordered child support obligations.

- A New York man was sentenced to 5 years probation for failure to pay child support. As part of his plea agreement, he made a one-time payment of $120,000 toward his arrearage and deeded his share of the former marital residence, valued at approximately $1 million, to his former spouse. He also agreed to execute monthly child support payments of $2,500 for 30 months with a lump sum payment of $25,000 due at the end of that period. Thereafter, he agreed to make monthly payments of $1,250 for an additional 30 months followed by a final payment of $20,000. This child support payment plan will satisfy both his current, court-ordered child support obligation and his arrearage. An avid golfer who occasionally plays on the senior golf tour, the man concealed his assets in a trust fund held by several members of his family. He failed to make any child support payments contending he had no assets.

- A Texas man was sentenced based upon an earlier plea agreement in which he admitted to failure to pay child support. As part of his plea agreement, the man agreed to pay $15,000 toward his arrearage of $173,000. When he produced only $13,000 of the required amount at his sentencing, the judge ordered the maximum sentence of 18 months incarceration. His imprisonment is to be followed by 1 year supervised release. The sentence also mandates that he pay full restitution totaling $186,097 and comply with all State orders for child support payment ($1,500 per month). As a result of his failure to support his four children, the custodial parent resorted to food stamps, and the oldest child dropped out of high school to help support the family.

- A child support case filed in Arizona resulted in the arrest and sentencing of a Texas man. The man was placed on 5 years probation and 3 months nighttime detention as part of a work release program, and was ordered to make monthly payments of $1,800 until his arrearage of $142,468 is paid in full.

- A California man was sentenced to 2 months imprisonment, 5 years probation and payment of $65,472 in restitution for failure to pay child support. The defendant, an architect who formerly managed a design firm, was ordered to pay child support for his two daughters in 1992. Despite this order, he made no payments between 1993 and late 1998. In early 1994, he moved to Utah where he earned over $36,000 as a design consultant in less than 9 months but still made no payments. Conditions of his probation included a restitution payment plan, financial supervision and disclosure requirements, and no contact with his former spouse.

- An Alabama man entered into a pre-trial diversion agreement for failure to pay child support. The agreement requires him to make restitution of $66,465 to the custodial parent and to perform 30 hours of community service. If he fails to make his scheduled payments, the original indictment, to remain pending during the pre-trial diversion period, will be enforced.

- In Washington, a man who failed to pay child support was sentenced to 5 years probation. He was also ordered to make monthly payments of $1,900 until his arrearage of $59,054 is paid. Prior to the man's arrest in January 1999, he had not made child support payments since April 1994. A project manager for a construction company in Colorado, the man pled guilty to willful failure to pay child support following his arrest. If the man pays less than the required $1,900 per month, the judge ordered that the unpaid arrearage balance will be subject to twelve percent annual interest.

- In Oregon, a man was sentenced to 30 days incarceration, given credit for time served, placed on 5 years probation and ordered to pay his arrearage of $53,000 for failure to pay child support. Although the man earns approximately $60,000 a year as a pipe fitter, he has not voluntarily paid child support since his divorce in 1990. In attempting to avoid his child support obligation, he frequently changed jobs and relocated to different States.

- In Florida, a man pled guilty for failing to pay $44,729 in child support. After two attempts failed to have him arrested and extradited on State criminal charges, the county friend of the court referred his case to the Michigan Child Support Multi-Agency Investigative Team. As part of his plea, the man paid the county friend of the court more than the required $38,000, money which was then turned over to his ex-wife and children. In addition, he was sentenced to 3 years supervised release and ordered to pay $500 a month until the remainder of his arrearage is satisfied.

- In California, a magistrate sentenced a man to 60 months probation and imposed full restitution of both the principle and the interest in the amount of $35,819 for failure to pay child support. In addition, the man may not possess a hand gun. Since the man is an avid hunter, the magistrate did allow him to possess a long gun in Minnesota where he currently resides. The man pled guilty to willful failure to pay legal child support.

During this period, OIG investigations of child support cases nationwide resulted in 43 convictions and court-ordered restitution of over $2.5 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.

Review and Adjustment of Child Support Orders

The Personal Responsibility and Work Opportunities Act of 1996 substantially changed States' responsibilities to review and adjust child support orders. Under the Act, periodic reviews of child support orders are no longer required. The CSE agencies are required to notify all parents every 3 years of their right to request a review of their child support orders. The agencies must conduct a parent-requested review if none has been performed within the last 3 years. States may act on behalf of public assistance custodial parents to initiate a review.

The OIG surveyed CSE agency directors in all States and collected in-depth information through site visits in 10 States. Since 32 States have discontinued or plan to discontinue the triennial review of public assistance cases, OIG determined that most child support orders

will not be reviewed unless a parent requests the review or a CSE worker initiates a review. In addition, OIG found four areas of particular concern: notification of parents of the right to request a review, medical support, collection of basic data and downward adjustments.

Subsequent to issuance of OIG's draft report, the President included a proposal to restore periodic reviews in the FY 2000 budget. While this addressed some of the issues raised in this report, OIG further recommended that OCSE remind States that they are required to notify parents every 3 years of their right to request a review of child support orders; urge States to use the review and adjustment process as an opportunity to ensure that medical support is provided; encourage States to collect basic data on the review and adjustment process as well as cost-benefit data including requests for downward modifications; and encourage States to review child support orders for families leaving welfare. The ACF concurred with OIG's findings and recommendations. (OEI-05-98-00100; OEI-05-98-00102)

Paternity Establishment

Performance Measure

Three related reports explored the issue of paternity establishment. They addressed State practices in providing written and oral notification of rights and responsibilities to parents who voluntarily acknowledge paternity outside the hospital; early implementation efforts of State child support agencies to offer voluntary paternity acknowledgment services through alternative sites; and recent data collection and analysis regarding use of Federal funds to pay State vital records agencies for paternity establishment services.

The OIG found that States have made serious efforts to provide both written and oral notification, as required by Federal law. However, some staff within vital records agencies and other alternative sites are still unaware of this obligation. While about half the States currently offer voluntary paternity acknowledgment services through some of their public assistance offices, few States have yet expanded service to other sites. State efforts to encourage participation have met with reluctance by some entities due to time demands on limited staff and lack of financial incentives. The OIG also found that while the number of State vital records agencies who receive Federal funds for paternity establishment activities has increased, vital records agencies in half the States still use only their own funds to pay for these activities; in some cases this is due to State confusion over Federal rules governing such payments. (OEI-06-98-00051; OEI-06-98-00052; OEI-06-98-00056).

New Hampshire's Procedures for Collecting Child Support from Independent Contractors

Performance Measure

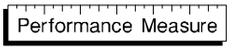
Federal law requires that all States have a system in place for businesses to report newly hired employees for the purpose of collecting child support payments. New Hampshire took this a step further by requiring businesses to also report the hiring of independent contractors. State officials reasoned that garnishing contractor earnings would improve

collections of current and past-due child support from a significant subset of the self-employed (one of the most difficult groups from which to collect payments). As a result of this initiative, the State collected an estimated $1.065 million in child support from independent contractors for the year ended October 12, 1998. The OIG recommended that ACF consider the merits of encouraging other States to require businesses to report the hiring of independent contractors. The ACF subsequently highlighted the results of OIG's review in its newsletter distributed to all child support agencies nationwide. (CIN: A-01-98-02503)

Expenditures for Missouri's Automated Child Support System

The CSE program was established to locate noncustodial parents, establish paternity and collect child support payments. To assist States in meeting these objectives, the Federal Government requires each State to develop an automated child support system and provides enhanced funding for system development. An OIG review found that Missouri exceeded the Federal ceiling for system development expenditures by $207,466. The overclaim would have been more than $2.2 million above the ceiling had the State not reduced its claim for a clerical error identified and reported earlier by OIG. The OIG recommended a recovery of the overclaim and additional evaluation of controls over future claims. (CIN: A-07-98-01033)

Technical Assistance for Quality Child Care



The Personal Responsibility and Work Opportunity Act of 1996 repealed a number of child care programs and created a single, integrated Child Care and Development Block Grant for low-income families. The ACF contracts with outside entities to provide technical assistance funded through this grant, which includes the coordination and support of regional and national conferences, national work groups, leadership forums, audio conference calls and creation of the national Child Care Information Center. In 1997, ACF further expanded its technical assistance capabilities by creating the Child Care Technical Assistance Network.

