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Message from the Inspector General

Recently sworn in as the Inspector General of an office known for the dedication of its employees and the success of its endeavors, I am honored to have this opportunity to serve as a member of the Department of Health and Human Services team.

I am especially proud of the work of this office during FY 2001 and pleased to announce record breaking accomplishments. This year OIG has achieved a savings of over \$18 billion, the greatest ever savings to the tax payer. We have achieved the most significant health care settlement in the history of our organization, totaling over \$800 million, and recorded \$1.5 billion in investigative receivables, the highest figure to date. In addition, we excluded 3,756 individuals and entities from participation in the Federal health care programs, a greater number than in any prior fiscal year.

As we face the challenge of maintaining this level of success, it is my goal to work with the service provider community by generating information, advice and compliance guidance to ensure their successful participation in HHS programs. We will rededicate our efforts to provide the best service possible to our beneficiaries and strengthen our efforts to prevent and respond to intentional fraud or abuse of our programs.

I look forward to working with Secretary Thompson, his senior Department officials and members of Congress so that we can continue meeting the needs of our program beneficiaries and the service provider community—all the while anticipating and preparing for the needs of the future. Through our joint efforts, HHS programs can work more effectively, at less cost, and with reduced risk to fraud and abuse.

Janet Rehnquist
Inspector General

Highlights

Statistical Accomplishments

For Fiscal Year (FY) 2001, OIG reported savings of \$18.011 billion comprised of \$16.1 billion in implemented recommendations and other actions to put funds to better use, \$411 million in audit disallowances and \$1.5 billion in investigative receivables. (Details pp. 61, 62, 66, and Appendix A.)

Also for FY 2001, OIG reported exclusions of 3,756 individuals and entities for fraud or abuse of the Federal health care programs and/or their beneficiaries, 423 convictions of individuals or entities that engaged in crimes against departmental programs, and 417 civil actions. (Details pp. 21 and 66.)

Significant Investigative Results

- HCA-The Healthcare Company, formerly Columbia/HCA Healthcare Corporation, paid over \$800 million to the Federal Government and several States to resolve its civil liability related to five areas of Medicare and Medicaid fraud. (Details p. 13.)
- Quorum Health Group, Inc., the owner of several acute care hospitals, agreed to pay the Federal Government \$77.5 million. The settlement resolved allegations that the provider engaged in certain improper cost reporting practices to Medicare. (Details p. 13.)

Medicaid Enhanced Payments

Focusing on States' exploitation of Medicaid "upper payment limit" regulations governing enhanced payments to public providers, OIG concluded that some States' use of intergovernmental transfers was a financing mechanism designed to maximize Federal Medicaid reimbursement, thus effectively avoiding the Federal and State matching requirements. Revised regulations from the Centers for Medicare and Medicaid Services (CMS), which are being phased in, will help to control—but not eliminate—the amount of Federal dollars available to States as enhanced payments. The CMS estimates that the revisions will save \$55 billion in Federal Medicaid funds over the next 10 years. (Details pp. 34-37.)

Quality of Care

During this period, OIG reported on several quality of care issues. Notable among them are the following:

- Through joint investigation and negotiation by multiple Federal and State agencies, Vencor, Inc., one of the Nation's largest operators of nursing homes and long term hospital services, agreed to pay the Government a total of \$219 million. The company also agreed to a comprehensive corporate integrity agreement under which the company must implement a plan designed to improve the quality of care in its facilities. (Details p. 4.)
- Evaluating the safety of dietary supplements, OIG found that since the FDA does not have the authority to require premarket approval of dietary supplements, it must rely on a voluntary adverse event reporting system to identify safety problems. The OIG found that the system detects relatively few adverse events, and the FDA often lacks information necessary to analyze the problems effectively. (Details p. 43.)
- The Orphan Drug Act of 1983 was designed to stimulate the development of drugs for rare diseases, and OIG found that the program is working as intended—products are generally accessible to patients; companies report excellent relationships with FDA; and no regulatory or legislative changes are needed at this time. (Details p. 42.)

Prescription Drugs

The OIG works to reduce Medicaid costs for covered prescription drugs. For example, OIG found that:

- States could save as much as \$1.08 billion if reimbursement for the top 200 brand-name drugs were based on actual pharmacy acquisition costs. (Details p. 33.)
- Medicaid lost drug rebates totaling \$80.7 million because some drug manufacturers excluded sales to certain health maintenance organizations from their “best price” determinations. (Details p. 32.)
- Medicaid could have saved \$140 million in Federal and State funds if States had purchased 16 HIV/AIDS antiretroviral drugs at the ceiling prices used by other Federal discount drug programs. (Details p. 34.)

The OIG also works to deter the improper use of drugs and the danger associated with illegal distribution of often highly addictive medications.

- Working jointly with the Drug Enforcement Administration and State and local authorities, OIG investigated illegal schemes—often involving beneficiaries, physicians, and other individuals who defrauded the Medicaid program—to obtain, use, distribute and sell prescription drugs, such as Oxycontin. (Details p. 31.)

Child Support Enforcement

The OIG continues to make the investigation of those parents who fail to pay court-ordered child support a priority. To address child support enforcement in an efficient and expeditious manner, OIG and the Office of Child Support Enforcement (OCSE) initiated “Project Save Our Children”—six multiagency, multijurisdictional investigative task forces. The OIG works with the OCSE, FBI, U.S. Marshals Service and other Federal, State and local partners to carry out its enforcement work. (Details p. 50.)

Provider Community Input

As part of an on-going effort to gather information on corporate integrity agreements, OIG recently held a roundtable discussion to afford providers and other entities an opportunity to share their unique insight into issues surrounding the implementation and maintenance of compliance programs that are subject to integrity agreements. The OIG also conducted a survey regarding the same issues. The results of these endeavors will help OIG further develop corporate integrity agreement requirements. (Details p. 27.)

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. The OIG has identified some items throughout this report as **performance measures** by placing the symbols ❖❖ following the item. 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.

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Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) administers the Medicare and Medicaid programs. Financed by the Federal Hospital Insurance Trust Fund, Medicare Part A provides hospital and other institutional insurance for persons aged 65 or older and for certain disabled persons. Medicare Part B (Supplementary Medical Insurance) is an optional program which covers most of the costs of medically necessary physician and other services and is financed by participants and general revenues.

The Medicaid program provides grants to States for medical care for qualifying low-income people. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average. The State Children's Health Insurance Program (SCHIP), created under the new title XXI of the Social Security Act, expands health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage.

The Office of Inspector General (OIG) continues to devote significant resources to investigating and monitoring the Medicare and Medicaid programs. These activities 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. In addition, these efforts have often led to criminal, civil and/or administrative actions against perpetrators of fraud and abuse.

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

PAYMENTS FOR MENTAL HEALTH SERVICES ♦♦

Medicare allowed \$185 million in 1998 for outpatient mental health services that were medically unnecessary, billed incorrectly, rendered by unqualified providers, and that were undocumented or poorly documented. The OIG identified problems most particularly with psychotherapy and psychological testing. In addition, OIG found that while some beneficiaries received excessive therapy services, others did not receive needed medication management services.

The OIG recommended that CMS identify problematic mental health services for pre-payment edits or post-payment medical review, promote provider awareness of documentation and medical necessity requirements for Part B mental health services, develop a specific and comprehensive listing of psychological assessments that can be correctly billed under psychological testing code 96100, and require carriers to initiate recovery of payments for the inappropriate outpatient mental health services identified in this report. The CMS concurred. (OEI-03-99-00130)

THERAPY FOR NURSING HOME PATIENTS

Medicare allowed, in error, approximately \$48.5 million for medically unnecessary (\$28.7 million), undocumented (\$12.2 million), and inadequately documented therapy (\$7.6 million) during the first 6 months of 1999, according to this study. This amount represents an overall error rate of 24.7 percent, and assuming that figures for the second half of 1999 were comparable to those for the first 6 months, the inappropriate allowances totaled \$97 million for the year.

The CMS concurred with OIG recommendations in this report regarding provider education, focused medical review, and reimbursement systems. (OEI-09-99-00560)

IMPROPER PAYMENTS FOR SKILLED NURSING FACILITY SERVICES

This report pointed out that Medicare is paying twice for the same service—once to a skilled nursing facility (SNF) under the Medicare Part A prospective payment system and again to an outside supplier under Medicare Part B. Under current law, a SNF is reimbursed a prospective payment for covered services rendered to its Medicare beneficiaries in a Part A stay. Outside providers and suppliers must bill the SNF (not Medicare Part B) for most services and supplies provided

and the SNF bills Medicare as required under the consolidated billing provision. In 1999, a total of \$47.6 million in potentially improper payments to Part B providers and suppliers occurred because edits were not established to detect and prevent supplier claims noncompliant with the consolidated billing provision. The following services were found to be most vulnerable:

<i>Type of Service</i>	<i>Potentially Improper Nationwide Payments (in millions)</i>
Outpatient Hospital	\$15.8
Ambulance	12.8
Laboratory	9.4
Radiology	5.9
Durable Medical Equipment	<u>3.7</u>
Total	\$47.6

Among other things, OIG recommended recovery of the improper payments and the establishment of payment edits within the Common Working File and the Medicare contractors' claims processing systems to ensure that outside providers and suppliers comply with the consolidated billing provision. The CMS concurred with these recommendations. (A-01-00-00538)

DURABLE MEDICAL EQUIPMENT IN SKILLED NURSING FACILITIES

Federal regulations prohibit Medicare Part B payments for durable medical equipment (DME) on behalf of a beneficiary who is in a qualifying Medicare Part A skilled nursing facility stay for an entire month. The OIG found, however, that the four DME regional carriers inappropriately paid an estimated \$35 million for such services from 1996 through 1998. Weaknesses in the carriers' claim processing systems were the primary cause of the improper payments.

In addition to recommending the recovery of the overpayments, OIG recommended that CMS work with the regional carriers in implementing edits to prevent improper Medicare Part B DME payments in the future. The CMS generally concurred. (A-01-00-00509)

TRENDS IN RESOURCE UTILIZATION GROUP ASSIGNMENT ♦♦♦

There were no major changes in the seven resource utilization group (RUG) assignments—special rehabilitation, extensive care, special care, clinically

complex, cognitively impaired, behavior problems, and reduced physical functions—since implementation of the prospective payment system in January 1999. Only small shifts have occurred in the proportion of residents assigned to RUGs within the rehabilitation category, which accounts for approximately 78 percent of Medicare resident assignments at admission. The OIG found no substantial changes in the characteristics of Medicare beneficiaries admitted to skilled nursing facilities including age, sex, race, or reason for Medicare eligibility since January 1999. (OEI-02-01-00280)

FRAUD INVOLVING NURSING HOMES

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

- The Government entered into a settlement agreement with Vencor, Inc., (Vencor), one of the Nation's largest operators of nursing homes and long-term hospital services, following a joint OIG and Department of Justice investigation of allegations of billing abuses and poor quality of care. The company agreed to pay the Government a total of \$219 million, including \$104.5 million to resolve civil claims of submitting improper claims to Medicare, Medicaid and TRICARE. Part of the agreement is also based on Vencor's failure to provide adequate health care at long term care facilities. In addition, the company agreed to enter into a 5-year corporate integrity agreement that requires Vencor to adopt a comprehensive quality assurance infrastructure at the corporate, regional and facility levels. The corporate integrity agreement also requires the company to engage an independent monitor approved by OIG, to provide an ongoing assessment of the company's quality assurance infrastructure, in order to identify and correct system deficiencies.

Additional provisions in the corporate integrity agreement require Vencor to conduct annual training of its employees, continue to operate an internal compliance helpline, enhance the company's current system of internal financial controls in order to promote compliance with Federal health care program requirements on billing and related financial issues, and retain an independent review organization to evaluate the integrity and effectiveness of the company's internal systems and report annually its findings to OIG. As a result of the company's filing for protection from

its creditors under Chapter 11 of the U.S. Bankruptcy Code, the terms of the settlement agreement were required to be approved by the Bankruptcy Court prior to becoming effective.

- National HealthCare Corporation (National HealthCare) and its related entities agreed to enter into a \$27 million civil settlement with the Federal Government and a 5-year corporate integrity agreement. The settlement resolves the provider's civil False Claims Act liability for the submission of false claims to Medicare from 1991 to 1996 in connection with certain nursing and restorative therapy services. The settlement also resolves certain pending administrative matters, and the settlement figure includes offset amounts relating to those matters. In terms of false claims, National HealthCare allegedly submitted, or caused to be submitted, improper cost reports for its nursing facilities around the country. The cost reports contained improper allocations of nursing labor costs between the Medicare certified units and the non-certified units and improper allocations of therapy costs.
- As part of a settlement agreement with the Government, the principal operator/co-owner of nursing homes and other health care businesses in Pennsylvania agreed to a 5-year exclusion for his role in causing two of his nursing facilities to furnish services to patients of a quality that failed to meet professionally recognized standards of health care. The settlement represented the first time OIG has excluded the owner of a health care facility based on the owner's responsibility for poor quality of care at the facility. An OIG investigation found that two nursing facilities under the owner's control exhibited a pattern and practice of failing to meet professional standards with respect to the physical, medical and personal care of their residents. Under the terms of the settlement agreement, the owner also agreed to pay \$8,250 to resolve a pending administrative appeal of civil monetary penalties that the CMS imposed against one of his nursing facilities for deficient care practices.

FLORIDA HOME HEALTH SERVICES

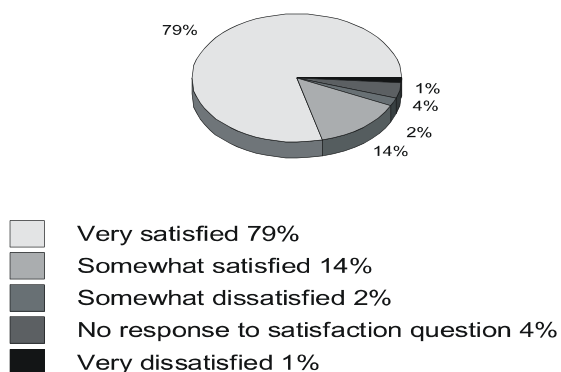
Based on a statistical sample, OIG found that at least \$38.3 million of \$649.8 million in Florida home health agency claims for the 9 months ending September 30, 1998, were unallowable or highly questionable. The majority of the unallowable claims were, in OIG's opinion, the result of inadequate physician involvement. Physicians did not always review or actively participate in developing the plans of care they signed.

Among other things, OIG recommended that CMS revise Medicare regulations to require certifying physicians to examine patients before ordering

home health care services and to see the patient at least once every 60 days. Believing that the new prospective payment system for home health services will significantly reduce the incentive to provide unnecessary services, CMS did not concur with this recommendation. However, OIG identified the lack of physician involvement as a longstanding problem significantly contributing to improper claims and payments and continues to emphasize the need for corrective action. (A-04-99-01195)

EXPERIENCE WITH HOME HEALTH CARE ♦♦

Medicare Beneficiary Satisfaction with Home Health Care



In this study, OIG found that 93 percent of those beneficiaries who began a new episode of Medicare home health care in January 2001 were satisfied with their care. Most beneficiaries reported positive relationships with their home health caregivers. Beneficiaries believed they were treated well and said they were not concerned for their safety. Satisfaction levels were high among all groups of recipients and did not

differ among beneficiaries with different diagnoses nor between those living in urban and rural locations. Just 4 percent expressed concern about the quality or adequacy of their care, such as missed appointments. Also, only 13 of the 501 respondents reported having difficulty gaining access to care. About 20 percent of beneficiaries believed they were not receiving all of the services they need; however, they may not be eligible for such services. (OEI-02-00-00560)

HOME CARE AFTER HOSPITAL DISCHARGE

The findings of this follow-up study of the effects of the prospective payment system on access to home health care for Medicare beneficiaries who are discharged from the hospital were consistent with those in our two previous studies.

The OIG found that virtually all Medicare beneficiaries discharged from the hospital had access to home health care under the prospective payment system, even though the number of home health agencies nationwide has decreased. However, some patients with certain medical conditions or service needs experienced delays, and some discharge planners attributed these delays to the prospective payment system. The results of this report demonstrated that the new prospective

payment system is not preventing access to home health benefits for Medicare beneficiaries who need it upon discharge from a hospital. (OEI-02-01-00180)

HOME HEALTH AGENCY FRAUD

Home health agencies (HHAs) represent an important segment of the health care industry because they allow many patients to remain in their own homes at less expense than might be incurred at a hospital or other institution. The OIG identified a number of fraudulent arrangements by which home health care providers, medical professionals and others associated with the operation of HHAs inappropriately billed Medicare and Medicaid, among them the following:

- Northeast Georgia Health System, Inc., and its related entities paid the Government \$6.4 million to settle a qui tam suit alleging False Claims Act violations. The related entities included Northeast Georgia Medical Center, Inc., (NGMC) and Northeast Georgia Health Resources, Inc., doing business as Hand-in-Hand Home Health (Hand-in-Hand). From 1994 through September 2000, Hand-in-Hand improperly submitted claims to Medicare and Medicaid for home health care visits to patients who were not homebound, did not require skilled care, or otherwise lacked the medical necessity for such care. Although Hand-in-Hand was sold in October 2000, OIG negotiated a 5-year corporate integrity agreement focused particularly on NGMC, owner and operator of two hospital campuses which treat Federal health care program beneficiaries.
- The owner of an HHA and his former wife agreed to pay the Government \$1.9 million to settle allegations of submitting false claims to Medicare. The scheme involved the utilization of Medicare-paid registered nurses and home health aides to treat individuals who had private insurance; the HHA would then bill both Medicare and private insurance for the same visit. Furthermore, the HHA's management staff took vacation trips disguised as legitimate Medicare sponsored training. The trips were later included as allowable costs on the cost report submitted to Medicare. Both the HHA's owner and former chief financial officer were also previously sentenced for their roles in this scheme.
- A Wisconsin woman was sentenced, for health care fraud, to 4 years probation and required to pay \$13,784 in restitution and a \$10,000 fine. One of 17 individuals involved in a scheme devised by the HHA's owners to defraud Medicare and Medicaid by billing for nonrendered and medically unnecessary home health services, she billed her services during times when she was actually working and traveling with a full-time job she held outside the HHA.

OUTPATIENT REHABILITATION FACILITY PROGRAM

This review assessed the allowability of costs claimed in a company's FY 1998 Medicare cost report for its outpatient rehabilitation facilities in Texas. The OIG questioned approximately \$18.4 million of the \$28.6 million in allocable expenses reported, primarily because they were not supported by documentation. In addition, certain clinic extension sites were not certified to provide outpatient rehabilitation services to Medicare beneficiaries.

The OIG recommended that appropriate repayment be made. The parent company currently responsible for these Medicare liabilities did not concur. (A-06-00-00051)

EXCESSIVE PAYMENTS FOR OUTPATIENT SERVICES

This report pointed out fundamental flaws in fiscal intermediaries' systems for paying outpatient claims to institutional providers. The OIG found that clerical billing errors by these providers generated \$12 million in Medicare overpayments. For example, overpayments of \$11.1 million resulted from providers' entering dates of service in the "Units of Service" field on the claim form. In these cases, the fiscal intermediary had inadvertently turned off edits designed to detect such errors. In other instances, overpayments were not precluded because edits for total charges were established at unreasonably high amounts. Although providers returned the overpayments in these instances, the Medicare trust fund lost as much as \$106,000 in interest because the overpayments remained outstanding for various periods ranging from 10 to 431 days.

To help ensure detection of such errors, OIG recommended that CMS implement edits in the Common Working File to reject potentially excessive Medicare claims for prepayment review. The OIG also recommended that CMS identify and collect any additional overpayments made on other outpatient claims that have the potential for excessive payments and stress the importance of standard Medicare claims processing system edits to the fiscal intermediaries. The CMS concurred. (A-01-00-00502)

NONPHYSICIAN OUTPATIENT SERVICE PAYMENTS

Under the inpatient prospective payment system, Medicare reimburses hospitals a predetermined amount for services furnished to Medicare beneficiaries

based on the illness and its classification under a diagnosis-related group (DRG). This amount covers nonphysician outpatient services rendered on the day of admission, during the inpatient stay, and up to 3 days before the day of admission. A duplicate payment occurs when such nonphysician outpatient services are paid separately. Five previous reports identified significant overpayments to prospective payment system hospitals as a result of noncompliance with this DRG payment window.

