Semiannual Report

April 1, 1995 - September 30, 1995

Office of Inspector General

Your Strongest Weapon to Fight Health Care Fraud . . .

1-800-HHS-TIPS

(1-800-447-8477)

- Every year, millions of dollars are lost to health care fraud. Everyone can play a role in putting an end to this by calling the Health and Human Services Confidential Tip Line: 1-800-HHS-TIPS.

- Please call Monday through Friday, 9 a.m. to 8 p.m., anytime you believe you have information about fraud. You do not have to give your name to make a real difference.

To report fraud, write to: Office of Inspector General
U.S. Department of Health and Human Services
HHS-TIPS Hot Line
P.O. Box 23489
Washington, DC 20026

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

A MESSAGE FROM THE SECRETARY

I am pleased to transmit this semiannual report describing the accomplishments of the Office of Inspector General (OIG) during the 6-month period ending September 30, 1995. In Fiscal Year 1995, OIG achieved more than $10 billion in fines, savings, restitutions, settlements and recoveries.

The OIG played a pivotal role in the Department's efforts to improve the quality of health care services provided to the public. In the debate over the Nation's health care system, there is general agreement that fraud, waste and abuse are issues that must be addressed if the Medicare and Medicaid programs are to remain viable. I would like to take this opportunity to report on the progress of our most recent initiative in this area, *Operation Restore Trust*.

Led by OIG in partnership with the Health Care Financing Administration and the Administration on Aging, this intensive collaborative effort is now underway in the five targeted States with the highest proportion of Medicare and Medicaid beneficiaries - New York, Florida, Illinois, Texas and California. The project draws upon the expertise of many Federal, State and private sector personnel who are directing their combined energies to crack down on Medicare and Medicaid fraud, waste and abuse associated with home health agencies, nursing homes and durable medical equipment suppliers.

To facilitate participation by the public, including medical providers and Medicare and Medicaid beneficiaries, OIG has instituted a national, toll-free, fraud hotline (1-800-HHS-TIPS). In conjunction with the Department of Justice, OIG has established a voluntary disclosure pilot program to allow companies to come forward with evidence of fraud or errors they have discovered within their own organizations.

In a time of fiscal austerity, collaborative activities such as these maximize our capacity to combat health care fraud, waste and abuse. I am confident that *Operation Restore Trust* will prove to be a wise investment, promoting greater efficiency and effectiveness in the Medicare and Medicaid programs, and saving money for the Government and the taxpayers. I appreciate the diligent efforts of the Inspector General and her staff in developing this project and working to ensure its success.

Donna E. Shalala

HIGHLIGHTS

Introduction

The Office of Inspector General (OIG) in the Department of Health and Human Services (HHS) has changed drastically during the 6-month period ending September 30, 1995. On March 31st, the Social Security Administration became an agency independent of HHS, and with that about a quarter of the OIG staff transferred to the new agency. With the departure, OIG has had to reexamine its use of resources in order to concentrate its work more fully in areas of health and welfare. The office is developing new and unique ways of approaching its mission to protect both the integrity of the Department's programs and the health and welfare of the beneficiaries served by the Department.

Yet despite the enormous changes during the last semiannual period, OIG has produced some of its most significant achievements to date. These achievements highlight its new methods of working cooperatively with other organizations, taking a focused look at specific programs and issues, and doing more with less. Highlighted below are some of the prime examples.

Operation Restore Trust

The President announced in May a 2-year partnership of Federal and State agencies working together to prevent and detect health care fraud in specific industries. This Operation Restore Trust initially targets five States which together account for 40 percent of the Nation's Medicare and Medicaid beneficiaries.

Operation Restore Trust, led by HHS OIG working jointly with the Health Care Financing Administration (HCFA) and the Administration on Aging, represents one of the largest and most complex efforts against health care fraud ever undertaken. The project is designed to share resources and collaborate with numerous entities to prevent and detect fraud and abuse in three rapidly growing sectors of the health care industry: home health agencies, nursing facilities and durable medical equipment suppliers.

In addition to numerous audits, inspections and criminal investigations, Operation Restore Trust also prompted a new OIG fraud hotline, 1-800-HHS-TIPS, and a voluntary disclosure program that encourages health care entities to come forward with fraud they discover for themselves. (See page 5)

Settlement Against Caremark, Inc.

In June, OIG announced the second largest health care fraud settlement ever, against Caremark, Inc. Caremark agreed to plead guilty and pay approximately $161 million in criminal fines, civil restitution and damages. In addition, the settlement included a corporate

compliance plan for Caremark. The OIG cited Caremark for kickbacks and fraud in its home infusion, oncology, hemophilia and human growth hormone businesses.

The settlement, announced in conjunction with the Department of Justice, was a prime example of a multi-pronged offensive against health care fraud. In addition to the cooperative work of several components within OIG, the efforts against Caremark included the work of more than 10 Federal agencies and numerous State agencies. (See page 26)

Efforts in Managed Care

A prime focus of OIG work over the past year has been the issue of managed care and health maintenance organizations (HMOs). This semiannual period OIG produced two inspection reports highlighting beneficiary experiences with HMOs and three audits that identified specific overpayments in managed care.

A survey of beneficiaries in Medicare risk HMOs concluded that most clients have adequate access to services and HMOs generally adhered to Federal enrollment standards. However, the inspection also identified areas needing improvement, particularly regarding services for disabled persons. In addition, this inspection work in managed care has made it possible to use data to identify troubled HMOs for specific review. These inspections were the latest in an ongoing series of reports dealing with beneficiaries and HMOs.

Based on OIG work in one of a series of managed care reviews, HCFA identified overpayments to HMOs totaling almost $70.5 million for Medicare beneficiaries erroneously classified as also being eligible for Medicaid. And, in several plan-specific managed care reviews, OIG found erroneous payments totaling nearly $1.5 million for beneficiaries who were either erroneously classified as eligible for higher payments or were no longer residing in the HMO's service area. (See pages 19-20)

Reporting Process for Blood Establishments

The OIG reviewed the process by which blood establishments notify the Food and Drug Administration (FDA) of errors and accidents that may affect the safety, purity or potency of their blood and blood products. While OIG determined that FDA generally processed error and accident reports in accordance with established procedures, it did identify two conditions — late reporting by licensed establishments and limited voluntary reporting by unlicensed establishments — which could hamper successful implementation of FDA's plan to expand the use of such reports. (See page 41)

The Rest of the Story

These accomplishments and initiatives are only part of the OIG story in the last fiscal year. The OIG reported $10.2 billion in savings for the fiscal year, comprising $9.2 billion in implemented recommendations to put funds to better use (detailed in Appendix A of the semiannual reports), and $1 billion in fines, restitutions, recoveries and settlements. During this fiscal year, OIG also reported 620 convictions and 1,563 administrative sanctions.

In addition to the above-cited examples, OIG reports and investigations have identified areas to reduce unnecessary spending; prevent and detect fraud and abuse; identify systemic management problems; promote improved service delivery; and help agencies develop and assess performance measures. The OIG has examined issues in the Department ranging from the Ryan White CARE Act, hospice care and home health, to investigational medical devices and child support.

OIG Work in Performance Measurement

In order to identify work done in the area of performance measurement, OIG has labeled some items throughout this report as "performance measures" with the symbol Performance Measure . Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program which is measured by the number of inoculations provided per dollar of cost. In OIG's opinion, the audits, inspections and investigations identified with the performance measure symbol offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals. These proposals are provided to management for their consideration as they develop their performance measures. In this report, more than 30 items are labeled as performance measures. (See Appendix F)

Chapter IV PUBLIC HEALTH SERVICE

Social Security Administration Independence

Chapter I

SOCIAL SECURITY ADMINISTRATION INDEPENDENCE

On August 15, 1994, the President signed into law Public Law 103-296, the Social Security Independence and Program Improvements Act of 1994. The Act established the Social Security Administration (SSA) as an independent agency effective March 31, 1995 with its own Office of Inspector General (OIG). The SSA OIG's accomplishments for this 6-month period are related in its own semiannual report. The independent SSA will have a presidentially appointed Inspector General (IG). However, until the new SSA IG is appointed and confirmed, the IG of the Department of Health and Human Services (HHS) is serving as Inspector General of both the HHS OIG and the new SSA OIG organizations.

Shortly after the independent agency legislation was signed into law, the HHS Secretary and the SSA Commissioner agreed upon a set of principles to guide the transition process. These principles reflected the commitment of HHS and SSA to work closely together during and after the transition period to ensure continuity of service to customers and fairness to employees. In keeping with these principles, HHS and SSA worked out the required transfer agreement describing the terms and conditions of the arrangement for the transfer of personnel and resources to SSA.

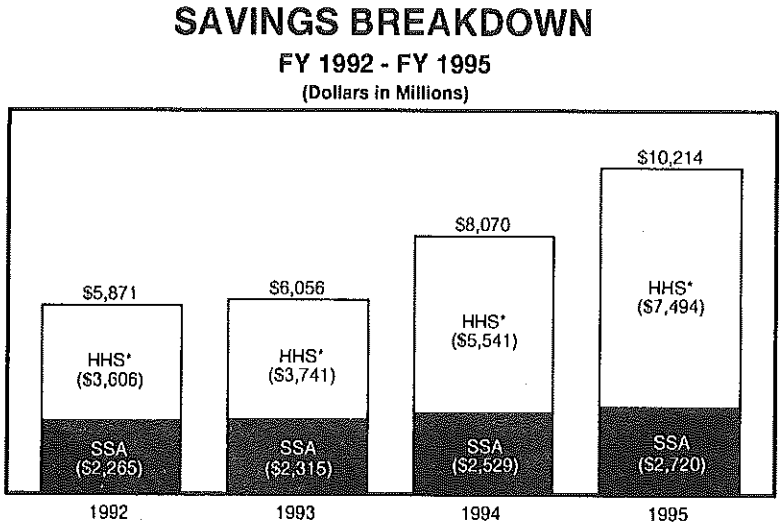
The HHS OIG transferred to SSA 259 positions which cut across the spectrum of OIG functions. The transfer also included furniture, equipment and applicable funding. As a result of the transfer, HHS lost its investigative presence in three locations. There are now 24 States without an investigative presence and 11 more with field offices of two or fewer agents. If budgets continue to decline, more regional and/or field offices will likely be closed.

The SSA is responsible primarily for administration of the Old Age, Survivors, and Disability Insurance and Supplemental Security Income (SSI) programs. In past years, OIG reviewed and made recommendations regarding all aspects of SSA's programs and operations, including disability benefits, information resources management, program integrity and efficiency, quality of service, representative payee and SSI benefits. The OIG also performed oversight of SSA's financial management by auditing SSA's financial statements, examining internal controls and reporting on the status of debt management activities. Convictions for fraud and abuse in Social Security programs were ordinarily

based on two types of deception: concealment of a recipient's status and/or the use of false Social Security numbers to obtain benefits.

The OIG's reported savings are composed of the dollar value of implemented OIG recommendations to put funds to better use through cost avoidances, budget savings, etc.; dollar amounts identified for recoupment as a result of management decisions in favor of audit and inspection findings and recommendations; and total fines, savings, restitutions, settlements and recoveries accruing from judicial or administrative processes resulting from OIG investigations.

In the last few fiscal years, SSA-related savings (primarily funds put to better use) have constituted a sizable portion of OIG's annual totals, as illustrated in the chart below.



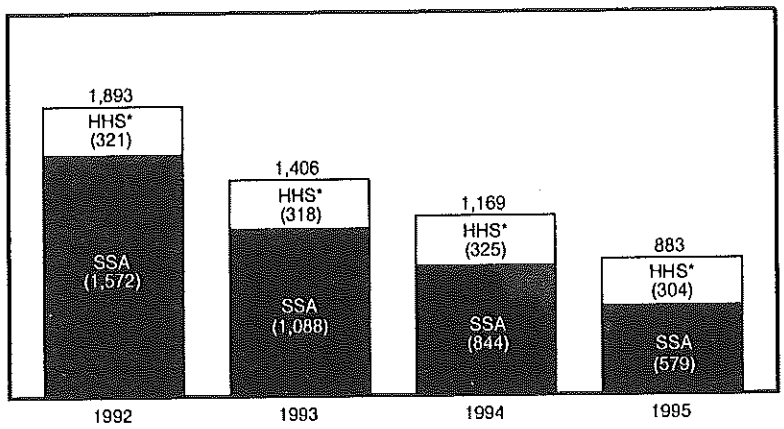
*HHS totals include health care and other savings.

The number of OIG convictions has markedly declined over the last few years as resource constraints resulted in fewer criminal investigators and a growing backlog of cases. In keeping with its commitment to the highest priorities, OIG reduced investigative coverage in some geographic and program areas. Existing staff were concentrated in the States with the most HHS program dollars and were deployed to work on the most serious program violations.

Historically, the vast majority of OIG's successful prosecutions have been related to SSA, as shown in the following chart.

PROSECUTIONS BREAKDOWN

FY 1992 - FY 1995



*HHS totals include health care and other areas.

Clearly, SSA's independence will have a profound effect on future HHS OIG savings and prosecutions statistics.

Operation Restore Trust

Chapter II

OPERATION RESTORE TRUST

At the Department of Health and Human Services (HHS), the Office of Inspector General (OIG) has undertaken a number of initiatives to ensure that its resources are deployed in the most efficient and cost-effective way and that its work products continue to be of the highest quality. One of OIG's major thrusts has been an intensified effort to combat fraud, waste and abuse in the Medicare and Medicaid programs. While the health care programs have always been vulnerable to fraud and abuse, recent years have seen a surge in complex schemes which often span several States and implicate millions of health care dollars. In an effort to respond to this growing problem most effectively, OIG has shifted its organizational culture toward an added emphasis on interdisciplinary teamwork. The OIG's auditors are working even more closely with its investigators when audit findings suggest criminal fraud; and OIG evaluators are using their analyses to identify program vulnerabilities, giving auditors and investigators targets for further development as well as case-specific data for existing investigations.

The benefits of greater collaboration and sharing of resources also have been realized in OIG's relationships with other Federal and State law enforcement and regulatory agencies. Using this expanded team concept, OIG is working jointly with the Health Care Financing Administration (HCFA) and the Administration on Aging (AoA) on a project designed to prevent and detect fraud and abuse in three rapidly growing sectors of the health care industry: home health agencies, nursing facilities and durable medical equipment suppliers. Operation Restore Trust (ORT), announced by the President on May 3, 1995, is a 2-year partnership of Federal and State agencies working together to protect the health care trust funds more effectively through shared intelligence and coordinated enforcement, and to enhance the quality of care for the programs' beneficiaries. The project has initially targeted five States which together account for 40 percent of the Nations' Medicare and Medicaid beneficiaries.

As the project's coordinator, OIG has assembled teams that include investigators from its Office of Investigations and the States' Medicaid Fraud Control Units; auditors and evaluators from both OIG and HCFA; quality assurance specialists from the State surveyors and durable medical equipment regional coordinators; State long-term care ombudsmen through AoA; and prosecutors from the Department of Justice and the State Attorneys General. These teams are conducting financial audits of providers, criminal investigations and referrals to Federal and State prosecutors, civil and administrative sanctions and

recovery actions, and surveys and inspections of nursing facilities. The collective experience of these teams also will be used to recommend to HCFA and the Congress program adjustments to prevent future fraud and to reduce waste and abuse.

The OIG is also enlisting the support and participation of the public and the industries that the initiative targets. A hotline (1-800-HHS-TIPS) has been established to receive allegations of fraud and abuse on a confidential basis. To further educate the public and health care providers, OIG will continue its practice of issuing special fraud alerts to identify and describe fraudulent and abusive health care practices. Moreover, a voluntary disclosure program has been initiated on a pilot basis under the auspices of ORT. Through this pilot program, OIG and the Department of Justice have established procedures by which home health and nursing home suppliers and providers in the five States may come forward with full disclosure of potential fraud and abuse. By doing so, self-disclosing providers may minimize the cost and disruption of an investigation, negotiate a monetary settlement in lieu of prosecution, and possibly avoid exclusion from Medicare and Medicaid program participation when appropriate. The disclosure program also benefits the Government by exposing schemes that might otherwise go undetected, and expediting the investigation and resolution of program abuses.

During this semiannual reporting period, initial project planning sessions were held in all five ORT target States. The fraud and abuse hotline, launched in late June 1995, has received over 10,000 calls, letters and complaints, of which almost a third indicated possible program fraud. Also during this period, OIG released two special fraud alerts, one which discussed cost report frauds, false claims schemes and kickbacks that plague the home health industry, and another which focused on abusive practices by suppliers of medical equipment to nursing homes.

All OIG ongoing and new cases related to fraud and abuse in the targeted areas of the five States have been gathered into the ORT project, so that they may benefit from its focused attention, expertise and energies. The ORT began with 135 investigations that met the parameters of the project. Since that time, 84 other investigations have been initiated, for a total of 219 cases involving more than 760 subjects. Fifty-three are joint investigations with other law enforcement agencies, including the Federal Bureau of Investigation, the United States Postal Service, the Railroad Retirement Board OIG, the Defense Criminal Investigation Service and State Attorneys General offices.

The distribution of cases among the target States mirrors the beneficiary population of each State. New York, California and Florida have 75 percent of the investigations. The remaining 25 percent are equally divided between Illinois and Texas. Nursing home facilities and related medical services comprise approximately 80 percent of the cases, home health agencies the remaining 20 percent.

By the end of this reporting period, OIG had achieved 20 criminal convictions, 8 civil judgments and 7 indictments in cases that are a direct result of the ORT initiative. Nineteen criminal convictions, 7 civil settlements and 7 indictments involved nursing facilities and related medical services cases, and 1 conviction and 1 settlement concerned home health agencies. In addition, OIG has collected a total of more than $31.9 million in fines, recoveries, settlements and civil monetary penalties during this same period. The first two exclusions of ORT providers from the Medicare and Medicaid programs for convictions of health care fraud have been processed.

Numerous ORT-related audit and inspection reports have been issued during this period. The OIG audit staff also met with the peer review organizations (PRO) for Florida and Illinois concerning medical reviews to be conducted by the PRO physicians to determine the full extent of improper payments made to hospices in those States. In addition, the OIG audit staff has initiated several home health agency eligibility and cost report audits, as well as various subacute care studies in California. Once developed, these studies will be conducted in the other ORT States. Medicaid audit reviews related to ORT issues are underway in New York, Texas and Illinois. In addition, the OIG evaluation staff in Dallas is collaborating with HCFA regional office personnel to develop a data collection mechanism for obtaining Medicare and Medicaid information for patients in nursing homes in Texas and Louisiana. Once an information collection protocol has been developed, the team will collect data and analyze it to identify possible program vulnerabilities. The methods developed will be shared with other ORT teams as models to apply in their States.

Within the text of the semiannual report, summaries of ORT-related audits, inspections and investigations finalized during this 6-month period have been labeled with the symbol  for ready identification.

The ORT project will take 2 years for completion and evaluation. If it proves to be both effective and efficient, other areas may be singled out for similar treatment. Employing these and other initiatives, OIG is working to ensure the integrity and efficiency of the Medicare and Medicaid programs and to protect the beneficiaries of those programs.

Health Care Financing Administration

Chapter III

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. Financed by the Federal Hospital Insurance Trust Fund, Fiscal Year (FY) 1995 expenditures for Medicare Part A are expected to exceed $110 billion. Medicare Part B (Supplementary Medical Insurance) is an optional program which covers most of the costs of medically necessary physician and other services. Financed by participants and general revenues, FY 1995 expenditures for Medicare Part B are estimated at $64 billion.

The Medicaid program provides grants to States for medical care for approximately 36 million low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children or Supplemental Security Income. 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. Federal Medicaid outlays rose dramatically from FY 1989 through FY 1992, at a 25 percent average annual rate. However, outlay growth slowed to less than 12 percent in FY 1993, followed by 8 percent growth in FY 1994. The decline in the rate of Medicaid increases is due to many factors, including legislative changes and States' efforts to control costs. Federal expenditures are expected to exceed $88 billion in 1995.

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

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

Medicare contractors; prohibition on Medicare payment for physician self-referrals; and new payment methodologies for graduate medical education.

The OIG has documented excessive payments for hospital services, indirect medical education, DME and laboratory services, which led to statutory changes to reduce payments in those areas. To ensure quality of patient care, OIG has assessed clinical and physiological laboratories; evaluated the medical necessity of certain services and medical equipment; analyzed various State licensure and discipline issues; reviewed several aspects of medical necessity and quality of care under PPS, including the risk of early discharge; and evaluated the care rendered by itinerant surgeons and the treatment provided by physicians performing in-office surgery.

The OIG also plays a role in the Department's Federal Managers' Financial Integrity Act process designed to detect and correct systemic weaknesses, and reviews HCFA's financial statements under the Chief Financial Officers Act.

Medicare Beneficiary Satisfaction: 1994

Performance Measure

Based on a national survey of randomly selected beneficiaries, OIG found that, overall, beneficiaries reported positive experiences with the Medicare program. More than 75 percent of respondents thought the program was understandable, and more than 80 percent were satisfied with the services provided by carriers. Compared to prior years, the inspection indicated several positive changes in the Medicare program. For example, the percentage of beneficiaries experiencing difficulty with claims processing decreased by 50 percent in the last 3 years.

However, the survey also revealed some areas of concern. Some beneficiaries had problems understanding Medicare payments for home health and hospital services. Thirty percent of the beneficiaries who tried to call their carriers were unable to reach them within two tries. Almost a third were unaware of their appeal rights. One-fourth did not know that Medicare limits what physicians can charge for a specific service. Finally, almost two-thirds did not know that Medicare paid for second surgical opinions.