A. State Administrators' Perspectives

In a survey of State child care administrators, OIG sought to determine the extent to which the technical assistance provided meets their needs and to garner their opinions on the format, content and logistical support for the technical assistance they require. Among other findings, OIG determined that the administrators consider large national conferences and small regional meetings the most beneficial technical assistance formats and regard the National Child Care Information Center a valuable technical assistance tool. Also, they are more satisfied with the content and focus of national conferences than other technical assistance events.

Based on OIG's analysis of the administrators' responses and suggestions, OIG recommended that ACF focus on five general approaches to enhance their program: maintain and improve effective technical assistance formats; focus technical assistance on areas of interest to program administrators; improve logistical support; continue to support the National Child Care Information Center, but enhance the technical assistance provided by the website; and reevaluate the structure and content of audio conference calls to better meet State administrators' needs. The OIG provided specific proposals in each of these areas. The ACF concurred with OIG's recommendations and described various improvements in their technical assistance initiatives. (OEI-07-97-00420)

B. Community Perspectives

Child care community leaders value ACF's technical assistance programs. They find regional meetings and conferences the most beneficial formats for receiving technical assistance and regard the National Child Care Information Center as a valuable technical assistance tool. This OIG report suggested that ACF improve advance notice and information about upcoming events, focus technical assistance on issues child care community leaders consider critical and continue to support the Information Center. (OEI-07-97-00421)

Interstate Compact on the Placement of Children

Performance Measure

The Interstate Compact on the Placement of Children is a contract among the States intended to ensure that children placed across State lines receive adequate protection and services. The ACF asked OIG to examine a number of issues regarding the interstate compact, including how the compact is implemented by States and its strengths and weaknesses.

A. State Structure and Process

In this inspection, OIG found that States have policies and procedures regarding the interstate compact that are generally uniform and comprehensive. However, States are sometimes unaware that children have been placed in their jurisdiction and half the States did not know how many children they had placed through the compact in 1997. While the compact has clearly been successful in establishing procedures for the interstate placement of children, there are weaknesses in the overall system which make some children vulnerable. The OIG recommended that ACF be prepared, where necessary, to provide technical assistance on how to more effectively implement the compact, especially in regard to placement notification and uniform data collection. The ACF found the report information useful. (OEI-02-95-00041)

B. Implementation

In a study involving the 10 States with the highest population of persons under age 18, OIG found that States are meeting the basic requirement of the compact: they are conducting

home studies, providing for children financially and supervising the placements. However, State administrators, local workers and other involved parties reported four main weaknesses in implementation: lack of knowledge about the compact among judges, attorneys and caseworkers; placements in violation of the compact; the lengthiness of the process; and the differing adoption laws among the States that may hinder placements.

The OIG made specific recommendations to those individuals and entities that have a role in the compact. These recommendations are intended to increase awareness and familiarity with the compact; reduce the lengthiness of the compact process; ensure that State compact offices continue to be the official contact point between States; make ACF training and technical assistance available to the States; and examine how the compact handles placement into residential care facilities. The ACF intends to work with appropriate officials to determine how it can promote awareness of the compact, provide training to State agency staff who implement the compact and support the development of model procedures to help the compact operate more effectively. (OEI-02-95-00044)

Head Start Grantee

At ACF's request, a special agreed-upon procedures review was performed concerning the financial and compliance activities of a St. Louis, Missouri Head Start grantee. The review focused on asset management, enrollment and attendance, indirect costs, nonfederal matching, and adequacy of the financial management and accounting systems.

The OIG found that the grantee claimed $146,790 of Head Start costs that were unallowable. The costs included duplicate payments for computer equipment ($83,960), unreported and unsupported nonfederal matching ($33,430) and excessive indirect cost charges ($29,400). In addition, the grantee's Head Start program was seriously underenrolled -- at least 670 children below the funded enrollment of 2,519 as of March 1999. Lastly, the grantee's accounting system and system of internal controls did not adequately ensure accurate reporting of Head Start expenditures and the safeguarding of program assets. Recommendations called for a refund of $146,790 to the Federal Government and actions to strengthen the grantee's accounting and internal control systems, and elimination of the enrollment shortfall. The ACF concurred. (CIN: A-07-99-01039)

Temporary Assistance for Needy Families: Improving the Effectiveness and Efficiency of Client Sanctions

The TANF program grants cash assistance on a time-limited basis to needy families, but requires States to implement more stringent work requirements than under the former Aid to Families with Dependent Children (AFDC) program. Clients who fail to comply with TANF program rules and requirements face sanctions, including cash assistance reductions ranging from $25 to lifetime ineligibility. States can decide how and when to inform clients

of sanction policies and sanction decisions. They use several methods to resolve client disputes of sanction decisions, including conciliation meetings.

This report presented a general overview of how sanctions are actually being used in TANF offices. The OIG concluded that these sanctions are most effective when they are administered on a case-by-case basis, and are useful for ferreting out clients who do not report earned income. They are less effective for clients who face significant barriers to employment, such as substance abuse, mental illness and illiteracy. (OEI-09-98-00290)

Employment Programs for Persons with Developmental Disabilities

Performance Measure

The OIG found that while State developmental disabilities councils did not obtain direct employment for persons with developmental disabilities, they did facilitate job opportunities for them by funding demonstration projects for promising employment approaches. Key factors in creating and maintaining jobs for persons with developmental disabilities included involvement of the employer community, collaborative arrangements among State entities and planning for long term support systems.

The OIG found that the greatest barrier to the development and administration of employment programs was availability of transportation; other barriers included poor job matching, high speed production jobs that were too stressful, traditional sheltered employment agencies, and mobile work crews and groups. Outcome data to assess the success or effectiveness of employment programs was not generally available, and available data was limited and inconsistent from State to State.

The OIG suggested that ACF work with the State councils to develop an ongoing inventory of successful employment initiatives and mandatory performance measures with which all State councils must comply. (OEI-07-98-00260)

Employment and Training Expenditures: Wisconsin

The OIG reviewed Wisconsin's employment and training expenditures claimed under the Title IV-F Job Opportunities and Basic Skills (JOBS) program and the Title IV-A AFDC demonstration project in FYs 1994 and 1995. These programs, which were later repealed by the Personal Responsibility and Work Opportunity Act of 1996, were intended to provide needy families with additional training and job development services beyond those available at the State and local level. However, OIG determined that Wisconsin's claims to the programs supplanted normal State job training activities. The State agreed that it inappropriately claimed $5,140,249 ($2,570,125 Federal share) for FY 1994 and $1,497,464 ($748,732 Federal share) for FY 1995. (CIN: A-05-98-00010)

Fiscal Year 1998 Financial Statement Audit of the Administration for Children and Families

Performance Measure

In support of its audit of the consolidated departmentwide financial statements for FY 1998, OIG contracted with an independent accounting firm to audit ACF's financial statements. The ACF received an unqualified opinion on the balance sheet and the statements of net cost and changes in net position. However, the accounting firm disclaimed an opinion on the statements of budgetary resources, financing and custodial activity because it could not reconcile these statements to the ACF general ledger. Officials of ACF agreed with the recommendations and are taking corrective action. (CIN: A-17-98-00003)

Administration on Aging's Health Care Fraud and Abuse Programs

Performance Measure

In an inspection on AoA's health care fraud and abuse programs, OIG found that its two antifraud initiatives used somewhat different approaches, but complemented one another well. The programs educated thousands of beneficiaries who then identified some instances of fraud and abuse.