This follow-up report points out that duplicate payments have decreased significantly. The OIG identified approximately \$5 million, nationwide, in potentially duplicate payments during 1997 and 1998, down from the \$27 million identified in the 3-year period covered by OIG's previous report. The OIG attributed this significant reduction to hospitals' compliance with OIG and DOJ settlement agreements. Recommendations called for CMS to ensure that systems edits are adequate to detect and prevent these duplicate payments, encourage fiscal intermediaries to continue educating providers on the DRG payment window, and require intermediaries to recover the \$5 million in potential overpayments. The CMS concurred. (A-01-00-00506)

OUTPATIENT PSYCHIATRIC SERVICES

A significant amount of outpatient psychiatric service claims submitted by a hospital in California did not meet Medicare criteria for reimbursement, according to this OIG report. Specifically, many charges either were unreasonable or unnecessary for the treatment of the patient's condition or were not adequately supported by the underlying medical records. Based on a statistical sample, OIG estimates that for calendar year 1998, over \$560,000 in outpatient psychiatric charges submitted by the hospital were unallowable.

In addition to recommending a financial adjustment, OIG proposed that the hospital strengthen its procedures to ensure that charges for outpatient psychiatric services are covered and properly documented in accordance with Medicare requirements. The hospital did not concur. (A-09-00-00067)

PERIODIC INTERIM PAYMENTS TO HOSPITALS

As noted in this report, a fiscal intermediary did not properly quantify periodic interim Medicare payments to some acute care prospective payment system hospitals. During the cost report settlement process, the intermediary omitted outlier payments when calculating total interim payments to five of the

eight hospitals that OIG reviewed. These hospitals were overpaid a total of \$637,000 as a result. Subsequent work by the intermediary identified additional net overpayments totaling \$10.7 million. Further, other intermediaries could have omitted outliers in determining total payments. During 1998, over 1,000 hospitals nationwide received periodic interim payments.

The OIG recommended that CMS monitor the intermediary's corrective actions, including collection of the overpayments, and work with OIG to determine whether other intermediaries correctly calculated interim payments during cost report settlements. The CMS concurred. (A-07-01-02616)

OVERPAYMENTS FOR 1-DAY HOSPITAL STAYS

In reviewing a CMS regional office's efforts to identify and recover overpayments for 1-day inpatient hospital stays in Pennsylvania, OIG found that the methodology for identifying claims produced good results—of 1,514 claims reviewed, 394 (26 percent) were found to be in error, resulting in overpayments totaling about \$4.8 million. The OIG pointed out that the fiscal intermediaries had not collected \$1.65 million of these overpayments primarily because the overpayment adjustments were made after the related hospital cost report was settled. Based on OIG findings, the intermediaries are in the process of collecting the \$1.65 million.

The OIG recommended, among other things, that CMS monitor the intermediaries' collection efforts to ensure that the overpayments are recovered and direct them to implement procedures to ensure the collection of future overpayment adjustments made after cost reports are settled. The CMS generally concurred. (A-03-00-00007)

HOSPITAL CLOSURES ❖❖

Findings in OIG's thirteenth annual report on this subject were consistent with those of previous years. In 1999, 64 general, short-term, acute care hospitals closed—1.3 percent of all hospitals. Twenty-one more hospitals closed in 1999 than closed in 1998. The additional closings were offset by 22 hospitals that opened or reopened in 1999. Eight more hospitals opened or reopened in 1999 than did in 1998. The hospitals that closed in 1999 were few in number and small in size. They had low occupancy rates and few patients were affected. The average daily patient load in the year prior to closure was 13 in rural hospitals and 40 in urban hospitals. Although residents of a few communities had to travel greater distances for hospital care, most had emergency and inpatient medical care available

within 10 miles of a closed hospital. After closure, 50 percent of hospitals were being used for other health-related services such as outpatient and long-term care facilities. (OEI-04-01-00020)

MAJOR HOSPITAL INITIATIVES

The OIG is involved in three national projects involving civil actions at hospitals that were falsely billing the Medicare program.

Physicians at Teaching Hospitals

The OIG has undertaken a nationwide initiative to review compliance with the rules governing reimbursement to physicians at teaching hospitals (also known as the PATH initiative). The specific objectives of the PATH audit initiative are to verify compliance with the Medicare rules governing payment for physician services provided by residents and teaching physicians and to ensure that all claims for physician services accurately reflect the level of service provided to the patient. In order to receive a separate payment from Medicare Part B for a service rendered to a patient, the teaching physician must have personally provided that service or have been present when the resident furnished the care.

Medicare, under Part A of the program, pays the direct costs of training residents through graduate medical education (GME) payments. Medicare also pays an additional amount in recognition of the additional costs associated with training residents, also known as indirect medical education (IME) payments. These payments can total over \$100,000 per resident per year. Medicare paid approximately \$7 billion to teaching hospitals in FY 2000 for the cost of training residents. These Medicare Part A payments described above include, in part, payments to teaching physicians for their roles in supervising residents.

To date, nine institutions have entered into settlements with the Federal Government to resolve potential False Claims Act liability under the PATH initiative, resulting in the Government's recovery of nearly \$100 million. As a condition of settlement, most of these institutions have also implemented compliance programs to prevent and detect future improper claims. Reviews completed at four other institutions disclosed no major problems with either billings in the teaching setting or upcoding, demonstrating that providers can and do bill the Medicare program correctly. Separately, 10 investigations, not part of the PATH initiative but which included billings for teaching physicians, concluded in False Claims Act settlements totaling almost \$51 million. In most of these

cases, the providers also entered into corporate integrity agreements with OIG. Reviews at two institutions resulted in administrative overpayment settlements totaling over \$780,000.

PPS Patient Transfer Project

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

The OIG found, however, that since 1986 many transferring hospitals inappropriately claimed full diagnosis-related payment rather than the per diem payment. The CMS has already acted on OIG's first report which identified \$227 million in recoveries and savings. The OIG's second report, issued in November 1996, and a more recent computer analysis of claims disclosed additional overpayments of approximately \$232 million. Currently, OIG is working with various U.S. Attorneys' Offices nationwide, along with CMS, on this continuing problem.

To date, OIG has settled PPS cases with three hospitals totaling over \$2.2 million. In addition, reviews at 11 institutions resulted in administrative overpayment settlements in the amount of \$4.8 million.

Pneumonia Upcoding

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

The OIG is currently assisting DOJ in investigating the coding for pneumonia at over 100 hospitals. To date, 34 hospitals have settled their

liability for such coding by paying over \$35.2 million and agreeing to corporate integrity requirements.

OTHER HOSPITAL INVESTIGATIONS

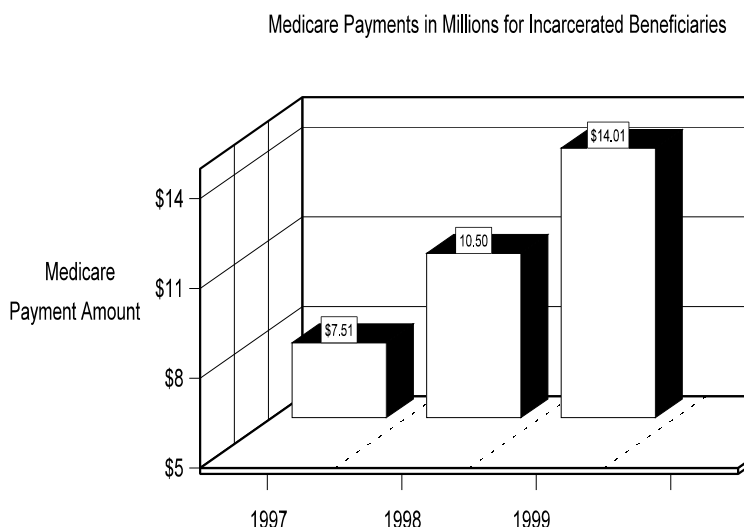
The following cases are significant examples of other hospital-related cases resolved during this period which were not part of the special projects described above:

- HCA-The Healthcare Company (HCA), formerly known as Columbia/HCA Healthcare Corporation, paid nearly \$790 million to the Federal Government and approximately \$14.7 million to several States (for the State portion of Medicaid payments) to resolve its civil liability for Medicare and Medicaid fraud related to: (1) upcoding of diagnosis-related groups (pneumonia and other diagnoses); (2) hospital lab unbundling and billing for medically unnecessary lab tests; (3) kickback and cost report (e.g., related party) violations arising from a series of acquisitions of home health agencies; (4) charging marketing costs as home health community education; and (5) billing for non-covered home health services. As part of the civil settlement, HCA also entered into a comprehensive 8-year corporate integrity agreement which is unprecedented in its scope and detail of its audit requirements. This settlement represents only a partial resolution of the Government's civil claims. The Government is in litigation with HCA regarding civil liability for hospital cost report fraud and for payments to physicians that violate the kickback and physician self-referral prohibitions.
- Quorum Health Group, Inc., (Quorum), the owner of several acute care hospitals, settled a case for \$77.5 million for engaging in certain fraudulent cost reporting practices in violation of the False Claims Act. The provider used "reserve" cost reports to determine its allowable Medicare costs and then filed a separate set of allegedly fraudulent cost reports to obtain greater Medicare reimbursement. Quorum also agreed to enter into a comprehensive 5-year corporate integrity agreement.

MEDICARE PAYMENTS FOR INCARCERATED BENEFICIARIES

Generally, Medicare payments cannot be made for medical services to Medicare beneficiaries who are incarcerated. This OIG report pointed out, however, that the Medicare program is extremely vulnerable to such payments because CMS does not identify Medicare beneficiaries who are in prison, making it virtually impossible for Medicare contractors to prevent improper payments.

The OIG identified \$32 million in potentially improper Medicare fee-for-service payments to providers on behalf of 7,438 incarcerated beneficiaries during calendar years 1997 through 1999.



The OIG recommended that CMS take procedural and systematic measures to obtain data from the Social Security Administration (SSA) that identifies incarcerated SSA beneficiaries and design and implement system controls in the enrollment database and Common Working File to alert contractors when a Medicare claim is submitted for services to an incarcerated beneficiary. The CMS agreed with the intent of the recommendations but hesitated to fully commit to implementing systems controls without further study. (A-04-00-05568)

MEDICARE PAYMENTS FOR DECEASED BENEFICIARIES

The OIG pointed out in this report that CMS paid \$4.1 million to MCOs for deceased beneficiaries in four States representing about 43 percent of all Medicare risk-based enrollees—Arizona, California, Colorado and Florida. The CMS recouped about \$833,000, but over \$3.2 million remained outstanding because CMS was not aware of all of the deaths and did not take action to collect some of the improper payments. Further, CMS continues to pay at least \$700,000 per year to MCOs for the deceased beneficiaries identified in this review.

The OIG recommended that CMS identify and recoup Medicare payments made on behalf of deceased beneficiaries in all States, including the \$3.2 million identified in this report. In addition, OIG recommended that CMS continue to strengthen procedures to prevent and detect payments to MCOs for deceased beneficiaries.

The CMS concurred. According to CMS officials, CMS has developed a process for quarterly reconciliation of death data to assist in identifying and recouping overpayments. As a result of this new process, CMS has recouped over \$4.2 million. (A-07-99-01298)

MEDICARE OUTLIER PAYMENTS

The Medicare program makes outlier payments, which are additional amounts beyond the basic diagnosis-related group payment, for inpatient cases with extraordinarily high costs. This report points out that outlier payments to an acute care hospital in Rhode Island increased by 395 percent from FY 1998 to FY 1999, from \$880,000 to \$4.3 million. During FY 1999, the hospital was overpaid an estimated \$3.1 million because the inpatient operating cost-to-charge ratio used to calculate outlier payments was incorrect. A clerical error on the hospital's FY 1996 cost report, which was not identified by the hospital or by the fiscal intermediary, was the root of the problem.

The OIG recommended that the hospital repay the \$3.1 million and strengthen its controls to prevent future improper outlier payments. The hospital concurred. (A-01-01-00517)

DUPLICATE MEDICARE PAYMENTS

In this report, OIG reviewed potential duplicate services from CMS' 5 percent National Claims History file for 1998. For 15 procedures that should rarely or never be billed more than once per day, OIG found 3,152 services involving potential duplicate payments made by the same carrier. The OIG estimated questionable allowances for these 15 codes to be approximately \$2.25 million and also found other potential duplicate payments involving over 2,000 other procedure codes.

The OIG recommended that CMS investigate Medicare's claims processing systems to determine why potential duplicate services were not detected and that CMS recover payments for inappropriate services. The OIG also recommended that CMS implement corrective edits within the claims processing systems to detect and reject inappropriate services, and if this is not cost effective, then that CMS conduct post-payment reviews, particularly in areas where high numbers of duplicate payments were detected. The CMS concurred. (OEI-03-00-00091)

TERMINATED MEDICARE CONTRACTOR

A contractor in Illinois processed and paid Medicare Parts A and B claims until the contractual relationship with CMS was terminated in 1998. Until that time, Medicare reimbursed the contractor for its Medicare employees' pension costs.

Regulations and Medicare contracts provide, however, that pension gains attributable to the Medicare segment of a terminated contractor's pension plan be credited to the Medicare program. This OIG report identified about \$2.1 million in excess pension assets that the contractor should remit to Medicare. (A-07-00-00112)

MEDICARE CONTRACTOR ADMINISTRATIVE COSTS

Under agreements with CMS, a Minnesota contractor processes and pays Medicare Parts A and B claims. Based on an independent review of the contractor's administrative costs claimed from October 1994 through July 1999, OIG recommended a financial adjustment of over \$1 million. Contractor officials concurred with the recommendation.

In addition, OIG recommended that almost \$174,000 of termination costs, which consisted of severance payments to employees who retired rather than accept positions with the replacement contractor, be set aside for CMS adjudication. The contractor did not agree with this recommendation. (A-05-01-00037)

SAME SERVICE PAYMENTS BY MULTIPLE CARRIERS

In this report, OIG reviewed billings by 86 providers for a sample of 242 potentially duplicate services involving 15 procedure codes. The OIG found that Medicare's claim processing system did not prevent duplicate payments by more than one carrier for any of the sample services. The OIG estimated total improper allowances for the sample services at \$446,000.

Percentage of Services Involving Potential Duplicates for 15 Sample Codes			
Provider	Number of services involving duplication	Total number of services overall	Percentage of services involving duplication
A	334	828	40%
B	966	2748	35%
C	114	332	34%
D	38	124	31%
E	115	565	20%

The OIG recommended that CMS revise Common Working File edits to detect and deny duplicate billings to more than one carrier. If this recommendation is determined not to be cost effective, then OIG recommended increased post-payment reviews should be conducted, particularly in areas where providers

commonly perform services in multiple carrier jurisdictions. The CMS concurred with these recommendations. (OEI-03-00-00090)

***BENEFICIARY COMPLAINT PROCESS:
A RUSTY SAFETY VALVE ❖❖***

This OIG report examines the effectiveness of the beneficiary complaint process administered by Medicare's peer review organizations (PROs). The OIG found the complaint process to be an ineffective safety valve that has changed little since an OIG inquiry 5 years ago. Its accessibility is questionable. The process rarely triggers any intervention beyond a letter to providers or physicians for substantiated complaints. It also fails to provide a meaningful response to complainants. The CMS' contract with the PROs treats complaints as a minor activity, and PROs also tend to be more oriented toward the medical community than to the beneficiary community.

The OIG recommended that CMS provide beneficiaries with an effective complaint process by either fixing the current PRO system or creating a new system outside the PROs. (OEI-01-00-00060)

***MEDICARE COVERAGE OF
NONPRACTITIONER SERVICES ❖❖***

Results of this report indicated that billings are rising rapidly for nonphysician practitioners, such as nurse practitioners, physician assistants, etc. It is unclear how much of the increase is due to real growth in services and how much is due to changes in billing practices. Additionally, payment controls, based on broad State scopes of practice, are limited. As such, carriers do not have sufficient guidance to distinguish which nonphysician practitioner services should be reimbursed by Medicare and which should not. The OIG plans to monitor nonphysician practitioner services for both overall trends and complex services. Though sensitive to the increasing monitoring burden on contractors, CMS concurs. (OEI-02-00-00290)

***UNESTABLISHED LABORATORY
TEST REGULATION***

This report examined the regulation of unestablished laboratory tests. For purposes of this report, these tests, such as "live blood cell analysis," are defined

as those not generally accepted by persons involved in traditional laboratory practice and oversight. The OIG found that live blood cell analysis tests and other unestablished tests have not met the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Furthermore, some laboratories performing unestablished tests may have improperly obtained CLIA certification. Most of the study respondents believe that unestablished laboratory tests should be regulated, but they differ on how this should be accomplished.

Among several OIG interim recommendations were that CMS should determine the usefulness of unestablished tests and improve test verification reviews. CMS concurred with the recommendations and agreed to find a long-term solution to problems associated with unestablished laboratory tests. (OEI-05-00-00250)

ENROLLMENT AND CERTIFICATION IN THE CLIA PROGRAM ♦♦

Significant vulnerabilities, such as lack of on-site visits, exist in waived and provider-performed microscopy laboratories. In many cases these laboratories have been found to be non-compliant. This OIG report found that, despite safeguards such as on-site visits, some vulnerabilities also exist for moderate and high complexity laboratories.

The OIG made several recommendations, including that the Centers for Medicare and Medicaid Services educate laboratory directors and consider conducting on-site visits to a random sample of waived and provider-performed microscopy laboratories. (OEI-05-00-00251)

Types of CLIA Certificates

Waiver: Issued to labs that only perform tests approved for home use or are so simple and accurate the chance of erroneous results is negligible or pose no harm to the user if performed incorrectly. Not routinely visited.

Provider-Performed Microscopy Procedure: Issued to labs where physician or other qualified provider performs specified procedures permitted by CLIA. Also permitted to perform waived tests. Not routinely visited.

Registration: Issued to labs that conduct testing of moderate and/or high complexity. Issued when the lab's application is accepted by CLIA and valid until lab is surveyed.

Compliance/Accreditation: Issued after lab is surveyed & found in compliance with all applicable CLIA requirements. Visited routinely.

CRIMINAL FRAUD

One of the most common types of fraud perpetrated against Medicare, Medicaid and other Federal health care programs involves the filing of false

claims or statements. Such false claims may be pursued civilly under the False Claims Act (for example, the hospital initiatives described in pages 11-13). In appropriate cases, false claims may also be prosecuted under Federal criminal statutes. The successful resolution of these matters often results from combining investigative efforts and resources with the FBI and other law enforcement agencies. Descriptions of criminal prosecutions that resulted from the investigation of both false claims-related offenses and other health-care related offenses during this period follow:

- A joint health care fraud task force in Florida investigated a complex Medicare fraud and kickback scheme involving two owners of a durable medical equipment company and clinic who, along with others, allegedly recruited Medicare beneficiaries to use their Medicare numbers. The beneficiaries allowed the use of their numbers to bill Medicare for equipment not provided and also signed fraudulent delivery receipts for the equipment in return for kickbacks.

In August 2000, an 83-count indictment charged 23 defendants, including the two owners and eight beneficiaries, for their roles in the conspiracy. In May 2001, a superseding indictment charged eight additional defendants with false claims, conspiracy to defraud, money laundering, and payment and receipt of kickbacks. The defendants' scheme resulted in the billing of over \$14 million in fraudulent Medicare claims. To date, 10 of the 31 individuals charged in connection with this investigation have pled guilty, and three have been sentenced.

- The owner of an Illinois business providing counseling services was sentenced to 40 months incarceration and required to pay \$6.7 million in restitution for submitting false claims for group psychotherapy sessions that either never occurred or were conducted by unlicensed personnel. To bill for these sessions, the owner used the Medicare provider numbers of licensed clinical social workers, physicians and other mental health professionals without their knowledge.