The OIG recommended that HCFA develop a plan for improving beneficiary satisfaction and understanding in the trouble areas mentioned above. The HCFA concurred with the recommendation. (OEI-04-93-00140)

Health Care Financing Administration's Combined Financial Statements

Performance Measure

This report presents the results of OIG's efforts to audit HCFA's combined financial statements for FY 1994, and includes an assessment of internal controls and compliance with laws and regulations. The OIG was not able to satisfy itself as to the fair presentation

of the Medicare accounts receivable balance of $2.8 billion because the internal controls over the processing of Medicare accounts receivable were not adequate. The OIG recognizes that HCFA has taken steps to improve its internal control structure. However, these efforts are not expected to be implemented for several years. In addition, the supporting documentation for HCFA's Medicare accounts payable balance of $24.9 billion was not made available to test its accuracy and completeness. Nor could HCFA provide sufficient data to enable OIG to use alternative auditing procedures to substantiate the account balance. Lastly, because HCFA recorded the Medicaid program on a modified cash accounting basis, it did not record the Federal share of Medicaid accounts receivable and accounts payable amounts recorded on States' records and financial statements. Accordingly, OIG did not express an opinion on the combined financial statements. (CIN: A-17-94-03032)

Internal Control Over Medicare Accounts Receivable for Fiscal Year 1994

The OIG's review of internal controls relating to processing Medicare accounts receivable found that contractors have not effectively implemented all the control procedures necessary to ensure the production of reliable financial information. As a result, OIG concluded that the risk is still high that HCFA's and the contractors' controls will not prevent or detect, on a timely basis, material misstatements that could occur in reported accounts receivable balances. Improvements are needed to controls to ensure that: adequate documentation is retained to support reported balances; accounts receivable data is appropriately summarized and verified; and assets and records are adequately safeguarded.

The OIG recommended that HCFA develop an approach to review and monitor the accounts receivable internal control structure to provide management reasonable assurance that adequate controls are present. The HCFA agreed and is taking corrective action. (CIN: A-01-94-00520)

General and Administrative Costs: ABC Home Health Services, Inc.

The OIG determined that in its FY 1992 cost reports ABC Home Health Services, Inc. claimed unallowable general and administrative expenses totaling $14.3 million. The general and administrative expenses were allocated to the home health agencies (HHAs) in the ABC chain and approximately 96 percent of these costs were reimbursed by the Medicare program.

Medicare program regulations generally require that for costs to be allowable, they must be reasonable, necessary for the maintenance of the health care entity and related to patient care. The unallowable costs identified in OIG's review included $9.8 million for externally developed computer software that was not yet operational; $1.8 million for salary and

related costs for personnel whose functions were not related to patient care or maintenance of the health care entity; over $380,000 in excess salaries and fringe benefits for two co-owners; $1 million for a leadership conference involving the same individuals and subject matter as other management meetings; $574,000 for marketing and promotional activities; $212,000 for entertainment and gifts; $73,000 for board of directors' fees; and $475,00 for decorations, lobbying and other unallowable costs.

The OIG recommended that HCFA direct the fiscal intermediary (FI) to remove the $14.3 million of unallowable costs from ABC's FY 1992 cost reports. In its response to the draft OIG report, HCFA generally agreed with the findings and recommendations. (CIN: A-04-93-02067)

Home Office Costs: Surgical Care Affiliates, Inc.

The HCFA requested that OIG audit the home office costs allocated by two major ambulatory surgical center (ASC) chains to the individual ASCs owned by these chains and included in a sample of 100 ASCs responding to a HCFA survey. The survey focused on overhead and certain surgical procedure costs and other items related to services rendered at ASCs participating in the Medicare program. Of the 100 ASCs included in HCFA's sample, 5 were part of the Surgical Care Affiliates, Inc. (SCA) chain.

Generally, Medicare regulations and guidelines require that reimbursable costs be reasonable, related to patient care, prudent and not in excess of actual costs incurred. The OIG determined that of the $13.3 million in home office costs charged by SCA to its affiliated ASCs, $7.2 million did not meet Medicare regulations or guidelines for reimbursement, including: debt guarantee fees of $4.3 million; management service fees of $2.4 million charged in excess of costs; and general and administrative expenses of $500,000 for abandoned development plans, information systems expenses, charitable contributions and wages not paid.

The SCA stated that while it did not question the validity of the criteria used in OIG's review, it believed that all incurred home office costs should be considered in setting ASC reimbursement rates. The OIG reported its findings to HCFA for use in developing new ASC facility payment rates. (CIN: A-04-94-02091)

Pension Segmentation: Mutual of Omaha Insurance Company

Medicare contractors are required to separately identify, allocate and report pension assets and costs for the Medicare segment of their business. The OIG determined that one such contractor, Mutual of Omaha Insurance Company (Mutual), understated Medicare pension assets as of 1992 by $3.9 million. Increasing the Medicare segment's assets by this amount will result in lower Medicare pension costs in future years, and higher reversions/refunds to Medicare in the event of a pension plan termination or a termination of the Medicare

contract. Mutual concurred with OIG's recommendation that it increase assets of the Medicare segment by $3.9 million. (CIN: A-07-94-00742)

Criminal Fraud

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

- A California ophthalmologist was sentenced to 135 months confinement and ordered to make restitution of more than $16.2 million, of which more than $15.5 million goes to Medicare and the remainder to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Railroad Retirement Board and Blue Cross. Convicted after a 5-month trial on 132 counts of mail fraud, false statements, false claims and illegal money transfers, he also had to pay a $50 penalty for each count. The ophthalmologist's medical practice had a community relations staff that did eye screenings at senior centers and nursing homes. He paid the head of the staff a bonus for each patient referred who underwent cataract surgery. He also made false entries on patients' charts to justify cataract, eyelid, laser and other surgical procedures. The ophthalmologist has been suspended by the State medical board.

- Using physical therapy codes, an Arizona osteopath billed acupuncture services provided by an acupuncturist who maintained an office next door. They both pled guilty and were sentenced to 5 years probation, of which 10 months is to be home confinement, and were ordered to make restitution of $117,900 jointly and severally. The osteopath also had to surrender his license to practice medicine.

- The operator and part owner of a Florida medical center and five related companies, a receptionist, an employee, two "recruiters" and a physician were sentenced for their parts in a conspiracy that defrauded Medicare and Medicaid of more than $3 million. The operator/part owner was sentenced to 41 months in jail and was ordered to pay close to $1.04 million in restitution. The receptionist and the two recruiters were sentenced to 3 and 5 years probation, respectively, with the first 6 months to be spent in a community confinement center, to make restitution of a total of $56,900, and to perform 100 and 250 hours of community service. The employee, who was president of a related company that was used to pay the recruiters, was sentenced to 6 months confinement and ordered to make restitution of $40,565. Finally, the physician was sentenced to 4 months in jail and ordered to make restitution of nearly $1.04 million. These individuals

brought to 9 the number sentenced of 12 persons who have pled guilty in a conspiracy in which recruiters were paid $30 to $150 for each elderly or poor patient they brought to the center for a battery of diagnostic tests that could be billed to Medicare and Medicaid. The tests were necessary, but the physician signed charts without seeing the patients.

- An Arizona man was sentenced in Federal court to 10 years imprisonment on charges related to Medicare fraud. The man's companies had contracts with several nursing homes to take x-rays using mobile equipment. He routinely billed Medicare for two-view chest x-rays when only one view was taken. The lengthy jail term was invoked partially because the man had a prior conviction for creating false Immigration and Naturalization Service documents when he owned a print shop. Moreover, he was not an x-ray technician and had falsified his certification application for a mobile x-ray lab. He was ordered to make restitution of $82,075.

- In Pennsylvania, a physician and his wife were sentenced for defrauding Medicare. The physician was sentenced to 30 months incarceration and 2 years supervised release, fined $300 and ordered to make restitution of $300,000. His wife was sentenced to 27 months incarceration and 2 years supervised release, and fined $200. The couple performed acupuncture on patients but represented to Medicare that they had performed neuromuscular junction testing. They defrauded an estimated $1 million or more, but the statute of limitations had run out on many of their actions.

- The owner of a Louisiana HHA was sentenced to 5 years probation and ordered to repay $119,000 she had defrauded the Medicare program. She included in Medicare cost reports the expenses of a costume shop she owned and a magazine she produced monthly. Expenses charged included payroll, leases, telephone service and advertising.

- A woman, her son and daughter-in-law were sentenced for conspiring to have their ambulance company bill Medicare and Medicaid for hospital trips when patients were actually being taken to their doctors' offices, a non-covered service. They also inflated mileage. Between 1989 and 1993 they were overpaid about $80,000. The woman and her son were sentenced to 12 months in jail and 2 years probation, with her being fined $15,000 and him $5,000. The daughter-in-law, who cooperated in the case, was given a reduced sentence of 2 years probation and fined $2,000. The ambulance company resolved a civil case by paying $100,000 and forfeiting assets of $106,000.

- In Hawaii, a physician was sentenced to 5 months in prison, 5 months home detention and 3 years probation and was fined $30,000 for defrauding Medicare, Medicaid and private insurers. A lengthy investigation established that she billed for hundreds of services not performed, estimated to exceed $3 million. Under the terms of her plea agreement, the physician paid $150,000 to Medicare and Medicaid. She continued to be employed as head of the tuberculosis program of the Hawaii Department of Health. She was the personal physician of the late Philippine dictator Ferdinand Marcos.

- A pharmacist was sentenced in Illinois to 30 days work release for Medicaid fraud, followed by 90 days home confinement, 3 years probation and 200 hours of community service. He was ordered to pay a $10,000 fine, $4,550 in restitution, $8,090 to cover the cost of court supervision and home monitoring, and a $50 assessment. His conviction was a result of Project Shi-Rx, which later became Project Goldpill of the Federal Bureau of Investigation (FBI), a joint OIG effort with the FBI, Drug Enforcement Administration and Food and Drug Administration to identify pharmacies submitting false Medicaid claims. His pharmacy was "shopped" by agents posing as Medicaid recipients who submitted prescriptions for various items. He repeatedly billed for filling the prescriptions for one agent and for refilling them even though the items were never dispensed. He then filled and refilled the same prescriptions for fictitious family members of the agent, even though none had been prescribed. In total, the pharmacist billed at least 175 items that had never been prescribed or delivered for the agent and his "family."

- An Iowa man was sentenced for making false statements to obtain Medicaid and Supplemental Security Income (SSI) payments. He had applied for SSI payments in March 1984, claiming to be suffering from cancer of the colon and liver and claiming no income nor any property other than his residence. At the time he owned two other pieces of property valued at about $18,000. Over the next few years he purchased six more houses that included 14 rental units which he rented for $250 to $300 a month, representing resources of more than $100,000. At the same time he repeatedly continued to deny ownership of any property other than his personal residence. As a result, he received $60,570 in Medicaid benefits and $36,380 in SSI benefits to which he was not entitled. He was sentenced to 8 months home confinement, followed by 3 years probation, and ordered to make full restitution to the two programs.

- In Ohio, the former director of a home health services corporation was convicted for forging physician signatures on approximately 200

certification and plan of treatment forms. The corporation had failed three successive State inspections for not having completed forms in a timely manner, and the former director stood to lose his job. He placed forged copies in patient charts until he could get the actual physician signatures on the original forms, after which he removed and destroyed the forged copies. Shortly after he began executing his scheme other employees reported his actions to the hospital, which fired him and cooperated in the investigation. He was fined and ordered to pay court costs, but was given no jail time because he did not personally benefit from the scheme and Medicare lost no money.

Monitoring Medicare Contractor Performance: A New Approach

This inspection provides an early, preliminary assessment of the new approach that HCFA used in 1994 to evaluate Medicare contractor performance in medical review and in fraud and abuse activities. The OIG found that, based on early experience, the new approach has improved HCFA's ability to assess contractor performance in medical review and in fraud and abuse. However, HCFA has not yet made full use of the information gathered in these medical reviews to further contractors' ability to safeguard Medicare payments.

The OIG recommended that HCFA central office obtain information from the regional offices to see how they are monitoring contractor improvement plans that arose from these reviews; develop a general format for key information to be contained in the written reports; and prepare an analysis of effective practices identified in this review and share this analysis with contractors. Both HCFA and the Assistant Secretary for Planning and Evaluation concurred with these recommendations. (OEI-01-93-00160)

Patient Dumping

Performance Measure

In an assessment of HCFA's effectiveness in investigating and resolving complaints involving potential violations of the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act, OIG found that HCFA regional offices were not always consistent in: conducting timely investigations of patient dumping complaints; sending acknowledgements to complainants; ensuring that provisions of the Act were addressed in substantiating violations; or ensuring that violations were referred to OIG for consideration of civil monetary penalties (CMPs).

The OIG recommended that HCFA amend its guidelines to the regional offices; conduct training on the requirements concerning patient dumping; ensure that all regional offices are following established procedures; and improve its process for referring cases to OIG's Office of Civil Fraud and Administrative Adjudication. In response to the draft report, HCFA concurred with the findings and recommendations, and initiated corrective action. (CIN: A-06-93-00087)

Trends in Urban Hospital Closure: 1987-1993

Hospital closure over the last decade has generated much public and congressional concern about access to care. However, OIG found that the rate of urban hospital closures has generally decreased in the period 1987 to 1993. Public hospitals closed at a lower rate than did private nonprofit and private for-profit hospitals. Urban hospital and emergency care were available nearby to most communities where a hospital closed. More than half the closed hospital facilities are being used for health related services. (OEI-04-95-00050)

Status Report: Medicare Nonphysician Outpatient Bills Submitted by Hospitals

Under PPS, Medicare reimburses hospitals a predetermined amount for inpatient services based on beneficiary illness and its classification under a diagnosis related group (DRG). Hospitals may not claim a separate payment for nonphysician outpatient services (such as all diagnostic tests and nondiagnostic services related to the admission) rendered during the DRG payment window (consisting of the 72 hours immediately prior to the day of admission, the day of admission and the inpatient stay).

Since the inception of PPS in 1983, hospitals have improperly billed Medicare for nonphysician outpatient services that were rendered during the DRG payment window. The OIG has issued four reports to HCFA identifying about $115.1 million in Medicare overpayments to hospitals caused by these improper billings. An ongoing fifth OIG review has disclosed that the improper billings continue. The OIG's preliminary estimate is that the potential overpayments to hospitals total over $26.5 million for 1992 and 1993.

Clearly more needs to be done to convince hospitals that they are to be held accountable for ensuring that their Medicare bills are accurate. Given that continued improper billings can be considered false claims and subject to the Federal False Claims Act provisions, OIG and the Department of Justice established a national project to: require hospitals to establish internal controls to prevent further improper billings for outpatient services; recover from hospitals previously identified improper payments, amounts assessed under the False Claims Act, or amounts agreed upon through voluntary settlements between the hospitals and the Federal Government; and require hospitals to refund the related deductible and coinsurance paid by beneficiaries.

The HCFA and the Medicare FIs are cooperating fully with the joint project. (CIN: A-03-94-00021)

Graduate Medical Education Costs

Medicare's new system for reimbursing teaching hospitals for graduate medical education (GME) costs uses a formula based on each hospital's average GME cost per physician intern

and resident for a designated base year. The OIG conducted a review to determine whether Medicare's FIs have adequately audited the GME costs and resident counts for the base year, and correctly established each hospital's average GME costs per resident.

The OIG found significant problems with the FI audits involving the accuracy of resident counts. As a result, OIG recommended recovery of $14.4 million for past years in individual reports to the FIs. In this final report, OIG recommends that HCFA: direct its FIs to emphasize the accuracy of the full-time equivalent resident counts in future audits of the payment years; monitor the effectiveness of these audits; and consider analyzing and comparing GME payments under the new payment methodology with actual GME costs, as part of its oversight responsibilities. (CIN: A-06-94-00059)

Capital-Related Cost Prospective Payment System's Base Year 1992

The Medicare program pays for the operating costs attributable to hospital inpatient services under a PPS. Public Law 100-203 required the Secretary to establish a PPS for capital-related costs (those costs associated with the use of physical assets) for cost reporting periods beginning in FY 1992. At the time HCFA developed the 1992 base year rate, 1989 cost reports were the most current data available.

This report presents the results of OIG's review to determine the accuracy of base year estimates used by HCFA to calculate prospective rates for capital expenditures paid to hospitals. Although HCFA used the best data available at the time, current actual cost experience indicates that HCFA's forecast estimates for base year 1992 costs were too high. Higher estimates will result in excessive payments to hospitals. By adjusting the estimates to reflect more current data, HCFA would reduce payment rates for capital related expenditures by about 7.5 percent.

In order to prevent overpaying hospitals in the future for capital costs, OIG recommended that HCFA adjust rates to reflect more current cost data. The OIG also recommended that HCFA continue to monitor the most current data (i.e., settling of unsettled cost reports for the remaining 36 percent of hospitals) and make any necessary further adjustments to the base rate. The HCFA concurred with the analysis, but did not comment on specific recommendations. (CIN: A-07-95-01127)

Hospital Outlier Payments: Blue Cross of Rhode Island

The OIG identified overpayments of nearly $2 million in a review of outlier payments made to two Rhode Island hospitals by Blue Cross of Rhode Island in FYs 1992 through 1994. Under PPS, FIs reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness involved and its classification under a

diagnosis related group. Inpatient stays which are extremely long or have extraordinarily high costs are eligible for additional outlier payments.

The 2 hospitals reviewed in detail by OIG had received approximately 50 percent of the outlier payments made to 12 Rhode Island hospitals. The OIG concluded that the $2 million overpayment to these two hospitals occurred because the FI misunderstood the Medicare regulations governing cost outlier payments. The OIG identified an additional $660,000 in overpayments which resulted from a billing error causing certain inpatient claims to inappropriately qualify for outlier payments.

The OIG recommended that the FI: ensure that the appropriate data is used in determining cost outlier payments; make the necessary adjustments to the cost reports of the two hospitals to recoup the $2 million overpayment; recoup the overpayments, if cost-effective, at the remaining Rhode Island hospitals; ensure that the inappropriate cost outlier payments of over $660,00 are recouped; and consider implementing a system edit to identify unreasonable charges. In its response to the draft OIG report, the FI concurred with the findings. (CIN: A-01-94-00519)

Medicare Risk Health Maintenance Organizations

A. Beneficiary Perspectives

Performance Measure

Medicare beneficiaries may join a health maintenance organization (HMO) through a risk contract under which Medicare pays a predetermined monthly amount per enrolled beneficiary. In return, the HMO must provide all Medicare covered services that are medically necessary, except hospice care. Once enrolled, Medicare beneficiaries are usually required to use HMO physicians and hospitals (lock-in), and to obtain prior approval from their primary care physicians for other than primary care.

Based on responses to a beneficiary survey, OIG concluded that Medicare risk HMOs provided adequate service access for most beneficiaries who had joined, and that they generally adhered to Federal enrollment standards for informing beneficiaries about application procedures, lock-in and prior approval for specialty care. However, survey results also indicated some serious problems with enrollment procedures and service access.

Rather than prescribing specific corrective actions, OIG identified areas in need of improvement and suggested techniques that HCFA might use to further monitor these areas. The HCFA should explore three areas immediately: beneficiaries should be better informed about their appeal rights as required by Federal law; service access problems reported by disabled end stage renal disease beneficiaries need to be carefully examined, as they are an especially vulnerable group; and Medicare risk HMOs should be monitored for inappropriate screening of beneficiaries' health status at application. Other beneficiary-reported issues meriting examination by HCFA concern: difficulty in making

routine appointments; declining health caused by HMO care; and HMOs' refusal to provide certain services. The OIG also suggested some protocols HCFA may wish to adopt for its instrument to survey disenrolling beneficiaries. The HCFA concurred with the report's recommendations. (OEI-06-91-00730)

B. Analysis of Survey Data

Performance Measure

Based on the results of the above survey, OIG constructed an HMO-level database which linked individual's responses with respective HMOs. From this data, OIG concluded that most reported problems were widespread among Medicare risk HMOs, but at varying degrees of intensity, and disenrollees generally experienced problems at a greater degree of intensity than enrollees.

The OIG believes that HMO-level data could prove especially useful in focusing monitoring efforts. Determining a problem's distribution may signal the need for programwide monitoring or targeting specific HMOs. In addition, such analysis can pinpoint a problem's degree of intensity. For an HMO-level analysis, OIG's experience suggests that HCFA may want to stratify by Medicare enrollment size, as well as for selected structural characteristics (such as model type and profit status) when surveying HMO beneficiaries. (OEI-06-91-00731)

C. Medica Health Maintenance Organization

In one of a series of reviews conducted under its strategic plan for the oversight of managed care, OIG found that Medica HMO incorrectly claimed enhanced institutional payments for some beneficiaries for over 5 years. Specifically, OIG determined that Medica received improper payments under its Medicare risk-based contract on behalf of beneficiaries who were improperly classified as institutionalized during the period January 1, 1989 through September 30, 1994. The OIG identified improper payments totaling over $93,000 for 15 out of 100 beneficiaries sampled. Projecting the statistical sample, OIG estimated that Medica received improper payments of at least $861,000 during the period.

The OIG recommended that Medica refund the $93,000 in improper payments identified during the audit and take appropriate action to quantify and refund additional overpayments projected by OIG. Also, OIG proposed that Medica establish more prescriptive policies and procedures for monitoring and reporting its beneficiaries' institutional status. Medica generally agreed with the findings and recommendations of the draft report and agreed to work with HCFA to arrive at an equitable settlement amount. (CIN: A-05-94-00053)

D. PacifiCare Health Maintenance Organization

In another review on managed care, OIG determined that PacifiCare received overpayments totaling over $617,000 for Medicare beneficiaries who were erroneously classified as eligible for Medicaid (dual eligible) or as having end-stage renal disease, or who no longer

resided in PacifiCare's service area (out-of-area). Previous OIG reports addressed problems with HCFA's computerized processing of these payment situations.

In addition to a financial adjustment, OIG recommended actions PacifiCare could take to preclude erroneous classification of Medicare beneficiaries in the above categories. Officials of PacifiCare concurred in all OIG's findings and recommendations. (CIN: A-06-94-00028)

Medicare Payments to Health Maintenance Organizations for Medicaid Special Status Beneficiaries

Based on OIG's work, HCFA has identified overpayments to HMOs nationwide totaling almost $70.5 million for beneficiaries who were erroneously classified as eligible for Medicaid. The HCFA makes fixed monthly payments to HMOs for Medicare beneficiaries. The payment rate is increased for certain high-cost categories of beneficiaries, including those beneficiaries also eligible for Medicaid (dual eligible). The overpayments occurred because an interface between HCFA computer systems did not recognize those beneficiaries initially classified as dual eligible, but who had subsequently lost their Medicaid eligibility. The HCFA concurred with OIG's recommendation that it take action to collect the overpayments. (CIN: A-04-94-01089)

Improper Medicare Payments for Hospice Care: Hospitals and Skilled Nursing Facilities

The OIG found that, during the period January 1, 1988 through December 31, 1992, hospitals and skilled nursing facilities (SNFs) were improperly paid an estimated $21.6 million for services related to hospice beneficiaries' terminal illnesses. It appeared that the claims were improperly paid because of processing weaknesses in HCFA's common working file system and/or adjudication of claims.