Performance data indicated that the community volunteer projects trained 3,700 individuals who educated over 60,000 Medicare beneficiaries. The Health Insurance Portability and Accountability Act-funded projects trained over 10,000 trainers who reached many additional beneficiaries. In total, projects referred at least 870 allegations to Medicare contractors or other agencies. However, most projects did not routinely track complaint outcomes, making it difficult to determine whether they produced more in savings than the amount of money invested in them. The OIG encouraged AoA to assure that grantees track key outcomes as they expand the program. (OEI-02-99-00110; OEI-02-99-00111)

General Oversight

Chapter IV

GENERAL OVERSIGHT

Introduction

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

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

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133, under which HHS is cognizant agency to audit the majority of the Federal funds awarded to major research schools, State and local government cost allocation plans, and separate indirect cost plans of State agencies and local governments. Also, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG became responsible for auditing the Department's financial statements beginning with the FY 1996 statements.

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

Reviews of Departmental Service Organizations

Performance Measure

In support of its HHS-wide FY 1998 financial statement audit, OIG contracted for reviews of four service organizations which provide common administrative, data processing and accounting services to the individual operating divisions. In accordance with Statement on Auditing Standards No. 70, independent accounting firms reviewed the service organizations' controls in operation and tested their operating effectiveness, especially the controls that may be relevant to a user organization's internal controls.

A. Central Personnel and Payroll System, Human Resources Services

In FY 1998, the Human Resources Services (HRS) office made significant improvements; the accounting firm reported only three exceptions relating to policies and procedures, compared with seven exceptions in FY 1997. Specifically, the firm determined that HRS did not have a fully implemented entitywide security program; did not protect its data from unauthorized access that could lead to improper modification, disclosure or deletions; and did not have an up-to-date disaster plan. The HRS has projects in place to address each of these exceptions. (CIN: A-17-99-00018)

B. Division of Financial Operations

The firm concluded that controls tested for the Division of Financial Operations (DFO) were operating with sufficient effectiveness, with some exceptions. For instance, certain duties were not adequately segregated; some application programmers who made accounting system changes had authority to make and test changes to source code, compile the code and move the altered code to the production library. The DFO officials concurred with this finding and are implementing corrective action.

In addition, the accounting firm concluded that DFO did not always apply standard general ledger posting rules, did not fully document and maintain a comprehensive list of reconciliations performed and did not adequately document data conversion between two accounting systems. The DFO officials did not concur with these findings. (CIN: A-17-98-00009)

C. Division of Payment Management

At the Division of Payment Management, the accounting firm determined that the controls tested were operating with sufficient effectiveness and noted no significant exceptions. (CIN: A-17-99-00011)

D. Center for Information Technology

Again, the accounting firm determined that the controls tested at the Center for Information Technology were operating with sufficient effectiveness and noted no significant exceptions. (CIN: A-17-98-00013)

Program Support Center's Year 2000 Compliance Activities

While seven of the eight PSC mission-critical systems were Y2K compliant as of April 1, 1999, the remaining system, the Payment Management System, did not meet the HHS compliance date of December 31, 1998. This system processes more than 1,000 transactions daily, serves over 20,000 grantees and disburses more than $165 billion annually. In an April 22, 1999 memorandum, OIG suggested that PSC consider investigating the feasibility of contracting for alternative administrative support services that are Y2K compliant from other Federal agencies or private contractors as an additional safeguard should the Payment Management System not be Y2K compliant by January 1, 2000. The PSC advised OIG on June 30, 1999 that the system had been recommended for certification as Y2K compliant by the independent verification and validation contractor and was subsequently certified compliant. (CIN: A-15-98-80002)

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 1999, OIG's National External Audit Review Center (located in Kansas City) reviewed about 1,300 reports that covered over $494.9 billion in audited costs. Federal dollars covered by these audits totaled $118.4 billion, about $56.8 billion of which was HHS money.

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

A. Office of Inspector General's Proactive Role

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

- Through evaluation of reported data, OIG is able to provide basic audit coverage and analyze reports to identify entities for high-risk monitoring and trends that could indicate problems within HHS programs. These problems are brought to the attention of departmental management who can take steps to improve program administration. In addition, OIG profiles

nonfederal audit findings of a particular program or activity over a period of time to identify systemic problems.

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

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number (800-732-0679). In addition, OIG offers various training; for example, formal training was provided to certified public accountant societies and State auditor staffs on issues related to Circular A-133.

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

- The OIG led the revision of the Initial Review Guide and Quality Control Review Guide issued by the President's Council on Integrity and Efficiency and used for quality assurance.

B. Quality Control

To rely on the work of nonfederal auditors, OIG maintains a quality control review process which assesses the quality of the nonfederal reports received and the audit work that supports selected reports. Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 1,323 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,286
Reports issued with major changes	10
Reports with significant inadequacies	27
Total audit reports processed	1,323

The 1,323 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling $28.8 million as well as 3,118 recommendations for improving management operations. In addition, these audit reports provided information for 52 special memoranda which identified concerns for increased monitoring by departmental management.

Resolving Office of Inspector General Recommendations

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

A. Questioned Costs

The following chart summarizes the Department's responses to OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs which are challenged because of violation of law, regulation, grant conditions, etc. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and section 5 of the Inspector General Act. These costs are separate from the amount ordered or returned as a result of OIG investigations (see page 76).

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

	Number	Dollar Value	
		Questioned	Unsupported
A. For which no management decision had been made by the commencement of the reporting period[1]	401	$328,456,000	$28,443,000
B. Which were issued during the reporting period	117	$94,363,000	$689,000
Subtotals (A + B)	518	$422,819,000	$29,132,000
Less:			
C. For which a management decision was made during the reporting period[2]:	152	$119,819,000	$7,101,000
(i) dollar value of disallowed costs[3,4]		$111,017,000	$140,000
(ii) dollar value of costs not disallowed		$8,802,000	$6,961,000
D. For which no management decision had been made by the end of the reporting period	366	$303,000,000	$22,031,000
E. For which no management decision was made within 6 months of issuance[5]	260	$228,109,000	$22,800,000

See Appendix D for footnotes.

B. Funds Put to Better Use

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

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

	Number	Dollar Value
A. For which no management decision had been made by the commencement of the reporting period[1]	41	$1,445,362,000
B. Which were issued during the reporting period	7	$76,778,000
Subtotals (A + B)	48	$1,522,140,000
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management		
(a) based on proposed management action[2]	19	$86,186,000
(b) based on proposed legislative action	0	0
Subtotals (a+b)	19	$86,186,000
(ii) dollar value of recommendations that were not agreed to by management	1	$8,000
Subtotals (i + ii)	20	$86,194,000
D. For which no management decision had been made by the end of the reporting period[3]	28	$1,435,946,000

See Appendix D for footnotes.

Legislative and Regulatory Review and Regulatory Development

A. Review Functions

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

B. Regulatory Development Functions

The OIG is responsible for the development and promulgation of a variety of sanction regulations addressing civil monetary penalty (CMP) and program exclusion authorities administered by the Inspector General, as well as safe harbor regulations related to the anti-kickback statute. Among the regulatory initiatives promulgated during the reporting period were final codifying regulations that addressed revised OIG sanction authorities resulting from Public Law 105-33. These final regulations (64 FR 39420; July 22, 1999) revised OIG's exclusion and CMP authorities set forth in 42 C.F.R. parts 1001 through 1003 as a result of the Balanced Budget Act of 1997. These revisions are intended to protect Medicare and other Federal health care programs by enhancing OIG's administrative sanction authority through new or revised exclusion and CMP provisions.

In addition, during this reporting period, the Inspector General signed and the Secretary cleared the following rules (currently at the Office of Management and Budget awaiting final clearance and publication):

- Final Rule: Health Care Fraud and Abuse Data Collection Program - Reporting of Final Adverse Actions. This final rule establishes the new national health care fraud and abuse data bank - the Healthcare Integrity and Protection Data Bank (HIPDB) - for the reporting and disclosure of certain final adverse actions taken against health care providers, suppliers and practitioners. The regulations will set forth the policy and procedures for implementing the new HIPDB.

- Proposed Rule: Privacy Act - Exempt Records System. This rule would exempt the new system of records from the HIPDB from certain provisions of the Privacy Act (5 U.S.C. 552a). The proposed exemption would apply to investigative materials compiled for law enforcement purposes in anticipation of civil, criminal or administrative proceedings.

- Final Rule: Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute. This final rule serves both to clarify various aspects of the original safe harbor provisions codified at 42 C.F.R. 1001.952, and to add new safe harbors designed to protect additional payment and business practices from criminal prosecution and civil sanctions under the anti-kickback statute.