KICKBACKS

Many businesses use referrals to meet the needs of customers or clients for expertise, services or items that 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. Referrals in and of themselves are legal. However, if referrals of Federal health care program beneficiaries are made in exchange for anything of value, both the giver and receiver may violate the Federal anti-kickback statute.

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 (1) referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Federal health care programs; or (2) purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service or item payable under the Federal health care programs.

Violators may be subject to criminal penalties and to exclusion from participation in Federal health care programs. They may also be subject to civil monetary penalties. The following cases are examples of anti-kickback enforcement actions:

- As part of an ongoing investigation into a complex patient brokering and kickback scheme, 10 individuals were sentenced in Florida—four of whom were principal owners in the largest illegal patient brokering network in the United States. From 1989 through 1997, the company engaged in the business of patient brokering, supplying patient referrals to inpatient psychiatric hospitals for up to \$6,000 per patient. The company acquired patient referrals, including Medicare beneficiaries, by paying kickbacks to referral sources. To disguise the patient referral fees as legitimate services, the company created false contracts and agreements with the hospitals.

The primary defendant was sentenced to 16 months imprisonment and required to pay \$1.575 million in restitution and a criminal fine totaling \$250,000. Three associates were ordered to pay a total of \$2.925 million in restitution and fines. The investigation also resulted in the sentencing of six additional individuals for their roles in kickback-related, patient brokering arrangements. To date, a total of 29 individuals have been sentenced since the inception of this investigation.

- In related kickback investigations, three physicians were sentenced in New York. One physician was sentenced to 2 years probation and ordered to pay restitution, fines and penalties totaling \$177,000 for tax evasion and accepting kickbacks. The physician entered into a kickback agreement with the owners of a medical supply company through which the physician referred patients to the company in return for DME and cash.

The other two, an internist and a cardiologist, were also sentenced for accepting kickbacks in exchange for patient referrals. The internist was sentenced, for illegal kickback activity, to 2 years probation and required

to pay a \$20,000 fine. The cardiologist was sentenced to 30 months incarceration and ordered to pay a \$10,000 fine for conspiracy and illegal kickback activity.

- In New York, the chief executive officer (CEO) and the chief operating officer of a durable medical equipment (DME) company were sentenced for violating the anti-kickback statute to 3 years probation and ordered to pay fines of \$20,000 and \$15,000, respectively. The two offered and paid kickbacks to an individual in exchange for the right to supply DME to his Medicare patients. To prevent discovery of the kickback arrangement, the two also devised an elaborate scheme which included a false contract for consulting services, drafted and signed by the CEO.

FRAUD AND ABUSE SANCTIONS

During this reporting period, OIG administered 2,354 sanctions, in the form of program exclusions or civil actions, on individuals and entities for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and/or their beneficiaries.

Program Exclusions

Title XI of the Social Security Act provides several grounds for excluding individuals and entities from participation in Medicare, Medicaid and other Federal health care programs. Exclusion essentially falls into two categories:

Mandatory—for those convicted of crimes related to programs or related to patient abuse or neglect and for those convicted of felonies for defrauding other health care programs or for the illegal manufacture or distribution of controlled substances.

Discretionary—for those who have lost a license to practice or the right to participate in a State health care program for reasons related to professional performance, professional competence or financial integrity, or providing substandard or unnecessary services.

Exclusions may also be authorized with respect to those convicted of crimes against health care programs and payers other than Medicare or Medicaid, in certain instances, and individuals who have failed to repay health education assistance loans (HEALs). (Additional details regarding HEALs on p. 44.)

Providers who are subject to exclusion are granted due process rights, including a hearing before an HHS administrative law judge and appeals to the HHS Departmental Appeals Board and the Federal district and appellate courts, regarding whether the basis for the exclusion exists and the length of the exclusion is reasonable.

During this reporting period, OIG excluded 2,146 individuals and entities. The following are examples of exclusions based on criminal convictions related to delivery of a health care item or service under the Medicaid program and to neglect or abuse of patients in association with those items or services:

- A Kansas dentist and her business were excluded for a 10-year period for submitting claims for services not performed. She also entered into a civil settlement for approximately \$85,000.
- A Colorado owner of a transportation company was excluded for a 5-year period. Assuming the identity of his deceased brother to obtain a Medicaid provider number, he started a transportation business and then over-billed Medicaid.
- A Tennessee physician was excluded for a 20-year period. In July 1999, he was excluded for loss of his medical license after his conviction of sexual battery, rape and attempted rape. He repeated the offenses and was again convicted in October 2000. The court sentenced him to 3 years in prison.
- A nurse from Tennessee was excluded for a period of 20 years following a conviction relating to the aggravated rape of a physically incapacitated female. The court sentenced him to 25 years in prison.
- Based on her conviction related to the extensive physical abuse of an 11-year-old resident, a nurse's aide from Mississippi was excluded for a period of 25 years. First excluded in June 1999, this is her second abuse-related exclusion.

Civil Penalties for Patient Dumping

Section 1867 of the Social Security Act (42 U.S.C. 1395dd) provides that when an individual presents to the emergency room of a Medicare-participating hospital, the hospital must provide an appropriate medical screening examination to determine whether that individual has an emergency medical condition. If an individual has such a condition, the hospital must provide either (1) treatment to stabilize the condition; or (2) an appropriate transfer to another medical facility.

If a transfer is ordered, the transferring hospital must provide stabilizing treatment to minimize the risks of transfer, and must ensure that the receiving hospital agrees to the transfer, has available space, and can effectuate the transfer through qualified personnel and transportation equipment. Further, a participating hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who needs services if the hospital has the capacity to treat the individual.

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

Between April 1, 2001, and September 30, 2001, OIG collected \$72,500 from four hospitals. The following is a sampling of the alleged violations involved in the FY 2001 Patient Anti-Dumping statute settlements from this reporting period:

- The mother of a 4-month-old infant sought treatment for her at a Wisconsin facility. Though the infant displayed severe symptoms, she was discharged. The case was settled for \$17,500.
- A 5-month-old infant was examined by a staff physician's assistant in California. Without consulting an ER physician, the assistant discharged him. The infant presented the next day, was transferred to a nearby children's critical care facility, and died shortly thereafter. The case was settled for \$15,000.

Civil Penalties for False Claims

Under the civil monetary penalties authorities enacted by the Congress, OIG may collect civil penalties and assessments from health care providers and others who submit false or improper claims to Medicare and other Federal health care programs. The OIG also assists DOJ in bringing (and settling) cases under the False Claims Act. Many providers elect to settle their cases prior to litigation. As part of resolving these cases, providers often agree to put compliance measures in place to avoid exclusion and to remain a provider in the Medicare program. The integrity programs established by these agreements are designed to prevent a recurrence of the fraudulent activities that gave rise to the case at issue.

The Government, with the assistance of OIG and often the FBI and other law enforcement agencies, recouped more than \$1.22 billion through both Civil Monetary Penalty Law and False Claims Act civil settlements related to the Medicare and Medicaid programs during this reporting period. Examples of these cases include the following:

- In California, Catholic Healthcare West (CHW) agreed to pay the Federal Government \$10.25 million to resolve its civil liability for submitting false claims to inflate reimbursement from Medicare, Medi-Cal and TRICARE. A qui tam complaint alleged that from January 1992 through December 1999, two CHW clinics submitted various false claims involving annual physical examinations, doctor referrals, provision of services and ancillary services. As part of the settlement agreement, the defendant also agreed to enter into a 3-year corporate integrity agreement to ensure its compliance with Federal health care program requirements.
- Urocor, Inc., an independent urological-related testing clinical laboratory in Oklahoma, agreed to payment of \$9 million for billing medically unnecessary lab tests and paying kickbacks to doctors. As part of the settlement, Urocor also agreed to enter into a 5-year corporate integrity agreement.
- In Alabama, HealthSouth Corporation (HealthSouth), the Nation's largest provider of rehabilitative health services, agreed to pay the Government \$7.9 million and to enter into a 5-year corporate integrity agreement to resolve their liability for submitting false Medicare and TRICARE cost reports. From 1992 through 1997, HealthSouth submitted improper claims to the Government.
- Valley X-ray, Inc., a mobile x-ray company in Michigan, agreed to pay \$1 million and to be permanently excluded from Federal health care programs to resolve its civil liability for alleged misconduct—knowingly submitting false claims to Medicare for transportation and EKG charges—from January 1991 through December 1998. The company's CEO is currently serving a 7-year prison term for his involvement in the misconduct.
- As part of the largest civil settlement to date with any individual health care provider in the District of Connecticut, the U.S. Attorney's Office entered into a consent judgment with a podiatrist who agreed to pay \$986,801 in order to settle Federal civil fraud claims. In addition, the podiatrist pled guilty to wire fraud for electronically submitting fraudulent bills to Medicare and was sentenced. He also agreed to the criminal forfeiture of his office building. During

the period from 1992 to 1997, Medicare paid for 50 or more procedures on each of more than 145 Medicare beneficiaries. In addition to his guilty plea and his agreement to a civil settlement, the podiatrist agreed to a permanent exclusion from participation in Federal health care programs.

Compliance Activities

Because the great majority of providers are honest and wish to avoid fraud and abuse issues, OIG has been actively working with the private sector to develop methods to prevent the submission of improper claims and inappropriate conduct. The OIG has already initiated significant outreach efforts with the private sector to encourage these compliance endeavors. The OIG's compliance program guidelines are available on the Internet at <http://www.hhs.gov/oig> in the "Compliance Tools" and "Fraud Detection & Prevention" sections.

The OIG continues in its efforts to promote voluntary compliance programs by providing guidance for the various sectors of the health care industry. To this end, OIG has developed and released nine compliance program guidances for: clinical laboratories, hospitals, home health agencies, third-party billing companies, durable medical equipment (DME), prosthetics and orthotics suppliers, hospices, Medicare+Choice organizations that offer coordinated care plans, nursing homes, and individual and small group physician practices. The OIG is currently working on compliance guidance for ambulance service providers and the pharmaceutical industry.

There are seven fundamental elements of an effective compliance program, including: implementing written policies, procedures and standards of conduct; designating a compliance officer and/or compliance committee; conducting effective training and education; developing effective lines of communication; ensuring compliance with standards through well-publicized disciplinary guidelines; conducting internal monitoring and auditing; and responding promptly to detected offenses and developing corrective action initiatives.

In addition to developing compliance program guidance which promotes the voluntary adoption of compliance measures by private industry, OIG monitors compliance and integrity obligations agreed to by health care providers as part of global fraud settlements of OIG audits and investigations. These compliance obligations are typically negotiated through an agreement commonly referred to as a corporate integrity agreement. When negotiating these integrity agreements, OIG takes into account an entity's existing voluntary compliance program. Presently, OIG is monitoring approximately 450 corporate integrity agreements.

To assist with efforts to verify compliance with the terms of the agreements, OIG staff conducts on-site visits to certain entities and providers subject to the compliance obligations. These site visits generally involve meeting with compliance staff and management, conducting employee interviews, reviewing claims and having a detailed discussion of annual reports submitted to OIG by the provider. Site visits often verify compliance with the corporate integrity obligations, but they have also uncovered and confirmed instances of noncompliance, including improper claims reviews and the provider's placement of prohibited costs related to a false claims settlement agreement on provider cost reports. They also serve as an educational tool for the entity or provider to discuss compliance efforts with OIG personnel.

PROVIDER SELF-DISCLOSURE

In keeping with a longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, on October 21, 1998, OIG issued a set of comprehensive guidelines for voluntary self-disclosures titled, "Provider Self-Disclosure Protocol." The Protocol is available on the Internet at <http://www.hhs.gov/oig> in the "Compliance Tools" section. In addition, it can be found in 63 *Federal Register* 58,399 (October 30, 1998).

Essentially, the Protocol guides providers and suppliers through the process of structuring a disclosure to OIG of matters uncovered that are believed to constitute potential violations of Federal laws (as opposed to innocent mistakes that may have resulted in overpayments). Pursuant to the Protocol, an appropriate submission would include a thorough internal investigation as to the nature and cause of the matters uncovered and a reliable assessment of their economic impact (e.g., an estimate of the losses to the Federal health care programs). The OIG evaluates each submission to determine the appropriate course of action. To date, OIG has received 116 submissions.

Among the benefits experienced by disclosing providers is the allocation of investigative resources that can contribute to an expeditious inquiry and a prompt resolution of the matter. Additionally, disclosing providers that demonstrate the effectiveness of their compliance programs and that, as part of the resolution of the matter, agree to continue such compliance activities may avoid entering into a corporate integrity agreement with OIG. In those cases where objective evidence of a comprehensive compliance program exists and OIG believes an agreement is necessary, OIG may make significant modifications in the term of an agreement or the role of the independent review organization.

Overall, the Protocol provides helpful guidance to providers and the community at large concerning how to achieve resolution of identified misconduct

through a cooperative and open relationship with the Government. To date, self-disclosure cases have resulted in 24 recoveries and 14 settlements collectively totaling over \$43 million. Successful resolution to provider self-disclosure cases are demonstrated in the following examples:

- In North Carolina, Fayetteville Associates in Laboratory Medicine, P.A., (Fayetteville Associates) agreed to pay the Government \$493,470 to settle a provider self-disclosure matter in which Fayetteville Associates acknowledged upcoding services. In early 1995, the director of Fayetteville Associates discovered that from approximately 1990 to 1994, a portion of the anatomical pathology services were billed under an improper code. In 1998, the company contracted with a health care management consultant firm to conduct a detailed billing audit of these services—which revealed overpayments to the medical laboratory from Medicare, Medicaid and TRICARE.
- In Hawaii, Rehabilitation Hospital of the Pacific (Rehabilitation Hospital) entered into a settlement agreement totaling \$399,675 with the Government. The settlement, which resulted from a voluntary disclosure to OIG, resolved the hospital's civil liability for submitting upcoded claims to Medicare and Medicaid for services performed by its physicians. Rehabilitation Hospital disclosed the billing issue following an extensive internal investigation.

INDUSTRY GUIDANCE

The OIG has continued to issue advisory opinions, special fraud alerts, special advisory bulletins and other guidance as part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry. For the period from April 1, 2001, through September 30, 2001, OIG accepted 21 advisory opinion requests and issued 14 advisory opinions. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), OIG has enlisted the help of the provider and beneficiary communities to prevent impropriety by soliciting proposals (via *Federal Register* notice) for modifying existing safe harbors to the anti-kickback statute. The OIG received three timely filed responses to the December 2000 notice.

PROVIDER COMMUNITY INPUT

Provider Roundtable

The purpose of a July 30, 2001, roundtable discussion co-sponsored with the Health Care Compliance Association was to afford providers and other

entities an opportunity to discuss the issues surrounding the implementation and maintenance of compliance programs subject to corporate integrity agreements. The meeting also offered OIG an opportunity to discuss its integrity agreement policy objectives and receive providers' unique insights on ways to accomplish these objectives. Over 50 health care providers and 30 Government representatives took part in group discussions which centered on independent review organizations, compliance education and training, compliance program infrastructure, and reporting to OIG.

Roundtable participants addressed many of the issues facing compliance officers and staff. Participants gained new insights into the challenges of creating effective compliance programs and had the opportunity to exchange perspectives on compliance from both the Government and the health care industry. The outcome of the roundtable discussions will offer OIG greater understanding of how the Government and provider community can work together to protect the integrity of the health care system. Given the constructive discussion among the participants, OIG will seek additional opportunities for Government-industry exchanges on these and other issues surrounding health care compliance programs.

OCIG/OEI Survey

Working together, the Office of Counsel to the Inspector General (OCIG) and the Office of Evaluation and Inspections (OEI) developed and distributed a survey to providers currently operating under corporate integrity agreements. The results of the survey will help OCIG further develop integrity agreement requirements and will supplement the information received at the Government-industry roundtable.

ADMINISTRATIVE COSTS INCLUDED IN ADJUSTED COMMUNITY RATE PROPOSALS

Through adjusted community rate proposals, managed care organizations (MCOs) present to CMS an initial rate that represents the "commercial premium" the MCO would charge its non-Medicare enrollees for services included in the managed care plan. This initial rate is then adjusted by various factors described in 42 C.F.R. § 422.310, including the relative costs to Medicare beneficiaries. At CMS' request, OIG reviewed the 1998 base year administrative costs included in the proposals of several plans for contract year 2000. The results underscored a significant problem noted in previous reviews; that is, there is no law or regulation governing the allowability of administrative costs included in the proposals, and Medicare is paying a disproportionate share of administrative costs.

For the proposals reviewed, millions of dollars of administrative costs would be considered inappropriate when compared against Medicare's general

principle of paying only reasonable costs. Costs included, for example, travel and entertainment, public relations, marketing, political and charitable contributions, memberships, and lobbying. In addition, the MCOs were unable to provide documentation for certain costs. The effect of including these costs was to increase the amounts needed for administration and to reduce the amounts available to beneficiaries in the form of additional benefits or reduced cost sharing. In one egregious case, an MCO in Florida, beneficiaries were adversely affected by about \$13.8 million during calendar year 2000.

The results of these reviews are being shared with CMS for its consideration of legislative changes. (A-02-00-01034, A-04-00-02168, A-05-00-00040, A-06-00-00052, A-07-00-00107, A-07-00-00114, A-09-00-00120, A-10-00-00013, A-14-00-00209)

MCO UNDERPAYMENT CLAIM

A national MCO chain with several risk contracts with CMS asserted that CMS had based its payments for enrolled Medicare beneficiaries on incorrect State and county address codes, resulting in a net \$21.7 million underpayment. At CMS' request, OIG reviewed the claim and estimated that it should be reduced by at least \$12.2 million. This reduction would account for unsupported or invalid items and for beneficiaries out of the area but not included in the claim.

In addition to recommending a \$12.2 million reduction in the claim, OIG recommended that CMS not settle with the MCO chain until further audit work is completed—which OIG believes will result in further reduction of the claim. According to CMS officials, the MCO chain has been providing information that is being processed through the CMS systems in order to determine exactly what the final amount of the claim will be. The CMS expects to fully process all of the information that the MCO chain has provided and to fully resolve this matter. (A-06-99-00060)

RESPIRATORY ASSIST DEVICES

In this inspection, OIG reviewed the payment categorization of bi-level respiratory assist devices with back-up rate and concluded that the current Medicare payment method used for this device is inappropriate. Under the current frequent and substantial payment category, suppliers are paid an established monthly rental fee as long as the device is medically necessary. Under the capped rental payment category, suppliers are paid a monthly fee for a stipulated amount of time at which point the beneficiary may opt to have Medicare purchase the machine on his behalf or to continue to rent the device on his own after the passage of a stipulated time

period. Findings indicated that this equipment requires only routine maintenance and patient monitoring. Further, supplier visits do not reflect the frequency stipulated by supplier protocols. Visits are inconsistent and often discontinued after a short period of time.

The OIG recommended that CMS proceed with its intention to move the bi-level respiratory assist device with back-up rate from the “frequent and substantial” payment category to the “capped rental” payment category—a change that would save Medicare \$11.5 million annually. (OEI-07-99-00440)

MEDICAL EQUIPMENT SUPPLIER COMPLIANCE

Medical equipment suppliers are required to comply with CMS standards to receive a billing number. Since a 1997 inspection which uncovered compliance problems, CMS and its contractor, the National Supplier Clearinghouse, began to require physical site inspections prior to application approval for a billing number. This follow-up report indicated that the compliance rate is considerably improved.

All suppliers complied with delivery, warranty, returns, repairs, complaints and disclosing ownership standards. Less than 1 percent of suppliers failed to comply with the standard requiring an appropriate physical address. Less than 15 percent of suppliers failed to comply with standards requiring appropriate liability insurance, licensure and inventory on-site or through contract. This report offers several suggestions to CMS for further improvement in compliance rates. (OEI 04-99-00670)

FRAUD INVOLVING DURABLE MEDICAL EQUIPMENT SUPPLIERS

The durable medical equipment (DME) industry suffers from waves of fraudulent schemes in which Federal health care programs are billed for equipment never delivered, higher-cost equipment than that actually delivered, unnecessary equipment or supplies, or equipment delivered in a State different from that billed in order to obtain higher reimbursement. During this reporting period, OIG obtained the following settlements and convictions regarding DME fraud:

- In Puerto Rico, 9 of 12 defendants involved in a kickback-related DME fraud scheme were sentenced. In February 2000, a 134-count indictment was handed down, charging all defendants with illegal kickback activity, conspiracy, mail fraud and money laundering among other violations. The scheme centered on the illegal exchange of kickbacks for patient referrals

by a DME company owner. The three remaining defendants, including the DME company owner, await sentencing based on their guilty pleas.