The OIG recommended that HCFA instruct the FIs to recover from the hospitals the nearly $209,000 of improper payments identified in its review of 100 sampled claims. Further, OIG proposed that for the remainder of the potential improper payments identified in a computer match but not included in the sample review, HCFA instruct the FIs to review related medical records and other available information, and seek refunds of any incorrect payments and make appropriate adjustment to hospital cost reports. In its response to the draft report, HCFA generally agreed with OIG's findings and recommendations. (CIN: A-02-93-01029)

Hospice Beneficiary Eligibility: Puerto Rico

The OIG reviewed the accuracy of beneficiary eligibility determinations and resultant Medicare reimbursements at Hospice Del Oeste, Inc. (HDO) and Hospice en el Hogar de

Manati (HHM). The OIG found that HDO claimed and improperly received Medicare reimbursements totaling about $1.1 million from November 10, 1992 to July 31, 1994. The HHM claimed and improperly received Medicare reimbursements totaling about $1.6 million from April 13, 1992 through July 31, 1994. These incorrect payments represented relatively high error rates in eligibility determinations for the claims reviewed at the two facilities. Although OIG found no reasonable explanation for these error rates, it determined that, for the majority of the time period covered by its review, claims processing controls at the Medicare FI, United Government Services (UGS), were not entirely adequate.

The OIG recommended that UGS improve its claims processing controls through the incorporation of more focused edits to detect and prevent payments on behalf of ineligible hospice beneficiaries. The improper Medicare reimbursements were referred to OIG's Office of Investigations (OI) for possible action. The UGS should therefore coordinate with OIG-OI prior to initiating recovery of the identified overpayments. The UGS concurred that additional claims processing controls are warranted, subject to HCFA's approval. (CIN: A-02-94-01029; CIN: A-02-94-01030)

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 762 sanctions, in the form of exclusions or monetary penalties, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. About half of the exclusions were based on conviction of program-related crimes, conviction of controlled substance manufacture or distribution, conviction related to patient abuse or loss of license to practice health care. Monetary penalties can be assessed under several CMP authorities which have been delegated to OIG.

A. Program Exclusions

Title XI of the Social Security Act provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, controlled substance abuse, revocation or surrender of a health care license, or failure to repay health education assistance loans (HEALs). Exclusion is mandatory for those convicted of program-related crimes or crimes relating to patient abuse. A significant number of OIG exclusions involve failure to repay HEALs, as discussed in more detail in the chapter on the Public Health Service. During this reporting period, OIG imposed exclusions on 705 individuals and entities in all.

The OIG reviews all factors involved in a case to determine whether an exclusion is appropriate and, if so, the proper length of the exclusion. Factors reviewed include information solicited directly from the provider and information obtained from outside

sources such as courts, licensing agencies, or other Federal or State programs. The following exclusions are examples of some imposed during this reporting period:

- In Texas, two DME suppliers and their two companies were excluded for 10 years after being convicted for billing Medicare for body jackets when they really supplied wheelchair pads, which Medicare does not cover.

- After a personal care worker was barred from the Medicaid program for patient abuse she was excluded nationally from Medicare and any State health care program for 15 years. She had struck one patient, used unauthorized chemical restraints to control him, locked him in a room and threatened him with bodily injury. Another vulnerable adult was discovered by a visitor to be dehydrated and covered in vomit and human waste.

- In Washington State, a physician convicted of submitting claims to Medicaid for services he never rendered was excluded for 15 years.

- A nurse's aide in Texas was excluded for 10 years after being convicted for deliberately breaking a patient's leg.

- The owner of a New York transportation company and the company were excluded for 10 years after convictions for submitting claims for transportation of patients they really never transported.

- A Pennsylvania dentist who was excluded for 5 years in 1991 for submitting false Medicaid claims was excluded for an additional 15 years after conviction for a similar crime. He had other dentists submit claims to the Medicaid program, for which he received a percentage of the proceeds.

- In Florida, a certified nurse assistant convicted of slapping and kicking a nursing home patient and stuffing a wash cloth in the patient's mouth was excluded for 10 years.

- A Massachusetts physician was excluded indefinitely because the State medical board revoked his license for using controlled substances.

- In Minnesota, a registered nurse was also excluded indefinitely after her license was suspended because of alcohol abuse.

- A Rhode Island physician whose medical license was suspended because of sexual involvement with one of his patients was excluded indefinitely from program participation.

Once a decision has been made to impose an exclusion, the provider is given notice and advised of the right to request a hearing before an administrative law judge (ALJ). If the provider is dissatisfied with the ALJ's decision, he may request a review by the Departmental Appeals Board (DAB). If he is still dissatisfied after this review, he may take his case to District Court. An appeal generally involves disagreement on whether the exclusion should have been imposed and related issues, and the length of time of the exclusion.

B. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law allows recoupment of monies lost through illegitimate claims, and it also protects health care providers by affording them due process rights similar to those available in the program exclusion process. Many providers elect to settle their cases prior to litigation. The Government, with the assistance of OIG, recouped more than $195 million through both CMP and False Claims Act civil settlements related to health care during this reporting period. Some examples of these cases include:

- A clinical laboratory company headquartered in New Jersey agreed to pay $8.6 million to the Government to settle allegations that it submitted false claims to Medicare and other Federal programs for laboratory tests never performed. The second largest blood testing laboratory in the Nation, the company had previously refunded $1.3 million, making the Government's recovery nearly $10 million when the case is completed. Based on a complaint by a former employee, the investigation covered laboratories in nine cities in nine different States. The company systematically billed for tests that were not completed or not successfully performed because of insufficient, deficient or inadequate samples, or invalid or unreliable results. Although these billing practices began in 1988 and were known by company officials since 1992, they made no effort to correct them.

- In New Jersey, the American subsidiary of a publicly traded United Kingdom corporation agreed to pay $4.9 million to settle allegations that it caused its customer-suppliers of DME to think its lymphedema pump was entitled to as much as $5,000 Medicare reimbursement. In reality it qualified for only $600 in reimbursement.

- An Ohio osteopath, his wife, his daughter and his corporation agreed to pay $355,700 in a global settlement for defrauding Medicare. The osteopath submitted fraudulent claims for medical services which were either billed at a false higher rate or billed at a rate higher than that charged non-Medicare patients. He was sentenced on the criminal aspect of the case to 12 months incarceration and 3 years supervised release for Medicare fraud, fined $5,000 and ordered to pay a $50 special assessment and $116,225 in restitution to the Department. He also agreed to a 10-year exclusion from the Medicare, Medicaid and other State health care programs. His wife, daughter and corporation were excluded from participation in Medicare, Medicaid and State health care programs for 5 years.

- The owner of a now-defunct toxicology services company in Kansas entered into a $150,000 agreement in settlement of liability for misrepresenting more than 900 laboratory claims submitted to the Medicare program for payment. Medicare paid the lab more than $14,150 for the tests, none of which were ordered by physicians and all of which were performed on Medicare patients seen at senior health fairs. The man also paid three senior citizen centers $5 for each patient referred for laboratory tests. Each center received $100 to $150.

- A Massachusetts cardiologist agreed to pay $134,000 to resolve his liability under the CMP law. Investigation showed that over a 2-year period he was overpaid $57,500 by Medicare because he billed for echocardiography as if he performed both the technical and professional parts of the procedure. The technical or testing part was actually performed by a laboratory he owned and he only interpreted the test results.

- In Virginia, sister and brother podiatrists agreed to pay $50,000 to settle allegations of false Medicare claims. The investigation showed that from January 1993 through April 1995 the sister had overbilled Medicare $15,400 and the brother more than $6,700 for "excisions," when all they did was routine foot care which is not covered by Medicare.

- A New York medical center agreed to pay a $45,000 CMP for a patient dumping violation. The case was opened as a result of a newspaper account of a man's being denied treatment for a heart attack at the hospital's emergency room. The man was transferred to another division of the hospital, where he suffered another heart attack and died.

- A 240-bed nursing home in New York City agreed to pay a CMP of $24,000 for filing inaccurate Medicare cost reports. For 8 years straight, the nursing

home failed to disclose that rent payments were made to a related party. If these costs had been allowed, the home would have received more than it was entitled to. The CMP was pursued because of the nursing home's repeated attempts to mislead the Government, even though no actual overpayment was made because the intermediary made the proper audit adjustments.

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 Federal anti-kickback statute.

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

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

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

Violators are subject to criminal penalties, or exclusion from participation in the Medicare and Medicaid programs, or both. The following cases are examples of some of the convictions, judgments and settlements resulting from OIG investigations during this reporting period:

- A national corporation agreed to pay $161 million to settle criminal and civil liabilities for paying kickbacks to physicians for referrals for its home infusion business and growth drug, for making improper billings and for failing to keep accurate records at some of its pharmacies. The company entered criminal pleas in Ohio and Minnesota, and agreed to cooperate in investigation of individuals involved in the schemes, including physicians. It also entered into a corporate integrity agreement with the Department to maintain a corporate ethics/compliance program for 5 years. The company sold its home infusion business and will no longer be engaged in that field.

It also cancelled its special arrangements with physicians and HHAs, and agreed to address its billing problems.

- The parent corporation of a Virginia health care provider of inpatient and outpatient services agreed to pay $2 million in settlement of liability for violating the Medicare anti-kickback statute. The company made income guarantees and office rent subsidies to physicians, granted low-interest or no-interest loans, forgave repayment of loans, provided staff support for a physician's private practice and entered "directorship" contracts in which physicians performed little or no services, to induce them to make referrals to the company. Medicare losses are estimated to total $335,000. The Department, CHAMPUS and the Medicaid program will share the settlement proceeds.

- A Texas ophthalmologist, his wife and their eye clinic were sentenced for committing Medicaid fraud and paying kickbacks for referrals. The three were ordered to jointly pay restitution of $271,750 to Medicaid, private insurance carriers and the Postal Inspection Service. Earlier they signed an agreement to pay the Department $848,900, of which $500,000 has already been received, in a global civil settlement. The ophthalmologist was sentenced to 18 months confinement, to be followed by 3 years probation. Since as far back as 1970, he had upcoded cataract treatments, changed patient charts to justify billing for cataract surgery he never performed, billed for surgery when he only removed a stitch, billed for seeing patients at a nursing home as individual office visits and billed for surgery for deceased patients. He also paid kickbacks to an employee of a senior citizens center for referrals. His wife assisted in dummying up patient charts to support the fraudulent billings. She was sentenced to 1 year probation, of which 4 months is to be home detention. The clinic was also sentenced to 1 year probation and ordered to pay a separate fine of $3,200.

- A Maryland physician was sentenced to 18 months in prison and fined $40,700 for accepting kickbacks for referring patients to an area cardiologist. The cardiologist, who was sentenced earlier to 6 months in jail and fined $200,000, cooperated in the case against the physician. He had paid the physician more than $50,000 over a 2-year period, basing the amount of each payment on the type and number of procedures for which each patient was referred (for example, he paid $200 for a referral for a treadmill test and $300 for cardiac catheterization). The physician was also given 3 years probation upon release and ordered to perform 1,000 hours community service.

State Regulation of Medigap Insurance

Performance Measure

Almost 75 percent of aged Medicare beneficiaries have private health insurance, including Medicare supplemental or "Medigap" insurance, to cover some of their noncovered expenses. The States were solely responsible for regulating Medigap until 1980, when the Congress responded to numerous reports of abuses in the marketing of Medigap insurance. The Omnibus Budget Reconciliation Act (OBRA) of 1990 contained the most recent amendment to the Medigap statutes.

In a survey involving State insurance commissioners and staff, counseling grantees, and organizations representing national insurers and consumer advocates, OIG found that implementation of OBRA 1990 Medigap reforms had substantially improved State regulation of Medigap insurance. Approximately 85 percent of the 156 survey respondents believed that Federal and State collaboration to implement OBRA 1990 Medigap provisions had been effective. However, respondent comments and OIG's analysis of complaint data highlighted three issues warranting further action by HCFA: the adequacy of HCFA's role in promoting the information, counseling and assistance (ICA) program; the usefulness of the National Association of Insurance Commissioners' (NAIC) complaints database system; and the anti-duplication provision of OBRA 1990 which hindered some beneficiaries from obtaining Medigap coverage.

The Social Security Act Amendments of 1994 provided clarification of the anti-duplication provision and other areas. The HCFA is now working with NAIC and the States to incorporate these changes into State law. In response to the remaining concerns, OIG recommended that HCFA: implement plans for direct regional office assistance to ICA grantees, make changes to improve the usefulness of the NAIC complaints database, and work with NAIC and State insurance departments to encourage States to adopt consumer safeguards exceeding the minimum standards. In comments to the draft report, HCFA concurred fully with OIG's recommendations. (OEI-09-93-00230)

Beneficiary Awareness of Publications

Performance Measure

As part of its 1994 survey to determine beneficiary satisfaction with Medicare, OIG asked beneficiaries about their awareness of the Medicare Handbook and seven other HCFA publications. Three-fourths of the beneficiaries surveyed in 1993 and 1994 said they knew about the Medicare Handbook. Most of them thought that it was helpful, easy to read and understand, and that it contained adequate information. The percentage of beneficiaries who were aware of HCFA's Guide to Health Insurance for People with Medicare increased from 13 percent in 1993 to 24 percent in 1994. The percentage of beneficiaries who were aware of HCFA's Guide to Choosing a Nursing Home decreased slightly from 9 percent in 1993 to 8 percent in 1994. As illustrated in the following chart, the percentage of beneficiaries aware of five other HCFA publications ranged from 4 to 14 percent.

AWARENESS OF HEALTH CARE FINANACING ADMINISTRATION PUBLICATIONS	
Publication	**Beneficiaries Aware**
Medicare and Other Health Benefits	14%
Medicare Coverage for Second Surgical Opinions	9%
Medicare Hospice Benefits	9%
Medicare and Coordinated Care Plans	6%
Medicare Savings for Qualified Beneficiaries	4%

The OIG recognizes that awareness of these publications may depend on a beneficiary's specific needs, and that most of them are referenced in HCFA's Medicare Handbook.

The OIG recommended that HCFA continue its current efforts and experiment with new methods to develop a more effective strategy to increase beneficiary awareness of its publications. The HCFA concurred with OIG's findings. Further, HCFA reported that it has several initiatives underway designed to educate Medicare beneficiaries and providers about Medicare's home health coverage, and it is working to improve the readability and distribution of existing publications. (OEI-04-93-00141)

Beneficiary Understanding of Explanation of Medicare Part B Benefits

Performance Measure

When a claim for medical insurance benefits is processed, Medicare sends a notice, the Explanation of Your Medicare Part B Benefits (EOMB), to the individual beneficiary. The HCFA has made and continues to make revisions to improve the EOMB, and has used focus groups and purposive interviews to evaluate EOMB effectiveness. The OIG sent a self-administered questionnaire to a random sample of Medicare beneficiaries who had claims processed since HCFA's last major revision of the EOMB to measure their understanding of this instrument.

The OIG found that beneficiaries appeared to understand most of the information on the EOMB, but that their understanding varied among different categories of information on the EOMB. As indicated in the following chart, understanding was highest with respect to basic descriptive information and lowest with respect to follow-up actions that could be taken in response to the EOMB.

BENEFICIARY UNDERSTANDING OF THE EXPLANATION OF MEDICARE BENEFITS			
	Percent		
	Correct	Incorrect	No Answer
Basic (provider, service, dates, claim and Medicare numbers, and who was paid)	83	11	6
Cost (amounts charged, approved, paid, applied to deductible and coinsurance)	71	17	12
Context (explanatory notes and definitions of key terms)	68	28	4
Action (appeal, questions, amount still owing and possibility of fraud)	64	24	12
Overall (all 23 survey questions with right/wrong answers)	**Average Percent***		
	72	**19**	**8**

** The percentages do not total 100 because of independent rounding.*

In general, beneficiaries regarded the EOMB as no more and no less difficult to understand than other notices they receive in the mail.

The OIG recommended that HCFA build on its prior efforts and aim to facilitate beneficiary understanding of the following: what the beneficiary needs to pay out of pocket, how the beneficiary can get more information, how to appeal Medicare's decision, and what to do if there appears to be fraud or abuse. In response to the draft report, HCFA concurred with the recommendation and stated that its Medicare Summary Notice initiative includes a plan for a section that will explain the actions necessary for an appeal, and a "Customer Service Information Box" that will display important information. (OEI-01-93-00120)

Physician Use of New Visit Codes

Performance Measure

The HCFA bases Medicare payments to physicians partly on a system of five-digit codes which represent the type and complexity of service provided as well as patient status (new or established). Effective in 1992, HCFA adopted new visit codes developed by the American Medical Association (AMA) which were designed to improve coding uniformity and accuracy.

In a survey of Medicare carriers and physicians, OIG requested that appropriate personnel code five clinical vignettes to determine how the new codes were used. The OIG found that both carriers and physicians had difficulty selecting codes accurately. Most carriers said that code definitions were unclear and that they believed that physicians were not using the codes uniformly and accurately. Further, OIG found that carriers have taken limited action to enforce compliance with the new visit codes.

Since the time of OIG's survey, HCFA and AMA have collaborated on and disseminated medical record documentation guidelines designed to clarify criteria for visit codes. Moreover, because of limited physician response to its survey, OIG believes that information presented in this report should be taken as preliminary. However, while OIG made no recommendations in this report, the data did raise concerns about: the accuracy of codes selected by physicians, the ability of carriers to correctly advise physicians on coding matters, and the extent to which carriers effectively and appropriately monitor physician use of the codes. These concerns will be addressed in future OIG reports. (OEI-04-92-01060)

Medical Necessity for Ambulance Services

In a prior OIG review (CIN: A-01-91-00513) issued in October 1992, OIG found that advanced life support (ALS) ambulances were being used in nonemergency situations, when, based on the patients' medical condition, basic life support ambulances could have met their transportation needs. Estimating annual savings of nearly $16 million, OIG recommended that HCFA revise the Medicare Carriers Manual (MCM) to require that payment for nonemergency ambulance services at the ALS level be allowed only when medically necessary, require carriers to establish controls ensuring that reimbursement is based on medical need, and revise guidelines to specify the items to be included in the all-inclusive ALS rate.

In a follow-up review, OIG noted that Medicare allowed charges for ALS ambulance services have nearly tripled from $170 million in 1989 to $507 million in 1993. While HCFA had been working on these issues, it had yet to draft proposed regulations, revise payment instructions in the MCM or require carriers to establish related controls. Subsequent to OIG's review, HCFA advised that it had issued a program memorandum in December 1994, specifying items to be included in an all-inclusive rate.

The OIG recommended that, as soon as possible, HCFA revise MCM instructions, require carriers to establish controls, and consider publishing a notice in the Federal Register reiterating Medicare policy in this area. In response to the draft report, HCFA agreed with OIG's recommendations, but stated its belief that necessary policy changes can only be achieved through new regulations. The OIG urged HCFA to expedite completion of its planned revisions to the regulations and the MCM. (CIN: A-01-94-00528)

Home Health Agencies: Alternative Coverage and Payment Policies

Performance Measure

To provide information to HCFA on how selected other payers structure and manage their home health benefits, OIG interviewed three Medicaid agencies, five private insurance companies, five HMOs, the Department of Veterans Affairs, and the Civilian Health and Medical Program of the Uniformed Services.

The OIG determined that other payers are similar to Medicare in their criteria for eligibility, requirements placed on HHAs, services covered under their basic home health benefit, quality monitoring processes, and the means used to pay providers. However, OIG found that other payers limit the benefit and use a variety of techniques to control utilization, and proposed that some of these approaches might hold promise for Medicare, including: the targeting of patient needs through establishment of different home health programs, managing cases for beneficiaries with chronic care needs, enlisting beneficiary participation through the use of Explanation of Benefits forms and copayments, and limiting coverage through caps or other means. The OIG believes that its additional work in the home health area, ongoing and planned, will assist HCFA in testing out some of these ideas. (OEI-12-94-00180)

Variation among Home Health Agencies in Medicare Payments for Home Health Services

This report describes the variation in average reimbursement per beneficiary for 6,803 HHAs for 1993, and assesses possible causes of the variation. The OIG found that: on average, the highest reimbursement group of HHAs received five times the amount of Medicare reimbursement per beneficiary as the lower group; average reimbursement per visit was similar among HHAs but the number of visits varied widely; higher reimbursement HHAs tended to be proprietary, for-profit, non-affiliated organizations, which provided seven times more aide visits than the lower reimbursement group; and differences in quality of service and beneficiary characteristics did not appear to explain the variation in average reimbursement.

The OIG recommended that HCFA intensify its efforts to scrutinize claims submitted by high-cost agencies and explore ways to prevent unscrupulous agencies from engaging in abusive practices. Controlling the number of home health care visits would save billions of Medicare dollars. The average number of visits per Medicare beneficiary for almost two-thirds of HHAs in 1993 was 33. Using HCFA projections of $14.4 billion in Medicare home health care expenditures for 1995, an average number of 33 visits per HHA would result in a savings of nearly $5 billion. (OEI-04-93-00260)

The Physician's Role in Home Health Care

Performance Measure

In an inspection conducted at HCFA's request, OIG examined the current role of the physician in Medicare home health care. The OIG found that physicians are most involved in referring patients, approving plans of care and monitoring the progress of complex patients. They are less involved in coordinating services, visiting patients at home and participating in interdisciplinary conferences. The HHAs and physicians surveyed identified obstacles and issues related to the physician's role in the areas of communication, paperwork, physician awareness and education, and the overall intensity of physician involvement.

The OIG recommended that HCFA continue its efforts to change the plan of care to ensure that it conveys critical information to caregivers and relieves physicians of an unnecessary burden. Also, OIG proposed that HCFA strengthen its efforts to educate both agencies and physicians about its policies regarding the physician's role in home health care. (OEI-02-94-00170)

Home Health Services in Florida

The OIG found that 26 percent of Florida HHA claims approved for payment by FIs in February 1993 did not meet Medicare reimbursement requirements. As a result, OIG estimates that $16.6 million of the $78 million the intermediaries paid to Florida providers for HHA claims for that month was unallowable. This problem occurred because physicians did not always review or actively participate in developing the plans of care that they signed, beneficiaries were not aware of HHA claims paid on their behalf, and intermediary reviews of HHA claims were not sufficient to detect unallowable claims.