- Interim Final Rule: Shared Risk Exception to the Anti-Kickback Statute. This rule establishes standards relating to the exception to the anti-kickback statute for risk-sharing arrangements, set forth in section 1128B(b)(3)(F) of the Social Security Act.

In addition, during this period, OIG developed and published a number of Federal Register notices that addressed development of OIG compliance program guidances, Special Fraud Alerts and Special Advisory Bulletins in a variety of areas. These included:

- Draft OIG Compliance Program Guidance for Certain Medicare+Choice Organizations (64 FR 33869; June 24, 1999)

- OIG Compliance Program Guidance for the Durable Medical Equipment, Prosthetics, Orthotics and Supply Industry (64 FR 36368; July 6, 1999)

- OIG Special Advisory Bulletin on Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries (64 FR 37985; July 14, 1999)

- Draft OIG Compliance Program Guidance for Hospices (64 FR 39150; July 21, 1999)

C. Congressional Testimony and Hearings

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

Employee Fraud and Misconduct

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

- In New York, a former Public Health Service (PHS) commissioned officer was sentenced to 21 months imprisonment and 1 year supervised release for sexual abuse of a prison ward. As a Lieutenant Commander for PHS, he worked as a physician's assistant at the Immigration and Naturalization Service Detention Center. He admitted to sexually molesting at least five detainees on more than 20 separate occasions during a 2-year period of his employment with PHS. After pleading guilty to three counts of sexual abuse of a prison ward in 1998, he immediately resigned from his position at PHS.

- A Regional Hub Director for the Administration for Children and Families (ACF), agreed to pay the Government $14,521 for allegedly submitting a false travel voucher. When he submitted the travel order, he allegedly misrepresented a friend's home in California as his own and moved the friend's household goods to his new duty station. The company's services cost the Government $7,260. The ACF waived its right to take adverse personnel action concerning his employment.

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 222 successful criminal actions. Also during this period, 550 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 197 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over $231.9 million was ordered or returned as a result of OIG investigations during this semiannual period. Civil settlements from investigations resulting from audit findings are included in this figure.

Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act (PFCRA), 31 U.S.C. sections 3801-3812, authorizes the imposition of civil money penalties (CMPs) and assessments against anyone who makes a false, fictitious, or fraudulent claim or written statement to a Federal agency. It was modeled after the CMP law (42 U.S.C. 1320a-7a) which is applicable to false or otherwise improper claims presented to Medicare, Medicaid or other Federal health care programs.

Under PFCRA, a person who presents a false, fictitious or fraudulent claim to a Federal agency may be subject to a CMP of up to $5,000 per claim or statement, as well as an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims and statements presented to the Department, and for reporting at the end of each fiscal year the number of investigations completed and matters referred for administrative action under PFCRA.

During FY 1999, no matters were specifically referred for administrative action solely under PFCRA. While all cases are routinely analyzed for potential action under PFCRA, at HHS the availability of other criminal, civil and administrative remedies (particularly the CMPL) often renders unnecessary the referral of cases for action solely under PFCRA. However, OIG does assert its administrative authority under PFCRA as one basis in settlement agreements, in which OIG is a party, that resolve cases arising under the False Claims Act and other Federal statutes. In addition, as part of these settlements, the defendant is released from liability under PFCRA.

Appendices

APPENDIX A

Savings Achieved through Policy and Procedural Changes Resulting from Office of Inspector General Audits, Investigations and Inspections April 1999 through September 1999

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

Legislative savings are annualized amounts based on Congressional Budget Office (CBO) estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected or for multiple years, if applicable. Total savings from these sources amount to $5,480.4 million for this period.

OIG Recommendation	Implementing Action	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Medicare Home Health Payments: Restructure the payment system for home health care to eliminate inappropriate incentives which unnecessarily increase cost and utilization; prevent unscrupulous providers from gaining entry into the program; and improve program controls, such as eligibility determinations and approval of plans of care and services. (OEI-04-93-00260; OEI-09-96-00110; CIN: A-04-96-02121)	Chapter I of Subtitle G of the Balanced Budget Act of 1997, which pertains to home health benefits, addresses OIG's concerns regarding the need to restructure and control the payment system for these services. For example, it mandates that a prospective payment system be developed and that the total payments in fiscal year (FY) 2000 be equal to the amount that would have been paid under the prior system if cost limits were reduced by 15 percent. It also eliminates periodic interim payments to home health agencies.	$1,900
Hospital Outpatient Policy: Extend congressionally mandated reductions in hospital costs. Hospitals should limit outpatient department (OPD) facility fees to the applicable ambulatory surgical center (ASC) rate or reduce payments for OPD services to bring them in line with ASC payments. (CIN: A-14-89-00221; CIN: A-09-91-00070; OAI-85-09-0046; OEI-09-88-01003)	Section 13521 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 mandated a reduction of 10 percent for outpatient capital costs. Sections 4521-4523 of the Balanced Budget Act (BBA) of 1997 eliminated formula-driven overpayments in FY 1998, extended reductions in payments for costs of hospital outpatient services, and established a prospective payment system (PPS) for hospital outpatient services for FY 1999.	1,890

OIG Recommendation	Implementing Action	Savings in Millions
Medicare Indirect Medical Education: The Health Care Financing Administration (HCFA) should base the indirect medical education adjustment factor on the level supported by HCFA's empirical data. (CIN: A-07-88-00111)	Section 4621 of the BBA reduced the indirect teaching adjustment factor from 7.7 percent in FY 1997 to 7.0 percent in FY 1998; 6.5 percent in FY 1999; 6.0 percent in FY 2000; 5.5 percent in FY 2001 and thereafter.	$750
Medicare Secondary Payer - Initial Enrollment Questionnaire: The HCFA should take steps to collect primary insurance information in a more timely and accurate manner, requiring beneficiaries to disclose other health insurance information, and should revise all Medicare claims forms to require spousal information before claims can be paid. (CIN: A-09-89-00100; OEI-07-90-00760)	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.	425
Graduate Medical Education Payments: The HCFA should reevaluate Medicare's policy of paying graduate medical education (GME) costs for all physician specialities and should consider submitting legislation to reduce Medicare's investment in GME to arrive at a more representative and accurate sharing of GME costs. (CIN: A-06-92-00020)	Sections 4623 and 4626 of the BBA provided for limits in the number of residents and offered payments for voluntary reductions in the number of residents to limit Medicare's share of GME costs.	100
Medicare Disproportionate Share: The disproportionate share adjustment should be reduced, if not eliminated, without redistribution of the funds to PPS hospitals. (CIN: A-04-87-01004)	Section 4403 of the BBA provided for reducing disproportionate share payments by 1 percent in FY 1998, 2 percent in FY 1999, 3 percent in FY 2000, 4 percent in FY 2001, 5 percent in FY 2002 and 0 percent thereafter.	70
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)	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.	55.4