- In Missouri, Lancer Medical, Inc., (Lancer Medical), its affiliated companies and individual owners agreed to pay the Government \$324,392 to resolve their liability for point of sale violations. Lancer Medical allegedly submitted claims for wound care supplies to a Pennsylvania carrier, rather than to a carrier in the State where the sales occurred, in order to receive a higher rate of reimbursement from Medicare. Upon learning of the Government's investigation into its improper practices, Lancer Medical also allegedly distributed a major portion of its assets to its shareholders in violation of the Federal Debt Collection Act.
- In California, an employee of a health insurance company and a DME company owner were sentenced to 5 years probation and required to pay a total of \$25,086 in restitution for mail fraud. The employee and the company owner participated in a scheme to defraud the health insurance company through false statements. Through their scheme, the owner submitted claims to the health insurance company for undelivered medical equipment. The employee caused the false insurance claims to be approved retroactively through the health insurance company's computer system and subsequently paid to the company owner.

PRESCRIPTION DRUG FRAUD

Working jointly with the Drug Enforcement Administration and State and local authorities, OIG has identified and investigated illegal schemes to obtain, use and distribute prescription drugs. The schemes often entail individuals who defraud the Medicaid program in order to receive the prescriptions and pay for the drugs. Individuals often obtain the prescription drugs under false pretenses for their own personal use or for resale. Participants in these often complex group schemes may include patients, beneficiaries, pharmacists, physicians and others. By investigating these schemes, OIG aims to deter the illegal use of prescription drugs, to curb the danger associated with street distribution of highly addictive medications and to protect the Medicaid program from making improper payments. Examples of cases related to prescription drug fraud follow:

- Oxycontin is the trade name of a time-release medication containing oxycodone, a controlled narcotic which can produce effect similar to heroin when misused. The following cases are related to fraud involving the drug.
 - In Maine, 21 people have been charged in an ongoing investigation involving groups of individuals using Medicaid and private insurance to

pay for illegally acquired Oxycontin, which was then illegally distributed. Subjects charged in this case obtained the drug by forging prescriptions and visiting multiple physicians simultaneously. Of the 21 persons charged, 18 have been charged with health care fraud in addition to drug-related offenses. To date, 19 individuals have pled guilty; and 12 subjects have been sentenced, with the average length of incarceration 20 months. Restitution orders have totaled \$41,540 to Maine Medicaid and \$9,606 to private insurance companies.

- In a separate investigation in Maine, a man was sentenced to 33 months in prison and required to pay \$2,473 in restitution for health care fraud and acquiring controlled substances by fraud. The man improperly used Medicaid to pay for 11 altered prescriptions for Oxycontin. This investigation resulted in the man's eighth felony conviction; his other convictions stemmed from a range of unrelated criminal activities.
- An invasive radiologist, who was also chief of the radiology department at a Virginia hospital, was sentenced for acquiring a controlled substance by misrepresentation, fraud, forgery, deception and subterfuge. The radiologist was sentenced to 2 years probation and required to pay a \$5,000 fine. From June 1998 through January 1999, the radiologist accessed the hospital's pharmaceutical cabinet and diverted morphine and fentanyl for his own use over 175 times. To conceal this diversion, he created charge tickets indicating that the drugs were for patients undergoing invasive procedures. Because many of the patients were Medicare beneficiaries, the program was inappropriately billed for pharmaceuticals taken under false pretenses.

MEDICAID PRESCRIPTION DRUGS

Drug Rebates

Medicaid is able to purchase drugs at the best price through rebates that are based on the difference between the best price and the average manufacturer price. "Best price" is defined as the lowest price at which drug manufacturers sell drugs to any purchaser and specifically includes sales to health maintenance organizations (HMOs). Although CMS guidance has allowed the exclusion of sales to drug repackagers from the best price, a previous OIG review found that some repackagers were HMOs and that manufacturers were excluding sales to such HMOs from their best price.

This follow-up review showed that 7 of 53 drug manufacturers excluded sales to 8 repackagers, 3 of which were HMO repackagers, for the top 200 Medicaid-reimbursed drugs in FY 1999. As a result, the Medicaid program lost drug rebates totaling \$80.7 million. The OIG recommended that CMS require the

drug manufacturers that excluded sales to HMOs from their best price determinations to repay the lost rebates. In addition, OIG recommended that CMS evaluate its policy guidance relating to the exclusion of sales to non-HMO repackagers from best price determinations, especially those repackagers that used the drugs for their own use and did not resell them. The CMS concurred. (A-06-00-00056)

Brand-Name Drugs

Following up on previous work, OIG conducted a nationwide review of pharmacy acquisition costs for brand-name drugs reimbursed under Medicaid.

Most States use average wholesale price (AWP) minus a percentage discount, which varies by State, as a basis for reimbursing pharmacies for drug prescriptions. Therefore, the objective of this review was to develop an estimate of the discount below AWP at which pharmacies purchase brand-name drugs.

Based on pricing information from 216 pharmacies in 8 States, OIG estimated that the national actual acquisition cost for brand-name drugs was an average of 21.84 percent below AWP. Under current policies in most States, the average discount below AWP for reimbursement of estimated acquisition cost was 10.31 percent in 1999. The OIG estimated that as much as \$1.08 billion could have been saved for the 200 brand-name drugs with the greatest amount of Medicaid reimbursement in 1999. This savings calculation was limited to ingredient acquisition costs and did not address other costs, such as dispensing fees.

The CMS agreed that an accurate acquisition cost should be used to determine drug reimbursement and will encourage States to review their estimates of acquisition costs in light of OIG findings. (A-06-00-00023)

RECOVERY OF PHARMACY PAYMENTS FROM LIABLE THIRD PARTIES

This report quantifies the Medicaid dollars at risk when State Medicaid agencies “pay and chase” pharmacy claims that have liable third parties, instead of using cost avoidance techniques. The OIG found States are at risk of losing over 80 percent (\$367 million) of the payments they tried to recover (\$440 million) in 1999 through the “pay and chase” approach. However, the cost-avoidance approach prevented \$185 million from being at risk. Almost three-quarters of States reported that third parties refuse to process or pay Medicaid pharmacy claims. The OIG also found that more States have problems with pharmacy benefit management companies than with all other types of third parties combined.

The CMS concurred with OIG recommendations to reduce the dollars at risk through such measures as reviewing cost avoidance waivers, tracking dollar amounts paid and recovered, improving claim formats, and educating third parties. (OEI-03-00-00030)

MEDICAID HIV/AIDS DRUG EXPENDITURES

Medicaid pays up to 33 percent more for 16 antiretroviral HIV/AIDS drugs than do other Federal Government drug discount programs. If the ten States surveyed had purchased these antiretrovirals at the Federal ceiling price used by the Departments of Veterans Affairs and Defense, the Coast Guard and certain public health agencies, Medicaid could have saved \$102 million in Federal/State funds (\$54 million Federal share) in FY 2000. The program could have saved \$140 million (\$73 million Federal share) if all States' payments for these drugs were limited by Federal ceiling prices.

The OIG recommended that CMS review the current reimbursement methodology and work with States to more accurately estimate pharmacy acquisition costs for the antiretrovirals and initiate a review of Medicaid rebates for them. (OEI -05-99-00611)

MEDICAID ENHANCED PAYMENTS TO PUBLIC PROVIDERS

States are allowed to make enhanced Medicaid payments (in addition to regular Medicaid payments) to city and county health care facilities and other public providers as long as the State's aggregate payment does not exceed the amount that would have been paid under Medicare (referred to as the upper limit). During this 6-month period, OIG continued to audit States' use of enhanced payments and the financial impact of intergovernmental transfers on the Medicaid program. As part of these audits, OIG reviewed the reasonableness and accuracy of enhanced payments and determined whether State claims were properly reported, sufficiently documented, and in accordance with approved State plans. The following reports were issued:

Six-State Roll Up

In consolidating the results of seven audits in six States, OIG reported that enhanced payments to local government-owned providers were not based on the actual cost of providing services to Medicaid beneficiaries, nor was there a direct relationship between the use of these funds and the quality of care provided by public facilities. Rather than retain the enhanced payments to provide services, nursing facilities transferred a large portion of the payments back to the States for other uses. While hospitals kept a large portion of the enhanced payments, they either did not receive Medicaid disproportionate share hospital payments from the States or returned the majority of the disproportionate share payments to the States through intergovernmental transfers.

The OIG concluded that the States' use of intergovernmental transfers in the enhanced payment program was a financing mechanism designed to maximize Federal Medicaid reimbursement, thus effectively avoiding the Federal/State matching requirements. In prior audits, OIG recommended that CMS revise the regulations on calculating the upper payment limit. The CMS concurred and on January 12, 2001, issued revisions to the regulations that included transition periods to gradually phase in the new regulations. The CMS estimates that the revisions will save \$55 billion in Federal Medicaid funds over the next 10 years. However, when fully implemented, these changes will only limit, not eliminate, State financial manipulation of the Medicaid program. The OIG made a number of recommendations to strengthen the regulations. In response to the draft report, CMS agreed in whole or in part with some of the recommendations. (A-03-00-00216)

North Carolina

For FYs 1996 through 1999, North Carolina made enhanced payments to public and private hospitals based on its Medicaid deficits. The deficits were calculated without consideration of disproportionate share hospital payments or the State/local governments' payments for indigent care. During the period reviewed, the State made payments to hospitals totaling \$647 million, generating \$412 million in Federal matching funds. The hospitals retained the payments and used the funds to pay facility expenses.

The OIG recommended that CMS provide States with definitive guidance on calculating the upper payment limit and review it annually, require that cost report data be the basis of the calculation, and require State plans to contain assurances that enhanced payments will be used to provide Medicaid services. The CMS generally concurred but plans to conduct selective financial reviews as appropriate and offer reimbursement methods suitable to individual States. (A-04-00-00140)

Alabama

Alabama made enhanced payments to State and local inpatient hospitals totaling about \$432 million (Federal share \$302 million) from October 1996 through July 2000. Of the Federal share, the hospitals retained about \$216 million and returned about \$86 million (28.5 percent) to the State. Contrary to the spirit of Medicaid's State/Federal matching requirements, the State, in effect, developed a mechanism to receive additional Federal funds without committing its share of required matching funds. Because 28.5 percent of the Federal funds were returned to the State, it did not appear that the State actually incurred an expense related to the enhanced payments. This raises the question of whether the amounts paid back to the State by the hospitals constituted a refund required to be reported as a collection and offset against expenditures reported to CMS.

The OIG estimated that the Federal Government will save approximately \$18.8 million in Alabama during the upper payment limit regulatory transition period. Once the regulatory changes are fully implemented, OIG estimates savings at about \$12.6 million annually, totaling about \$63 million over 5 years. (A-04-00-02169)

In another report, OIG pointed out that Alabama did not compute its inpatient hospital enhanced payments in accordance with its approved State plan amendment. In FY 1998, the State made two revisions to its funding pool calculations used in determining enhanced payment amounts. First, the State began using Medicare prospective payment system principles in computing the Medicare upper payment limit instead of using Medicare cost principles as required by the State plan amendment. Second, the State began including privately owned facilities in computing the enhanced payments, although the amendment required that payments be based on public facilities. As a result, the State made excessive enhanced payments over 4 years totaling \$240.4 million (\$168.3 million Federal share).

The OIG recommended that Alabama refund the \$168.3 million to the Government. The State did not concur, stating that it was justified in using Medicare prospective payment principles in computing the Medicare upper payment limit because the State no longer required hospitals to file Medicaid cost reports and that it acted within the scope of the regulations by including payments related to privately owned facilities. (A-04-00-02171)

Pennsylvania

In this report, OIG pointed out that in reporting enhanced payments to CMS, Pennsylvania overclaimed \$89 million in Federal matching funds during State FYs 1997 through 1999. In addition, OIG estimated that the State may have overclaimed \$65 million for 1990 through 1996, bringing the total to a potential \$155 million. These amounts represent the differences between (1) the actual enhanced payments supported by intergovernmental transfers and State voucher transmittals and (2) claimed payments actually reported by the State to CMS.

The OIG recommended that the State (1) discontinue the practice of overclaiming Federal matching funds by overreporting payments; (2) refund \$89 million to the Federal Government; and (3) together with CMS, determine if matching funds were overclaimed for the period 1990 through 1996 and, if so, refund the associated amounts. The State did not concur with OIG's findings. (A-03-00-00211)

Nebraska

The OIG found that Nebraska did not correctly compute enhanced payments for FYs 1998 and 1999. The approved State plan required that the computation be

based on the difference between allowable Medicare payment rates and actual Medicaid payment rates to nursing facilities. The allowable Medicare payment rate for each facility included a wage index factor. Because the State did not use the wage index in its calculations of allowable Medicare payment rates, enhanced payment claims were overstated by about \$72 million (\$44 million Federal share).

The OIG recommended that the State refund the \$44 million and use the wage index factor in calculating all future enhanced funding pools. While agreeing with the need to use the wage index factor, the State contracted with a consulting firm to identify any corrections needed in OIG's report. (A-07-00-02083)

***DISPROPORTIONATE SHARE HOSPITAL
PROGRAM: LOUISIANA***

Under Medicaid, States make additional payments, called disproportionate share hospital payments, to hospitals for the uncompensated costs of serving disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 mandates that these payments not exceed the individual hospitals' uncompensated care costs.

In two reports, OIG pointed out that disproportionate share hospital payments to 10 hospitals in Louisiana during State FY 1998 were calculated in accordance with the approved State plan. However, payments to the individual hospitals exceeded uncompensated care costs by a total of about \$26.7 million. Also, OIG did not express an opinion on the allowability of \$4.2 million in claimed overhead costs because it could not determine the reasonableness of the methodology used to calculate the costs.

In addition to recommending financial adjustments, OIG recommended implementation of controls to ensure that disproportionate share payments are determined accurately in the future. Auditee officials generally agreed to implement the recommendations. (A-06-00-00026, A-06-00-00058)

***MEDICAID REIMBURSEMENT OF CLINICAL
LABORATORY SERVICES: CONNECTICUT***

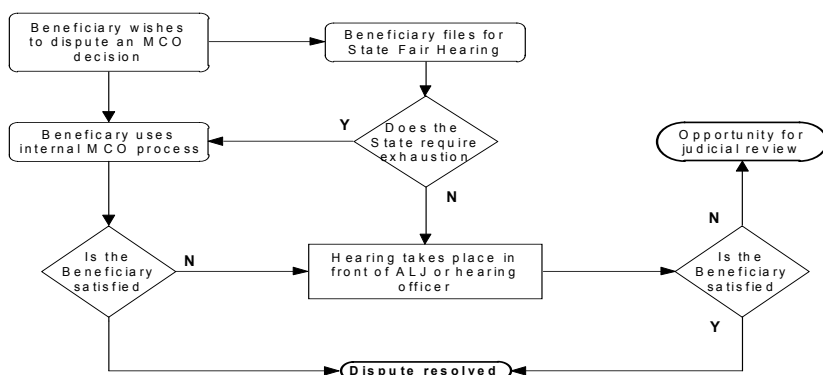
Under Medicaid requirements, reimbursement to providers for clinical laboratory and pathology services may not exceed what the Medicare program

recognizes as reimbursement for the same services. This OIG review found that Connecticut had not updated its clinical laboratory fee schedule since 1994, during which time Medicare payments for many such services decreased. As a result, the State made overpayments totaling \$2.8 million (\$1.4 million Federal share) from 1996 through 1999.

The OIG recommended that the State make a financial adjustment for the overpayments identified and update clinical laboratory fee schedules on a regular basis to ensure that amounts paid do not exceed the Medicare reimbursement amounts. The State agreed to do so. (A-01-01-00003)

MEDICAID DISPUTE RESOLUTION

Dispute resolution systems for Medicaid managed care enrollees have been established in the States sampled for this study, but those States conduct few hearings and managed care plans receive relatively few complaints and grievances. Member materials and notices are often inadequate, and regulations governing fair hearing time frames are flexible, but can be ambiguous. The States have different



interpretation of the plan's role, as well as their own in fair hearings. The OIG found that oversight of Medicaid managed care dispute resolution is inconsistent.

The OIG recommended that CMS develop model beneficiary notices and handbooks, improve regional

oversight, and view dispute data as a way to improve quality of care. The CMS concurred. (OEI-09-99-00450)

FEDERAL AND STATE PARTNERSHIP: JOINT AUDITS OF MEDICAID

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

sectors. To date, partnerships have been developed in 24 States. Reports issued to date have resulted in identifying over \$192 million in Federal and State savings and have led to joint recommendations for savings at the Federal and State levels, as well as improvements in internal controls and computer system operations.

- During this reporting period, a joint audit with an Illinois State agency determined that hospitals claimed excessive Medicaid reimbursement by coding patient transfers to other prospective payment system hospitals as discharges. As a result, from July 1996 through February 2000 potential overpayments totaled an estimated \$2.3 million (Federal share \$1.15 million). The report recommended that the State provide additional guidance to hospitals concerning codes for discharges and transfers; review controls to detect, monitor and correct improperly coded discharges; and make appropriate efforts to recover the potential overpayments. The State concurred. (A-05-00-00049)

MEDICAID FRAUD

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

The Inspector General is delegated the authority to annually certify each MFCU eligible to receive Federal grant funds under the Medicaid fraud control program. The MFCUs receive 90 percent Federal funding for the first 3 years of operation and 75 percent thereafter. During FY 2001, OIG is providing oversight for and administration of approximately \$106.7 million in funds granted by CMS to the units to facilitate their mission.

Since the inception of the Medicaid fraud control program, the MFCUs have successfully convicted thousands of Medicaid providers and have recovered hundreds of millions of program dollars. Although most Medicaid fraud cases are investigated by the units, OIG works with the units and/or other law enforcement agencies on such cases as well. The following instances of OIG's successful efforts in Medicaid fraud cases bear noting:

- A Federal judge in Florida issued a judgment totaling \$46 million in a civil case against a psychiatrist and several mental health clinics he owned for damages to the Government. In February 1997, OIG joined an investigation by the FBI and the Florida MFCU which revealed that the psychiatrist

utilized unlicensed mental health counselors to conduct group sessions at his clinics. He also falsely claimed that the clinics employed a number of his family members, and a record review showed that he filed or caused to be filed numerous false claims for providing partial hospitalization or group therapy. The psychiatrist, who was also charged criminally with health care fraud, was scheduled to plead guilty in 1999 but failed to appear in court. A warrant was issued for his arrest; he remains a fugitive.

- As the result of joint efforts which included representatives from the North Carolina, Ohio and Rhode Island MFCUs, CVS Corporation (CVS) agreed to pay the United States \$4 million for the submission of claims for partially-filled prescriptions to Medicaid, TRICARE and the Federal Employees Health Benefits Program. In addition, CVS entered into a comprehensive 4-year corporate integrity agreement.
- Through a joint investigation which included the Indiana MFCU, a former podiatrist was sentenced to 68 months imprisonment and required to pay \$2.76 million in restitution plus investigative costs for mail fraud, criminal forfeiture and criminal contempt. The investigation showed that the podiatrist operated a scheme to defraud health insurance programs by billing for nonrendered, medically unnecessary and upcoded services. This case represented the largest criminal health care settlement to date in the State of Indiana.
- As the result of an investigation by the West Virginia MFCU, a physician settled a case with the United States for \$310,000 for the submission of upcoded evaluation and management services, provided in a hospital setting, to the Medicare and Medicaid programs. In addition, the physician agreed to enter into a corporate integrity agreement for a period of 3 years.
- As the result of a joint case with the Connecticut MFCU, the former coordinator of a mental health facility's evening alcohol and drug therapy program pled guilty to forgery. The therapist was given an 18-month suspended sentence and 3 years probation, with a special condition that he cannot work in a Medicare or Medicaid health care facility. The therapist's conviction stemmed from his alteration and falsification of documents used to bill third party payers. His misconduct came to OIG's attention through a self-disclosure made by the mental health facility, his former employer. The investigation found that the therapist falsified group psychotherapy attendance rosters used by the facility to bill Medicare and Medicaid. In March 2001, the facility agreed to pay the Government \$260,000 to resolve its liability for these improper billings.