The OIG recommended that HCFA revise Medicare regulations to require that the treating physician establish the plan of care and specifically prescribe the type and frequency of home health services provided, require intermediaries to notify beneficiaries when HHA claims are paid on their behalf, and require intermediaries to perform more in-depth reviews of claims. The HCFA generally concurred with OIG's recommendations. (CIN: A-04-94-02087)

Nonprofessional Services in Skilled Nursing Facilities

The OIG examined the appropriateness of allowing Medicare Part B payments for nonprofessional institutional services covered by the SNF benefit. Many services and supplies billed directly to Part B are the same as nonprofessional institutional services covered under Part A. If provided by the SNF, they would typically be included in the rate paid by Medicare for beneficiaries in a Part A covered SNF stay. However, if provided by a supplier directly to the beneficiary, billing could be made to Part B instead.

Over $70 million was allowed by Medicare Part B for enteral nutrition, incontinence supplies and surgical dressings provided to SNF residents in 1992. The OIG concluded that paying for these nonprofessional services and supplies under Part A could save money for beneficiaries and for Medicare, and could reduce improper incentives for providers.

The OIG recommended that HCFA develop a legislative proposal to prohibit entities other than the SNF from seeking coverage on behalf of persons in Part A covered SNF stays for enteral nutrition, incontinence care and surgical dressings, and limit Medicare coverage of these services to Part A. Further, OIG recommended that HCFA clarify regulations regarding dietary services required to be provided by nursing homes to include parenteral and enteral nutrition services. (OEI-06-92-00864)

Coverage of Enteral Nutrition Therapy

Enteral nutrition therapy provides liquid nourishment to the digestive tract of patients who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Medicare classifies enteral nutrition therapy under the prosthetic device benefit. To aid the DME regional carriers' revision and standardization of Medicare coverage policy, HCFA requested that OIG contact other payers to determine their coverage policies for enteral therapy.

In a survey of Medicare risk-contracted and private HMOs, facilities from the Department of Veterans Affairs, Medicaid State agencies, commercial payers and Blue Cross Blue Shield associations, OIG found that most routinely cover enteral nutrition therapy. Compared to other payers, Medicare's coverage requirements are similar in some areas and more restrictive in others. The OIG will review how other payers price enteral nutrition therapy products and compare their units of pricing, payment mechanisms and supplier networks to Medicare's policy. (OEI-03-94-00020)

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. Two years ago, HCFA published new regulations addressing reimbursement problems that have recurred over the years, especially those created by telemarketing and carrier shopping. It is hoped that consolidation of claims processing into four regional jurisdictions, as specified in the regulations, will resolve many of these problems. In the meantime, OIG continues to obtain settlements and convictions of unscrupulous suppliers for other schemes, as shown in the following examples:

- The owner of record of a New York DME company was sentenced for fraudulently billing Medicare $2.36 million over an 18-month period. The company participated in a fraud scheme that in total cost Medicare more than $6 million. The scheme involved at least four doctors, eight salespersons and three company principals who engaged in false statements, kickbacks and conspiracy by billing Medicare for reimbursable items such as hospital beds and wheelchairs which beneficiaries never received. The owner was sentenced to 37 months in prison and 2 years probation, and ordered to pay a $100 special assessment. Earlier he agreed to forfeit $736,500 in cash and property already seized, in settlement of a civil suit for overcharging Medicare. He had to make restitution of an additional $112,000.

- A physician formerly licensed to practice medicine in Florida was sentenced to 26 months in jail to be followed by 3 years supervised release. He was forbidden to have anything to do with a medically related concern during his probation, and ordered to make restitution of $441,260 to HCFA. The physician pled guilty to conspiracies involving the submission of false Medicare claims for DME and for vascular testing, and for home health care treatment plans he signed for patients he never treated.

- The owner of a now-bankrupt DME company in Illinois was sentenced to 5 months imprisonment and 5 months home confinement for defrauding Medicare of close to $61,000 over a 1-year period. The owner obtained names and health insurance claims numbers of nursing home patients. He then forged physicians' signatures on medical necessity forms and filed claims for equipment, including beds, wheelchairs and mattresses, which he never provided. The investigation of this individual uncovered a sordid past that included a criminal conviction for murder. Former employees interviewed recalled episodes of sexual misconduct and violence. During the investigation, the owner filed for bankruptcy and made false statements, but the trustee decided not to prosecute.

Impact of the Clinical Laboratory Improvement Amendments on the Availability of Laboratory Services

Performance Measure

In February 1992, HCFA issued regulations implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988, which extended Federal regulation to all sites, including a significant number of physician office laboratories (POLs) and other sites that had previously been exempt from Federal regulation. Concerned about the possibility that laboratory sites, especially POL sites, might cease operations and thus restrict patient access to certain types of laboratory tests, HCFA requested that OIG study the issue.

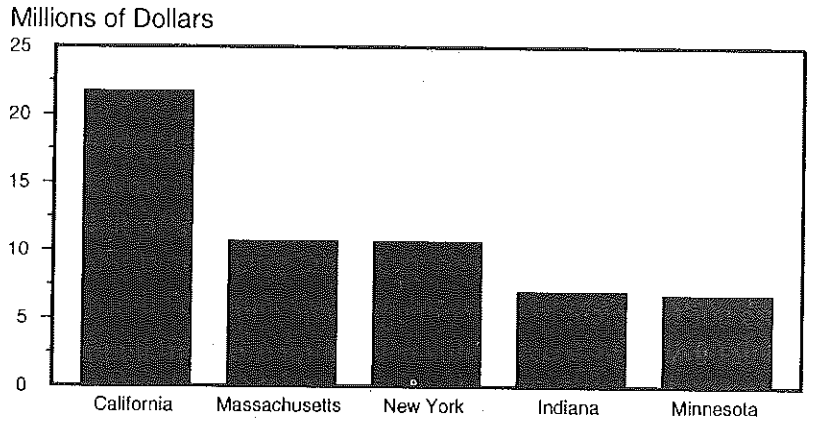
The OIG found that since passage of CLIA, the volume, number of laboratory tests performed per patient and expenditures increased rapidly. Growth seemed to have slowed after implementation in 1992, but data was incomplete. It appeared that CLIA had not affected physicians' ability to secure laboratory services for their patients; all the physicians contacted in the study indicated that they had access to laboratory services. The availability of laboratory services to patients living in rural areas also appeared not to have been restricted by CLIA. Physicians who changed their in-office laboratory operations were influenced by factors broader than CLIA. These factors included other government regulations and nongovernment factors, such as practice sales and/or mergers, and the rise of managed care. (OEI-05-94-00130)

Medicaid Estate Recovery Programs

The OBRA 1993 required States to recover expended Medicaid funds from the estates of Medicaid long term care decedents. The OIG found that 27 States had such programs. States with recovery programs reported that they were cost-effective and returned substantial amounts of money to the State and Federal Governments. As illustrated in the following chart, the top five States recouped over $50 million in Medicaid estate recoveries in FY 1993.

MEDICAID ESTATE RECOVERY

TOP FIVE STATES IN FY 1993



The OIG noted that States have experienced various challenges in their efforts to establish effective and efficient estate recovery programs, such as: the need for enabling State legislation; insufficient resources and limited staffing; and difficulties in using liens, detecting out-of state assets, and tracking the deaths of surviving spouses.

During the last 2 years, HCFA has conducted numerous training and technical assistance conferences on estate recovery, including substantial new efforts since OIG completed its

survey. To reinforce these initiatives, OIG recommended that HCFA: develop performance indicators to track States' progress in implementing the OBRA 1993 requirements, target mechanisms for recovery that have high dollar payoff and identify strategies to help make necessary information available to State agencies to pursue those mechanisms, and monitor closely States' progress in obtaining enabling State legislation and pursue legislative authority to impose sanctions or penalties if States do not act within a reasonable period of time to implement OBRA 1993. The HCFA concurred with all the recommendations and initiated action to implement them. (OEI-07-92-00880)

Medicaid Credit Balance Reporting Requirements

In a review of Medicaid State agency procedures, OIG found that the States are not adequately monitoring Medicaid credit balances at providers. Nineteen States did not have any method to identify these Medicaid overpayments and recover them, and only eight had established monitoring procedures that address the identification of Medicaid credit balances in providers' patient accounts.

The OIG recommended that HCFA establish a national Medicaid credit balance reporting mechanism similar to the Medicare Part A credit balance reporting procedures. The HCFA should allow individual States the option of an exemption from or an adjustment to the basic reporting system if the State presents a feasible alternative that will accomplish the same goals as the national Medicaid credit balance reporting system. Further, OIG proposed that HCFA actively monitor the national Medicaid credit balance reporting mechanism. The HCFA generally concurred with OIG's recommendations and initiated corrective action. (CIN: A-05-93-00107)

Medicaid Drug Use Review Programs

Performance Measure

The OBRA 1990 required State Medicaid agencies to implement comprehensive drug use review (DUR) programs to improve the quality and cost-effectiveness of drug therapies. In a study of States' experience in carrying out this mandate, OIG identified nine lessons learned: develop credible drug use criteria; be selective in developing and applying drug use criteria; apply drug use criteria with a high degree of specificity; examine patterns of drug use, prescribing and dispensing; present data in ways that facilitate analysis and corrective action; intervene with providers having questionable prescribing and dispensing practices in ways that motivate change; foster compliance with patient counseling requirements; educate physicians and pharmacists proactively about appropriate prescribing and dispensing practices; and establish ongoing research efforts to help guide the program.

While States have crafted many different approaches to DUR and have learned from their experience, OIG believes that DUR programs face many challenges, which, if not adequately addressed, could undermine their effectiveness. These include: the adequacy of privacy safeguards, the protection of beneficiaries against poor providers, the sufficiency of

patient education, the programs' dependence on vendors, problems with Medicaid claims data, the validity of cost-savings estimates, the balance between cost and quality, and the implications of managed care. (OEI-01-92-00800)

Psychiatric Center Clients Temporarily Released to Acute Care Facilities: New York

The OIG determined that New York State has and is continuing to improperly claim Federal financial participation (FFP) for clients aged 21 to 64 who are temporarily released from State-operated institutions for mental diseases (IMDs) when they are temporarily released to acute care facilities for inpatient medical treatment. In the period January 1, 1991 through March 31, 1991, OIG found that the State improperly claimed $584,000 (Federal share $292,000). The OIG believes that the potential amount of improperly claimed FFP is significant based on an unaudited FFP adjustment of approximately $9.2 million for the period January 1, 1991 through December 31, 1993.

The OIG recommended that the State refund the identified $292,000 in improperly claimed FFP, immediately implement procedures to cease claiming FFP for IMD clients aged 21 to 64 who are temporarily released to general acute care hospitals for inpatient medical treatment, and establish appropriate edits in its Medicaid management information system to prevent these improper claims from being made in the future. Also, OIG proposed that the State voluntarily compute and process an FFP adjustment on stays by IMD clients aged 21 to 64 who were temporarily released to acute care hospitals for inpatient medical treatment during the period January 1, 1991 to present.

The State did not agree with the findings and recommendations, arguing that regulations do not require exclusion of the claimed costs. The HCFA concurred with OIG's findings and recommendations, and is examining the same issue in New Jersey. (CIN: A-02-93-01036)

State Medicaid Fraud Control Units

In FY 1994, payments by both the Federal and State Governments to Medicaid health care providers exceeded $140 billion. The Medicaid fraud control units (MFCUs) are responsible for investigating fraud in more than 94 percent of all Medicaid health care provider payments. Forty-five States now have units and are receiving funds and technical assistance from OIG. Additional States are expected to submit applications to establish units as required by the Omnibus Budget Reconciliation Act of 1993. The MFCUs conduct investigations, and bring to prosecution persons charged with defrauding the Medicaid program or with patient abuse and neglect.

During FY 1994, OIG administered approximately $68.5 million in appropriated grants to the MFCUs. The MFCUs reported 298 convictions and $18.5 million in fines, restitutions and overpayments collected for the period January 1, 1995 through June 30, 1995.

Public Health Service

Chapter IV

PUBLIC HEALTH SERVICE

Overview of Program Area and Office of Inspector General Activities

The activities conducted and supported by the Public Health Service (PHS) represent this country's primary defense against acute and chronic diseases and disabilities. The PHS's programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. The PHS encompasses: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed drugs, biological products and medical devices; Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support the development, distribution and management of health care personnel, other health resources and services; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Health Care Policy and Research (AHCPR), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), to assist States in refining and expanding treatment and prevention services. The PHS will spend nearly $22 billion in Fiscal Year (FY) 1995.

In the past 5 years, the Office of Inspector General (OIG) has significantly increased its oversight of PHS programs and activities. The OIG has concentrated on a variety of issues such as biomedical research funding, substance abuse, Indian health services, drug approval processes and community health center programs. The OIG has also looked at the regulation of drugs, foods and devices, and explored the potential for improving these activities through user fees. The OIG has conducted audits of colleges and universities which annually receive substantial research funding from the Department. The OIG continues to examine several PHS-wide policies and procedures to determine whether proper controls are in place to guard against fraud, waste and abuse. These activities include preaward and recipient capability audits, and evaluation of PHS's information resources management activities. This oversight work has provided valuable recommendations to program managers for strengthening the integrity of PHS policies and procedures.

State Oversight of Tobacco Sales to Minors

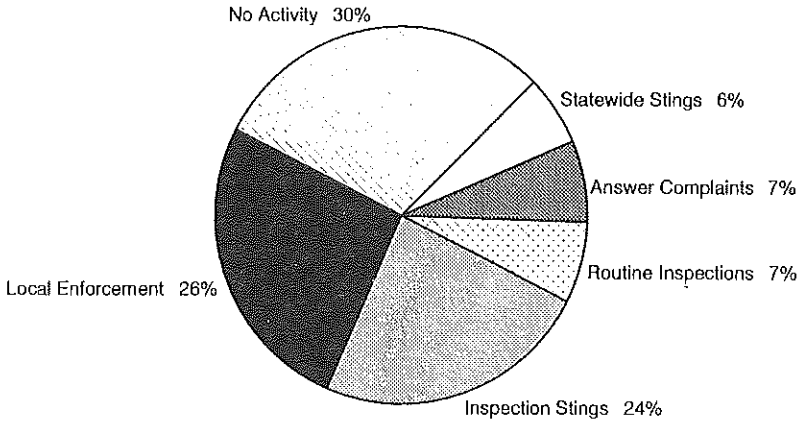
Performance Measure

Section 1926 of the Public Health Service Act required States, by Federal FY 1994, to enact laws prohibiting the sale and distribution of tobacco products to individuals under age 18. Section 1926 also called for the States to enforce these laws; to perform yearly, random, unannounced inspections to measure the level of tobacco sales to minors; and to report annually to the Secretary of the Department of Health and Human Services (HHS) their progress in reducing such sales. Although final regulations had not yet been issued, the States were required to implement section 1926.

In a study of State activities to monitor and enforce their laws prohibiting tobacco sales to minors, OIG found that most States had performed unannounced inspections to monitor compliance, but most did not use scientific sampling to select the vendors to be inspected. Further, OIG determined that a majority of States did not have statewide enforcement, as illustrated by the following chart.

ENFORCEMENT ACTIVITY

PERCENTAGE OF STATES REPORTING MAIN ENFORCEMENT ACTIVITY



The States reported various problems with implementing section 1926: inadequate guidance from the Department; lack of priority given to State tobacco laws; lack of necessary tools, such as central listings of vendors; and lack of resources. While issuance of the final regulations will greatly help the States, OIG concluded that they will need technical assistance on how to meet the requirements spelled out in the regulations. The PHS has prepared a technical assistance guide and plans to conduct teleconferences for the States upon release of the final regulations. (OEI-02-94-00270)

Services to Persons with Both Mental Health and Substance Abuse Disorders

Performance Measure

For this inspection, OIG contacted staff who work directly with individuals with both mental health and substance abuse disorders in 30 programs located in 20 States. Their effectiveness in working with these clients, who are often seriously ill, is reportedly hampered by a lack of formal education, training or prior experience related specifically to these frequently paired disorders.

The OIG recommended that PHS develop a plan to use its education, training and technical resources more effectively to increase knowledge about these disorders and their treatment among clinicians, other professionals and service providers. The PHS concurred with the recommendation. (OEI-05-94-00150; OEI-05-94-00151)

Reporting Process for Blood Establishments

Performance Measure

The OIG reviewed the process by which blood establishments notify FDA of errors and accidents that may affect the safety, purity or potency of their blood and blood products. Blood establishments engaged in interstate shipping of their products must be licensed by FDA and are required to submit reports of errors and accidents. Unlicensed establishments have been asked by FDA to voluntarily submit these reports. The error and accident reporting process is a valuable management tool, and FDA plans to expand its use as an "early warning" device for field offices and the blood industry.

While OIG determined that FDA generally processed error and accident reports in accordance with established procedures, the study identified conditions which could hamper the successful implementation of FDA's plan to expand the use of the reports. The OIG recommended that FDA: expedite the development and issuance of revisions to the Federal regulation on error and accident reporting so as to be more specific as to the time frame for reporting; expedite the development and issuance of a regulation requiring unlicensed blood establishments to submit error and accident reports; and expand the Center for Biologics Evaluation and Research's use of existing information in its current error and accident data base to identify blood establishments that regularly fail to submit timely error and accident reports, and to provide additional trend analysis reports to FDA field offices and blood establishments. In response to the draft report, PHS agreed with OIG's recommendations. (CIN: A-03-93-00352)

Investigational Devices

Performance Measure

In some instances, manufacturers must establish the safety and efficacy of new medical devices through clinical trials before FDA will clear them for marketing. To further guard patient safety, institutional review boards (IRBs) approve and monitor clinical research within local hospitals.

At FDA's request, OIG used four case studies to assess whether controls over clinical testing of investigational devices ensure patient safety and sound clinical research. In its review, OIG identified problems in three major control areas: the accounting and tracking of investigational devices, and the local oversight by IRBs including the informed consent process. The following chart summarizes the problems identified for each device.

PROBLEMS FOUND IN FOUR CASE STUDIES				
	Device A	Device B	Device C	Device D
Device Tracking	✔	✔	✔	
IRB Oversight	✔	✔	✔	✔
Informed Consent		✔	✔	

The OIG concluded that, in the current environment, investigational devices are often treated as if they were already approved as safe and effective. While the results of OIG's review are not sufficient to determine the precise extent of problems, they do raise serious concerns about systemic weaknesses and cast reasonable doubt on the efficacy and reliability of the current oversight process. The FDA intends to carefully review the regulations and policies regarding clinical investigations and take necessary action to ensure that clinical investigations of medical devices are conducted with high ethical standards and in accordance with all Federal rules pertaining to patient protection. (OEI-05-94-00100)

Food and Drug Administration's Processing of New Drug Application for Therafectin

In September 1993, FDA informed Greenwich Pharmaceuticals, Inc., that its application for a new drug to treat rheumatoid arthritis (Therafectin) could not be approved because there was insufficient data demonstrating the drug's effectiveness. Subsequently, OIG received a congressional request to review Greenwich's concerns that FDA did not follow applicable administrative procedures in reviewing the drug application.

The OIG found that, in general, FDA processed the application properly. Although OIG noted certain administrative shortcomings, it found no evidence that they affected the approval status of the application. In the final analysis, Greenwich was not able to adequately demonstrate — either to FDA or an Arthritis Advisory Committee — that Therafectin was effective for the treatment of rheumatoid arthritis. The FDA is, however, instituting administrative improvements to strengthen the new drug application review process. (CIN: A-15-94-00023)

National Practitioner Data Bank

Performance Measure

Since September 1, 1990, the National Practitioner Data Bank has received and maintained records of malpractice payments and adverse actions against licensed health care practitioners. It provides hospitals and other health care entities with information relating to the professional competence and conduct of health care practitioners. The HRSA requested that OIG update its February 1993 inspection report on the usefulness and impact of Data Bank reports to hospitals, and to address the Data Bank's relevance to managed care organizations.

The OIG determined that 83 percent of hospital officials and 96 percent of managed care officials found the Data Bank reports they received to be useful, although they seldom made different privileging decisions than they would have made without them. The OIG concluded that the Data Bank was operating much more smoothly than during its early implementation period, but that any evaluation of its usefulness and impact would necessarily depend on one's expectations. As a source of information about adverse actions and medical malpractice payments, the Data Bank seemed to be working quite well. As a unique source of information, it clearly had some value: in OIG's samples, 28 percent of the reports provided new information to hospitals and 22 percent of the reports provided new information to managed care organizations. Without additional information, however, it was more difficult to assess the Data Bank's success as a mechanism to protect the public by preventing incompetent and/or unprofessional practitioners from practicing in hospitals. The PHS expressed appreciation for OIG's inquiries and indicated that the report would be helpful in administering the program. (OEI-01-94-00030; OEI-01-94-00032)

Ryan White CARE Act

Performance Measure

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 expires in 1995 and its first reauthorization is pending before the Congress. The Act was designed to provide health care to those who would otherwise not have access to such care and emergency relief funding to communities with the highest number of reported acquired immune deficiency syndrome (AIDS) cases.

Utilizing data from its prior studies in this area and from more current field work, OIG found that emerging human immunodeficiency (HIV)/AIDS populations, including minorities, women, immigrants, young people and non-English speaking individuals, present service delivery problems for Ryan White grantees. Despite grantee efforts, many respondents believed that Ryan White programs do not serve minority and other emerging populations as well as they should. Moreover, OIG determined that little program outcome evaluation has been undertaken at the national or local levels. The OIG recommended that HRSA work with Ryan White grantees to identify and disseminate ways to serve the emerging populations affected by HIV/AIDS. Further, PHS should develop practical ways

to determine whether Ryan White program goals are being accomplished overall and by individual grantees. (OEI-05-93-00336)

In a related report, OIG described a variety of experiences of Ryan White grantees in coordinating client services between providers. (OEI-05-93-00335)

Area Health Education Centers

Performance Measure

The Area Health Education Center (AHEC) program is one strategy adopted by the Federal Government to address the issue of recruiting and retaining health care practitioners in rural areas. The program's goal is to link health professions education with service delivery in underserved areas by bringing together the academic resources of university health sciences centers with local clinical resources.