OIG Recommendation	Implementing Action	Savings in Millions
Fraud and Abuse Provisions of the Balanced Budget Act:		
Require durable medical equipment (DME) suppliers and home health agencies (HHAs) to provide Social Security numbers (SSNs) and employer identification numbers (OEI-04-96-00240; OEI-09-96-00110); refuse to enter into a provider agreement with any HHA whose owners or principals have prior criminal records or are the relatives of the owner of a provider who had defrauded the Medicare program (OEI-09-96-00110); allow HCFA to apply "inherent reasonableness" provisions when assessing the appropriateness of Medicare payments (OEI-03-94-00392); authorize competitive bidding as a means of providing Medicare services (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230); and require DME suppliers and HHAs to post surety bonds as a condition of participation (OEI-04-96-00240; OEI-09-96-00110). Also, clarify which general and administrative and fringe benefits costs at hospitals and HHAs are related to patient care; specifically, distinguish between employee benefits and/or perquisites to entertainment and patient care, and specify that cost of entertainment, goods or services for personal use, alcohol, all fines and penalties and associated interest, dues, and membership costs associated with civic and community organizations are unallowable. (CIN: A-03-92-00017; CIN: A-04-93-02067)	Subtitle D of the BBA contained a number of provisions that corresponded to and were supported by OIG work: for example, the BBA authorized the Secretary to collect SSNs and employer identification numbers from entities under Medicare, Medicaid and title V; authorized the Secretary to refuse to enter into contracts with physicians or suppliers that have been convicted of felonies; authorized the exclusion of entities owned or controlled by the family or household members of excluded individuals; authorized HCFA to make inherent reasonableness adjustments up to 15 percent to all Part B services except physician services; authorized up to 5 demonstration projects to be completed by December 31, 2002 (one must be oxygen and oxygen equipment), which can have multiple sites, to allow competitive bidding; and prohibited "reasonable cost" payments for items such as entertainment, gifts and donations, education expenses and personal use of automobiles. The BBA also required DME suppliers, HHAs and others to post a surety bond of a minimum of $50,000.	$50
Hospital Sales:		
The HCFA should eliminate the requirement that Medicare make adjustments for gains and losses when hospitals undergo changes of ownership. (OEI-03-96-00170)	Section 4404 of the BBA eliminated the requirement that Medicare make adjustments by setting the Medicare capital asset sales price equal to the net book value.	50
Rural Health Clinics:		
The oversight and functioning of the current cost reimbursement system should be improved by implementing caps on provider-based rural health clinics (RHCs) and allowing States to do so, or finding other ways to make reimbursement between provider-based and independent RHCs more equitable. In addition, the certification process should be modified to increase State involvement and ensure more strategic placement of RHCs. Recertification should be required of RHCs within a specific time limit (for example 5 years), applying new criteria to document the need and impact on access. (OEI-05-94-00040)	Section 4205 of the BBA extended the per-visit payment limits to provider-based clinics and stipulated that the shortage area requirements designation be reviewed triennially.	30

OIG Recommendation	Implementing Action	Savings in Millions
Hospice Certification: The HCFA should restructure hospice benefit policies to curb inappropriate growth in the program, particularly with regard to the fourth benefit period. (OEI-05-95-00250; CIN: A-05-96-00023)	Sections 4441-4449 of the BBA of 1997 contained provisions to control hospice payments and practices, such as replacing the current unlimited fourth benefit period with an unlimited number of 60 day benefit periods (each requiring recertification).	$30
Payments for Ambulance Services: The HCFA should seek legislative authority to develop a fee schedule for ambulance transportation and examine the inherent reasonableness of current allowable charges. (OEI-05-95-00300)	Section 4531 of the BBA of 1997 made interim reductions in ambulance payments by limiting the allowed rate of increase and mandated the establishment of a fee schedule by January 1, 2000. Such fee schedule is to be set so that aggregate payments are reduced by 1 percent.	10
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)	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.	5
PUBLIC HEALTH SERVICE AGENCIES		
Audit of Harvard University's Indirect Cost Proposal: The Division of Cost Allocation (DCA) should utilize the OIG's recommendations on allocation of research space, depreciation and salaries and fringe benefits to negotiate facilities and administrative (F&A) cost rates at Harvard University. (CIN: A-01-94-04009)	In addition to the original negotiations, DCA utilized this report to negotiate a 3-year rate extension of F&A costs for FYs 1998-2000.	2

Other	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
VARIOUS OPERATING DIVISIONS		
Results of Investigations: In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the operating division.	The operating division takes action based on the results of the OIG investigation to suspend or terminate payments to the offending individual or entity.	5

APPENDIX B

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

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

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Modify Formula for Costs Charged to the Medicaid Program: The Health Care Financing Administration (HCFA) should consult with the Congress on modification of the Federal medical assistance percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per capita income relationships. (CIN: A-06-89-00041)	The HCFA did not agree with the recommendation, and no legislative proposal was included in the President's current budget.	$4,100
Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)	The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.	2,040
Medicare Coverage of State and Local Government Employees: Require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (CIN: A-09-88-00072)	Although HCFA included a proposal to mandate Medicare coverage for all State and local government employees in the FY 1990 budget submission, no legislative proposal was included in the President's current budget. Also, HCFA did not agree with the recommendation to make Medicare the secondary payer.	1,559
Clinical Laboratory Tests: Develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CIN: A-09-89-00031; CIN: A-09-93-00056)	The HCFA agreed with the first recommendation but not the second. The Balanced Budget Act of 1997 reduces Medicare fee schedule payments by lowering the cap to 74 percent of the median for payment amounts beginning in 1998. Also, there will be no inflation update between 1998 and 2002. The President's current budget proposes to reduce the fee schedule ceiling from 74 to 72 percent.	1,130*

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

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

OIG Recommendation	Status	Savings in Millions
Chemistry Panel Tests: The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 tests identified by the OIG audit. (CIN: A-01-93-00521)	The HCFA agreed with 8 of the 10 tests recommended for addition to the list and added 6 of these tests to its carrier manual. The HCFA will periodically review applicable tests and related equipment. Also, although a legislative proposal to add further tests was included in the President's FY 1997 budget, the Congress decided (through the Balanced Budget Act of 1997) to achieve savings through other means, including freezing laboratory payments through 2002 and reducing the national payment cap to 74 percent of the median of all fee schedules.	$130
Paperless Claims: The HCFA should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing by physicians who submit claims on paper and who have a moderate to high level of interest in making the switch. This effort should be coordinated with efforts to promote further use of electronic data interchange by providers under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996. The HCFA should also begin to plan now for the policy changes that will be necessary to achieve an almost completely paperless environment for processing Medicare claims. These policy changes can include targeting a date when all physicians will be mandated to submit paperless claims, targeting a date when paperless claims submission will become a condition for Medicare participation physician status, or continuing to accept paper claims but imposing a filing fee to cover the incremental cost of doing so. (CIN: A-05-94-00039; OEI-01-94-00230)	The HCFA concurred with OIG's recommendations. The President's current budget proposes to allow an assessment of a $1 fee on any claim not submitted electronically.	126
Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (CIN: A-06-94-00039)	The OIG is continuing to monitor the Medicaid drug rebate program.	123

OIG Recommendation	Status	Savings in Millions
Medicaid Cost Sharing: The HCFA should promote the development of effective cost sharing programs by: allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services; allowing for higher beneficiary cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800)	The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. However, HCFA has no current plans for providing information on States' cost-sharing experiences.	$122
Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The HCFA should propose legislation to expand the diagnosis related group (DRG) payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)	The HCFA agreed to recover the improper Medicare billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and OIG. The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's current budget.	83.5
Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)	The HCFA considered a proposal recommending that the Medicare 190-day lifetime limit for psychiatric admissions be extended to general hospitals; however, such a proposal was not included as part of the President's current budget.	47.6
Nonemergency Advanced Life Support Ambulance Services: The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513; CIN: A-01-94-00528)	The HCFA issued a final regulation which addresses the coverage of ambulance services and vehicle and staff requirements. The agency intends to address advanced and basic life support services as part of the negotiated rulemaking process on the ambulance fee schedule which began in early 1999.	47
Limit Reimbursement for Hospital Beds: The HCFA should take immediate steps to reduce Medicare payments for hospital beds used in the home. This should include the elimination of the higher reimbursement rate currently paid during the first 3 months of rental. (CIN: A-06-91-00080; OEI-07-96-00221; OEI-07-96-00222)	The HCFA concurred with the recommendations and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency has included hospital beds and supplies as part of its ongoing competitive bidding demonstration project for durable medical equipment.	40