Other Operating Divisions

The activities conducted and supported by other HHS operating divisions (OPDIVs) represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. These divisions within the Department include the following:

National Institutes of Health (NIH)
Food and Drug Administration (FDA)
Centers for Disease Control and Prevention (CDC)
Health Resources and Services Administration (HRSA)
Indian Health Service (IHS)
Agency for Toxic Substances and Disease Registry (ATSDR)
Agency for Healthcare Research and Quality (AHRQ)
Substance Abuse and Mental Health Services Administration
(SAMHSA)

The OIG continues to examine policies and procedures throughout these agencies to determine whether proper controls are in place to guard against fraud, waste and abuse. These activities include preaward and recipient capability audits. This oversight work has provided valuable recommendations to program managers for strengthening the integrity of agency policies and procedures.

FY 2000 FINANCIAL STATEMENT AUDITS ❖❖

In support of its audit of the consolidated HHS-wide financial statements for FY 2000, OIG audited, through contracts with independent public accounting firms, the financial statements of the major operating divisions. Agency officials are taking corrective action on most of the recommendations.

- Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry: The accounting firm issued an unqualified opinion on the CDC and ATSDR FY 2000 financial statements and noted one material weaknesses for not having a fully integrated accounting system. (A-17-00-00008)
- Food and Drug Administration: The FDA received an unqualified opinion on the FY 2000 financial statements. No material weaknesses were noted in the system of internal controls. (A-17-00-00006)
- Health Resources and Services Administration: The HRSA received an unqualified opinion on the FY 2000 financial statements. One material weakness was noted for not routinely analyzing grant expenditures and advances. (A-17-00-00003)
- National Institutes of Health: The accounting firm issued an unqualified opinion on the NIH FY 2000 financial statements and noted two material weaknesses for lacking an integrated financial system and for insufficiently analyzing grant expenditure activity. (A-17-00-00007)
- Substance Abuse and Mental Health Services Administration: The SAMHSA received an unqualified opinion on the FY 2000 financial statements. One material weakness was noted for not routinely analyzing grant expenditures and advances. (A-17-00-00002)

THE ORPHAN DRUG ACT

Assessing the implementation of the Orphan Drug Act of 1983, a law designed to stimulate the development of drugs for rare diseases, OIG found that the program is working as intended. The incentives in the law and FDA's administration of the program motivate drug companies to develop orphan products. Marketing exclusivity, which limits competition, is the most powerful incentive in the Orphan Drug Act. These products are generally accessible to patients, and

although they can be costly, price alone has not prevented patients from obtaining them. Companies reported an excellent relationship with FDA.

The OIG has concluded that no regulatory or legislative changes are needed at this time. This report is significant because it examines a program that provides substantial benefits to industry and the millions of Americans who suffer from rare diseases. (OEI-09-00-00380)

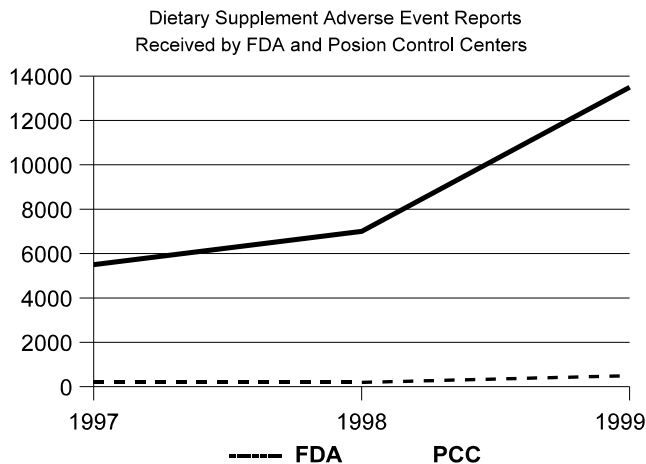
NONREPORTING TO THE NATIONAL PRACTITIONER DATA BANK ❖❖

Prompted by reports that physicians who lost their licenses to practice in one State were continuing to practice in others, Congress established the National Practitioner Data Bank in 1986. Conducted at the request of HRSA, this OIG report assessed the extent to which managed care organizations (MCOs) report the adverse actions they have taken against health care practitioners to the Data Bank. The OIG discovered that 84 percent (1,176 out of 1,401) of MCOs have never reported an adverse action to the Data Bank.

There are several possible explanations for nonreporting, but the two most likely are that nonreporting is a result of (1) limited focus on clinical oversight and/or (2) reliance on downstream entities—hospitals, physician practice groups, and State licensure boards—to conduct quality monitoring of practitioners. This report raises a broad concern about the limitations of the downstream entities upon which MCOs rely. (OEI-01-99-00690)

INADEQUATE ADVERSE EVENT REPORTING FOR DIETARY SUPPLEMENTS ❖❖

Unlike new prescription and over-the-counter drugs, the FDA does not have the authority to require dietary supplements to undergo premarket approval for safety and efficacy. Therefore, the FDA must rely on its voluntary adverse event reporting system to identify safety problems. As is true of most adverse event reporting systems, the FDA's system detects relatively few adverse events. The OIG found that the FDA's reporting system is inherently limited as a tool to safeguard consumers. For those events that are reported, the FDA often lacks much of the information—medical, product, manufacturer, consumer, and clinical—necessary to effectively analyze adverse event reports and generate possible signals of concern.



The OIG recommended that the FDA facilitate greater detection of adverse events, obtain more relevant information concerning the adversity and increase disclosure to the public. The FDA is proceeding, within available resources, in improving the system. (OEI-01-00-00180)

EXCLUSIONS FOR HEALTH EDUCATION ASSISTANCE LOAN DEFAULTS

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

After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Once the individual has been declared in default, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid and all Federal health care programs for nonpayment of these loans. During this 6-month period, 351 individuals and related entities were excluded as a result of PSC referral of their cases to OIG.

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

After being excluded for nonpayment of their HEAL debts, a total of 1,469 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debt. This figure includes the 127

individuals who have entered into such a settlement agreement or completely repaid their debt during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals over \$102 million. Of that amount, over \$10.9 million is attributable to this reporting period. In the following examples, each individual entered into a settlement agreement to repay the amount indicated:

- A West Virginia osteopath—\$958,000
- A Michigan physician—\$230,000
- A Pennsylvania dentist—\$194,000
- A New York physician—\$182,000

MISUSE OF GRANT FUNDS

Resolution of charges of misuse of HHS grant funds occurred in the following examples during this reporting period:

- A Massachusetts woman was sentenced to 3 years probation and ordered to pay \$83,025 in restitution for theft concerning programs receiving Federal funds. The woman embezzled Federal funds from an organization receiving HHS grant monies to conduct research on programs for the homeless.
- In connection with a grant fraud investigation, the sixth and final subject was sentenced in Wisconsin based on his guilty plea to a State charge of felony theft. The investigation revealed that the employee of an HHS grantee misappropriated approximately \$32,000 in various Federal, State and local grant funds, including Administration for Children and Families (ACF) funds. The employee generated checks from the grantee payable to her son, her son's acquaintances and her landlord. The checks were drawn from an account funded by ACF grant monies.
- The former administrative officer of an HHS grantee in Colorado was sentenced to 7 days incarceration, 3 years probation and ordered to pay \$4,705 in restitution for wire fraud. The administrative officer illegally used the grantee's credit card to make personal purchases and to provide a down payment on her vehicle. The credit card charges were ultimately paid from the grantee's operating account funded by HHS. Due to her ineffective and fraudulent administration of the grant, the grantee lost its HHS funding and terminated its operations.

***RESEARCH UNIVERSITY
DISCLOSURE STATEMENTS***

To promote accountability and fiscal integrity, OIG reviews disclosure statements submitted by major research universities as required by the cost accounting standards incorporated into OMB Circular A-21. These reviews determine whether the cost accounting practices presented in the disclosure statements are complete, accurate, current, and consistent with cost accounting standards and OMB Circulars A-21 and A-110.

The OIG is responsible for determining the adequacy and compliance of 140 disclosure statements submitted to the Department for approval. To date, OIG has reviewed 58 such statements and, as appropriate, has recommended that universities establish new, or revise existing, policies and procedures or that they revise those practices that are inconsistent with cost accounting standards or cost principles. These recommendations help to strengthen financial controls and ensure the integrity of the billions of Federal research dollars to be awarded to major universities in future years. (Various audit report numbers)



Administration for Children and Families

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

The OIG reviews those programs serving children and families. Reports have focused on ways to increase the efficient use of program dollars; to more effectively implement programs; to better coordinate programs among the Federal, State and local governments; and to strengthen States' financial management practices.

***FY 2000 FINANCIAL STATEMENT AUDIT:
ADMINISTRATION FOR CHILDREN AND FAMILIES ❖❖***

In support of its audit of the consolidated Departmentwide financial statements for FY 2000, OIG contracted with an independent accounting firm to audit ACF's financial statements. The ACF received an unqualified opinion on its financial statements. One material weakness was noted for not routinely analyzing grant expenditures and advances to detect material errors and unusual fluctuations. The ACF officials agreed with the findings and are taking corrective action on most of the recommendations. (A-17-00-00001)

CHILD CARE CLAIMS: NORTH CAROLINA

At ACF's request, OIG reviewed North Carolina's retroactive child care claims under Title IV-E foster care and other grants for the period October 1, 1993, through October 31, 1997. Based on a statistical sample, OIG estimated that the State was reimbursed approximately \$48.2 million in unallowable costs. In most cases, a consultant to the State did not properly determine the allowability of the claims, and the State did not adequately review the claims before submitting them to the Federal Government. In addition, the State's accounting system did not identify which grant was used to pay for a child's care, and the State did not maintain records that showed to which grant these payments were initially and subsequently assigned.

The OIG recommended that the State refund the \$48.2 million, develop accounting procedures that identify the grant used to pay for a child's care, maintain documentation to support eligibility for all child care claims for required periods, and monitor its consultants to ensure that only allowable child care claims are filed for Federal financial participation. State officials generally did not agree with the findings and recommendations. (A-04-98-00123)

***AID TO FAMILIES WITH DEPENDENT
CHILDREN PROGRAM: OVERPAYMENTS***

Under the former Aid to Families With Dependent Children (AFDC) program, State agencies were obligated to recover any overpayments to recipients by reducing future payments to the recipients or by collecting a cash settlement. Although the program was repealed and replaced with the Temporary Assistance

to Needy Families program, the requirement to recover AFDC overpayments remains in effect. States must return to the U.S. Treasury the Federal share of the overpayments that they collect.

As part of a nationwide review, OIG assessed the process used by six New England States to identify and return the Federal share of AFDC overpayments collected as of December 31, 2000. The OIG found that, of the amount collected, approximately \$12.4 million should be refunded to the Federal Government. The States agreed to return this amount and have already repaid over 90 percent. (A-01-01-02502)

***PROMOTING SAFE AND STABLE
FAMILIES: NEW YORK ♦♦***

Since FY 1994, ACF has awarded Title IV-B, Subpart 2 grants to States to promote safe and stable families. In FY 2001, funding for this program totaled \$305 million, and the President's budget for FY 2002 includes an additional \$200 million. In light of this planned increase, OIG assessed New York's use of program funds over the years.

New York elected not to apply for any program funds in FYs 1997 through 2001 because it could not meet the maintenance-of-effort requirements for both this program and the TANF program. Although the State participated in the program during FYs 1994 through 1996, one county was unable to spend \$167,000 of the FY 1994 allotment. The OIG also found that the State met its cost-sharing requirements during the years of participation. However, financial status reports for 2 years were submitted late. (A-12-01-00010)

***NEW YORK CHILD WELFARE
INFORMATION SYSTEM***

State Agency Child Welfare Information Systems, which are eligible for Title IV-E funding, are designed to allow child welfare workers online access to information on child protection, foster care, and adoption services. At ACF's request, OIG reviewed the costs that New York State claimed for Federal reimbursement under Phase I of the development and implementation of its child welfare information system (called CONNECTIONS).

The ACF had determined that the State's Phase I costs were outside the scope of developing and implementing the system. New York was unable to provide

detailed supporting documentation for Phase I costs because the accounting records did not segregate Phase I and II costs. As a result, neither the State nor OIG could identify the costs. However, the State proposed, and ACF accepted, a downward adjustment of \$12.4 million (Federal share \$9 million) based on previously approved budgeted figures. (A-02-99-02008)

MARYLAND CHILD PROTECTIVE SERVICES ♦♦

In this review, OIG determined whether a county-operated child protective agency in Maryland responded to reports of child abuse and neglect, known as referrals, in accordance with State and county requirements. The OIG found that the agency had a comprehensive outreach awareness program to provide child abuse and neglect information to the community and that its screening process was appropriate for determining whether a referral should be investigated.

However, the agency needed to better ensure that risk assessments and investigations complied with State requirements. For example, some investigations were not completed within the required 60-day period, risk assessments and investigation reports did not always document the family's history of prior involvement with the agency, and continuing services were not always offered to families when abuse or neglect was indicated. State and county officials generally agreed with OIG's recommendations to strengthen the agency's procedures, particularly supervisory oversight. (A-12-00-00004)

CHILD SUPPORT ENFORCEMENT

The OIG has made the detection, investigation and prosecution of absent parents who fail to pay court-ordered child support a priority. The OIG has worked with the Office of Child Support Enforcement (OCSE), DOJ, U.S. Attorneys' Offices, FBI, U.S. Marshals Service and other Federal, State and local partners to develop programmatic and operational procedures to expedite the collection of child support and to bring to justice those who willfully disregard their obligations. Since 1995, OIG has opened 1,519 investigations of child support cases nationwide which have resulted in 456 convictions and court-ordered criminal restitution and settlements of over \$25.9 million.

Investigative Task Forces

In 1998, OIG and OCSE initiated "Project Save Our Children," a criminal child support initiative made up of multiagency, multijurisdictional

investigative task forces. The task forces are designed to identify, investigate and prosecute the most egregious criminal nonsupport cases both on the Federal and State levels through the coordination of law enforcement, criminal justice and child support office resources. The six task force regions are the following:

Task Force Region	Task Force Headquarters	Task Force States
Mid-Atlantic	Baltimore, Maryland	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Midwest	Columbus, Ohio	Illinois, Indiana, Michigan, Ohio, Wisconsin
Northeast	New York City	Connecticut, New Jersey, New York, Puerto Rico
Southeast	Atlanta, Georgia	Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina
Southwest	Dallas, Texas	Louisiana, Oklahoma, Texas
West Coast	Sacramento, California	Arizona, California, Hawaii, Nevada, Oregon, Washington

Central to the above task forces are the screening units located in each task force region and staffed by analysts and auditors from both OIG and OCSE. The units receive child support cases from the States, conduct preinvestigative analyses of these cases through the use of databases and then forward the cases to the investigative task force units where they are assigned and investigated. The task force approach streamlines the process by which the cases best suited for criminal prosecution are identified, investigated and brought to fruition.

At this point, the task force units have received over 3,700 cases from the States. As a result of the work of the task forces, 157 Federal arrests have been executed and 113 individuals sentenced. The total ordered amount of restitution related to Federal investigations is \$4.8 million. There have been 298 arrests on the State level and 244 convictions or civil adjudications to date, resulting in \$9.9 million in restitution being ordered.

Investigations

During this period, OIG investigations of child support cases, nationwide, resulted in 64 convictions and court-ordered criminal restitution

of over \$3 million. Examples of the Federal arrests, convictions and sentences resulting from OIG's enforcement work, both inside and outside the task force regions, include the following:

- A Federal judge in Florida sentenced a man to 5 years probation and ordered him to pay \$322,976 in restitution for failure to pay child support. The man, a citizen of the United Kingdom and a legal resident of Florida, owns and operates a marketing firm incorporated with his current wife; most of the firm's earnings have been reported under her name. Since 1990, he has earned over \$735,000.
- In Texas, a man was sentenced to 5 years probation and ordered to pay \$77,283 in restitution for failure to pay child support. The man is employed by the United States Postal Service in Illinois where he earns approximately \$40,000 a year. He has been ordered to pay \$900 a month in support of his three children. His last voluntary child support payment occurred in July 1998.
- As part of three separate child support enforcement cases in Nevada, three individuals were sentenced for failure to pay child support. One was sentenced to 5 years probation and ordered to pay \$74,454 in restitution. A second was sentenced to 5 years probation and ordered to pay \$39,683 in restitution; and the third was sentenced to 5 years probation and ordered to pay \$32,900 in restitution.
- A man was sentenced in New York for failure to pay child support. He was ordered to pay \$68,640 in restitution, serve 5 years probation, enter a substance abuse program, refrain from the use of illegal drugs and alcohol and was prohibited from owning a firearm. At the time of his divorce in 1992, the man was ordered to pay \$80 a week in support for each of his two children. He avoided making these payments by moving from New York, to Virginia, to Arizona and eventually to California.
- A Montana man pled guilty to failure to pay child support and was sentenced in Washington to 5 years probation and ordered to pay \$67,320 in restitution. The man had not made any child support payments in 7 years for this three children who reside in Washington. The man deposited his earnings as a repairman in his girlfriend's business bank account. The man has an extensive criminal history which includes domestic violence.

- In the first child support enforcement case successfully prosecuted in Maine, a man was sentenced to 5 years probation and ordered to pay \$28,917 in restitution for failure to pay child support. In 1993, the court ordered him to pay \$92 a week in support of his two children. Since that time, he consistently failed to meet this obligation, and the only payments received occurred through tax intercepts. The investigation determined that although the man changed jobs often, he had earned reportable income. Investigation also revealed that as the result of an automobile accident, the man received an insurance settlement of approximately \$34,000 in 1993.
- In Minnesota, a man was sentenced to 5 years probation and ordered to pay \$18,852 in restitution for failure to pay child support. The man abandoned his 2-year-old daughter and her mother in 1997. Although ordered to make support payments of \$150 a month and gainfully employed since 1997, he never made a voluntary payment. Since his arrest in the fall of 2000, the man has remained current in his child support obligation via wage withholdings and has renewed contact with his daughter and her mother.

DECISION OF 6TH CIRCUIT COURT OF APPEALS

A September 25, 2000, decision of the 6th Circuit Court of Appeals had an impact on OIG child support enforcement investigative efforts. The Child Support Recovery Act made it a Federal crime to fail to pay child support on behalf of an out-of-state child. In United States v. Faasse, 227 F.3d 660 (6th Cir. 2000), the Court held that this Act exceeded Congress's commerce clause authority and was therefore unconstitutional. The Court granted rehearing *en banc* and on September 14, 2001, vacated the original decision. In the interim, however, the decision hampered pursuit of some child support nonpayment cases in the States covered by the 6th Circuit.

General Oversight

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

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133, under which HHS is cognizant agency to audit the majority of the Federal funds awarded to major research schools, State and local government cost allocation plans, and separate indirect cost plans of State agencies and local governments. Also, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities and other nonprofit organizations. Beginning with the FY1996 statements, OIG became responsible for auditing the Department's financial statements.

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

RESULTS ACT REVIEW PLAN ❖❖

The Government Performance and Results Act (GPRA) of 1993 mandates that Federal agencies establish strategic planning and prepare annual performance plans, beginning with FY 1999. The annual performance plans are to set forth measurable goals defining what will be accomplished during the year, and annual reports are to compare actual performance with those goals. The OIG's work in this area is focused on those measures related to mission-critical issues and areas at high risk of fraud, waste, and abuse and includes assessments of data collection methods and controls over the systems that produce performance data. The OIG notes that an ongoing objective of its audits, inspections and investigations is to identify performance results and offer recommended improvements.