The OIG found that AHECs are enhancing rural practitioners' access to health care information by linking them with medical library resources, and that AHECs are responding to the needs of many types of practitioners for continuing education on clinical topics. For the most part, however, AHECs are missing opportunities to educate practitioners about innovations in health care delivery. Moreover, while AHECs are beginning to use telecommunications to provide support to isolated practitioners, they are not yet taking advantage of the full potential of this technology.

The OIG recommended ways in which PHS could strengthen the role of AHECs by facilitating their ability to focus support services on three areas: clinical practice guidelines, managed care and telecommunications. The PHS agreed with OIG's recommendations and identified actions it will undertake to implement them. (OEI-01-93-00570)

Financial Management Controls over the National Hansen's Disease Program

The National Hansen's Disease program is administered by HRSA. With an annual funding level of approximately $20 million, the program provides scientific and technical leadership in all aspects of Hansen's disease, and operates a center in Louisiana for the care of Hansen's disease patients. In response to a congressional request, OIG investigated the circumstances surrounding the Department's late FY 1993 request to the Congress for a reprogramming of $1.4 million to the program. The OIG believes that effective implementation of recommendations presented in this report would provide PHS with strengthened financial management controls in HRSA. The PHS generally concurred with OIG's recommendations or agreed with their intent, and initiated plans for corrective action. (CIN: A-15-94-00026)

Exclusions for Health Education Assistance Loan Defaults

The Health Education Assistance Loan (HEAL) program provides money to students seeking an education in a health-related field of study. Repayment of these loans is deferred until they have graduated and begun to earn some money. Although PHS aggressively tries to secure repayment, some loan recipients ignore their indebtedness.

The Social Security Act permits and, in some instances, mandates exclusion from Medicare and State health care programs for nonpayment of these loans. Since mid-1992, over 1,000 people have been excluded for defaulting on their HEAL debts. During this 6-month semiannual period, 127 were excluded as a result of PHS referral of their cases to OIG.

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

At the conclusion of this reporting period, 413 individuals had taken advantage of the opportunity and entered into settlement agreements or completely repaid their HEALs. The amount of money being repaid through settlement agreements or through complete repayment totals over $25 million.

Physician Participation in the Vaccines for Children Program

Performance Measure

This inspection identified issues affecting physician participation in the Vaccines for Children (VFC) program. The OIG found that paperwork requirements, inefficient vaccine delivery systems and the lack of vaccine delivery systems in some States could discourage or impede physician participation. Recently established maximum allowable payment rates for administering vaccines could remove a potential barrier to physician participation.

The OIG recommended that CDC continue to develop efficient and reliable vaccine accountability mechanisms and explore alternative vaccine delivery systems. The PHS concurred with the recommendations, and reported that CDC is developing an accountability system for the VFC program that balances the need for accountability with the need for a system that encourages physician participation. Further, PHS stated that CDC is committed to establishing a delivery system for States that do not choose to deliver vaccines themselves. (OEI-04-93-00320)

Resolution of Unaccounted for Property: Centers for Disease Control and Prevention

In a review of property management at CDC, OIG determined that the agency does not have policies and procedures to implement the HHS requirement for promptly resolving cases of missing property. As of February 1993, $8.2 million of CDC's $171.7 million in property was unaccounted for. By February 1994, CDC's records indicated that they had found or otherwise resolved all but $1.6 million of that property. An OIG analysis determined that 36 percent of those items had been missing for over 3 years, and that 82 percent of the items missing over 3 years had not been reported to a board of survey for resolution. The OIG recommended that PHS strengthen CDC's management controls over property by: promptly resolving missing property, performing reconciliations as required by the Department, separating key duties within CDC property management functions to maintain an adequate system of checks and balances, conducting a management control review (MCR) of property management which fully complies with standards, and establishing and promoting the use of a hotline for the anonymous referral of information on property at risk. The OIG also proposed that PHS ensure that its guidance for conducting property MCRs complies with Office of Management and Budget and HHS requirements. The PHS concurred with many of OIG's recommendations and indicated that it planned to take appropriate action. (CIN: A-15-94-00020)

Superfund Financial Activities: Fiscal Year 1993

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

A. National Institute of Environmental Health Sciences

Through interagency agreements (IAGs) with the Environmental Protection Agency (EPA), the National Institute of Environmental Health Science (NIEHS) obligated $52 million and disbursed $55 million in Superfund resources during FY 1993. The OIG found that NIEHS generally administered the fund according to Superfund legislation, but that there were areas in need of improvement. The OIG recommended that PHS: direct NIH and NIEHS to implement procedures to ensure timely submission of the minority contractors utilization report, follow up with the Office of the Secretary to ensure that the minority contractors utilization report is submitted to EPA in a timely manner, direct NIH to establish procedures to ensure that all Superfund grantees submit audit reports, direct NIH to sanction grantees who are unwilling to have a proper audit conducted, and direct NIH to take immediate action to have all required audits performed. The PHS concurred with OIG's recommendations and submitted a corrective action plan. (CIN: A-04-94-04545)

B. Agency for Toxic Substances and Disease Registry

During the period October 1, 1992 through September 30, 1993, ATSDR's obligations of Superfund resources totaled $59 million and disbursements totaled $56 million. The OIG determined that ATSDR generally administered the fund according to the Superfund legislation, but that corrective action was needed in some areas. The OIG recommended that PHS: direct CDC and ATSDR to ensure that two remaining recipients comply with the requirements to have audits conducted and submitted to the appropriate organization; direct CDC and ATSDR to ensure that all reporting requirements are met by agencies with which ATSDR has IAGs; and implement procedures to ensure timely submission of the minority contractors report, following up with the Office of the Secretary to ensure that the report is submitted to EPA in a timely manner. The PHS concurred with OIG's recommendations and provided a plan of corrective action. (CIN: A-04-94-04543)

Indian Health Service's Billings and Collections from Private Health Insurance Companies

The OIG determined that IHS had not established the controls necessary to ensure that amounts billed to private health insurance companies for medical services provided in IHS facilities were accurate and covered all allowable services. As a result, OIG estimated that IHS underbilled private insurers by $7.3 million for the 3-month period ending March 31, 1993. In addition, IHS did not contact private health insurance companies or otherwise follow up on an estimated $1.2 million of unpaid claims.

To maximize collections, OIG recommended that IHS establish the necessary internal controls, assign adequate resources to its business offices, provide additional training to business office staff to ensure that claims for all covered services are filed and accurate, and implement complete and timely follow-up procedures. The PHS concurred with OIG's findings and recommendations. (CIN: A-06-93-00080)

Federal Approaches to Funding Public Health Programs

Prepared at the request of PHS, this report provides an overview of the advantages and disadvantages of categorical and block grants as presented in the professional literature. It also outlines a research and demonstration strategy that PHS could undertake which would be responsive to the Administration's interest in block grant funding for many PHS programs.

The literature indicated that at various times block grants have contributed to greater administrative efficiency and more integrated management systems, and even increased State and local spending. But the evidence in these areas was limited. It was even more limited on questions concerning the effect of block grants on administrative costs, service delivery, responsiveness to State and local spending, and targeting services to the needy. The OIG recommended that PHS develop a strategy to use performance indicators in ways

that would allow grantees substantial discretion in using Federal funds yet hold them sufficiently accountable for their performance. The PHS agreed with the recommendations, noting the "Performance Partnership Grants" programs proposed to the Congress, and another initiative it has undertaken to establish and use performance measures. (OEI-01-94-00160)

Identifying Unnecessary Internal Controls: Staff Survey

Performance Measure

Executive Order 12861 required that all executive departments and agencies eliminate 50 percent of their internal controls by 1996. At the Department's request, OIG developed and tested a prototype that agencies could use to identify unduly burdensome or unnecessary controls. In interviews conducted by OIG, 154 PHS field staff identified 260 internal controls that they believed were unduly burdensome or unnecessary. Most unnecessary controls pertained to approvals and the need for delegations of authority.

The OIG concluded that focus groups are an effective means of identifying internal controls that may be unduly burdensome or unnecessary, but that the next step is to identify the reason for each control before modifying or eliminating it. The OIG believes that agencies' efforts to reduce internal controls would be incomplete without field staff input, and that ongoing efforts to reduce internal controls are necessary to prevent their proliferation.

This report will be followed by two additional inspection phases. The OIG will provide PHS with a list of every internal control identified by staff as unduly burdensome or unnecessary. It will also develop a methodology to analyze the controls identified by staff and test this methodology using a sample of controls selected along with PHS and the Office of the Secretary. This should help agencies determine the reason for each control and enable them to decide whether the control should be retained, modified or eliminated. (OEI-09-94-00210)

Chief Financial Officers Act: Financial Statement Audits

The Chief Financial Officers (CFO) Act requires that OIG ensure that certain funds — revolving funds, trust funds, and funds with substantial commercial activity — prepare financial statements and have them audited. In accordance with the CFO Act, OIG contracted with independent public accountants to audit several PHS funds.

A. Public Health Service's Service and Supply Fund: Fiscal Year 1994

Performance Measure

The purpose of PHS' Service and Supply Fund is to provide consolidated financing and accounting for business-type operations involving the provision of common services to customers in PHS and other governmental entities. In the auditors' opinion, the fund's statement of financial position and the related statement of operation and changes in net

position as of and for the year ending September 30, 1994, are presented fairly. The auditors noted an internal control weakness in the area of accrued liabilities, and Fund management has concurred with the presented recommendations. Auditors' tests disclosed no material instances of noncompliance with laws and regulations. (CIN: A-17-94-00038)

B. Food and Drug Administration's Revolving Fund for Certification and Other Services: Fiscal Year 1994

Performance Measure

The Fund accounts for receipts and expenses related to FDA's certifying the safety and effectiveness of insulin, and the safety of color additives in foods, drugs, cosmetics and medical devices. In the auditors' opinion, the fund's statement of financial position and the related statement of operation and changes in net position as of and for the year ending September 30, 1994 are presented fairly. Auditors' tests disclosed no weaknesses or any material instances of noncompliance with laws and regulations. (CIN: A-17-94-00040)

C. Food and Drug Administration's Prescription Drug User Fee Account: Fiscal Year 1994

Performance Measure

The Prescription Drug User Fee Act of 1992 authorizes FDA to utilize revenues from fees paid by the pharmaceutical industry to expedite its review of human drug applications and supplements. Such fees are accounted for through the prescription drug user fee account. In the auditors' opinion, the account's statement of financial position and the related statement of operation and changes in net position as of and for the year ending September 30, 1994 are presented fairly. The auditors identified a reportable condition weakness in the internal control structure because the account lacks written methodologies and procedures needed to accumulate costs allocable to the account. Tests of compliance disclosed no instances of noncompliance. (CIN: A-17-95-00046)

Fraud and Abuse of Grant Funds

The following cases concluded during this period dealt with fraud and abuse of PHS grant funds:

- Two former university professors, who also were presidents of small research companies, were sentenced in Connecticut for defrauding NIH and the Air Force. The men received almost $500,000 each in grants for research to be performed by their companies. Investigation showed that the research was actually performed at the University of Connecticut by graduate students as part of their course work. Most of the questioned funds were intended for indirect costs which were not incurred. Both men were sentenced to 6 months incarceration, 3 months in a halfway house and 3 years supervised release. One was ordered to pay $28,150 in restitution and assessment fees, and the other $24,200.

- The former fiscal manager of a Louisiana community center pled guilty to embezzling more than $6,500 in PHS funds. The man used his position to increase his salary in small increments, which went undetected until the center decided to review his request for a salary increase. He was placed on probation for 5 years and home confinement for 180 days. He paid back the money embezzled before he was indicted.

Administration for Children and Families, and Administration on Aging

Chapter V

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. Expenditures for the ACF programs are expected to exceed $32 billion for Fiscal Year (FY) 1995. The major programs include: Aid to Families with Dependent Children (AFDC), Emergency Assistance, Child Support Enforcement (CSE), Foster Care, Job Opportunities and Basic Skills (JOBS) training, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant program.

The Family Support Act of 1988 was the last comprehensive restructuring of the welfare system to reduce long term dependency on welfare programs. The Office of Inspector General (OIG) reviews the cost-effectiveness of the various social services and assistance programs, including determining whether authorized services are rendered to eligible recipients at the lowest cost. Recently, the Senate and the House of Representatives passed welfare reform bills that will, if implemented, make changes in program requirements and funding provisions. Regardless of whether welfare continues as an entitlement or is administered under a block grant arrangement, OIG will seek to identify opportunities for program improvement.

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

Federal funding of the Administration on Aging (AoA), which reports directly to the Secretary, is about $900 million annually. The AoA awards grants to States for establishment of comprehensive community-based systems that assist the elderly in maintaining their independence and in remaining in their homes as long as possible. The assistance is targeted to the socially and economically disadvantaged, especially the

low-income minority elderly, and includes supportive services, nutrition services, education and training, low-cost transportation and housing, and health services.

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

Review and Adjustment of Child Support Orders

Under the Family Support Act, States are required to develop a plan for review and adjustment of child support orders; initiate a review, should either parent or the child support agency request one; and adjust support orders, where appropriate, in accordance with State established guidelines. Effective October 13, 1993, States are also required to have implemented procedures whereby support orders will be reviewed, no later than 36 months from the date of establishment or the last review, and adjusted in accordance with States' guidelines for support award amounts. The OIG found that while all State child support agencies had written procedures or guidelines in place to demonstrate how their review and adjustment process is to function, two-thirds of them acknowledged being behind in the review and adjustment requirements. Three-quarters of the agencies lacked an advanced automated system, and almost half cited a lack of staffing resources as another obstacle in processing the large number of review and adjustment cases. Agencies reported several other barriers in processing review and adjustment cases.

While recognizing that ACF is in no position to provide financing to overcome States' perceived resource limits or address every barrier reported, OIG suggested that ACF continue to monitor the situation. The OIG recommended that ACF help the States by continuing to: communicate with them to determine their status in updating their automated systems and to encourage them to meet the October 1, 1995 deadline for having in effect an operational and certified computerized support enforcement system, provide training in anticipation of a Federal mandate requiring all States to enact the Uniform Interstate Family Support Act, and provide guidance and technical assistance helping States to fully understand and implement their requirements for review and adjustment. (OEI-07-92-00990)

Federal Tax Refund Offset Program: California

The OIG reviewed California's procedures for ensuring that collections of delinquent child support payments were effectively being made under the Federal Tax Refund Offset program. The OIG found that the State's procedures were generally adequate for ensuring that offsets were being made against Federal tax refunds. However, the State could increase recoveries (OIG estimated about $2.9 million over a 2-year period) and the number of cases accepted by the Internal Revenue Service for offset if it used available procedures for correcting Social Security numbers. The State concurred.

In addition, the State earned $2.1 million (Federal share $1.4 million) of interest on child support monies but did not report the interest earned as program income as required by Federal regulations. The State did not concur, asserting that interest earned was used to finance the AFDC program when child support collections fell short, but it did not provide documentation to support its position. (CIN: A-09-93-00083)

Monitoring Private Child Placing Agencies

Performance Measure

For some of its foster care placements, Texas contracts with private child placing agencies to recruit qualified foster homes, place children in these homes and monitor the placements. The OIG found that the State did not actively supervise the child placing agencies and did not actively monitor the care of the children in the foster homes. In many instances, caseworkers did not follow treatment plans or visit children under their care; foster children were placed in potentially harmful situations; background checks were incomplete; and many foster parents were not trained. As a result, the efficiency and effectiveness of delivering foster care services were limited, the health and safety of some children were at risk and some children did not always receive the required treatment or services.

The OIG recommended that the State ensure that foster children receive treatment in accordance with their treatment plans, State caseworkers make the required visitations, foster homes are inspected for compliance with fire and health standards, and the National Crime Information Center system is used to conduct nationwide background checks. The State concurred with the findings, and to a limited extent, with the recommendations. (CIN: A-06-94-00041)

State Use of Special Needs Adoption Funds for Nonrecurring Costs

The ACF was concerned that State adoption agencies might not be fully utilizing the special needs adoption nonrecurring costs provisions of the Social Security Act. In response, OIG surveyed State adoption officials regarding their States' use of Federal matching funds to reimburse adopting parents of special needs children for nonrecurring expenditures such as court costs and attorney fees.

The OIG found that most States utilize special needs adoption nonrecurring funds, but that this is not always reflected on their Federal reporting forms; at least 17 percent more funds were spent in FY 1994 than were reported as special needs adoption nonrecurring costs. However, most States were not proactive in informing parents that their nonrecurring special needs adoption costs could be reimbursed. Also, four States reported not using Federal matching funds. (OEI-06-94-00560)

Head Start Grantee

At ACF's request, OIG reviewed allegations of financial mismanagement by a Head Start grantee, the Middlesex County Economic Opportunity Corporation (MCEOC). The OIG found that MCEOC drew excessive cash advances from the Department's payment management system and then used the excess funds for unapproved Head Start and non-Head Start purposes. Although OIG found no instances of nonpayment of vendors as alleged, its review did confirm that invoices were not always paid promptly. The review of labor costs charged to the Head Start grant did not identify any personnel paid with Head Start funds who appeared to be working on tasks unrelated to Head Start. However, because MCEOC did not have a system to support the distribution of labor charges, as required by the Office of Management and Budget Circular A-122, OIG could not be reasonably assured that the time charged to the Head Start agreement was accurate and reflected actual employee effort on the project. Finally, a selective review of costs charged to the Head Start program during program year 1994 identified $237,563 of costs which OIG believed were unallowable. The grantee agreed with the findings and plans to initiate corrective action to prevent reoccurrence. (CIN: A-02-94-02004)

Aid to Families with Dependent Children Program: Preeligibility Fraud Investigative Units

To prevent fraud and alleviate resulting overpayments caused by incorrect applicant-provided information, some States and local AFDC offices have established preeligibility fraud investigative units. Thirty-nine local offices surveyed by OIG reported that investigations by such units resulted in savings of over $41 million in program funds in 1992. Staff said they most often relied on basic investigative techniques, such as interviews with relatives, neighbors, landlords and employers; unannounced visits to applicant's homes; matching applicant-provided financial information with Federal and State databases; and assisting eligibility caseworkers in interviewing applicants. While most units were organizationally independent of AFDC benefit payment sections since their missions differ, officials agreed that the units were most effective when located near eligibility staff to promote effective communication, timely referrals, quick feedback and accessibility to files.

The OIG recommended that ACF encourage and help all States establish preeligibility fraud investigative units by disseminating information on such units to States and localities without them, and offering technical assistance to States interested in establishing such units. The ACF reported that it makes information on innovative programs available to States and is developing a catalogue that will make such information more usable. (OEI-04-91-00101)

Job Opportunities and Basic Skills Training Program: Participant Perspectives

Performance Measure

The OIG surveyed 183 JOBs participants at 8 sites on their experiences, opinions and attitudes about the program. As in an earlier survey (OEI-06-90-00150), OIG found that

most respondents gave high marks to the overall JOBS program, its activities and support services. Seventy percent of respondents graded the overall program A or B, as illustrated in the following chart.

JOB OPPORTUNITIES AND BASIC SKILLS PARTICIPANTS GAVE HIGH MARKS TO THE PROGRAM

Factors Rated	Grades				
	A	B	C	D	F
JOBS program overall	33%	37%	23%	5%	2%
JOBS as a means to get off welfare	43%	26%	17%	9%	5%
Case manager's efforts to assist participants	44%	24%	18%	7%	7%

Nevertheless, many respondents said they did not receive, or had problems utilizing, needed services. Services mentioned most often were transportation, child care, education and vocational/technical training. Eighty percent of the respondents suggested needed JOBS program improvements to foster self-sufficiency and improve support services. That included 26 percent who recommended placing more emphasis on education and training to prepare participants for careers which would increase their earning capacity above the minimum-wage level.

The OIG believes that interviews of JOBS program participants can provide useful insights into the problems and successes of the program, and encourages ACF to continue such direct participant feedback activities through future surveys at other States and sites. (OEI-06-93-00560)

Refugee Assistance Programs

Performance Measure

The OIG reviewed refugee resettlement activities in Florida to determine whether the efficiency and effectiveness of the social services and targeted assistance programs could be improved. Current refugee program regulations did not limit time-eligibility for these programs. In 1992, Florida received over 23 percent of the Office of Refugee Resettlement's (ORR's) budget of $111 million for social services and targeted assistance. Targeted assistance is provided to help offset the impact on local costs associated with high concentrations of refugees. Jackson Memorial Hospital (JMH) in Miami is the only hospital in the country receiving targeted assistance funding; this amounted to $10 million in 1992.

The OIG found that many of the refugees who were provided grant services under these programs in Florida had been in the United States more than 5 years and some were not financially needy. A study commissioned by ORR showed that after the refugees' initial years in the country, the effect of services on the achievement of economic self-sufficiency diminished significantly. To better focus the refugee program to meet the needs of more newly arriving refugees, OIG recommended that ACF limit the time period for refugee participation in social service and targeted assistance programs, and ensure that Florida limits targeted assistance funded medical services provided by JMH to needy refugees. Implementation of these measures would result in an estimated annual savings of $9.1 million.

The ACF agreed with OIG's findings and recommendations, and noted that ORR has issued the final regulation to limit time-eligibility for refugee social services and targeted assistance to a refugee's first 5 years in the United States. (CIN: A-04-93-00062)

Nutrition Program for the Elderly: Use of Commodities

Performance Measure

Under the Older Americans Act, AoA grants State Agencies on Aging and tribal organizations funds for the Elderly Nutrition Program (ENP). The United States Department of Agriculture (USDA) supports the ENP through its nutrition programs for the elderly which provide entitlements in commodities, cash or a combination of the two. In FY 1993, USDA distributed only 3 percent ($5 million) of these entitlements in commodities and 97 percent ($145 million) in cash.

Based on the results of an audit in 18 States, OIG determined that there are opportunities to provide more meals to older Americans, without increasing Federal expenditures, by using more USDA commodities. The States acknowledged that removing existing barriers would likely increase their use of commodities. These barriers could be overcome by: fostering better communications and working relationships with State distribution agencies which handle USDA commodities; assuring a better variety of commodities; and improving dependability, quality and packaging of commodities. While AoA does not have direct authority over how the commodity program is administered, OIG believes that in its leadership role, AoA could become more involved with States and USDA in expanding the use of commodities and taking advantage of relative savings. In response to the draft report, AoA and USDA generally agreed to address these issues through joint efforts. (CIN: A-01-93-02510)

General Oversight

CHAPTER VI

GENERAL OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities. The Office of the Secretary (OS) will spend $194 million in Fiscal Year (FY) 1995, including $86 million attributable to the Working Capital Fund, to provide overall direction for departmental activities as well as common services such as personnel, accounting and payroll to the individual operating divisions. Central to these activities is the development of the Department of Health and Human Services' (HHS') budget and its execution, as well as the related activities of establishing and monitoring departmental policy for debt collection, cash management, and payment of HHS grants and contracts. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

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

The OIG's FY 1995 work in departmental management and Governmentwide oversight focuses principally on financial management and managers' accountability for resources entrusted, standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance.