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

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

OIG Recommendation	Status	Savings in Millions
Preclude Improper Medicaid Reimbursement for Clinical Laboratory Services: State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings that contain duplicate tests, recover overpayments and make adjustments for the Federal share of the amounts recovered. (CIN: A-01-95-00005; CIN: A-05-95-00035; CIN: A-01-96-00001; CIN: A-06-95-00078; CIN: A-06-95-00031; CIN: A-04-95-01108; CIN: A-04-95-01109; CIN: A-07-95-01139; CIN: A-07-95-01147; CIN: A-04-95-01113; CIN: A-07-95-01138; CIN: A-09-95-00072; CIN: A-05-96-00019; CIN: A-10-95-00002; CIN: A-01-95-00006; CIN: A-02-95-01009; CIN: A-03-96-00200; CIN: A-03-96-00202; CIN: A-03-96-00203; CIN: A-05-95-00062; CIN: A-06-96-00002; CIN: A-06-95-00100)	The HCFA wrote to all State Medicaid directors on January 15, 1997, alerting them to the OIG review, encouraging them to use Medicare's bundling policies and urging them to install appropriate payment edits in their claim processing systems.	$17
Medicare Claims for Railroad Retirement Beneficiaries: Discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)	While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.	9.1
Medicare Orthotics: Develop guidelines that better define orthotic devices; develop policies for orthotic codes; develop screens for billing many orthotic devices on the same day or within a short time frame; pay special attention to billing for orthotics in nursing facilities; work with the American Orthotic and Prosthetic Association to develop a table of devices that should not be used together, and consider stricter standards to determine who is allowed to bill for orthotics. (OEI-02-95-00380)	The HCFA concurred with the recommendations and has revised its national codes to distinguish among categories of devices. The OIG is currently conducting a follow-up to this study.	7.9

OIG Recommendation	Status	Savings in Millions
Third Party Liability Settlements and Awards: The HCFA should develop legislative proposals to close the loopholes in the Omnibus Budget Reconciliation Act of 1993 that allow Medicaid beneficiaries, who receive settlements and awards from third parties as a result of accidents, to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. The HCFA should also develop guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties. (CIN: A-09-93-00033)	The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g., health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements. In June 1996, HCFA issued guidelines which set forth advice on ways in which States can better recover Medicaid expenditures from established third-party settlements, especially for the disabled population.	$3
Indirect Medical Education: Reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (CIN: A-07-88-00111)	The HCFA agreed with the recommendation, and the Balanced Budget Act of 1997 reduces the IME adjustment factor from the current 7.7 percent in Fiscal Year (FY) 1997 to 5.5 percent in 2001 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.	to be determined
Medicare Secondary Payer - End Stage Renal Disease Time Limit: Extend the Medicare secondary payer (MSP) provisions to include ESRD beneficiaries without a time limitation. (CIN: A-10-86-62016)	The HCFA was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. The HCFA favored indefinitely extending the MSP provision for all other services and included this proposal in an earlier budget submission. Although the Balanced Budget Act of 1997 extends MSP policies for individuals with ESRD to 30 months, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.	to be determined

OIG Recommendation	Status	Savings in Millions
Home Health Agencies: The HCFA should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (CIN: A-04-95-01103; CIN: A-04-95-01104; OEI-04-93-00262; OEI-04-93-00260; OEI-12-94-00180; OEI-02-94-00170; CIN: A-04-94-02087; CIN: A-04-94-02078; CIN: A-04-96-02121; CIN: A04-97-01169; CIN: A-04-97-01166; CIN: A-04-97-01170)	Although the Congress and the Administration included provisions to restructure home health benefits in the Balanced Budget Act of 1997, HCFA still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. While agreeing in principle, HCFA said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. The OIG will continue to do work in this area.	to be determined
Modify Payment Policy for Medicare Bad Debts: The OIG presented an analysis of four options for HCFA to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable, and the inclusion of a bad debt factor in the DRG rates. The HCFA should seek legislative authority to further modify bad debt policies. (CIN: A-14-90-00339)	The HCFA agreed with the recommendation to include a bad debt factor in the DRG rates. The Balanced Budget Act of 1997 provides for some reduction of bad debt payments to providers. The President's current budget proposes to reduce the percentage (from 55 percent to 45 percent) that Medicare pays for bad debts and to extend this policy to providers beyond hospitals. However, additional legislative changes are needed to implement the modifications that OIG recommended.	to be determined
Establish Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: The HCFA should seek legislation that would require participating drug manufacturers to pay Medicaid drug rebates based on average wholesale price (AWP) or study other viable alternatives to the current program of using average manufacturer price (AMP) to calculate the rebates. This legislation would have resulted in about $1.15 billion in additional rebates for 100 brand name drugs with the highest total Medicaid reimbursements in Calendar Years 1994-96. (CIN: A-06-97-00052)	The HCFA disagreed with the recommendation to seek a legislative change, believing that such legislation was not feasible at the time. However, HCFA stated that changing AMP to AWP would reduce the administrative burden involved in the AMP calculations and planned a comprehensive study of AWP.	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: Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)	In the absence of specific authorizing legislation, the Food and Drug Administration (FDA) is precluded by statute from imposing user fees to cover additional functions. The FY 2000 President's budget request for FDA proposes that FDA be given new user fee authority to enhance premarket review activities for medical devices and food additive petitions.	$189.3
Medicare Rates for Indian Health Service Contracted Health Services: The Indian Health Service (IHS) should revise its legislative proposal to incorporate OIG's updated savings figures and should identify elements to be included in the implementing regulations. Also, IHS should continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates and should strategically identify and pursue other opportunities where lower rates may be negotiated. (CIN: A-15-97-50001)	The IHS concurred with OIG's recommendations and is revising its legislative proposal for submission in the FY 2000 legislative cycle, identifying elements to be developed in its implementing regulations and continuing its efforts to obtain discount rates throughout its service area.	8.2
Recharge Center Costs: The Assistant Secretary for Management and Budget should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (CIN: A-09-96-04003)	The Deputy Assistant Secretary for Grants and Acquisition Management concurred with the recommendations. In addition, the Council on Government Relations generally agreed and stated that the proposed criteria should be included in the Compliance Supplement to OMB Circular A-133, which provides guidance to independent auditors in conducting compliance audits of educational institutions.	1
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Medical Child Support: Increase the number of noncustodial parents providing medical support for their children and reduce Medicaid costs by either requiring noncustodial parents to pay for all or part of the Medicaid premiums or establishing a new comprehensive health insurance plan for children with premiums paid by noncustodial parents. (CIN: A-01-97-02506)	The Administration for Children and Families and HCFA agreed with OIG's findings and recommendations. State officials will move to consider a legislative change and budget option to address the recommendation for the 1999 legislative session.	11.4

OIG Recommendation	Status	Savings in Millions
GENERAL OVERSIGHT		
Simplify Administrative/Indirect Cost Allocation Systems: The OMB should simplify the process for charging administrative/indirect costs to Federal programs through reform of the cost allocation plans. Options for reform include use of block grant awards, a flat percentage rate for administrative/indirect costs, and negotiation of a nonadjustable rate for a predetermined number of years. (CIN: A-12-92-00014)	Some of OIG's recommendations are cited in the National Performance Review report that calls for reform of the cost allocation process. The OMB's revision of Circular A-87 addressed those recommendations. However, further reform is needed to address the bulk of administrative/indirect costs charged to the Federal Government.	$660

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

OIG Recommendation	Status
HEALTH CARE FINANCING ADMINISTRATION	
Improve the Health Care Financing Administration's Implementation of the Federal Managers' Financial Integrity Act Program: The Health Care Financing Administration (HCFA) should reevaluate its review of the Common Working File to ensure that all functional responsibilities of the system are included in Federal Managers' Financial Integrity Act reviews. (CIN: A-14-93-03026)	The HCFA still does not agree with the need to expand financial management reviews to other systems, such as the Common Working File.
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 also has a task force to help with rebate resolution.
Ensure that the Medicare Accounts Receivable Balance Is Fairly Presented: The HCFA should require contractors to implement or improve internal controls and systems to provide sufficient documentation to support reported accounts receivable. Because of insufficient documentation, OIG again was not able to satisfy itself as to the fair presentation of the Medicare accounts receivable balance ($3.6 billion in FY 1998). (CIN: A-17-95-00096; CIN: A-17-97-00097; CIN: A-17-98-00098)	The HCFA has contracted with a consulting service to assist in validating the FY 1998 accounts receivable activity and balance, as well as the activity for the first 6 months of FY 1999, and to recommend any accounting changes or adjustments.
Consider Recommended Safeguards over Medicaid Managed Care Programs: The HCFA should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)	The HCFA generally concurred with OIG's recommendations but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.