The OIG's continuing payment error rate reviews at the Centers for Medicare and Medicaid Services (CMS) relate directly to assessment of CMS-generated financial performance data. The CMS uses OIG's annual estimate of the Medicare fee-for-service error rate as a basis for setting performance goals and for measuring performance. For FY 2000, OIG reported an estimated 6.8 percent error rate, and CMS met its 7 percent target that year. The CMS goal is to reduce this rate to 6 percent by 2001 and 5 percent by 2002.

During this reporting period, an OIG review of the Office for Civil Rights FY 1999 GPRA report found that the office did not accurately report performance results and did not have an adequate system for validating the information presented in its performance report. This conclusion was based on exceptions found in a judgmental sample of 63 of the 209 review or investigation cases used to prepare the performance report. The OIG recommended that the Office for Civil Rights (1) issue guidance to its regional offices to ensure that performance results are accurately and consistently reported; (2) enhance its data validation process to ensure that future performance results are reliable; and (3) review and, where appropriate, clarify the explanations and descriptions of performance measures and reported results in future performance plans. In response, the office is taking steps to improve the accuracy and verification of data in future years' reports. (A-12-00-00009)

Upcoming is a review of ACF's use of State-supplied data for performance measurement. The OIG will determine whether ACF has taken adequate steps to validate State data used in one or more major programs.

FY 2000 FINANCIAL STATEMENT AUDIT: PROGRAM SUPPORT CENTER ❖❖

In support of its audit of the consolidated HHS-wide financial statements for FY 2000, OIG audited, through a contract with an independent public accounting firm, the financial statements of the Program Support Center (PSC). The report noted continued improvement in PSC's financial management processes. The PSC received an unqualified opinion on its FY 2000 financial statements, and no material weaknesses were noted in the system of internal controls. (A-17-00-00005)

DEPARTMENTAL SERVICE ORGANIZATIONS ❖❖

In support of its HHS-wide FY 2000 financial statement audit, OIG contracted for examinations of four service organizations that provide common administrative, data processing and accounting services to individual operating divisions. In accordance with Statement on Auditing Standards No. 70, independent accounting firms examined the organizations' controls and tested their operating effectiveness.

- Center for Information Technology: The accounting firm issued an unqualified opinion and noted no significant exceptions at the Center. (A-17-00-00010)
- Central Personnel and Payroll System, Human Resources Services: The accounting firm issued an unqualified opinion and noted no significant exceptions. (A-17-00-00012)
- Division of Financial Operations: The firm concluded that controls tested were operating effectively but with exceptions. Problems were noted in such areas as risk assessment, the entity-wide security program, segregation of duties, and access controls. Officials of the division agreed with most of the findings. (A-17-00-00009)
- Division of Payment Management: The accounting firm issued an unqualified opinion and noted no significant exceptions. (A-17-01-00021)

MONITORING DEPARTMENTAL INTERNET SITES ❖❖

In this review of departmental monitoring of personally identifiable information on users of its web sites, OIG found that, contrary to departmental

policy, four operating divisions collected such information through the use of persistent “cookies.” This information was collected without obtaining the required Secretarial prior approval, and users were not warned that such information was being collected. The OIG also found that 21 of the Department’s web sites designed for children did not contain privacy statements or links to a privacy statement as required by the Children’s Online Privacy Protection Act.

The OIG recommended that departmental policy be amended to require frequent review of web sites to detect the use of persistent cookies and that the persistent cookies detected be immediately disabled. The OIG also recommended that the Department direct the Chief Information Officers (CIOS) of the operating divisions to ensure that web sites do not use persistent cookies without the proper waiver from the Secretary and that the web sites for children are in compliance with applicable laws. Finally, OIG recommended that all web site originators be required to certify to their respective CIOs that they are in compliance. (A-01-01-03000)

ABUSE OF PERSONS WITH DISABILITIES

Facilities receiving Medicare or Medicaid funding are subject to CMS’ conditions of participation as well as State laws and regulations. However, many other facilities, such as group homes, some residential schools, and supervised apartments, do not receive Medicare or Medicaid funding, and up to 90 percent of persons with disabilities reside in such facilities. These people must rely on State protections, which vary widely. This report provides a summary of systems used by some States to identify, investigate and resolve incidents of abuse or neglect of persons with disabilities.

The OIG recommended that CMS, the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, and the Food and Drug Administration work cooperatively to provide information and technical assistance to States to (1) improve the reporting of potential abuse or neglect of persons with disabilities, (2) strengthen investigative and resolution processes, (3) assist in analyzing incident data to identify trends indicative of systemic problems, and (4) identify the nature and cause of incidents to prevent future abuse. (A-01-00-02502)

FY 2000 DRUG CONTROL FUNDS

Agencies that participate in the National Drug Control Program are required to annually submit to the Office of National Drug Control Policy a

detailed accounting of all funds expended on program activities during the previous year. The agencies' respective Inspectors General are responsible for expressing an opinion on the reliability of the assertions in the accounting reports.

The OIG reviewed the detailed submissions of the six HHS agencies required to submit those reports for FY 2000: ACF, CDC, CMS, IHS, NIH, and SAMHSA. Based on these reviews, OIG was unable to determine that management assertions were reliably reported in the agencies' reports. (A-15-01-80006, A-15-01-80010, A-15-01-80008, A-15-01-80005, A-15-01-80011, and A-15-01-80007)

NEW JERSEY PENSION SURPLUS

In June 1994, New Jersey withdrew \$180.2 million from its public employee retirement systems and transferred the funds to the State's General Fund. The Department requested that OIG determine whether the Federal Government had received its share of the \$180.2 million for pension contributions made on behalf of federally funded programs, grants, and contracts. Office of Management and Budget Circular A-87 requires that States credit the Federal Government for its share of withdrawn pension funds.

The OIG found that the Federal Government was due a refund of \$6.6 million. Additionally, using the monthly interest rates earned by the State's General Fund from July 1994 to March 2001, OIG computed interest due the Federal Government in the amount of \$3 million. State officials concurred and refunded \$9.6 million. (A-02-01-02005)

ESCHEATED WARRANTS

Federal regulations require that States promptly refund the Federal portion of escheated warrants, which are uncashed and unclaimed checks. As noted below, two reviews identified problems in meeting this requirement

Puerto Rico

In three previous audits, covering the period July 1975 through June 1993, OIG identified serious deficiencies in Puerto Rico's handling of escheated warrants, which resulted in a recovery of \$28.8 million to the Federal Government. At the request of the Department, OIG followed up to determine whether Puerto Rico had implemented adequate controls to ensure that Federal programs received timely credit for escheated warrants from July 1993 through June 1998.

Finding no significant progress, OIG worked with Puerto Rico officials to develop a methodology for determining an appropriate credit that could serve as a basis for reaching a negotiated settlement. Using this methodology, OIG identified a potential credit of almost \$2 million due the Federal Government for FY 1994. The OIG recommended that the Department use this work to reach a settlement with Puerto Rico for the full period covered by the review. (A-02-99-02004)

Florida

This OIG report noted that Florida credited the Aid to Families With Dependent Children and Temporary Assistance to Needy Families (TANF) programs for the Federal share of escheated warrants for the period July 1993 through September 1997. However, from October 1997 through September 1998, the State did not credit \$42,000 (\$21,500 Federal share) of escheated warrants pertaining to TANF in accordance with either Federal regulations or State criteria. State officials said that they inadvertently failed to do so.

The OIG recommended that the State credit the TANF program the \$21,500 and take steps to ensure that escheated warrants are reported as required. State officials generally agreed with the findings and the recommendations. (A-04-00-00133)

NONFEDERAL AUDITS

The OMB Circular A-133 establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities are required to have an annual organization-wide audit which includes all Federal money they receive. These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the second half of FY 2001, OIG's National External Audit Review Center reviewed about 850 reports that covered \$568.9 billion in audited costs. Federal dollars covered by these audits totaled \$171.9 billion, about \$78.6 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. By taking a proactive stance, OIG identifies entities for high-risk monitoring and any trends that could indicate problems in HHS programs. In addition, OIG profiles nonfederal

audit findings of a particular program or activity over time to identify systemic problems. As a further enhancement of audit quality, OIG provides training and technical assistance to grantees and the auditing profession.

To rely on the work of nonfederal auditors, OIG maintains a quality control review process which assesses the nonfederal reports received and the audit work that supports selected reports. During this reporting period, OIG reviewed and issued 850 nonfederal audit reports which fall into the following categories:

<i>Reports issued:</i>	
<i>Without changes or with minor changes</i>	<i>832</i>
<i>With major changes</i>	<i>11</i>
<i>With significant inadequacies</i>	<i><u>7</u></i>
<i>Total</i>	<i>850</i>

The 850 reports included recommendations for HHS program officials to take action on cost recoveries totaling \$6.1 million, as well as 2,499 recommendations for improving management operations. In addition, these audit reports provided information for 60 special memoranda which identified concerns for increased monitoring by departmental management.

RESOLVING RECOMMENDATIONS

The tables on the following pages are provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and section 5 of the Inspector General Act and indicate the dollar value of actions taken on OIG recommendations.

In Table 1, “Dollar Value Questioned” costs are those challenged because of violation of law, regulation, grant conditions, etc. “Dollar Value Unsupported” costs are those not supported by adequate documentation.

Table 2 summarizes recommendations that funds be put to better use through cost avoidances, budget savings, etc.

These costs are separate from the amount ordered or returned as a result of OIG investigations. (Details p. 66.) All footnotes and additional explanatory information can be found in Appendix D.

Table 1: Reports With Questioned Costs

<i>Reports</i>	<i>Number of Reports</i>	<i>Dollar Value Questioned</i>	<i>Dollar Value Unsupported</i>
Section 1			
For which no management decision had been made by the beginning of the reporting period ¹	475	\$548,701,000	\$51,222,000
Issued during the reporting period	120	\$754,733,000	\$155,629,000
Total Section 1	595	\$1,303,434,000	\$206,851,000

Section 2			
For which management decision was made during the reporting period ^{2,3}			
Disallowed costs		\$76,516,000	\$595,000
Costs not disallowed		\$12,358,000	\$153,000
Total Section 2	183	\$88,874,000	\$748,000

Section 3			
For which no management decision had been made by the end of the reporting period			
Total Section 1 minus Total Section 2	412	\$1,214,560,000	\$206,103,000

Section 4			
For which no management decision was made within 6 months of issuance ⁴	300	\$296,930,000	\$295,900

Table 2: Funds Recommended to be Put to Better Use

<i>Reports</i>	<i>Number of Reports</i>	<i>Dollar Value</i>
Section 1		
For which no management decision had been made by the beginning of reporting period ¹	32	\$6,598,957,000
Issued during the reporting period	10	\$56,806,002,000
Total Section 1	42	\$63,404,959,000

Section 2		
For which management decision was made during the reporting period		
Value of recommendations that were agreed to by management		
Based on proposed management action	3	\$4,640,00
Based on proposed legislative action		
Value of recommendations that were not agreed to by management	4	\$7,757,000
Total Section 2	7	\$12,397,000

Section 3		
For which no management decision had been made by the end of the reporting period ²		
Total Section 1 minus Total Section 2	35	\$63,392,562,000

LEGISLATIVE AND REGULATORY REVIEW AND REGULATORY DEVELOPMENT

Review Functions

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

Regulatory Development Functions

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

- *Final Rulemaking on Revisions and Technical Corrections to 42 CFR Chapter V:*

The rule will address, among other things, revisions or clarifications to the definition "item or service," to the reinstatement procedures relating to exclusions resulting from a default on health education or scholarship obligations, and to the limitations period applicable to exclusions. In addition, the rule will set forth a number of technical corrections to the current regulations and clarify various issues and inadvertent errors appearing in OIG's existing regulatory authorities in order to achieve greater clarity and consistency.

- *Safe Harbor for Ambulance Restocking Arrangements Under the Anti-Kickback Statute:*

This rule sets forth a safe harbor under the anti-kickback statute to protect certain arrangements involving hospitals or other receiving facilities that replenish drugs and medical supplies used by ambulance providers (or other responders) when transporting patients to hospitals or receiving facilities.

In addition, during this period, OIG worked towards developing the following:

- Revised final regulations addressing a statutory exception to the anti-kickback statute for shared risk arrangements
- A final rule addressing a CMP safe harbor to protect payment of Medicare and Medigap premiums for ESRD beneficiaries
- Proposed rulemaking amending OIG exclusion regulations addressing excessive claims

During this period, OIG published several *Federal Register* notices that set forth OIG policy and procedures in various areas. These included the following:

- An OIG special advisory bulletin on Practices of Business Consultants (66 FR 36583; July 12, 2001)
- A notice announcing a change in user fees for the Healthcare Integrity and Protection Data Bank (66 FR 31245; June 11, 2001)
- A solicitation notice regarding development of compliance program guidance for the pharmaceutical industry (66 FR 31246; June 11, 2001)

Congressional Testimony and Hearings

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

EMPLOYEE FRAUD AND MISCONDUCT

The OIG has oversight responsibility for the investigation of allegations of wrongdoing by Department employees when it affects internal programs. Most of

the persons employed by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities, as illustrated in the following examples:

- A Federal judge in Maryland sentenced a former NIH research scientist and his wife for willfully infringing copyrights by selling compact disks containing thousands of dollars of copyrighted computer software. The former NIH employee was sentenced to 36 months supervised probation and was ordered to pay \$30,988 in restitution to several software companies and a \$6,055 fine for his participation in the scheme which involved using the NIH computer network to facilitate the sale of the software. His wife was sentenced to 36 months supervised probation and was ordered to pay \$30,988 in restitution to several software companies and a \$2,000 fine for her involvement.
- In Maryland, a former NIH employee was sentenced to 36 months supervised probation and was ordered to pay \$23,300 in restitution for theft of Government property. While working in an NIH mail room, the employee stole 19 Government and private checks made payable to NIH.

INVESTIGATIVE PROSECUTIONS

During this semiannual reporting period, OIG investigations resulted in 210 successful criminal actions. Also during this period, 738 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 232 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over \$1.25 billion was ordered or returned as a result of OIG investigations during this reporting period. Civil settlements from investigations resulting from audit findings are included in this figure.

PROGRAM FRAUD CIVIL REMEDIES ACT

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

Under PFCRA, a person who presents a false, fictitious or fraudulent claim to a Federal agency may be subject to a civil monetary penalty of up to \$5,000 per claim or statement, as well as an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims and statements presented to the Department.

During FY 2001, no matters were specifically referred for administrative action solely under PFCRA. While all cases are routinely analyzed for potential action under PFCRA, at HHS the availability of other criminal, civil and administrative remedies often renders unnecessary the referral of cases for action solely under PFCRA. However, OIG does assert its administrative authority under PFCRA as one basis in settlement agreements, in which OIG is a party, that resolve cases arising under the False Claims Act and other Federal statutes. In addition, as part of these settlements, the defendant is released from liability under PFCRA.

Appendices

Appendix A
***Savings Achieved through Policy and Procedural Changes Resulting from Audits,
Investigations and Inspections***
April 1, 2001 through September 30, 2001

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

Legislative savings are annualized amounts based on Congressional Budget Office (CBO) estimates consistent with CBO savings. In keeping with OIG policy, savings from the Medicare provisions of the Balanced Budget Act (BBA) of 1997 were adjusted downward to reflect CBO estimates for related provisions of the Balanced Budget Refinement Act (BBRA) of 1999. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected or for multiple years, if applicable.

Total savings from these sources amount to \$6,555 million for this period.

<i>OIG Recommendation</i>	<i>Implementing Action</i>	<i>Savings (millions)</i>
<i>Centers for Medicare and Medicaid Services</i>		
Medicare Home Health Payments: Restructure the payment system for home health care to eliminate inappropriate incentives which unnecessarily increase cost and utilization; prevent unscrupulous providers from gaining entry into the program; and improve program controls, such as eligibility determinations and approval of plans of care and services. (OEI-04-93-00260; OEI-09-96-00110; CIN: A-04-96-02121)	Chapter I of Subtitle G of the BBA of 1997 (as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998), which pertains to home health benefits, addresses OIG's concerns regarding the need to restructure and control the payment system for these services. For example, it mandates that a prospective payment system be developed and that the total payments in fiscal year (FY) 2000 be equal to the amount that would have been paid under the prior system if cost limits were reduced by 15 percent. It also eliminates periodic interim payments to home health agencies.	\$4,270
Medicare Indirect Medical Education: The Centers for Medicare and Medicaid Services (CMS) should base the indirect medical education adjustment factor on the level supported by CMS' empirical data. (CIN: A-07-88-00111)	Section 4621 of the BBA (as amended by the BBRA of 1999) reduced the indirect teaching adjustment factor from 7.7 percent in FY 1997 to 7.0 percent in FY 1998; 6.5 percent in FY 1999; 6.0 percent in FY 2000; and 5.5 percent in FY 2001 and thereafter.	1,170

<p>Medicare Secondary Payer - Initial Enrollment Questionnaire: The CMS should take steps to collect primary insurance information in a more timely and accurate manner, requiring beneficiaries to disclose other health insurance information, and should revise all Medicare claims forms to require spousal information before claims can be paid. (CIN: A-09-89-00100; OEI-07-90-00760)</p>	<p>Since 1995, all Medicare beneficiaries are being asked to complete the Initial Enrollment Questionnaire and list any other health insurance they have. The CMS has reported that two-thirds of all new beneficiaries are voluntarily completing the questionnaire and this has helped CMS document 110,000 cases each year in which new beneficiaries have other coverage.</p>	<p>425</p>
<p>Graduate Medical Education Payments: The CMS should reevaluate Medicare's policy of paying graduate medical education (GME) costs for all physician specialties and should consider submitting legislation to reduce Medicare's investment in GME to arrive at a more representative and accurate sharing of GME costs. (CIN: A-06-92-00020)</p>	<p>Sections 4623 and 4626 of the BBA provided for limits in the number of residents and offered payments for voluntary reductions in the number of residents to limit Medicare's share of GME costs.</p>	<p>240</p>
<p>Medicare Disproportionate Share: The disproportionate share adjustment should be reduced, if not eliminated, without redistribution of the funds to prospective payment system (PPS) hospitals. (CIN: A-04-87-01004)</p>	<p>Section 4403 of the BBA provided for the reduction of disproportionate share payments by 1 percent in FY 1998, 2 percent in FY 1999, 3 percent in FY 2000, 4 percent in FY 2001, 5 percent in FY 2002 and 0 percent thereafter.</p>	<p>160</p>
<p>Hospital Outpatient Policy: Extend congressionally mandated reductions in hospital costs. Hospitals should limit outpatient department (OPD) facility fees to the applicable ambulatory surgical center (ASC) rate or reduce payments for OPD services to bring them in line with AZC payments. (CINs: A-14-89-00221; A-09-91-00070; & OEI-85-09-0046; OEI-09-88-01003)</p>	<p>Section 13521 of the Omnibus Budget Reconciliation Act of 1993 mandated a reduction of 10 percent for outpatient capital costs. Sections 4521-4523 of the BBA of 1997 eliminated formula-driven overpayments in FY 1998, extended reductions in payments for costs of hospital outpatient services, and established a PPS for hospital outpatient services for FY 1999.</p>	<p>60</p>
<p>Fraud and Abuse Provisions of the Balanced Budget Act: Require durable medical equipment (DME) suppliers and home health agencies (HHAs) to provide Social Security numbers (SSNs) and employee identification numbers (OEI-04-96-00240 & OEI-09-96-00110); refuse to enter into a provider agreement with any HHA whose owners or principals have prior criminal records or are the relatives of owners of a provider that had defrauded the Medicare program <i>continued—</i></p>	<p>Subtitle D of the BBA contained a number of provisions that corresponded to and were supported by OIG work. For example, the BBA authorized the Secretary to collect SSNs and employer identification numbers from entities under Medicare, Medicaid and Title V; authorized the Secretary to refuse to enter into contracts with physicians or suppliers that have been convicted of felonies; authorized the exclusion of entities owned or controlled by the family or household members of excluded individuals; authorized CMS to make inherent reasonableness adjustments up to 15 percent to all Part B</p>	<p>60</p>