Nonfederal Audits

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

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In FY 1995, OIG's National External Audit Review Center (located in Kansas City) reviewed over 4,300 reports that covered over $1.1 trillion in audited costs. Federal dollars covered by these audits totaled $282 billion, about $146 billion of which was HHS money.

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

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

A. Office of Inspector General's Proactive Role

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

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

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

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number (800-732-0679) and through training. During the past 6 months, 670 individuals were provided with technical assistance through OIG's toll free number. In addition, formal training was provided to certified public

accountant societies and State auditor staff on issues related to Circulars A-128 and A-133.

- The OIG also has been heavily involved with OMB and the American Institute of Certified Public Accountants in developing authoritative guidance.

B. Quality Control

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

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

Reports issued without changes or with minor changes	1,669
Reports issued with major changes	13
Reports with significant inadequacies	301
Total audit reports processed	1,983

The 1,983 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling $30.1 million as well as 3,841 recommendations for improving management operations. In addition, these audit reports provided information for 65 special memoranda which identified concerns for increased monitoring by departmental management. The reports were also used to develop five areas for follow-up by OIG auditors.

Resolving Office of Inspector General Recommendations

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

A. Questioned Costs

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

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

	Number	Dollar Value (in thousands)	
		Questioned	Unsupported
A. For which no management decision had been made by the commencement of the reporting period[1]	393	$212,098	$12,714
B. Which were issued during the reporting period[2]	172	$123,025	$1,171
Subtotals (A + B)	565	$335,123	$13,885
Less:			
C. For which a management decision was made during the reporting period[3]:	279	$144,889	$1,569
(i) dollar value of disallowed costs		$123,321	$336
(ii) dollar value of costs not disallowed		$21,568	$1,233
D. For which no management decision had been made by the end of the reporting period	286	$190,234	$12,316
E. For which no management decision was made within 6 months of issuance[4]	134	$117,034	$11,252

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 (in thousands)
A. For which no management decision had been made by the commencement of the reporting period[1]	42	$741,694
B. Which were issued during the reporting period	22	$5,071,158
Subtotals (A + B)	64	$5,812,852
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	25	$460,657
(b) based on proposed legislative action	0	$0
Subtotals (a+b)	25	$460,657
(ii) dollar value of recommendations that were not agreed to by management	3	$273
Subtotals (i + ii)	28	$460,930
D. For which no management decision had been made by the end of the reporting period[2]	36	$5,351,922

See Appendix D for footnotes.

Legislative and Regulatory Review and Regulatory Development

A. Review Functions

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. During this reporting period, OIG reviewed 36 of the Department's regulations under development and 5 departmental legislative proposals.

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

B. Legislative and Regulatory Development Functions

The OIG also develops a variety of legislative proposals and sanction regulations for the civil monetary penalty (CMP) and program exclusion authorities which the Inspector General administers.

During this reporting period, OIG continued its development of several regulatory initiatives related to the safe harbor provisions under the Medicare and State health care programs' anti-kickback statute, and various rulemaking efforts related to expanding and revising its CMP and peer review organization sanction authorities. These efforts included publication of a final rule with comment period addressing CMPs for prohibited referrals by physicians to other health care entities. The OIG has also completed its development of revised final rulemaking for establishing safe harbor provisions under the anti-kickback statute to protect certain health care plans, such as health maintenance organizations, that offer incentives to enrollees or that enter into negotiated price reduction agreements with health care providers.

C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process. For example, OIG testified at eight hearings during this 6-month period, principally on health care fraud and abuse issues. On several occasions, the testimony concerned OIG recommendations which, if implemented, could produce billions of dollars in annual savings to the Government. These recommendations are contained in the OIG Cost Savers 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.

Interest Earned on Self-Insurance Funds: Pennsylvania

At the request of the Assistant Secretary for Management and Budget, OIG verified the calculation used by Pennsylvania to determine the Federal share of interest earned on self-insurance fund balances for the 5-year period ending June 30, 1994. The review was limited to determining the accuracy of the rates of return used by the Commonwealth to compute interest earned on the funds and the Federal participation rates used to determine the Federal share of the interest income.

The OIG found that Pennsylvania did not use in its calculation the exact rates of return on invested funds maintained by its Treasury Department and the most current Federal participation rate developed by its Office of the Budget. The State's revised calculation showed that it owed the Federal Government $12,433,571, $321,036 more than originally proposed. The OIG recommended that the Department require Pennsylvania to refund the revised amount. (CIN: A-03-95-00452)

Employee Fraud and Misconduct

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

- Toward the end of 1994, a former Food and Drug Administration (FDA) inspector, turned food importer, was sentenced in New Jersey to 63 months in jail — the maximum allowed under Federal guidelines — for conspiracy, bribery and illegal importation. He was fined $10,000. Since then three other former FDA inspectors have been sentenced for accepting bribes from the importer to allow previously rejected seafood imports admitted. Two were given 6 and 8 months confinement, and the third ordered to perform 200 hours of community service. They were fined a total of $13,000.

- Three Public Health Service commissioned officers were sentenced in Rhode Island for making false official certificates or writings. The investigation originated as an anonymous OIG hotline complaint. While working during Government duty hours, the three officers obtained Federal grants for microbiology testing and billed for this work through laboratories in which they held a financial interest. All three failed to disclose their financial interest on the Confidential Statement of Employment and Financial Interest form. All three were fined $500 and ordered to pay a $25 assessment.

- An Indian Health Service (IHS) physician assistant signed a pre-trial diversion agreement in Arizona calling for 18 months probation and 80 hours of community service, plus submitting to random drug and alcohol screening and appropriate treatment or counselling. The man misrepresented himself as a medical doctor and prescribed controlled narcotics for his own and others' use. Pharmacies in one town dispensed over 1,300 controlled narcotics for 64 fraudulent prescriptions he wrote. His employment was terminated. A lab technician who received a share of some of the prescriptions resigned his position.

- A former IHS employee was sentenced in Federal court in the State of Washington for stealing overpayment refund checks sent to IHS by health service providers under contract with IHS. The employee forged the checks over several years, deposited them in her personal bank account and spent the money. She was sentenced to 4 months in jail and 3 years supervised release, and ordered to make restitution of more than $50,700.

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 187 successful criminal actions. Also during this period, 229 cases were presented for prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 200 individuals and entities.

The number of convictions in this period declined because of the departure of the Social Security Administration. In keeping with its commitment to Operation Restore Trust, OIG has concentrated on the five States where most of the health care dollars are spent.

In addition to terms of imprisonment and probation imposed in the judicial processes, more than $195 million was ordered or returned as a result of OIG investigations during this semiannual period.

Program Fraud Civil Remedies Act

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

each fiscal year investigations completed under PFCRA and referred for administrative action.

During FY 1995, no settlements were made under PFCRA. While all cases are routinely analyzed for potential action under PFCRA, the availability of OIG's CMP authorities in health care matters often renders PFCRA unnecessary. Also, PFCRA cannot comfortably be applied to many of the grants and contracts issued and administered by HHS. Unlike the Medicare program, these awards do not involve single claims for payment. Instead, the grants or contracts are large and complex, and it is frequently difficult to demonstrate that a single misrepresentation was material to the overall award.

Appendices

APPENDIX A

Implemented Office of Inspector General Recommendations to Put Funds to Better Use
April 1995 through September 1995

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

Legislative savings are annualized amounts based on Congressional Budget Office estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures for the year in which the change is effected. Total savings from these sources amount to $4,873.2 million for this period.

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Use of Donations and Provider Tax Revenues: Discontinue use of donations and provider tax revenues as a financial mechanism to fund States' share of Medicaid expenditures. (CIN: A-14-90-01009; CIN: A-14-91-01010; CIN: A-03-91-00203)	Public Law 102-234 prohibits donations made by providers, and entities related to providers, except for donations for direct costs of outstationed eligibility workers. In November 1992, the Health Care Financing Administration (HCFA) issued interim final regulations implementing the Public Law 102-234; certain sections of the law were effective January 1, 1992, without regulation. While savings began to be realized in Fiscal Year (FY) 1993, the effect of the legislation was more marked in FYs 1994 and 1995.	$1,467
Capital-Related Costs of Inpatient Hospital Services: Discontinue inappropriate Medicare prospective payment system (PPS) payments for hospital costs. (ACN: 14-52083; ACN: 09-52020)	Section 4001 of the Omnibus Budget Reconciliation Act (OBRA) 1990 provides for a 10 percent reduction for capital-related payments attributable to portions of cost reporting periods or discharges occurring from October 1, 1991 and ending September 30, 1995.	920
Personal Care Services: Reinstate personal care services as a State optional service. (CIN: A-02-93-01022)	Section 13601 of OBRA 1993 repeals the mandate for coverage of personal care services and allows the States to cover personal care services furnished outside the home, effective October 1, 1994.	850

OIG Recommendation	Status	Savings in Millions
Medicare Laboratory Reimbursements: The Medicare fee schedule allowances for clinical laboratory tests should be brought in line with the prices physicians are paying for tests purchased from independent laboratories. (OAI-02-89-01910; CIN: A-09-89-00031)	Section 4154 of OBRA 1990 reduced the national cap to 88 percent of the median of all fee schedules and limited the annual fee schedule increase for clinical laboratory tests to 2 percent for 1991, 1992 and 1993. Section 13551 of OBRA 1993 reduces the national cap to 76 percent of the median of all fee schedules, and froze the annual update for 1994 and 1995.	$795
Capital-Related Costs of Outpatient Hospital Services: Discontinue inappropriate Medicare PPS payments for hospital costs. (ACN: 14-52083; ACN: 09-52020)	Section 4151(a) of OBRA 1990 reduces payments for outpatient capital by 15 percent for portions of cost reporting periods in FY 1991 and by 10 percent in FYs 1992 through 1995.	400
Disproportionate Share Hospitals: Disproportionate share payments to hospitals should be related to costs incurred in treating Medicaid and indigent patients to correct the inequities and abuses in current payment methodologies. (CIN: A-06-90-00073)	Section 13621 of OBRA 1993 prohibits designation of a hospital as a disproportionate share hospital (DSH) for purposes of Medicaid reimbursement unless the hospital has a Medicaid inpatient utilization rate of at least one percent. It also limits DSH payment adjustments to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid (other than DSH payment adjustments) and uninsured patients.	200
Medicaid Transfer of Assets: Strengthen the transfer of assets rules so that people cannot give away property to qualify for Medicaid. Assets and income from special needs trusts should be counted for Medicaid qualifying purposes and be subject to third party liability recovery. (OAI-09-86-000078; CIN: A-09-93-00072)	Section 13611 of OBRA 1993 provides for a delay in Medicaid eligibility for institutionalized individuals or their spouses who dispose of assets for less than fair market value on or after a specified look-back date; sets forth rules under which funds and other assets of an individual placed in trust by or on behalf of an individual or the spouse are treated, for purposes of Medicaid eligibility, as resources available to the individual, and under which payments from the trust are to be considered assets disposed of by the individual; and specifies that, for purposes of applying transfer of assets prohibitions, the look-back period with respect to trusts is 60 months.	75

OIG Recommendation	Status	Savings in Millions
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
Coverage of Conventional Eyewear: Exclude Medicare coverage of conventional eyewear following cataract surgery. (CIN: A-04-88-02039)	Section 4153 of OBRA 1990 limits Medicare coverage of eyeglasses following cataract surgery to one pair of glasses.	55
Conversion Factors Used in the Anesthesia Payment Formula: The HCFA should adjust the area-specific conversion factors now used to conversion factors which correlate to geographic multipliers. (CIN: A-07-90-00296)	Section 4103(a) of OBRA 1990 requires the Secretary to estimate a national weighted average conversion factor and reduce it by 7 percent.	50
Low Cost Ultrasound: The HCFA should prohibit payment for tests conducted with pocket dopplers, and advocate revisions in procedure codes and reimbursement rates to reflect the different levels of sophistication and quality of the diagnostic information provided. (OEI-03-88-01401; OEI-03-91-00460; OEI-03-91-00461)	The HCFA issued an instruction prohibiting separate payment for tests conducted with pocket dopplers and revised the Physician's Procedural Coding handbook to revise imaging codes for hand-held ultrasound devices.	5.8

APPENDIX B

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

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

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Modify Formula for Costs Charged to the Medicaid Program: The Health Care Financing Administration (HCFA) should consult with the Congress on modification of the Federal Medical Assistance Percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per-capita income relationships. (CIN: A-06-89-00041)	No legislative proposal was included in the President's Fiscal Year (FY) 1996 budget.	$4,100
Indirect Medical Education: Reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether any adjustment factor is warranted for all teaching hospitals. (CIN: A-07-88-00111)	The HCFA states that its study of recent data indicates that the IME factor should be reduced. The HCFA's conclusion is supported by other groups. In its March 1995 report to the Congress, the Prospective Payment Assessment Commission (PROPAC) recommended that, for FY 1996, the IME factor be reduced from 7.7 percent to 6.7 percent. The PROPAC stated that ultimately the IME factor should be 4.5 percent.	2,130
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, 1988. 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 the President's FY 1995 budget contained a proposal to include under Medicare all State and local government employees hired before April 1, 1988, no legislative proposal was included in the President's FY 1996 budget.	1,559

OIG Recommendation	Status	Savings in Millions
Clinical Laboratory Tests: Require laboratories to identify and bill profiles (groups of related tests) at reduced rates whenever they are ordered, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CIN: A-09-89-00031)	Although the President's FY 1995 budget included a proposal to reinstitute coinsurance for clinical laboratory services, no legislative proposal was included in the President's FY 1996 budget.	$1,130
Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)	The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.	1,100
Medicare Secondary Payer - Retroactive Recoveries: The HCFA should ensure that contractors' resources are sufficient and instruct contractors to recover improper primary payments; ensure that contractors take sufficient action to preclude the loss of backlogged Medicare secondary payer (MSP) cases (claims where contractors are more than one quarter behind in sending a demand letter) because the recovery period lapsed; implement financial management systems to ensure all overpayments are accurately recorded; and pursue alternative strategies such as contingency contracts, demonstration and incentive programs, or fund collection activities from recovery proceeds. (CIN: A-01-90-00509; CIN: A-01-91-00525; CIN: A-04-91-02004; CIN: A-04-92-02037; CIN: A-04-92-02057; CIN: A-02-93-01006; CIN: A-04-92-02049; CIN: A-14-94-00392; OEI-07-89-01683)	Adequate, consistent funding levels of payment safeguards, including MSP, have not been established. However, HCFA believes that it has sufficient funding to process the existing MSP backlog. The HCFA has also developed an MSP overpayment tracking system. However, this system has not been fully implemented at all contractors and it is not considered a financial management system. Efforts to stabilize funding of payment safeguards by establishing a mechanism that secures funding from the trust funds are being pursued by HCFA. The HCFA will consider demonstration projects.	961.6

OIG Recommendation	Status	Savings in Millions
Medicare Secondary Payer - Avoid Future Overpayments: The HCFA should revise the justification for an FY 1990 legislative proposal, which would require insurance companies, underwriters and third-party administrators to periodically submit employer group health policy (EGHP) coverage data directly to HCFA, and resubmit it. The HCFA should administratively: revise all Medicare claims forms to require a positive or negative response pertaining to other health insurance coverage; request that the Social Security Administration maintain beneficiary spousal information in its master beneficiary record system for use by HCFA; assure compliance with all initial enrollment procedures and collect health insurance information for disabled beneficiaries during the required disability waiting period. (CIN: A-09-89-00100; CIN: A-09-91-00103; CIN: A-14-94-00392; CIN: A-14-94-00391; OEI-07-90-00760; OEI-07-90-00763)	The legislative proposal was not included in the President's FY 1996 budget. The HCFA is considering OIG's administrative recommendations.	$900
Reduce Hospital Capital Costs: Seek legislative authority to continue mandated reductions in capital payments beyond FY 1995. The HCFA should determine the extent of the capital reductions that are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070; CIN: A-14-93-00380)	The HCFA is seeking public comment on reducing prospective capital rates.	820
Medicaid Payments to Institutions for Mentally Retarded: The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)	The HCFA nonconcurred with OIG's recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA and OIG negotiated an agreement for HCFA to send the report to all State Medicaid directors. This action has been taken.	683

OIG Recommendation	Status	Savings in Millions
Medicare Secondary Payer - End Stage Renal Disease Time Limit: Extend the MSP provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016)	The President's FY 1996 budget contains a proposal to extend the MSP provision for individuals with ESRD to 24 months. Notwithstanding this proposal, OIG continues to advocate that Medicare should always be a secondary payer for ESRD beneficiaries.	$503
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt policy. The OIG presented an analysis of four options for HCFA to consider including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system (PPS) hospitals which are profitable, and the inclusion of a bad debt factor in the diagnosis related group (DRG) rates. (CIN: A-14-90-00339)	This proposal was not included in the President's FY 1996 budget.	487.7
Terminate Medicare Disproportionate Share Adjustments: Terminate disproportionate share adjustment payments without redistribution of the funds to PPS hospitals. Payments under PPS adequately compensate hospitals for services provided to Medicare patients, including low-income patients. (CIN: A-04-87-00111)	Although the President's FY 1995 budget contained a proposal to phase down Medicare disproportionate share payments, no legislative proposal was included in the President's FY 1996 budget.	430
Flexible Benefit Plans: The value of flexible benefit plans, as defined by section 125 of the Internal Revenue Code, should be included in the hospital insurance portion of the Federal Insurance Contributions Act taxable wage base. (CIN: A-05-93-00066)	The HCFA agreed with OIG's recommendation.	420
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. As a final measure, HCFA may submit a legislative proposal to remove these stays from the usual DRG payment methodology. No proposal was included in the President's FY 1996 budget.	210

OIG Recommendation	Status	Savings in Millions
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 is studying various options for legislative changes and believes a total restructuring of the GME payment system may be necessary. No legislative proposal was included in the President's FY 1996 budget.	$157.3
Eliminate Inappropriate Payments for Total Parenteral Nutrition: The HCFA should: instruct carriers to adhere to a strict interpretation of the coverage guidelines for concentrated, purified nutrients; require the carriers to intensify review of certificates of medical necessity, discuss therapeutic options with physicians and monitor the use of nutrients over time; and review research into the clinical appropriateness of and payment methodologies for intradialytic parenteral nutrition (IPN). (OEI-12-92-00460; CIN: A-04-93-02073)	While HCFA generally agreed with OIG's recommendations, a subsequent review revealed that new claims were being paid for IPN contrary to Medicare coverage guidelines and the carriers' own guidelines which do not provide coverage for supplemental nutrition.	96.8
Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The fiscal intermediaries should recover improper payments made to hospitals for nonphysician outpatient services (such as diagnostic tests and laboratory tests) rendered within 72 hours of the day of an inpatient admission, and refund the beneficiaries' coinsurance and deductible related to these payments. The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)	The HCFA agreed to recover the improper billings and to refund the beneficiaries' coinsurance and deductible. It did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's FY 1996 budget.	92.1 [1]
Reduce Medicare Payments for Hospital Outpatient Department Services: Establish a legislative initiative to reduce the current payments for services in outpatient departments to bring them more in line with ambulatory service center (ASC) approval payments. Pay outpatient departments the ASC-approved rate or adjust hospital payments by a uniform percentage. (CIN: A-14-89-00221; OEI-09-88-01003)	The HCFA is currently preparing a report to the Congress on developing a PPS for outpatient departments. In addition, although the President's FY 1995 budget contained a proposal to eliminate a formula-driven overpayment in hospital outpatient departments, no legislative proposal was included in the President's FY 1996 budget.	90

OIG Recommendation	Status	Savings in Millions
Generic Drugs: The HCFA should identify and alert States to methods which would encourage the use of lower priced generic drug products in the Medicaid program. The HCFA should also take a more active role to encourage States to use generic drugs; provide stronger incentives for States to adopt policies that encourage use of generic drugs; monitor the States' efforts to encourage the use of lower priced drugs; and formally assess those activities. (CIN: A-06-93-00008)	The HCFA has provided a copy of the OIG report to States and encouraged them to use lower priced generic products. The HCFA needs to institute a strong system of monitoring and assessing States' efforts by including a generic drug evaluation as part of its Drug Utilization Review program.	$49
Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)	The HCFA considered a proposal recommending that the 190-day lifetime limit for psychiatric hospitals be exteuded to general hospitals; however, such a proposal was not included as part of the President's FY 1996 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)	The HCFA expects to issue a regulation in late 1995 that would shift the policy focus away from the type of vehicle used and towards the medical condition of the beneficiary.	47
Medicaid Payments for Employer Group Health Insurance: The HCFA should continue to strongly support States implementing Section 1906 of the Social Security Act, and should propose legislation that allows States to pay EGHP deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules. (OEI-04-91-01050)	The HCFA concurred with the first recommendation and has been working in partnership with regional offices and States to promote full implementation. The HCFA deferred comment on the second recommendation.	32
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 sbaring amounts; and/or recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services; and allowing for higher beneficiary cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800)	The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. It plans to solicit information from States implementing cost sharing and distribute it to States that do not impose it. Several States have submitted waiver applications to HCFA to develop demonstration projects which include experimental cost sharing provisions.	19.8