OIG Recommendation	Status
Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program: The HCFA should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The HCFA should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)	The HCFA did not concur stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP, but did not provide specific written methodology for computing AMP.
Physician Office Surgery: The peer review organizations (PROs) should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)	The HCFA has issued policy guidance and manual instructions to explicitly state that PROs have the responsibility to review all care in physician offices when a beneficiary complains.
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)	The HCFA is currently pursuing the recommended administrative action through improved information systems to guard against making improper Medicare payments to the Blue Cross and Blue Shield plans. Also, the President's FY 1999 budget includes a legislative proposal to clarify MSP requirements.
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.
Medicare Beneficiary Satisfaction with Durable Medical Equipment Regional Carrier Services: The HCFA should evaluate ways to increase beneficiary satisfaction with the one durable medical equipment regional carrier with a low rating, and review effective ways to educate beneficiaries on what constitutes fraud and abuse. (OEI-02-96-00200)	The HCFA concurred. The HCFA conducts annual evaluations to identify ways to improve performance. The HCFA is also working to develop new outreach techniques to increase beneficiaries' knowledge on detecting fraud and abuse.
Pressure Reducing Support Services: The HCFA should establish the requirement for periodic review and renewal of the medical necessity for beneficiaries' use of group 2 support surface equipment. (OEI-02-95-00370)	The HCFA did not concur.
Excessive Medicare Payments for Prescription Drugs: The HCFA should examine its Medicare drug reimbursement methodologies. (OEI-03-97-00290)	The Balanced Budget Act of 1997 reduced Medicare payments by limiting them to 95 percent of the average wholesale price. Additional corrective action is warranted and called for in the President's 1999 and 2000 budget and legislative programs.

OIG Recommendation	Status
Medicaid Accounts Receivable and Accounts Payable: The HCFA should continue its annual survey process or find a suitable alternative to estimate net accounts payable. Trend data on receivables and payables over time should be developed for each State and used to improve the estimation model. (CIN: A-17-95-00096; CIN: A-17-97-00097; CIN: A-17-98-00098)	The HCFA sent the FY 1998 survey to the States well in advance of the due date.
PUBLIC HEALTH SERVICE OPERATING DIVISIONS	
Require Participation in the 340B Drug Pricing Program: To ensure that grantees are accessing lower priced drugs, which enables them to provide additional services, the Health Resources and Services Administration (HRSA) should require all eligible entities to participate in the 340B drug pricing program. (CIN: A-01-98-01500)	The HRSA published a Federal Register notice that would require all eligible entities to participate in the 340B program. Because all responses to the notice were negative, HRSA instead decided to address the issue administratively by issuing a policy statement and guidance to grantees.
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 is piloting redesigned titles IV-B and IV-E child welfare reviews. A notice of proposed rulemaking was published in September 1998, and the final rule is in clearance. In addition, the child welfare waiver demonstrations are allowing several States to test alternative approaches to the title IV-E requirements.
GENERAL OVERSIGHT	
Update Cost Principles for Federally Sponsored Research Activities: The Department should act to modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (CIN: A-01-92-01528)	The Department is revising hospital cost principles to be consistent with OMB Circulars.
Guidelines to Reimburse Educational Institutions and Nonprofit Organizations: The Department should work with OMB to revise applicable cost principles to reflect the change in accounting for post retirement benefit (PRB) costs arising from implementation of Financial Accounting Standards Board Opinion 106. It should also advise negotiators for the Department's Division of Cost Allocation to pay special attention to such costs when reviewing fringe benefit rates for schools and nonprofit organizations. (CIN: A-01-93-04000)	The OMB has revised Circular A-87 to limit PRB costs to the amount funded, but has no plans to revise Circular A-21. However, the Department has instructed negotiators that PRB costs claimed under Circulars A-21 and A-122 should be treated in the same manner as the provisions of Circular A-87.

APPENDIX D

Notes to Tables I and II

Table I

[1] The opening balance was adjusted downward by $10.8 million.

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

CIN: A-03-97-43787	State of Virginia: Grantee submitted documentation to revise plan in the amount of $428,200
CIN: A-04-96-01139	Venice Hospital: Grantee adjusted overpayment of $72,892
CIN: A-07-96-39484	Omaha Tribe: Tribe supplied documentation in the amount of $51,483

Not detailed are revisions to previously disallowed management decision totaling $81,067.

[3] Included in management decisions to disallow is $9,750 in audits performed by the Defense Contract Audit Agency.

[4] Included in management decisions to disallow $27.1 million that was identified in nonfederal audit reports.

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

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

CIN: A-09-96-00054	Blue Cross of California Admin. Cost, Aug. 1996, ($1,653,079)
CIN: A-09-94-01022	Intelligenetics #N01-GM-72110, Oct. 1994, ($12,400)
CIN: A-03-97-00013	BC/BS FY 89-92 Incremental Claim, Sept. 1998, $11,723,785
CIN: A-07-98-02522	Pension Segmentation BS California Termination, April 1999, $7,623,524
CIN: A-09-97-44262	State of California, April 1997, $7,419,900
CIN: A-03-91-00552	Independent Living Program, March 1993, $6,529,545 (Related recommendation of $10,161,742 outstanding on Table II)
CIN: A-10-97-48849	State of Oregon, July 1997, $6,379,395
CIN: A-07-92-00578	Blue Cross/Blue Shield of Texas Inc., Unfunded Pension Costs, Oct. 1992, $6,244,637
CIN: A-07-97-01213	Pension - Travelers Termination, Feb. 1998, $5,624,747
CIN: A-07-96-02001	Medicare Part B Admin Costs at BC/BS Colorado, Dec. 1996, $4,483,104
CIN: A-07-98-01224	BC/BS KY-Unfunded Pension Costs, Oct. 1998, $4,286,294
CIN: A-07-97-01234	Rocky Mountain Pension Termination, May 1998, $4,079,171
CIN: A-05-94-00080	Associated INS. Medicare Administrative Costs, July 1996, $3,954,632
CIN: A-09-95-00056	Review of Training Activities - CA Dept of Social Services., Aug. 1996, $3,934,717

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

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

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

CIN: A-03-94-00029 Veritus INC - Admin. Cost, Feb. 1998, $3,140,363

CIN: A-07-93-00633 Pension Segmentation - Aetna Life Insurance Co, Oct. 1993, $3,011,376

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

CIN: A-09-98-50183 State of California, Mar. 1998, $3,000,000

CIN: A-07-92-00585 Pension Segmentation BC/BS of California, Jan. 1994, $2,973,504

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

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

CIN: A-07-96-01185 BCBS Rocky Mountain Pension Segmentation, June 1997, $2,743,438

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

CIN: A-05-92-00026 Associated Insurance Co - Medicare Administrative Audit, Feb. 1992, $2,530,409

CIN: A-02-91-01006 Blue Shield of Western NY Medicare Adm CTS Porter, Sept. 1991, $2,379,239

CIN: A-02-93-02001 Manpower Demonstration RES Corp. HHS100890030, Oct. 1994, $2,024,444

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

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

CIN: A-05-95-00059 Audit Of Administrative Costs - BCBS Michigan, Jan. 1997, $1,787,345

CIN: A-02-94-01030 Hospice Eligibility Review IN PR - Manati - ORT, June 1995, $1,598,837

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

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

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

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

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

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

CIN: A-05-95-00042 BC/BSA Administrative Costs - Contracted Audit, Dec. 1995, $1,333,598

CIN: A-02-98-52102 Puerto Rico Family Dept. of Children and Families, March 1998, $1,321,656

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

CIN: A-07-93-00700 BC/BS of Mass - Unfunded Pension Costs, May 1994, $1,290,740

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

CIN: A-10-97-47406 State of Idaho, April 1997, $1,262,577 (Related recommendation of $5,900,000 outstanding on Table II)

CIN: A-07-97-01223 Pensions - Kentucky Blues/Segmentation, Oct. 1998, $1,236,890

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

CIN: A-07-93-00665 Travelers Insurance Co - Unfunded Pension Cost AUD, Oct. 1993, $1,218,963

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

CIN: A-09-98-00052 California Medical Rev Inc., Jan. 1999, $1,067,991

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

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

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

CIN: A-01-98-00500 Payment Edits for Psychiatric ATMA Part B Carrier, Sept. 1998, $1,000,000