<p>Fraud and Abuse Provisions of the Balanced Budget Act Continued— (OEI-09-96-00110); allow CMS to apply “inherent reasonableness” provisions when assessing the appropriateness of Medicare payments (OEI-03-94-00392); authorize competitive bidding as a means of providing Medicare services (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230); and require DME suppliers and HHAs to post surety bonds as a condition of participation. (OEI-04-96-00240; OEI-09-96-00110). Also, clarify which general and administrative and fringe benefit costs at hospitals and HHAs are related to patient care; specifically, distinguish between employee benefits and/or perquisites to entertainment and patient care, and specify that cost of entertainment, goods or services for personal use, alcohol, all fines and penalties and associated interest, dues, and membership costs associated with civic and community organizations are not allowable. (CINs: A-03-92-00017 & A-04-93-02067)</p>	<p>services except physician services; authorized up to five demonstration projects to be completed by December 31, 2002 (one must be oxygen and oxygen equipment), which can have multiple sites, to allow competitive bidding; and prohibited “reasonable cost” payments for items such as entertainment, gifts and donations, education expenses and personal use of automobiles. The BBA also required DME suppliers, HHAs and others to post surety bonds of a minimum of \$50,000.</p>	
<p>Hospice Certification: The CMS should restructure hospice benefit policies to curb inappropriate growth in the program, particularly with regard to the fourth benefit period. (OEI-05-95-00250; CIN: A-05-96-00023)</p>	<p>Sections 4441-4449 of the BBA of 1997 contained provisions to control hospice payments and practices, such as replacing the current unlimited fourth benefit period with an unlimited number of 60 day benefit periods (each requiring recertification).</p>	60
<p>Hospital Sales: The CMS should eliminate the requirement that Medicare adjust for gains and losses when hospitals undergo changes of ownership. (OEI-03-96-00170)</p>	<p>Section 4404 of the BBA eliminated the requirement that Medicare make adjustments by setting the Medicare capital asset sales price equal to the net book value.</p>	50
<p>Rural Health Clinics: The oversight and functioning of the current cost reimbursement system should be improved by implementing caps on provider-based rural health clinics (RHCs) and allowing States to do so, or finding other ways to make reimbursement between provider-based and independent RHCs more equitable. In addition, the certification process should be modified to <i>continued—</i></p>	<p>Section 4205 of the BBA extended the per-visit payment limits to provider-based clinics and stipulated that the shortage area requirements designation be reviewed triennially.</p>	40

Appendix A

Rural Health Clinics Continued— increase State involvement and ensure more strategic placement of RHCs. Recertification should be required of RHCs within a specific time limit (for example 5 years), applying new criteria to document the need and impact on access. (OEI-05-94-00040)		
Payments for Ambulance Services: The CMS should seek legislative authority to develop a fee schedule for ambulance transportation and examine the inherent reasonableness of current allowable charges. (OEI-05-95-00300)	Section 4531 of the BBA of 1997 made interim reductions in ambulance payments by limiting the allowed rate of increase and mandated the establishment of a fee schedule by January 1, 2000. Such fee schedule is to be set so that aggregate payments are reduced by 1 percent.	10

Administration for Children and Families

Availability of Health Insurance for Title IV-D Children: The OIG recommended that the State of Connecticut either (i) implement policies and procedures to require noncustodial parents (NCPs) to pay all or part of the Medicaid premiums for their dependent children or (ii) to establish a statewide health insurance plan that provides reasonably priced comprehensive coverage for children, with premiums paid by NCPs. (CIN: A-01-97-02506)	The BBA of 1997 established Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), to enhance Medicaid coverage provided to children and allow States to create insurance options for families who exceed Medicaid resource and income limits. Connecticut received CMS approval in April 1998 to initiate a child health program. Under Connecticut law, applicants include noncustodial parents under court orders to provide health insurance.	5.7
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Various Operating Divisions

Results of Investigations: In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the operating division.	The operating division takes action based on the results of OIG investigation to suspend or terminate payments to the offending individual or entity.	4.3
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Appendix B
Unimplemented Office of Inspector General Recommendations
to Put Funds to Better Use

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

More detailed information may be found in OIG's *Red Book*.

<i>OIG Recommendation</i>	<i>Status</i>	<i>Savings (millions)</i>
Centers for Medicare and Medicaid Services		
Formula for Costs Charged to the Medicaid Program: The Centers for Medicare and Medicaid Services (CMS) should consult with the Congress on modification of the Federal medical assistance percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per capita income relationships. (CIN: A-06-89-00041)	The CMS did not agree with the recommendation.	\$4,100
Medicare Coverage of State and Local Government Employees: The CMS should require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (CIN: A-09-88-00072)	The CMS agreed with the recommendation to mandate Medicare coverage for all State and local government employees but did not agree with the recommendation to make Medicare the secondary payer.	1,559
Overstated Managed Care Capitation Rates: The CMS should seek legislation to correct the overstated base-year rates or eliminate any future increases in managed care capitation rates. (CIN: A-05-99-00025)	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 increased payments to Medicare+Choice organizations but did not modify the base-year amounts due to the overstated actuarial assumptions. The OIG believes that managed care payment rates continue to be excessive.	1,260

Appendix B

<p>Excessive Medicare Payments for Prescription Drugs: The CMS should examine its Medicare drug reimbursement methodologies. (OEI-03-97-00290; OEI-03-97-00292; OEI-03-97-00293; OEI-03-97-00390; OEI-03-95-00420; OEI-03-94-00390)</p>	<p>The BBA of 1997 reduced Medicare payments by limiting them to 95 percent of the average wholesale price (AWP). The OIG believes additional corrective action is warranted.</p>	<p>1,600</p>
<p>Clinical Laboratory Tests: The CMS should develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CINs: A-09-89-00031 & A-09-93-00056)</p>	<p>The CMS agreed with the first recommendation but not the second. The FY 2001 budget included a proposal to reduce payment updates from 2003 through 2005 and a proposal to reinstate laboratory cost sharing. In addition, the BBA required the Secretary to contract with the Institute of Medicine for a study of Part B laboratory test payments; CMS may use the results to develop a new payment methodology.</p>	<p>1,130*</p>
<p>Hospital Capital Costs: The CMS should determine the extent that capital reductions are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CINs: A-09-91-00070 & A-14-93-00380)</p>	<p>The CMS did not agree with the recommendation. Although the BBA of 1997 reduces capital payments, it does not include the effect of excess bed capacity and other elements included in the base-year historical costs. The President's FY 2001 budget would have reduced capital payments and saved \$630 million in FY 2001 through FY 2005.</p>	<p>820</p>
<p>Medicaid Payments to Institutions for Mentally Retarded: The CMS 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 reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and/or seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)</p>	<p>The CMS did not concur with OIG's recommendation. The CMS 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 CMS and OIG negotiated an agreement for CMS to send the report to all State Medicaid directors. This action has been taken. However, pursuant to section 4711 of the BBA of 1997, the Secretary shall conduct a study on the effect of access to, and the quality of, services provided to beneficiaries of the rate-setting methods used by States.</p>	<p>683</p>

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

<p>Payment Policy for Medicare Bad Debts: The OIG presented four options for CMS to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable, and the inclusion of a bad debt factor in the diagnosis-related group (DRG) rates. The CMS should seek legislative authority to further modify bad debt policies. (CIN: A-14-90-00339)</p>	<p>The CMS agreed with the recommendation to include a bad debt factor in the DRG rates. The BBA of 1997 provides for some reduction of bad debt payments to providers. The President's FY 2001 budget proposes to reduce the percentage (from 55 to 45 percent) that Medicare pays for bad debts. However, additional legislative changes are needed to implement the modifications that OIG recommended.</p>	340
<p>Hospital Admissions: The CMS should seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services. (CINs: A-05-89-00055 & A-05-92-00006)</p>	<p>The CMS proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services.</p>	210
<p>Graduate Medical Education: The CMS should 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 and submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020)</p>	<p>The CMS did not concur with the recommendations. Although the BBA of 1997 contains provisions to slow the growth in Medicare spending on GME, OIG believes that its recommendations should be implemented and that further savings can be achieved.</p>	157.3
<p>Paperless Claims: The CMS should lead a target outreach to encourage voluntary conversion to paperless Medicare claim filing by physicians who submit claims on paper and who have a moderate to high level of interest in making the switch. This effort should be coordinated with efforts to promote further use of electronic data interchange by providers under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996. The CMS should begin to plan now for the policy changes that will be necessary to achieve an almost completely paperless environment for processing Medicare claims. These policy changes can include targeting a date when all physicians will be mandated to submit paperless claims, <i>continued—</i></p>	<p>The CMS concurred with OIG's recommendations. The President's FY 2001 budget proposes to allow an assessment of a \$1 fee on claims not submitted electronically.</p>	126

<p>Paperless Claims Continued—targeting a date when paperless claim submission will become a condition for Medicare participation, or continuing to accept paper claims but imposing a filing fee to cover the incremental cost of doing so. (CIN: A-05-94000039; OEI 01-94-002300)</p>		
<p>Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (CIN: A-06-94-00039)</p>	The OIG is continuing to monitor the Medicaid drug rebate program.	123
<p>Expansion of the Diagnosis Related Group Payment Window: The CMS should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)</p>	The CMS did not concur with the recommendation to further expand the payment window.	83.5
<p>Inpatient Psychiatric Care Limits: The CMS should develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services and apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)</p>	The CMS agreed with OIG's findings but stated that further analysis would be required before any legislative changes could be supported.	47.6
<p>Nonemergency Advanced Life Support Ambulance Services: The CMS 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. (CINs: A-01-91-00513 & A-01-94-00528)</p>	The BBA of 1997 required that CMS link payments to services provided and that the definitions of basic life support and advanced life support ambulance services be subject to negotiated rulemaking. The Negotiated Rulemaking Committee Statement on the Medicare Ambulance Services Fee Schedule was signed in February 2000. The CMS published the proposed rule, which includes revised physician certification requirements, in the <i>Federal Register</i> in September 2000.	47
<p>Reimbursement for Hospital Beds: The CMS should take immediate steps to reduce Medicare payments for hospital beds used in the home. This should include the elimination of the higher reimbursement <i>continued—</i></p>	The CMS concurred with the recommendations and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency is examining payment allowances and methodologies at other payers and is reviewing data to determine if	40

Reimbursement for Hospital Beds Continued— rate currently paid during the first 3 months of rental. (CIN: A-06-91-00080; OEI-07-96-00221; OEI-07-96-00222)	Medicare payments are excessive. However, the BBRA of 1999 imposed a moratorium on the application of CMS' "inherent reasonableness" authority. Thus, while the moratorium is in place, CMS may not act on a determination that costs are excessive.	
End Stage Renal Disease Payment Rates: The CMS should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)	The CMS agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities. While the Omnibus Budget Reconciliation Act of 1990 prohibited CMS from changing these rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatment. A March 1996 study by ProPAC recommended an increase to the current rates, but CMS did not believe an across-the-board increase was warranted and intended to monitor facilities' costs and other factors to determine if a rate increase would be appropriate. Toward this end, the BBA of 1997 requires the Secretary to audit the cost reports of each renal dialysis provider at least once every 3 years. The CMS planned to begin these audits in FY 1999. Section 222 of the BBRA of 1999 increased each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above the payment for services provided on December 31, 1999, and for services during 2001 by 1.2 percent above the payment for services provided on December 31, 2000.	22*
Medicaid Reimbursement for Clinical Laboratory Services: State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings that contain duplicate tests, recover over-payments, and make adjustments for the Federal share of the amounts recovered. (CINs: A-01-95-00005; A-05-95- 00035; A-01-96-00001; A-06-95-00078; A-06-95-00031; A-04-95-01108; A-04-95-01109; A-07-95-01139; A-07-95-01147; A-04-95-01113; A-07-95-01138; A-09-95-00072; A-05-96-00019; A-10-95-00002; <i>continued—</i>)	The CMS wrote to all State Medicaid directors on January 15, 1997, alerting them to OIG's review, encouraging them to use Medicare's bundling policies and urging them to install appropriate payment edits in their claim processing systems. Currently, OIG is conducting several follow-up reviews in this area.	17.8

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

Medicaid Reimbursement for Clinical Laboratory Services Continued— A-01-95-00006; A-02-95-01009; A-03-96-00200; A-03-96-00202; A-03-96-00203; A-05-95-00062; A-06-96-00002; A-06-95-00100; A-04-98-01185)		
Medicare Orthotics: The CMS should take action to improve Medicare billing for orthotic devices. The CMS should also require standards for suppliers of custom-molded and custom-fabricated orthotic devices. (OEI-02-99-00120)	The CMS generally concurred. However, CMS did not agree to set specific standards for suppliers of custom-molded and custom-fabricated devices.	33
Medicare Claims for Railroad Retirement Beneficiaries: The CMS should discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)	The FY 2002 budget does not include this type of legislative proposal.	9.1
Indirect Medical Education: The CMS should reduce the indirect medical education (IME) adjustment factor to the level supported by CMS' empirical data and initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (CIN: A-07-88-00111)	The CMS agreed with the recommendation, and the BBA of 1997, as amended by the BBRA of 1999, reduces the IME adjustment to 5.5 percent in 2002 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.	TBD *
Medicare Secondary Payer—End Stage Renal Disease Time Limit: The CMS should extend the Medicare secondary payer (MSP) provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016)	The CMS was concerned that an indefinite MSP provision might encourage insurers to drop services that are uneconomical, namely facility dialysis and transplantation. Although the BBA of 1997 extends MSP policies for individuals with ESRD to 30 months, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.	TBD

**To Be Determined*

<p>Home Health Agencies: The CMS should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (OEI-04-93-00262; OEI-04-93-00260; OEI-12-94-00180; OEI-02-94-00170; CINs: A-04-95-01103; A-04-95-01104; A-04-94-02087; A-04-94-02078; A-04-96-02121; A-04-97-01169; A-04-97-01166; A-04-97-01170; A-04-99-01194)</p>	<p>Although the Congress and the Administration included provisions to restructure home health benefits in the BBA of 1997, CMS still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. Subsequent to implementation of the BBA, OIG's four-State review found that unallowable services continue to be provided because of inadequate physician involvement. While agreeing in principle, CMS said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification.</p>	TBD
<p>Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: The CMS should seek legislation that would require participating drug manufacturers to pay Medicaid drug rebates based on average wholesale price (AWP) or study other viable alternatives to the current program of using average manufacturer price (AMP) to calculate the rebates. This legislation would have resulted in about \$1.15 billion in additional rebates for 100 brand-name drugs with the highest total Medicaid reimbursements in Calendar Years 1994-96. (CIN: A-06-97-00052)</p>	<p>The CMS disagreed with the recommendation to seek a legislative change, believing that such legislation was not feasible at the time. However, CMS stated that changing AMP to AWP would reduce the administrative burden involved in the AMP calculations and planned a comprehensive study of AWP.</p>	TBD

Various Operating Divisions

<p>User Fees for Food and Drug Administration Regulations: Extend user fees to inspections of food processors and establishments. (OEI-05-90-01070)</p>	<p>In the absence of specific authorizing legislation, the Food and Drug Administration (FDA) is precluded by statute from imposing user fees to cover additional functions. The FY 2001 President's budget request for FDA proposes that FDA be given new user fee authority to perform premarket review of direct food additives, food export certificates, and medical device review of 510(k)s.</p>	75.9
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<p>Medicare Rates for Indian Health Service Contracted Health Services: The Indian Health Service (IHS) should revise its legislative proposal to incorporate OIG's updated savings figures and should identify elements to be included in the implementing regulations. Also, IHS should continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates and should strategically identify and pursue other opportunities where lower rates may be negotiated. (CIN: A-15-97-50001)</p>	<p>The IHS concurred with OIG's recommendations. This proposal is on the Department's list of legislative initiatives for 2002. The IHS notes that by applying a 5-percent inflation factor, the savings projection for 2002 would be almost \$11 million.</p>	<p>8.2</p>
<p>Recharge Center Costs: The Assistant Secretary for Management and Budget should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (CIN: A-09-96-04003)</p>	<p>The Deputy Assistant Secretary for Grants and Acquisition Management concurred. In addition, the Council on Government Relations generally agreed and stated that the proposed criteria should be included in the Compliance Supplement to OMB Circular A-133, which provides guidance to independent auditors in conducting compliance audits of educational institutions.</p>	<p>1.9</p>

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).

<i>OIG Recommendation</i>	<i>Status</i>
<i>Centers for Medicare and Medicaid Services</i>	
Accountability Over Billing and Collection of Medicaid Drug Rebates: The CMS 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 CMS with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (CIN: A-06-92-00029)	The CMS 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 CMS issued interim regulations in FY 1996.
Fairly Presenting the Medicare Accounts Receivable Balance: The CMS should require Medicare contractors to implement or improve internal controls and systems to ensure that reported accounts receivable are valid and documented. (CINs: A-17-95-00096; A-17-97-00097; A-17-98-00098; A-17-00-00500; A-17-00-02001)	The CMS hired consultants to assist in validating the FY 1999 accounts receivable activity and balance, as well as the activity for the first 6 months of FY 2000. The agency also provided training on accumulating and verifying receivable balances. The President's FY 2001 budget included funding to establish financial management controls at the contractors and to hire contractor staff to implement the controls.
Safeguards Over Medicaid Managed Care Programs: The CMS should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)	The CMS 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.
Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program: The CMS should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The CMS should also develop a more specific policy for calculating AMP <i>continued—</i>	The CMS did not concur, stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP but did not provide specific written methodology for computing AMP.

<p>Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program Continued— which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)</p>	
<p>Physician Office Surgery: The peer review organizations (PROs) should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)</p>	<p>The CMS has issued policy guidance and manual instructions to explicitly state that PROs have the responsibility to review all care in physician offices when a beneficiary complains.</p>
<p>Medicare Beneficiary Satisfaction with Durable Medical Equipment Regional Carrier Services: The CMS should evaluate ways to increase beneficiary satisfaction with the one durable medical equipment regional carrier with a low rating, and review effective ways to educate beneficiaries on what constitutes fraud and abuse. (OEI-02-96-00200)</p>	<p>The CMS concurred. The CMS conducts annual evaluations to identify ways to improve performance. The CMS is also working to develop new outreach techniques to increase beneficiaries' knowledge on detecting fraud and abuse.</p>
<p>Pressure Reducing Support Services: The CMS should establish the requirement for periodic review and renewal of the medical necessity for beneficiaries' use of group 2 support surface equipment. (OEI-02-95-00370)</p>	<p>The CMS did not concur.</p>

General Oversight

<p>Cost Principles for Federally Sponsored Research Activities: The Department should modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (CIN: A-01-92-01528)</p>	<p>Hospital cost principles have been updated in a draft regulation which is expected to be issued as a notice of proposed rulemaking by September 30, 2001.</p>
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Appendix D
Notes to Tables 1 and 2

Notes to Table 1

¹The opening balance was adjusted upward by \$41 million.

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

- CIN: A-04-98-49864 NA-Head Start of Alamance & Caswell Counties: Grantee Supplied Documentation to Support Question Cost for \$137,631.
- CIN: A-06-99-55361 OTOE-Missouria Tribe of Indians: Grantee Supplied Documentation to Support Question Cost for \$2,700.
- CIN: A-06-00-64997 State of Oklahoma: Grantee Supplied Documentation to Support Question Cost for \$12,400.
- CIN: A-10-01-65062 NookSack Indian Tribe: Grantee Supplied Documentation to Support Question Cost for \$20,528

³Included are management decisions to disallow \$45 million that was identified in nonfederal audit reports.