OIG Recommendation	Status	Savings in Millions
Monitored Anesthesia: The HCFA should study the appropriateness of paying the same amount for monitored anesthesia care and general anesthesia in view of the fact that other insurers are more restrictive than Medicare. (OEI-02-89-00050)	The HCFA does not concur with this recommendation.	$18
Establish Mandatory Prepayment Edit Screens for Medicare and Medicaid: The HCFA should move swiftly with the process of establishing mandatory prepayment edit screens for the Medicare and Medicaid programs. (CIN: A-03-91-00019)	The HCFA believes that the OIG approach does not consider the carriers' responsibility to establish Medicare coverage and payment policy when there is no national HCFA policy. The OIG disagrees. Good internal control procedures would require basic edit checks to ensure that the procedure codes are not manipulated. The HCFA, however, is addressing the rebundling issue in the development of its Medicare Transaction System, a single integrated claims processing system for both Part A and Part B claims that will replace the 14 different systems now used by Medicare contractors.	12.9
Limit Reimbursement for Hospital Beds: The HCFA should develop a new approach for reimbursing suppliers for hospital beds used by Medicare beneficiaries at home. A new reimbursement methodology should reflect a hospital bed's useful life and the number of times a bed can customarily be rented over that period. (CIN: A-06-91-00080)	Although the President's FY 1995 budget contained a proposal that would authorize competitive bidding for durable medical equipment, no legislative proposal was included in the President's FY 1996 budget.	9.8
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)	As introduced in the House, H.R. 3400, the Government Reform and Savings Act of 1993 (which addressed many of the National Performance Review recommendations) called for the repeal of the authority for a separate carrier chosen by the Railroad Retirement Board.	9.1
Medicare Payments for Orthotic Body Jackets: The OIG should require the durable medical equipment regional carriers (DMERCs) to closely monitor claims for body jackets, including: analysis of payment trends, provision of an early warning of abusive practices and monitoring of suppliers who have engaged in abusive practices. (OEI-04-92-01080)	The HCFA concurred and has instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices. The statistical analysis DMERCs produce quarterly reports and monthly ad hoc reports which assist the DMERCs in identifying potential abusive practices, and monitor those suppliers that appear to engage in abusive practices.	7

OIG Recommendation	Status	Savings in Millions
Medicare's Reimbursement for Hospital Emergency Room X-Rays: The HCFA should pay for reinterpretations of x-rays only when attending physicians specifically request a second physician's interpretation in order to render appropriate medical care before the patient is discharged. (OEI-02-89-01490)	The HCFA will revise the hospital emergency room x-ray interpretation policy guidelines in the Medicare Carriers Manual 2020G. The manual revision is currently under development.	$4
Third Party Liability Settlements and Awards: The HCFA should develop legislative proposals to close the loopholes in the Omnibus Budget Reconciliation Act of 1993 that allow Medicaid beneficiaries who receive settlements and awards from third parties as a result of accidents to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. The HCFA should also develop guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties. (CIN: A-09-93-00033)	The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g. health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements.	3
Hospital General and Administrative and Fringe Benefit Costs: Revise the Provider Reimbursement Manual (PRM) to provide explicit guidelines on the allowability of certain general administrative and fringe benefit costs. (CIN: A-03-92-00017)	The HCFA will conduct an in-depth analysis of the issues identified by OIG and will revise the PRM as appropriate to address specific categories of general and administrative and fringe benefit costs in order to provide better guidance to hospitals, other providers and intermediaries concerning the allowability of these costs.	2.1 [2]
PUBLIC HEALTH SERVICE		
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)	In the absence of specific authorizing legislation, the Food and Drug Administration is precluded by statute from imposing user fees to cover additional functions.	44.4
Limit Graduate Student Compensation: The Assistant Secretary for Management and Budget (ASMB) should work with the Office of Management and Budget (OMB) to revise Circular A-21 to stipulate a reasonableness standard for graduate student compensation charged to federally sponsored research based on assigned responsibilities and not to exceed compensation paid to other individuals of similar experience for similar work. (CIN: A-01-94-04002)	The ASMB endorsed the OIG recommendation, concluding that a prudent person would not provide greater compensation to individuals who are less qualified by education and practical experience than others performing similar work.	5.7

OIG Recommendation	Status	Savings in Millions
Recharge Center Costs: Universities should: improve their oversight of recharge centers; develop and implement policies and procedures for the operation of recharge centers that are consistent with OMB Circular A-21; establish and maintain adequate accounting and recordkeeping procedures for recharge centers; and analyze and adjust billing rates to eliminate deficit and surplus funds. (CIN: A-09-92-04020)	The ASMB concurred with the recommendations and has recommended to OMB that Circular A-21 be revised to provide more definitive guidance on the financial operations of recharge centers.	$3.2
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Reducing Federal Financial Participation: The Administration for Children and Families should consult with the Congress on modifications to the Federal medical assistance percentages formula which would result in distributions of Federal funds that would more closely reflect per-capita income relationships. (CIN: A-06-90-00056)	This proposal was not included in the President's FY 1996 budget.	1,100
Reduce Incentive Payments and Base Them on States' Performance: Base incentive payments on the States' demonstrated ability to meet Federal child support enforcement (CSE) requirements and performance objectives. Also, consider OIG rccommended options to reduce financial incentives realized by States that would result in a more equitable cost sharing with the Federal Government. These options are: limiting incentives to a hreak-even point where a State's share of Aid to Families with Dependent Children collections, plus incentive, equal the State's share of CSE costs; eliminating incentives to poor performing States; and reducing the Federal share of administrative costs. (CIN: A-09-91-00147; CIN: A-09-91-00034)	This proposal was not included in the President's FY 1996 budget.	277
Limit Federal Participation in States' Costs for Administering the Foster Care Program: Limit Federal participation in foster care administrative costs through one of the following actions: limit future increases in administrative costs to no more than 10 percent per year; fund administrative activities via a single block grant with future increases based on the consumer price index; limit administrative costs to a percentage of maintenance payments; or restrict, through legislation, the filing period for retroactive claims, namely require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. (CIN: A-07-90-00274; OEI-05-91-01080)	This proposal was not included in the President's FY 1996 budget.	247

OIG Recommendation	Status	Savings in Millions
GENERAL OVERSIGHT		
Disallow Interest Charges on Unfunded Liabilities of Government Pension Plans: The OMB should revise Circular A-87 limiting Federal sharing of actuarially determined pension costs, including amortization of unfunded liabilities, to situations where the State and local governmental unit are funding such costs through an actuarially sound plan. Interest costs caused by late funding should not be allowed. (CIN: A-09-87-00031)	Because of the sensitivity and financial impact of the proposed changes on the State and local governmental entities, OMB has expended considerable effort working with State and local interest groups prior to issuance as a draft proposed rule change. The OIG continues to recommend that OMB clarify the rule relating to pensions by finalizing revisions to Circular A-87.	$1,300
Pension Reserves: Recover the Federal Government's proportionate share of pension reserve funds used by California to pay current period employer pension costs. (CIN: A-09-92-00116)	The Department's Division of Cost Allocation concurred with OIG's finding; resolution with the State is in progress. The State did not agree that the Federal Government should receive a proportionate share of the reserves saying that the use of the funds was mandated by State law specifically restricting the use to State funding sources only.	111
Internal Service Funds: California should refund the Federal share of accumulated surpluses in its internal service fund that provides goods and services to State agencies on a cost reimbursable basis, and adjust billing rates to eliminate future surpluses or deficits. (CIN: A-09-93-00039)	The Department's Division of Cost Allocation generally agreed with OIG's findings. However, California did not concur.	12.2

[1] *Includes a one-time recovery of $8.6 million.*

[2] *Medicare savings only. The bulk of costs were passed to other health care consumers.*

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	
Kidney Acquisition Cost: The Health Care Financing Administration (HCFA) should establish uniform fiscal oversight of the organ acquisition costs of all Medicare artificial organ procurement organizations. (OEI-01-88-01331)	The HCFA largely disagrees with this recommendation.
Medicare Carrier Assessment of New Technologies: The HCFA should foster greater consistency among carriers in their coverage and pricing decisions, by providing carriers with selective access to comparative information on new technologies, reviewing carrier performance and working with the Public Health Service (PHS) to disseminate information on new health care technologies. (OEI-01-88-00010)	The HCFA indicated that it recognized the problems with the carrier assessment of new technologies and had taken steps to correct the problems. The OIG plans to conduct a follow-up study to determine if effective actions have been completed.
Carrier Maintenance of Provider Numbers: The HCFA should establish adequate safeguards for detection of abusive providers. (OEI-06-89-00870)	The HCFA is taking steps to address the problems identified in the report, which OIG will monitor. The HCFA agreed to issue a modification to the Medicare Carrier Manual which will clearly state that carriers have a responsibility to ensure the integrity of provider numbers and that only those practitioners and providers with legal authority to practice are given and may retain provider numbers. The HCFA is also implementing changes to the contractor evaluation process, durable medical equipment claims processing and supplier requirements, and provider number system.
Improve the Health Care Financing Administration's Federal Managers' Financial Integrity Act Program: The HCFA should enhance the testing used to evaluate the contractors' claims processing internal controls. (CIN: A-14-93-03026)	The HCFA agreed and has established a work group comprised of OIG and HCFA staff members to address Medicare contractors' controls. The work group is developing an internal control review protocol to review contractors' controls.

OIG Recommendation	Status
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 hopes to have final regulations during Fiscal Year (FY) 1996.
Physical Therapy in Physicians' Offices: The HCFA should take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. Some options are: conduct focused medical review; provide physician education activities; apply existing physical therapy coverage guidelines for other settings to physicians' offices. (OEI-02-90-00590)	The HCFA concurred with options one and two, and have distributed copies of the report to the carriers to determine if the issues identified are problems in their service areas. The HCFA is also forming a work group that represents physicians who provide physical therapy services in their offices to focus on the clinical appropriateness of services provided, including monitoring of these services.
Use of Nursing Homes and Medigap Guides: The HCFA should work with the Social Security Administration (SSA) and the Assistant Secretary for Public Affairs to develop a more effective strategy to make the booklets available to all beneficiaries. (OEI-04-92-00481)	The HCFA concurred with OIG's recommendation. It is also considering other OIG suggestions, such as distributing information through physicians' offices, hospital personnel and post offices to continue to improve its communication with beneficiaries.
Medicare Trust Funds' Accounts Receivable Balances: The HCFA needs to improve its internal controls and the controls of its fiscal intermediaries and carriers related to the recording and reporting of accounts receivables. Additionally, HCFA needs to properly estimate the allowance for uncollectible receivables and determine the amounts to be written off as uncollectible. In a review conducted in accordance with the Chief Financial Officers Act, OIG continued to find weaknesses in contractors' controls. (CIN: A-01-92-00516; CIN: A-14-93-03027)	The HCFA concurred with the intent of most of the recommendations and is taking corrective actions. However, HCFA has still been unable to resolve all the critical problems. The HCFA and OIG will continue to work together to develop corrective action plans to resolve these deficiencies. The HCFA has established a work group to review Medicare contractor operations and systems, analyze contractor controls and identify internal control weaknesses. The work group has contracted with a Medicare contractor and a certified public accounting firm to develop an approach to evaluate internal controls at Medicare contractors. The HCFA has also requested a clarification of the reporting of Medicaid financial information from the Federal Accounting Standards Advisory Board.
Medicare Trust Funds' Accounts Payable Balances: The HCFA should improve its internal controls and the controls of its fiscal intermediaries and carriers related to the recording and reporting of accounts payable. The HCFA should also perform Federal Managers' Financial Integrity Act (FMFIA) sections 2 and 4 reviews on all carrier accounts payable internal controls and financial management systems. (CIN: A-04-92-02054; CIN: A-05-92-00106)	The HCFA concurred with the recommendations. Regarding recommendations to perform FMFIA section 2 and 4 reviews at contractors, a work group is developing an internal control review protocol to review contractors' controls.

OIG Recommendation	Status
Improve Financial Management Systems to Enhance Financial Reporting: The HCFA should develop and implement financial management systems and related accounting and administrative internal controls to ensure that all Medicare liabilities are reported to the HCFA general ledger at fiscal year end. (CIN: A-14-92-03015)	The HCFA agreed that reasonable data should be included in the reporting of Medicare liabilities. However, HCFA asserts that the process for developing a reasonable estimate of a liability for provider reports would be too cumbersome. The HCFA is currently developing the Medicare Transaction System that will include an integrated accounting subsystem to estimate the amount of appealed cost reports.
Clarify the Allowability of General and Administrative Costs at Medicare Hospitals: The HCFA should revise the Provider Review Manual (PRM) to further clarify the allowability of specific types of general and administrative and fringe benefit costs. (CIN: A-03-92-00017)	Based on its analysis of OIG's finding and similar findings in a General Accounting Office report, HCFA will consider revising the PRM to address specific categories of general and administrative and fringe benefit costs to provide better guidance to hospitals concerning the allowability of these costs.
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.
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.
Use of Emergency Rooms by Medicaid Beneficiaries: The HCFA should encourage States to develop initiatives to review and reduce nonemergency use of emergency rooms by Medicaid beneficiaries, and assist them through data analysis instructions, expedited review of waiver applications for managed care and dissemination of effective emergency room control practices. (OEI-06-90-00180)	The HCFA indicated that it was concerned that it may not have sufficient resources to encourage States to develop initiatives to review and reduce nonemergency use of emergency rooms or disseminate annual reports on effective practices, but it will assist States by expediting the review of State applications for waivers to implement their efforts to control emergency rooms.

OIG Recommendation	Status
Avoid Future Medicare Secondary Payer Overpayments: To identify Medicare secondary payer (MSP) situations, HCFA should continue to implement its corrective action plan to eliminate the designation of MSP as a high risk area, and seek legislation which would require employers to report other health insurance coverage on the W-2 and tax statement. (CIN: A-09-89-00100; OEI-07-90-00760; OEI-07-90-00763)	The HCFA is continuing implementation of the corrective action plan. The HCFA did not agree with the recommendation on use of the W-2, indicating that it preferred to evaluate the outcome of recent legislation which mandated a data exchange between the Internal Revenue Service, SSA and HCFA.
Recover Past Medicare Secondary Payer Overpayments: The HCFA should ensure that there is adequate funding available to contractors to pursue collection of MSP overpayments, and instruct contractors to recover the MSP overpayment backlog and notify insurance companies of improper payments within recovery regulation time frames. (CIN: A-09-91-00103; CIN: A-04-92-02037)	The HCFA is in the process of establishing funding needs for recoveries and agreed to make recovery of backlog cases a top priority.
Review Social Security Administration Procedures that Impact Medicare Trust Funds: The HCFA should review SSA's wage certification procedures to ensure that the transfer of Medicare Hospital Insurance trust funds is consistent and performed in accordance with the Social Security Act. (CIN: A-14-92-03013)	The SSA is pursuing a legislative solution to this problem.
Sanction Referral Authority of Peer Review Organizations: The HCFA should adopt one or more of the following options for changing the peer review organization (PRO) authority: repeal or modify the "unwilling or unable" requirement; substantially increase the monetary penalty; maintain the authority as it now exists, but mandate referrals to State medical boards when PROs confirm serious quality of care problems. (OEI-01-92-00250)	The HCFA opposed the first option, supported the second and concurred with the third. It plans to develop a Memorandum of Agreement which will provide the necessary mechanism for PROs to exchange information about those physicians found to have serious quality of care problems with the States.
Payments for Total Parenteral Nutrition: The HCFA should review research concerning the use of intradialytic parenteral nutrition (IDPN). If IDPN is considered reasonable and necessary for the treatment of a subset of end stage renal disease patients, it should be paid on a per-capita basis, with discounts negotiated by each facility or the networks, or by using some other method that takes into account the efficiencies associated with facility administration of the nutrients. (OEI-12-92-00460; CIN: A-04-93-02073)	The HCFA agreed that there has been inappropriate coverage of IDPN in the past and has proposed changes in the policy to ensure appropriate coverage. While HCFA generally agreed with OIG's inspection report recommendations, a subsequent audit revealed that new claims were being paid for IDPN. This audit report, Medicare Part B Payments for Intra-Dialytic Parenteral Nutrition, found that payment for IDPN continued after release of the inspection report.
Physician Office Surgery: The PROs should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)	The HCFA continues to work with the PROs to refine a methodology for review of quality of care for ambulatory services. The implementation plan is to expand the review of ambulatory services to additional States, first on a pilot basis, then on an implementation basis in other States.

OIG Recommendation	Status
Patient Advance Directives - Early Implementation Experience: The HCFA should develop and issue specific regulatory guidelines clarifying acceptable documentatiou methods to assist providers in meeting the requirements of the Federal statute. The statute requires providers to inform individuals of any rights they have under State law regarding self-determination. (OEI-06-91-01130)	The HCFA did not concur with the recommendation, but is willing to provide assistance to States by issuing interpretive guidelines for survey and certification containing examples of what would constitute acceptable documentation of whether a patient has an advance directive.
PUBLIC HEALTH SERVICE	
Fully Implement Internal Controls in the Food and Drug Administration's Medical Device 510(k) Review Process: The Food and Drug Administration (FDA) should modify its exception report for use on a quarterly basis to detect possihle manipulation of the 510(k) process; periodically sample reviewer workload to ensure compliance with the "first-in, first-reviewed" policy; require reviewers to document responses to all items on the review checklist; conduct bioresearch monitoring inspections on devices likely to result in 510(k) submissions; complete postmarket testing of the four devices it selected for review and increase the number sampled for future tests; include in its quality control reviews an independent scientific evaluation of reviewers' 510(k) decisions; and periodically monitor employee compliance with procedures for employee/industry contacts. (CIN: A-03-92-00605)	The PHS has reported that FDA has made significant progress in rectifying deficiencies in this program area, and that it will continue to monitor FDA's efforts until all corrective actions are implemented.
Tighten Controls of the Advance Payment System Used by the Indian Health Service to Advance Cash to Contractors and Grantees: The PHS should: consider reporting the problems identified in the advance payment system used by the Indian Health Service (IHS) to advance funds to its contractors and grantees as a material internal control weakness or a material nonconformance under FMFIA; assess the propriety of funds advanced to 16 contractors who commingled IHS funds with their other funds; and evaluate alternatives for improving the current system of advancing funds to IHS contractors and grantees. (CIN: A-06-90-00001)	In its July 21, 1994 report on the status of corrective actions taken on OIG reports, PHS noted that IHS has corrected certain problems disclosed by the OIG report. Correction of all the problems will reportedly be completed when all area office tribal contracts are transferred to the departmental payment management system, expected by December 31, 1995.
Federal Involvement in Patents: The National Institutes of Health (NIH) should develop procedures to obtain information on patents issued to NIH grantees and determine if these patents were developed with Federal funds. (CIN: A-15-93-00029)	The PHS generally concurred with OIG's recommendations. The NIH has completed its review of patents issued to one grantee and found additional patents that were made with NIH support. The NIH has implemented a pilot project to assess the accuracy of reporting compliance for selected research institutions and has contacted the U.S. Patent Office to develop procedures which will lead to better monitoring of all federally supported patents.

OIG Recommendation	Status
Ensure that All Superfund Grantees Are Audited: The PHS should direct its Superfund agencies to establish procedures to ensure that all Superfund grantees submit audit reports and that grantees that are unwilling to have a proper audit conducted are sanctioned. (CIN: A-04-93-04506; CIN: A-04-93-04518)	The PHS directed the Superfund grant offices to take steps to ensure that all Superfund grantees provide the required audit reports.
Improve Financial Reporting and Monitoring of Research Funds at Universities: The Department should require grantees to submit a revised budget for the use of unspent grant funds when a substantial carryover of funds occurs from one budget period to another. Additionally, the Department should expedite the pilot project for obtaining detailed expenditure data from universities. (CIN: A-06-91-00073)	The Assistant Secretary for Management and Budget and PHS concurred with OIG's recommendations. In April 1992, the Office of Management and Budget (OMB) gave the Department approval to conduct a pilot project with selected universities to obtain detailed expenditure data by electronic transfer. This project is still under development. In addition, PHS added language to its grant policy statement that defines "significant rebudgeting."
Improve Accountability Over National Institutes of Health's Management and Service and Supply Funds' Activities: The NIH should improve accountability over personal property and inventory by performing monthly reconciliations and perform adequate follow-up procedures on discrepancies noted by physical counts. The NIH should also develop policies and procedures for retaining supporting accounting documentation. (CIN: A-15-93-00008)	A Board of Survey was initiated and presented a series of recommendations to improve property management.
Improve Controls Over Advisory Committee Conflict of Interest: The NIH should: review advisory committee members' financial disclosure forms to identify perceived or actual conflicts of interest; require ongoing reviews to identify changes in financial interest that could result in conflicts of interest; revise required financial disclosures to include involvement in nonfederal grants and contracts; and provide guidance to determine when a waiver should be sought to obtain essential services of a committee member. (CIN: A-15-93-00020)	The NIH concurred with OIG's recommendations and has taken actions which, when fully implemented, will significantly strengthen internal controls.
Implement a Charging System for Centers for Disease Control and Prevention Data Processing Costs: The PHS should require the Centers for Disease Control and Prevention (CDC) to implement a system for charging data processing costs to its component centers consistent with the provisions of the Federal Information Processing Standards Publication 96. (CIN: A-04-92-03503)	The PHS did not concur with OIG's recommendations. However, it agreed to analyze its charging systems and correct any major inequities. The CDC reported that it analyzed its computer charges and found them not to be based on actual utilization. However, it stated that the charges included other costs incurred and that it will analyze these costs to ascertain whether there are any actual inequities.
Improve Monitoring of Community Health Center Grantee Financial Controls: The PHS should strengthen its monitoring procedures to improve community health centers' accountability over grant funds. (CIN: A-07-92-00518)	The PHS concurred with OIG's recommendations and indicated that onsite peer reviews began in FY 1994 to strengthen monitoring of community health centers.