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

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

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

CIN: A-09-98-49528 Hawaii Dept. of Human Service, Oct. 1997, $952,016

CIN: A-05-92-00060 Contractor Audit - BC/BS - Admin., Feb. 1993, $879,609

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

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

CIN: A-07-98-01225 BC/BS KY Pension Costs Claimed, Oct. 1998, $736,134

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

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

CIN: A-02-98-01004 Nylcare Managed Care Administrative Costs, Dec. 1998, $688,723

CIN: A-09-97-00078 Physician Billings, Jan. 1999, $683,264

CIN: A-04-99-54416 State of Florida, Nov. 1998, $668,791

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

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

CIN: A-01-98-00503 Psychiatric Output Services at the Franklin Medical Center, Nov. 1998 $646,517

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

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

CIN: A-07-96-01178 Medicare Pension Costs Claimed BC/BS Mich., Nov. 1996, $631,248

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

CIN: A-10-99-57240 State of Idaho, Jan. 1999, $594,000

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

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

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

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

CIN: A-03-97-00009 Peer Review Systems Inc./CCAS/Ohio, Mar. 1997, $545,405

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

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

CIN: A-09-99-56858 Hawaii Dept. of Human Services, Feb. 1999, $502,000

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

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

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

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

CIN: A-06-99-56489 State of Louisiana, Jan. 1999, $421,206

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

CIN: A-02-97-01006 BC/BS of Western NY, Feb. 1999, $366,506

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

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

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

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

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

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

CIN: A-10-97-49306 State of Alaska, Aug. 1997, $287,125

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

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

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

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

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

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

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

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

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

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

CIN: A-06-99-56489 State of Louisiana, Jan. 1999, $213,709

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

CIN: A-01-99-54113 State of Rhode Island & Providence Plantations, Oct. 1998, $209,630

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

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

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

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

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

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

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

CIN: A-03-99-00007 Forest Ambulance Service, Dec. 1998, $173,189

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

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

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

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

CIN: A-07-98-02526 Unfunded Pension Liability - BC/BS of Arkansas, Sept. 1998, $153,269

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

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

CIN: A-09-99-52846 Intertribal Council of California, Feb. 1999, $136,360

CIN: A-02-98-01002 Ipro Closeout Audit, Dec. 1998, $135,492

CIN: A-09-99-56378 Fresno Indian Health Assoc., Jan. 1999, $134,465

CIN: A-07-97-02500 Pension Segmentation BC/BS Connecticut, Mar. 1998, $122,548

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

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

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

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

CIN: A-02-96-02001 International Rescue Committee Refugee Program, Jan. 1998, $108,604 (Related recommendation of $90,528 outstanding on Table II)

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

CIN: A-07-95-01159 NE BCBS Pension Segmentation, Jan. 1996, $96,955

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

CIN: A-03-98-00007 Delmarva Pro, Dec. 1998, $95,709

CIN: A-09-98-00065 Latino Resources, Jan. 1999, $95,102

CIN: A-10-97-00003 Psychiatric Outpatient Services, Feb. 1998, $94,643

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

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

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

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

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

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

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

CIN: A-03-98-00008 VA Health Quality Center Rev, Dec. 1998, $78,207

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

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

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

CIN: A-08-96-42696 Blackfeet Tribe, July 1996, $71,988

CIN: A-01-97-00520 CFO Audit of HCFAs Financial Statements, July 1998, $69,031

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

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

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

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

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

CIN: A-08-99-54138 Rosebud Sioux Tribe, Nov. 1998, $56,223

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

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

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

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

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

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

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

CIN: A-09-99-55207 Fresno Indian Health Assoc., Jan. 1999, $47,742

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

CIN: A-09-99-56858 Hawaii Dept. of Human Services, Feb. 1999, $44,144

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

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

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

CIN: A-07-98-02030 DOSHI - CPA Report, Nov. 1997, $35,703

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

APPENDIX G

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

Pursuant to section 205 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, the Inspector General is required annually to solicit proposals (via Federal Register notice) for modifying existing safe harbors to the anti-kickback statute and for developing new safe harbors and special fraud alerts. In accordance with this requirement, on December 10, 1998, the Office of Inspector General (OIG) published a notice in the Federal Register soliciting such proposals. The OIG received seven timely-filed responses from a cross-section of organizations, associations and other interested parties. Some of these respondents commented generally on areas of concern; others provided detailed proposals for new or modified safe harbor regulations.

The OIG is currently preparing a comprehensive safe harbor rule that will finalize certain proposals for new and clarified safe harbors published in the Federal Register in 1993 and 1994. This rulemaking is in the governmental clearance process. Several respondents to the 1998 annual solicitations suggested safe harbors in subject areas addressed by the 1993 and 1994 notices of proposed rulemaking. Such suggestions (received in response to the annual solicitations) included:

- Investments in ambulatory surgical centers and other facilities where physicians practice, including investment interests held by nonsurgeon and nonphysician investors;
- Referral agreements for speciality services, such as cross-referral and comanagement agreements between optometrists and ophthalmologists.
- Modifications to the existing discount safe harbor;
- Modifications to the existing personal services and equipment leasing safe harbors; and
- Modifications to the existing investment interests safe harbor.

These safe harbor suggestions will be addressed (but not necessarily adopted) in the rulemaking on the 1993 and 1994 proposals.

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

In response to the 1998 annual solicitation, OIG received the following two suggestions for safe harbors concerning subject areas other than those addressed in the rulemaking described above:

- Modifying the safe harbors generally to exclude from protection business arrangements involving parties previously sanctioned by Medicare or Medicaid. The OIG is studying this suggestion.
- Adding a new safe harbor for physician-owned therapeutic services (such as mobile lithotripsy) where the physician performs or supervises the performance of the therapeutic services. The OIG will not promulgate a safe harbor for physician-owned therapeutic services, such as mobile lithotripsy, because many such ventures result in increased costs to the Federal health care programs. The investment interests in small entities safe harbor, 42 C.F.R. 1001.952(a)(ii), may be available for some therapeutic services ventures that meet the safe harbor criteria.

More generally, one respondent expressed concern about various coding and billing deficiencies and the need for better monitoring; another urged that OIG not create an exception to section 1128A(a)(5) of the Social Security Act for insurance premium payments by end stage renal disease facilities.

Finally, OIG is continuing to study safe harbor suggestions received in response to annual solicitations published in 1996 and 1997 and reported in the semiannual report published in November 1998. The OIG anticipates publishing a proposed rulemaking for new safe harbors in early 2000.

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 99-499	Superfund Amendments and Reauthorization Act of 1986
P.L. 101-576	Chief Financial Officers Act of 1990
P.L. 102-486	Energy Policy Act of 1992
P.L. 103-62	Government Performance and Results Act of 1993
P.L. 103-355	Federal Acquisition Streamlining Act of 1994
P.L. 103-356	Government Management Reform Act of 1994
P.L. 104-156	Single Audit Act Amendments of 1996
P.L. 104-191	Health Insurance Portability and Accountability Act of 1996
P.L. 104-193	Personal Responsibility and Work Opportunity Act of 1996
P.L. 104-208	Federal Financial Management Improvement Act of 1996

Office of Management and Budget Circulars:

A- 21	Cost Principles for Educational Institutions
A- 25	User Charges
A- 50	Audit Follow-up
A- 76	Performance of Commercial Activities
A- 87	Cost Principles for State, Local and Indian Tribal Governments
A-102	Grants and Cooperative Agreements with State and Local Governments
A-110	Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations
A-122	Cost Principles for Nonprofit Organizations
A-123	Management Accountability and Control
A-127	Financial Management Systems
A-129	Policies for Federal Credit Programs and Non-Tax Receivables
A-133	Audits of States, Local Governments and Non-Profit Organizations
A-134	Financial Accounting Principles and Standards

General Accounting Office Government Auditing Standards

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

Title 42, United States Code, sections 263a(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, sections 3729-3733, (the False Claims Act) and 3801-3812 (the Program Fraud Civil Remedies Act)

Title 42, United States Code, sections 1320a-7, 1320a-7a, 1320b-10, 1320c-5, 1395l, 1395m, 1395u, 1395dd and 1396b

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