OIG Recommendation	Status
Costs Incurred under Acquired Immune Deficiency Syndrome Grants: The PHS should develop a performance measure for acquired immune deficiency syndrome (AIDS) grants based on the extent to which grant funds are used for grant administration versus provision of direct services. (CIN: A-03-93-00351)	The PHS concurred with the intent of the OIG recommendation to develop a performance measure for AIDS grants. The PHS did not agree to modify its current grants award process, but plans to stress the need to closely monitor amounts proposed for administrative costs, particularly in those cases where the amounts proposed are higher than average experience.
ADMINISTRATION FOR CHILDREN AND FAMILIES	
Summarization of Head Start Grantee Audit Findings: The Administration for Children and Families (ACF) should increase training and technical assistance to grantees; strengthen procedures regarding grantee monitoring and use of interest bearing accounts, and refunding interest income; implement the new audit requirement for nonprofit organizations administering Federal programs; develop procedures to detect grantees with interfund transfers; reevaluate procedures to ensure that excess cash is not drawn; and obtain evidence that excess balances are collaterally secured when awarding grants. The ACF should also reemphasize that the nonfederal match is properly documented and met; require evidence of current licensing or compliance with all of the facility standards; and emphasize use of sales tax exemptions and timely deposits of tax refunds. (CIN: A-07-91-00425)	The ACF is in general agreement with the recommendations.
Fees for Child Support Services Provided to Non-Aid to Families with Dependent Children Applicants: The ACF should continue to pursue legislative proposals to: ensure that States charge a reasonable fee when providing child support services to non-Aid to Families with Dependent Children (AFDC) applicants; reduce the large disparity in application fees charged by States; and charge an annual user fee for non-AFDC clients. In lieu of a legislative proposal, ACF could study the feasibility of alternative means for States to recoup from non-AFDC clients the cost of providing services. (CIN: A-06-91-00048)	The ACF submitted legislative proposals in 1991 and 1992 to address this issue. No legislative proposal was included in the President's FY 1996 budget.
Undistributed Child Support Payments: The ACF should remind States to: monitor and expedite the distribution of collected child support payments; place undistributed payments in interest bearing accounts; and report escheated payments and interest as State income. (CIN: A-09-93-00030)	The ACF agreed to participate in a joint effort with OIG to determine the extent of these problems, but disagreed with the need to remind States of ACF's policies and procedures for undistributed collections. The ACF expected considerable alleviation of the undistributed collections as States complete their automated systems.

OIG Recommendation	Status
Wage Withholding of Child Support Payments: The ACF should work with State child support enforcement agencies to ensure standardized court order forms; issue detailed guidance to employers about the legal process for garnishment of wages for child support; and establish an electronic funds transfer system for expediting the payment process. (CIN: A-12-91-00016)	The ACF is working with State agencies regarding standardized court order forms and has implemented the remaining recommendations.
Overpayments of Aid to Families with Dependent Children: The ACF should take steps to improve controls by State agencies in detecting and recovering AFDC overpayments, and obtain information needed to effectively manage State overpayment collection activities. (CIN: A-01-92-02506)	The ACF agreed with OIG's recommendations and is taking corrective action.
On-the-Job-Training Provided Under the Job Opportunities and Basic Skills Program: The ACF should encourage States to establish and implement procedures for determining the success of Job Opportunities and Basic Skills (JOBS) participants and the On-the Job Training program. The ACF should also ensure that the On-the-Job Training and other components of JOBS are being effectively monitored in all States. (CIN: A-05-93-00019)	The ACF agreed with OIG's recommendations and is taking corrective action.
Strengthen Head Start Grantees' Financial Management Systems: The ACF should intensify efforts to assure that Head Start grantees have adequate systems of internal controls; maintain proper accounting records; have systems for assuring program requirements are met; and obtain acceptable independent audits and submit reports in accordance with Federal requirements. The ACF should also take appropriate action when grantees do not meet these requirements. (CIN: A-17-93-00001)	The ACF generally agreed with OIG's recommendations.
Measure Head Start Grantees' Performance: The ACF should establish and implement performance measures and procedures for determining Head Start grantees' compliance with program requirements, and as a basis for establishing uniform ratings and identifying management practices that create high-risk conditions. (CIN: A-04-90-00009)	The ACF agreed with the importance of strengthening performance measurement criteria but disagreed with OIG's conclusions relative to high-risk conditions. The ACF is now completing a major initiative to develop Head Start performance measures designed to assess the quality and effectiveness of the program nationally through stating outcomes for children and families and through program indicators.
Ensure that Head Start Program Attendance Goals and Matching Requirements are Met: The ACF should establish and implement procedures to ensure that center-based Head Start grantees attain the expected attendance goal of 85 percent of funded enrollment. The ACF should also seek a legislative change to require that funding levels be based on current conditions (not historic funding levels) and require current information to support requests for waivers of nonfederal matching requirements. (CIN: A-04-90-00010)	The ACF noted that it is obtaining information from its grantees to improve internal reporting procedures. As far as average daily attendance, ACF states that an average daily attendance of 85 percent is a service goal, not a program requirement of Head Start grantees. The ACF is also reviewing Head Start procedures to grant waivers.

OIG Recommendation	Status
Health and Safety Standards at Child Care Facilities: The ACF should work with States to improve the health and safety practices of child care facilities. In addition to actions ACF is already taking, OIG recommended that ACF provide State agencies with identified best practices including: parental involvement, provider self-appraisals and private/public partnerships. (CIN: A-04-94-00071; CIN: A-07-93-00718; CIN: A-12-92-00044)	The ACF generally concurred with OIG's findings and recommendations, and is taking actions to enhance the health and safety standards of child care facilities.
Improve the Federal Foster Care Program: The OIG provided options for ACF to consider in its efforts to improve its partnership with State and local governments in administering the Federal Foster Care program. The options included streamlining the process; determining whether legislative change is needed; and determining if certain program requirements could be changed to facilitate compliance. (CIN: A-12-93-00022)	The ACF concurred on the issues raised in OIG's report. The ACF has convened two teams whose task is to redesign the titles IV-B and IV-E child welfare reviews. The objectives of the teams are consistent with issues and options described in OIG's report.
Improve Oversight of Audits of Office of Community Service Grantees: The ACF should track Office of Community Services grantees' implementation of recommendations made as a result of single audits, and follow-up with grantees to ensure actions taken were effective. (CIN: A-12-92-00043)	The ACF agreed and will take steps to implement the recommendations within the limitation of current staffing resources.
Colocating Intergenerational Programs: The Administration on Aging (AoA) and ACF should examine whether demonstrated successes in colocating programs and facilities in the private and public sector can be more broadly applied to departmental programs on a voluntary basis. (CIN: A-05-94-00009)	The AoA and ACF generally agreed with OIG's recommendations.
GENERAL OVERSIGHT	
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify the Department of Health and Human Services' (HHS') disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to PHS, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040)	The OS and OASH are in the process of consolidating into one unit. The OASH had taken the lead in this area and has met with headquarters operating division emergency preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved.
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The OASH should issue guidelines to improve disaster planning. The plans of each operating and staff division should spell out lines of communication with each other, and should specify headquarters and regional lines of communication with the Federal Emergency Management Agency. (OEI-09-90-01040)	The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department. The OASH and OS are consolidating.

OIG Recommendation	Status
Ensure that New York Allocates Training Costs to Federal Programs for Actual Number of Attendees: The Department should be more aggressive when approving State plans to ensure that the State (among other actions): allocates future training contracts to programs based on the actual number of participants; maintains documentation which clearly details which programs benefit from future training and, where applicable, allocates training costs to all benefitting programs; and discontinues using third party contributions provided by private contractors to meet its share of training costs. (CIN: A-02-91-02002)	The Department's Division of Cost Allocation (charged with approval of State cost allocation plans) expressed agreement with the findings and recommendations.
Reform the Systems for Determining State and Local Government Administrative/Indirect Costs: The OIG identified a number of options, some of which require legislative action, to facilitate the allocation of administrative/indirect costs to Federal grants and contracts. These include: establishing a block grant to pay administrative/indirect costs, negotiating nonadjustable rates for a predetermined number of years, and assigning the responsibility for negotiating rates for all entities within a State to one Federal agency. (CIN: A-12-92-00014)	The National Performance Review Report included OIG's recommendations. The OMB is working on the development of guidelines to assist States in the charging of administrative/indirect costs to Federal programs.
Revise Hospital 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 OMB Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (CIN: A-01-92-01528)	The Department intends to begin work on revising hospital cost principles when the revisions of the Governmentwide cost principles for universities and State and local governments (OMB Circulars A-21 and A-87, respectively) are finalized by OMB.
Guidelines to Reimburse Educational Institutions and Nonprofit Organizations: The Department should work with OMB to revise applicable cost principles to reflect the change in accounting for post retirement benefit 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 post retirement benefit costs to the amount funded, and agreed that similar provisions should be incorporated in future modifications of circulars applicable to educational institutions and nonprofit organizations (OMB Circulars A-21 and A-122, respectively). In the interim, the Department has issued instructions to negotiators.
Implement Random Moment Sampling Systems and Other Time Studies: The Department, in conjunction with OMB, should issue definitive, authoritative guidelines for States adopting random moment time studies. (CIN: A-07-93-00645)	The Department agreed with OIG's conclusion and is working with OMB in the development of guidelines related to the determination of administrative costs, including standards for the use of random moment time studies.

APPENDIX D

Notes to Tables I and II

Table I

[1] The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of $57.2 million.

[2] Included in the reports issued during the period are management decisions to disallow $28,128 in costs attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

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

CIN: A-09-93-00039	CA Dept of General Services - Internal Service: Previously disallowed working capital reserve was allowed which reduced the amount to be refunded by $4,599,000.
CIN: A-09-92-00119	ISF Health and Welfare Data Center: Additional documentation was provided to reduce the amount of refund requested by the Federal Government by $3,204,000.
CIN: A-06-95-31840	State of Texas: Disallowed funds were reimbursed in prior fiscal year of $960,593.

Not detailed are additional revisions to previously reported management decisions totaling $834,768.

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

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

CIN: A-02-92-01021	Medicare Credit Balance - Roll Up, April 1994, $14,900,000
CIN: A-03-91-00552	Independent Living Program - National, March 1993, $6,529,545 (Related recommendation of $10,161,742 outstanding on Table II)
CIN: A-07-92-00578	BC/BS of Texas Inc - Unfunded Pension Costs, October 1992, $6,244,637
CIN: A-03-89-00046	MD BC/BS Administrative Cost, FY 85-88, September 1991, $5,996,278
CIN: A-05-93-00054	Ill-Associated Ins Group- Contract Audit, October 1993, $3,355,560
CIN: A-05-93-00013	MI BC/BS - Contract Medicare Audit, April 1993, $3,0120,916
CIN: A-07-93-00633	Pension Segmentation - AETNA Life Ins Co, October 1993, $3,011,376
CIN: A-07-92-00585	Pension Segmentation BC/BS of CA., January 1994, $2,973,504
CIN: A-07-92-00579	BC/BS of Michigan Inc- Unfunded Pension Costs, October 1992, $2,535,698
CIN: A-05-92-00026	Assoc Ins Co.- Medicare Administrative, February 1992, $2,530,409
CIN: A-03-91-00030	Outpatient Credit Balances, July 1994, $2,504,600
CIN: A-02-91-01006	BC/BS of Western NY Medicare Administrative Costs, August 1991, $2,379,239
CIN: A-03-90-02003	BC of Western PA Administrative Cost FY 86-89, August 1993, $2,218,528
CIN: A-02-93-02001	Manpower Demonstration Res Corp, October 1994, $2,024,444

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

CIN: A-03-90-00051 MD BC/BS Administrative Cost, August 1991, $1,438,414

CIN: A-05-93-00057 MI BC/BS, July 1993, $1,409,954

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

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

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

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

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

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

CIN: A-03-93-00025 PBS Excess Payments/Lab Profile Tests/Medicare, December 1994, $953,377

CIN: A-05-92-00060 Contractor Audit- BC/BS Administrative, February 1993, $879,609

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

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

CIN: A-02-94-27564 State of New Jersey, June 1994, $693,146

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

CIN: A-10-95-00001 KCMBS Administrative Cost Audit, January 1995, $620,138

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

CIN: A-04-93-01069 Monitoring Administrative Cost Audit - Medicare Part A, July 1994, $590,844

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

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

CIN: A-06-92-00102 JOBS: Federal Financial Participation, October 1993, $438,996 (Related recommendation of $14,999 outstanding on Table II)

CIN: A-06-93-00042 BC/BS TX Administrative Cost - Medicare, January 1993, $434,134

CIN: A-01-94-00509 Mass BC/BS Administrative Cost Part A, September 1994, $355,414

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

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

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

CIN: A-09-92-00105 ISF - TEAL Date Center, August 1994, $265,000

CIN: A-05-93-00025 Ohio Dept Human Services - Follow-up on State IG Report, July 1993, $251,013

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

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

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

CIN: A-10-94-29857 University of Washington, January 1995, $205,227

CIN: A-05-93-24819	Economic Opportunity Committee of St.Clair Co., August 1993, $188,691
CIN: A-10-92-00005	WPS Administrative Cost, February 1992, $179,891
CIN: A-05-94-28643	Community Action Against Poverty of Greater Indian, January 1994, $176,159
CIN: A-05-94-29229	West Central Wisconsin Community Action Agency Inc., March 1994, $167,977
CIN: A-03-94-26611	State of Delaware, December 1993, $163,100
CIN: A-01-94-00521	Audit of Non PPS A/G and Capital Costs NE Rehab, January 1995, $160,170
CIN: A-09-92-06850	Santa Ysabel Band of Mission Indians, September 1992, $151,081
CIN: A-09-94-31413	Asian American Health Forum Inc, D/B/A Asian and PAC, August 1994, $149,378
CIN: A-06-94-31156	State of Louisiana, August 1994, $135,933
CIN: A-05-92-00048	WI Physician Services, Pension - Medicare vs. ERISA, October 1992, $130,577 (Related recommendation of $2,068,964 outstanding on Table II)
CIN: A-09-92-00093	BC Arizona Administrative Cost, August 1992, $129,518
CIN: A-07-93-00709	BC/BS of Conn. - Pension Segmentation Audit, April 1994, $119,472
CIN: A-04-93-20785	State of Florida, June 1993, $103,486
CIN: A-05-94-31408	Tri County Community Action Commission Inc., July 1994, $98,110
CIN: A-01-92-19975	State of Massachusetts, September 1992, $96,703
CIN: A-08-95-33784	Carbon Co Child Development Program, January 1995, $94,090
CIN: A-04-93-000594	Refugee Social Services and Targeted Assistance - Fl, September 1994, $84,676
CIN: A-05-95-33679	Family and Social Services Administration, February 1995, $84,130
CIN: A-10-93-00017	Medicaid Third Party Liability - Washington State, February 1995, $75,395
CIN: A-05-95-33723	Economic Opportunity Committee of St. Clair Co., January 1995, $74,746
CIN: A-02-93-02518	Biederman Kelly and Shafer, February 1994, $72,883
CIN: A-03-91-02002	Delaware BC Administrative Cost, October 1991, $66,858
CIN: A-04-94-33305	Clark Atlanta Univ., September 1994, $65,848
CIN: A-06-94-27816	South Plains Health Provider Organization Inc., March 1994, $60,900
CIN: A-09-95-35367	KE OLA MAMO, March 1995, $59,733
CIN: A-06-92-19887	Central Tribes of the Shawnee Area Inc., July 1992, $57,944
CIN: A-10-95-34230	Grant County Community Action Council, November 1994, $55,004
CIN: A-09-95-35323	Community Health Centers of Southern Nevada Inc., March 1995, $54,078
CIN: A-05-94-31614	Lake-Geauga United Head Start Inc., July 1994, $53,354
CIN: A-04-95-32994	United South and Eastern Tribes Inc., January 1995, $53,074
CIN: A-01-95-35567	Vermont Protection and Advocacy Inc., February 1995, $50,936
CIN: A-03-93-03306	Survey Research Assoc., December 1993, $48,779

CIN: A-05-95-31906 West Central Illinois Legal Assistance, November 1994, $44,709

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

CIN: A-03-92-00351 Frederick Cancer Research and Development Center, April 1993, $35,531

CIN: A-04-93-20785 State of Florida, June 1993, $33,511

CIN: A-09-93-00106 Review of RSS and TAP Grants - CDSS, February 1995, $31,001

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

CIN: A-05-95-33224 Community Action of Greater Indianapolis, November 1994, $32,116

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

CIN: A-03-95-35277 Appalachian Regional Head Start Inc., March 1995, $30,188

CIN: A-04-95-35142 Montgomery Community Action Committee Inc., February 1995, $29,665

CIN: A-06-92-20334 Pueblo of Jemez, September 1992, $20,156

CIN: A-03-93-22091 Pennsylvania State Univ., September 1993, $19,878

CIN: A-02-93-24129 Council Of Jewish Federations,Inc., May 1993, $19,152

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

CIN: A-04-93-20961 Commonwealth of Kentucky, January 1993, $15,000

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

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

CIN: A-10-93-26035 State of Washington, September 1993, $13,575

CIN: A-10-93-22136 Yomba Shoshone Tribe, November 1992, $12,832

CIN: A-02-94-31463 Newburgh Comm Action Committee, September 1994, $12,513

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

CIN: A-09-93-07000 San Juan Southern Paiute Tribe, March 1992, $10,433

CIN: A-05-94-31542 Council for Economic Opportunities in Greater Clev., June 1994, $9,374

CIN: A-04-94-27087 State of Tennessee, June 1994, $9,139

CIN: A-05-94-32755 Community Care in Union County Inc., September 1994, $8,308

CIN: A-03-93-21785 DC Dept of Human Services, October 1993, $8,166

CIN: A-09-95-33652 Hawaii Dept. of Health, December 1994, $7,613

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

CIN: A-04-94-00079 Head Start-Financial Management Prac of TCRC Child Care, October 1994, $7,241

CIN: A-03-95-35038 Terrific Inc., February 1995, $7,216

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

CIN: A-09-95-33264 Commonwealth of Northern Mariana Islands, November 1994, $6,415

CIN: A-01-93-24739 State of New Hampshire, August 1993, $5,758

CIN: A-06-94-33301 Guadalupe Economic Services Corp, January 1995, $5,416

CIN: A-01-94-27881 State of Maine, June 1994, $5,235

CIN: A-04-95-35229 Blue Ridge Community Action Inc., March 1995, $5,171

CIN: A-09-95-33283 Commonwealth of the Northern Mariana Islands, November 1995, $5,171

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

CIN: A-04-95-34750 Hemophilia of Georgia Inc., January 1995, $4,779

CIN: A-06-95-36430 Muskogee County Community Action Foundation Inc., March 1995, $4,502

CIN: A-01-95-32620 State of Connecticut, January 1995, $4,070

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

CIN: A-07-94-25955 State of Kansas, December 1993, $2,783

CIN: A-08-94-30703 Mountain Plains Youth Services Coalition, August 1994, $2,745

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

CIN: A-09-95-33404 Hawaii Dept.of Human Services, December 1994, $2,103

B. Reports in litigation:

CIN: A-09-91-00155 Blackburn Care Home, November 1991, $1,772,944 (Related recommendation of $662,370 outstanding on Table II)

CIN: A-06-92-00017 IHS Creek Contract Closeout, May 1992, $468,217

CIN: A-09-93-00091 Walker McDonald - Indirect Cost, October 1992, $68,663

CIN: A-03-92-00033 BC of West VA Termination, November 1992, $25,200

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

CIN: A-05-94-30273 Central Ill Economic Development Corp., May 1994, $12,518

CIN: A-03-91-02004 W VA BC Administrative Cost FY 85/90 and Termination Cost, November 1992, $7,556

C. Reports that have subsequently been resolved:

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

CIN: A-03-93-21104 State of Pennsylvania, June 1993, $150,000

CIN: A-06-93-24846 Mescalero Apache Tribe, September 1993, $3,565

Table II

[1] The opening balance was adjusted to reflect a downward adjustment of $564.8 million.

[2] Management decisions have not been made within 6 months of issuance on seven reports. Discussions with management are ongoing and it is expected that the following reports will be resolved during the next semiannual reporting period:

CIN: A-01-94-04002 Graduate Student Compensation at Selected Universities, October 1994, $5,700,000

CIN: A-06-91-00089 Audit of CN B Accts to Det Status of IHS Cash OH, April 1992, $445,890

CIN: A-02-95-34946	City of Caguas Puerto Rico, March 1995, $64,206
CIN: A-04-95-35393	Four Square Community Action Inc., February 1995, $31,500
CIN: A-05-95-34659	Northwest Michigan Human Services Agency Inc., January 1995, $12,441
CIN: A-09-94-27864	Solano County Economic Opportunity Council Inc., March 1994, $12,178
CIN: A-05-95-34400	Northwestern Ill Community Action Agency, December 1994, $4,449

APPENDIX E

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

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

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	62
Section 5(a)(1)	Significant problems, abuses and deficiencies	throughout
Section 5(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	throughout
Section 5(a)(3)	Prior significant recommendations on which corrective action has not been completed	appendices B and C
Section 5(a)(4)	Matters referred to prosecutive authorities	64
Section 5(a)(5)	Summary of instances where information was refused	none
Section 5(a)(6)	List of audit reports	under separate cover
Section 5(a)(7)	Summary of significant reports	throughout
Section 5(a)(8)	Statistical table I - reports with questioned costs	60
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	61
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none

APPENDIX F

Performance Measures

In OIG's opinion, the following audits, inspections and investigations finalized during this semiannual period offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals.

APPENDIX G

Audits, Inspections and Investigations Related to Operation Restore Trust

The following audits, inspections and investigations finalized during this semiannual period relate to Operation Restore Trust. This multidisciplinary Federal and State approach to preventing and detecting fraud in home health agencies, nursing homes and durable medical equipment suppliers is discussed in Chapter III. These report and case summaries are labeled with the symbol  in the text.

ACRONYMS

ACF	Administration for Children and Families
AFDC	Aid to Families with Dependent Children
AHEC	Area Health Education Center
AIDS	acquired immune deficiency syndrome
ALJ	administrative law judge
AoA	Administration on Aging
ASC	ambulatory surgical center
ASMB	Assistant Secretary for Management and Budget
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control and Prevention
CFO	Chief Financial Officer
CLIA	Clinical Laboratory Improvement Amendments
CMP	civil monetary penalty
CSE	child support enforcement
DME	durable medical equipment
DRG	diagnosis-related group
DUR	drug use review
EGHP	employer group health policy
EOMB	explanation of Medicare benefits
ESRD	end stage renal disease
FDA	Food and Drug Administration
FFP	Federal financial participation
FI	fiscal intermediary
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GME	graduate medical education
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHA	home health agency
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IME	indirect medical education
JOBS	Job Opportunity and Basic Skills
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health
OASH	Office of the Assistant Secretary for Health
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
ORR	Office of Refugee Resettlement
ORT	Operation Restore Trust
PFCRA	Program Fraud Civil Remedies Act
PHS	Public Health Service
PPS	prospective payment system
SNF	skilled nursing facility
SSA	Social Security Administration
VFC	Vaccines for Children

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 98-502	Single Audit Act of 1984
P.L. 99-499	Superfund Amendments and Reauthorization Act of 1986
P.L. 100-504	Inspector General Act Amendments of 1988
P.L. 101-121	Governmentwide Restrictions on Lobbying
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

Office of Management and Budget Circulars:

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

General Accounting Office "Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

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

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

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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