⁴Due to administrative delays, many of which are beyond management's control, resolution of the following audits was not completed within 6 months of issuance; however, based upon discussions with management, resolution is expected before the end of the next semiannual reporting period:

- CIN: A-07-99-00980 Assist Review of Medicare A/R HCFA RO KCMO January 2000, \$39,730,982
- CIN: A-02-99-02007 NYS DFA - Rev. Retroactive Juvenile Justice Claims, April 2000, \$32,614,777
- CIN: A-04-00-65030 State of South Carolina, July 2000, \$31,755,510
- CIN: A-04-98-00122 Emergency Assistance Claims-NC HHS/Div Mental Health, September 1999, \$25,993,849
- CIN: A-07-99-01279 O/P Psych, January 2001, \$18,515,190
- CIN: A-05-94-00064 MI BCBS, Audit of Admin Costs, June 1996, \$15,609,718
- CIN: A-07-96-01176 Medicare Excess Pension Assets - BC Michigan, November 1996, \$11,904,263
- CIN: A-03-97-00013 BCBSM FY 89-92 Incremental Claim, September 1998, \$11,723,785
- CIN: A-05-99-00070 Monitoring - Contract Audit of HCSC & Termination, March 2000, \$9,921,720
- CIN: A-05-00-00045 OIG Partnership: State Auditor Report on Medicaid, May 2000, \$8,500,000
- CIN: A-09-97-44262 State of California, April 1997, \$7,300,000
- CIN: A-03-91-00552 Independent Living Program - National, March 1993, \$6,529,545
- CIN: A-02-99-02001 NYS Rev of Retroactive Kinship Claims, September 2000, \$5,833,676
- CIN: A-07-99-02537 Blue Cross & Blue Shield of Massachusetts, November 1999, \$5,270,461
- CIN: A-05-96-00058 Close-out Audit of Medicare Contract-BCBS-MI, December 1997, \$5,226,443
- CIN: A-01-97-00516 Admin. Costs-part A & B, Railroad Retire Board, June 1999, \$4,939,184
- CIN: A-07-96-02001 Medicare Part B Admin Costs at BCBS Colorado, December 1996, \$4,483,104
- CIN: A-07-98-01263 Denver CMHC, May 2000, \$4,447,607
- CIN: A-05-94-00080 Associated Ins. Medicare Administrative Costs, July 1996, \$3,954,632
- CIN: A-07-00-00109 Medicare Contract Term. & Seg. Closing- Galic, September 2000, \$3,505,560
- CIN: A-06-97-00029 Retention of Fees Child Placing Agencies Louisiana, September 1998, \$3,450,173
- CIN: A-02-95-01019 Staff Builders Home Office Medicare Cost Rev. ORT, August 1998, \$3,434,274
- CIN: A-05-93-00054 IL-Associated Insurance Group-Contract Audit, October 1993, \$3,355,560
- CIN: A-03-94-00029 Veritus Inc - Admin Cost, February 1998, \$3,140,363
- CIN: A-05-98-00042 Administar Ins. Co.- Admin. Costs Audit, September 1999, \$3,111,728

Appendix D

CIN: A-06-99-00057 Audit of Medicare Rehab Agency Svcs in TX, RHS, in, January 2001, \$3,097,201
CIN: A-05-93-00013 MI-BCBS - Contract Medicare Audit, April 1993, \$3,010,916
CIN: A-09-98-50183 State of California, March 1998, \$3,000,000
CIN: A-01-95-00504 Medicare Parts A & B Admin Costs - AETNA, January 1996, \$2,938,223
CIN: A-01-96-00508 Medicare Admin Costs Parts A & B and RRB - Travelers, March 1996, \$2,803,260
CIN: A-05-97-00005 Administrative Costs Claimed under Medicare A & B, February 1998, \$2,569,067
CIN: A-07-92-00579 BC/BS of Michigan Inc - Unfunded Pension Costs, October 1992, \$2,535,698
CIN: A-05-92-00026 Associated Insurance Co. - Medicare Admin, February 1992, \$2,530,409
CIN: A-07-98-02523 BC/California - FACP, April 1999, \$2,408,019
CIN: A-02-91-01006 Blue Shield of Western NY Medicare Adm Cts Porter, September 1991, \$2,379,239
CIN: A-04-97-01166 Rev. Home Hlth Svcs by Staff Builders Home Hlth, April 1999, \$2,300,000
CIN: A-04-97-01170 Review Home Hlth Svcs by Medicare Home Hlth Svcs, April 1999, \$2,200,000
CIN: A-04-00-02162 Review Treatment of Qualified Dischrgs @ FCSO, February 2001, \$2,042,060
CIN: A-05-00-00034 Provena St. Joseph Hospital-O/P Psych Services, November 2000, \$1,978,583
CIN: A-04-97-01169 Review Home Hlth Svcs by Medtech Home Hlth Svcs, April 1999, \$1,900,000
CIN: A-06-96-00009 New Mexico BCBS Admin Cost - Contracted, November 1997, \$1,879,366
CIN: A-05-97-00014 Group Health Plan Inc.(Healthpartners) Inst. Benes, June 1998, \$1,787,345
CIN: A-04-00-66032 State of Florida, August 2000, \$1,713,052
CIN: A-04-97-02143 Review Therapy Svcs in Life Care SNF's in TN, December 1999, \$1,638,025
CIN: A-02-97-01039 Medassist - ORT Orthotics Provider Target, November 1999, \$1,616,222
CIN: A-06-99-00006 Contract Audit of BCBS Administrative Costs, November 1999, \$1,615,063
CIN: A-04-99-01196 OIG-HCFA Joint Review of JMY Medical Corp., December 2000, \$1,600,417
CIN: A-03-96-00012 BCBSM Part-B Non-renewal Costs, August 1998, \$1,557,459
CIN: A-05-93-00057 MI BCBS of MI-Contract Audit, July 1993, \$1,409,954
CIN: A-09-01-67037 Hawaii Dept. Of the Attorney General , January 2001, \$1,407,910
CIN: A-09-96-00064 ORT - Hospice - California, March 1997, \$1,350,000
CIN: A-10-91-00011 WPS - Keystone Computer Acquisition, October 1992, \$1,346,681
CIN: A-05-95-00042 BCBSA Administrative Costs - Contracted Audit, December 1995, \$1,333,598
CIN: A-05-00-00004 New Center Community Mental Health Center, June 2000, \$1,181,000
CIN: A-02-97-01026 EDDY VNA (#337152) HHA Eligibility Review, September 1999, \$1,131,593
CIN: A-05-98-00050 Follow-up Medicaid Clinical Laboratories, July 1999, \$1,097,036
CIN: A-02-94-01029 Hospice Eligibility Review in PR - San Germane - ORT, June 1995, \$1,070,814
CIN: A-09-98-00052 California Medical Review Inc. (CA. Pro), January 1999, \$1,067,991
CIN: A-05-94-00047 Nationwide Ins., Medicare Part B Admin. Costs, September 1995, \$1,049,309
CIN: A-07-99-01278 ORF-MO, September 2000, \$1,042,522
CIN: A-03-98-00048 The Program, Inc. - CMHC, November 2000, \$1,009,493
CIN: A-01-98-00500 Payment Edits for Psychiatric at MA Part B Carrier, September 1998, \$1,000,000
CIN: A-09-94-01010 Closeout Audit - Cont No. N01-ES-75196 (Stratagene), March 1994, \$983,208
CIN: A-08-99-55285 NA-South Dakota Urban Indian Health Inc., June 1999, \$902,377
CIN: A-08-99-55284 NA-South Dakota Urban Indian Health Inc., June 1999, \$902,046
CIN: A-04-00-01210 Review Treatment-qualified Dischrgs - BCBS GA, December 2000, \$891,000
CIN: A-05-92-00060 Contractor Audit - BCBS - Admin, February 1993, \$879,609
CIN: A-02-97-01034 Dr. Pila Foundation Home Care Program (Ponce), September 1999, \$857,208
CIN: A-07-98-02533 Travelers FACP, December 1998, \$854,214
CIN: A-06-99-00013 Medicare Part A Admin NM BCBS, December 1999, \$817,487
CIN: A-02-98-01040 Niagara City Dept. Of Health #337001-HHS Elig Review, December 1999, \$807,679
CIN: A-03-99-00008 BCBS of Delaware - Part A, January 2000, \$798,939
CIN: A-07-99-00981 Assist Review of Medicare A/R HCFA RO Denver, January 2000, \$754,926
CIN: A-05-91-00136 Community Mutual Ins Co. Admin Costs, August 1992, \$720,668
CIN: A-09-97-00078 Physician Billings Dr. Spencer, January 1999, \$683,264

CIN: A-04-00-61620	State of North Carolina, March 2000, \$664,773
CIN: A-09-99-00083	Blue Shield Termination Costs, December 1999, \$659,763
CIN: A-05-00-64226	NA-Illinois Dept. of Public Aid, May 2000, \$654,017
CIN: A-01-98-00503	Psychiatric O/P Services at the Franklin Med Ctr, November 1998, \$646,517
CIN: A-06-99-56489	State of Louisiana, January 1999, \$634,915
CIN: A-01-99-00535	Audit of M/C Part A Admin Costs-Anthem BC/BS Ct, August 2000, \$621,256
CIN: A-09-98-00095	Blue Shield of California, October 1999, \$612,569
CIN: A-06-98-00066	ORT Review of Ultimate Home Health Care Inc., October 1999, \$602,982
CIN: A-04-94-01078	Monitoring Admin Cost - Audit Medicare Part.B BCBS SC, July 1994, \$594,092
CIN: A-04-93-01069	Monitoring Admin Cost - Audit Medicare Part A BCBS SC, July 1994, \$590,844
CIN: A-05-99-00062	Americare Physical Therapy Services, December 2000, \$503,619
CIN: A-09-99-56858	Hawaii Dept. Of Human Services, February 1999, \$502,000
CIN: A-03-93-21786	District of Columbia Dept. Of Human Services, October 1993, \$501,747
CIN: A-03-92-16229	State of Pennsylvania, March 1992, \$496,876
CIN: A-05-01-67384	Michigan Dept. Of Community Health , February 2001, \$488,737
CIN: A-04-98-01192	Review America's Behav.Health Care's Part. Hospitaliz, December 1999, \$452,928
CIN: A-06-00-00011	Final Administrative Cost Proposal - AR BCBS, November 2000, \$442,177
CIN: A-09-98-49239	NA-Hermandad Mexicana Nacional Legal Center Inc., November 1997, \$419,364
CIN: A-05-97-00013	Pacificare of CA-HMO Institutional Status Project, April 1998, \$407,784
CIN: A-05-00-00030	Contracted Audit-nationwide Ins.-medicare Admin., October 2000, \$385,081
CIN: A-04-00-01208	Outpatient Clinic Costs, Coral Gables Hospital, Fl, February 2001, \$384,295
CIN: A-06-99-58928	Arkansas Office of Child Support Enforcement, April 1999, \$367,273
CIN: A-04-96-01134	Partic. Part of HCFA Surv. Team-colonnade MCAL-ORT, February 1997, \$358,338
CIN: A-04-96-01136	Partic. Part of HCFA Surv. Team-Survey Savanah-ORT, December 1996, \$354,537
CIN: A-01-99-00518	Psychiatric Outpatient Svcs at Danbury Hospital, May 2000, \$342,168
CIN: A-02-01-65217	Puerto Rico Dept. Of the Family , December 2000, \$317,042
CIN: A-04-97-01175	Keystone Pro, June 1998, \$310,787
CIN: A-04-96-01129	Parti.part HCFA Surv.Team-Ameri.trans.Care (ORT), February 1997, \$284,378
CIN: A-05-96-00069	CPA Audit of Hooper Holmes HHA G&A -OI Case Open, February 1998, \$280,515
CIN: A-01-00-00511	Review of O/P Pharmacy Svc-Baystate Med Ctr, November 2000, \$279,409
CIN: A-06-97-00015	New Mexico Pro Close out Audit, September 1999, \$268,844
CIN: A-05-01-67360	Michigan Family Independence Agency , February 2001, \$267,632
CIN: A-09-94-30178	State of Arizona, June 1994, \$267,021
CIN: A-03-98-00027	KHPW/Institutional Status/Medicare, November 1998, \$263,573
CIN: A-02-99-01026	South Jersey Rehab (ORF), November 2000, \$241,774
CIN: A-04-97-01152	Close out Audit - Michigan Pro, June 1997, \$228,630
CIN: A-05-00-60454	St. Croix Chippewa of Wisconsin, December 1999, \$224,452
CIN: A-01-00-00549	Beth Israel Audit of Outpatient Pharmacy Svc, March 2001, \$221,905
CIN: A-05-99-00067	WPS Part B Administrative Costs, November 2000, \$221,644
CIN: A-04-96-01135	Partic. Part of HCFA Surv. Wash. Manor Nursg - ORT, February 1997, \$220,483
CIN: A-09-96-00094	ORT-Monitor CPA Audit of "Dynasty" HHA Cost Report, July 1997, \$217,720
CIN: A-05-00-57443	Michigan Family Independence Agency, July 2000, \$216,563
CIN: A-05-96-00052	ORT Assist-Ancillary Costs-NW Com. Hosp., June 1997, \$206,508
CIN: A-03-98-00014	Connecticut Pro Inc/CCAS/HHS-100-95-0033, February 1998, \$202,662
CIN: A-06-96-00064	ORT SNF Research at Methodist Hospital, January 1997, \$200,000
CIN: A-05-97-00006	MI - Wayne State U/NIH Request/Romero Grant, June 1997, \$195,809
CIN: A-03-99-00007	Forest Ambulance Service - External, December 1998, \$173,189
CIN: A-05-96-00031	WIPRO/Equipment Depreciation, August 1996, \$167,033
CIN: A-07-99-01287	Wellmark Admin Costs 98, November 1999, \$160,626

Appendix D

CIN: A-03-97-00016 Quality Improvement Pro Inc/CCAS/Puerto Rico, February 1998, \$158,925
CIN: A-03-98-00034 Freestate HP/Institutional Status/Medicare, March 1999, \$156,987
CIN: A-08-99-60402 State of South Dakota, July 1999, \$142,748
CIN: A-03-98-00025 Abingdon Ambulance Company - Abingdon, VA, January 1999, \$139,325
CIN: A-05-00-00031 Contracted Audit of UGS-Medicare Admin. Costs, November 2000, \$138,182
CIN: A-09-99-52846 Inter-Tribal Council of California Inc., February 1999, \$136,360
CIN: A-02-98-01002 IPRO Closeout Audit - CPA Contract Monitoring, December 1998, \$135,492
CIN: A-06-00-00014 Rev of Infusion Therapy Claims @ Doctors Healthcare, June 2000, \$132,238
CIN: A-09-01-66969 Fresno Indian Health Association Inc., February 2001, \$116,607
CIN: A-05-97-00023 Kaiser Foundation-HMO Institutional Status Project, April 1998, \$116,096
CIN: A-02-96-02001 International Rescue Committee - Refugee Program, January 1998, \$114,631
CIN: A-03-99-00003 Aetna-US Healthcare/Institutional Status/Medicare, July 1999, \$113,993
CIN: A-03-95-03329 Henderson Associates/CACS/ASC/282-91-0012, March 1997, \$111,289
CIN: A-02-96-01001 VNS of NY Home Care - ORT/HHA Target, September 1997, \$110,841
CIN: A-01-00-62266 State of Maine, March 2000, \$106,500
CIN: A-04-00-64861 State of North Carolina, June 2000, \$105,219
CIN: A-02-99-58263 Puerto Rico Office of the Governor Office of Child, July 1999, \$101,799
CIN: A-10-00-61811 State of Washington, January 2000, \$101,047
CIN: A-05-00-65775 State of Wisconsin, September 2000, \$98,586
CIN: A-09-97-00066 Walter McDonald - Indirect Cost Rate Audit, March 1998, \$95,733
CIN: A-05-00-65108 NA-Illinois Dept. of Public Aid, July 2000, \$95,309
CIN: A-09-98-00065 CSBG Disc. Grant #90EE004901 - Latino Resources, January 1999, \$95,102
CIN: A-01-99-00507 Nationwide Ref O/P Psych Svc at Acute Care Hospitals, March 2000, \$94,716
CIN: A-10-97-00003 BCWAAK-Adm Costs Remote Network Activities Fy93&94, February 1998, \$94,643
CIN: A-06-96-43195 Pueblo of Isleta, June 1996, \$92,969
CIN: A-07-95-01164 Medicare Admin Costs - General American, December 1995, \$89,929
CIN: A-06-00-00013 Review of Infusion Therapy Claims @ Spring Creek N, June 2000, \$89,288
CIN: A-08-99-56914 Rural America Initiatives, July 1999, \$87,468
CIN: A-04-96-38655 State of North Carolina, April 1996, \$83,237
CIN: A-04-94-02080 Finalization of BCBS FL Data Match, June 1995, \$79,316
CIN: A-03-98-00008 VA Health Quality Center Review ORG/PRO/CCAS/VA, December 1998, \$78,207
CIN: A-04-96-01137 Partic. Part of HCFA Surv.Team-Daytona Nursg-ORT, December 1996, \$76,130
CIN: A-01-99-00530 Nationwide Rev of O/P Psych Svcs @ Psych Hospitals, December 2000, \$75,413
CIN: A-09-00-60032 Lovelock Paiute Tribe, December 1999, \$74,187
CIN: A-01-00-00503 Review of Medicare Outlier Payments-Mass General, December 2000, \$73,019
CIN: A-01-99-57863 State of Connecticut, May 1999, \$67,594
CIN: A-07-01-67750 VIA Christi Regional Medical Center Inc. & Subsid, January 2001, \$65,117
CIN: A-09-00-60444 Yomba Shoshone Tribe, December 1999, \$64,030
CIN: A-05-99-00045 Kaiser Health Plan of Ohio - Institutional Status, May 2000, \$61,177
CIN: A-05-96-00072 MI Dept. Of Community Health/Medicaid Lab Services, August 1997, \$59,956
CIN: A-01-96-00505 CFO Audit of HCFA's Financial Statements, July 1997, \$59,327
CIN: A-03-99-00200 PSU-Geisinger/Phy Credit Balances/Medicaid, December 1999, \$59,051
CIN: A-02-00-62534 City of New York New York, January 2000, \$58,309
CIN: A-07-92-00526 MMIS Enhanced FFP Costs, July 1992, \$58,149
CIN: A-05-96-00051 ORT Assist-ancillary Costs - St. Joseph, June 1997, \$58,008
CIN: A-09-97-00059 Health Services Advisory Group, Inc Pro-Az, May 1997, \$57,925
CIN: A-04-01-67287 Covington Protestant Childrens Home, December 2000, \$56,335
CIN: A-08-99-54138 Rosebud Sioux Tribe, November 1998, \$56,223
CIN: A-04-96-01125 Partic.-Part of HCFA Survey Team-Rosemont-ORT February 1997, \$55,306
CIN: A-04-00-64899 NA-State of Tennessee, July 2000, \$55,129

CIN: A-07-97-01206 Pension - Washington/Alaska - Unfunded, March 1997, \$54,000
 CIN: A-10-00-62761 Burns Paiute Indian Tribe, February 2000, \$53,516
 CIN: A-08-00-60687 South Dakota Foundation for Medical Care, November 1999, \$52,536
 CIN: A-06-99-59854 State of Louisiana, August 1999, \$51,788
 CIN: A-09-01-65664 NA-Lovelock Paiute Tribe, December 2000, \$50,473
 CIN: A-09-95-00095 Health Services Advisory Group, Inc (HSAG), December 1995, \$49,585
 CIN: A-03-93-03306 Survey Research Assoc. CACS N01-ES-45067, December 1993, \$48,779
 CIN: A-09-99-52845 Inter-Tribal Council of California Inc., February 1999, \$43,315
 CIN: A-09-99-57306 Picayune Rancheria of the Chukchansi Indian Tribe, September 1999, \$43,159
 CIN: A-03-99-00017 PSU-Hershey/Phy Credit Balances/Medicare, December 1999, \$41,712
 CIN: A-09-00-60443 Yomba Shoshone Tribe, January 2000, \$41,373
 CIN: A-02-95-34279 Puerto Rico Dept. Of Health, June 1995, \$40,207
 CIN: A-02-95-34275 Puerto Rico Dept. Of Health, June 1995, \$37,515
 CIN: A-03-97-44742 Association of Teachers of Preventive Medicine Inc, February 1998, \$37,260
 CIN: A-02-99-59166 Cypress Hills Child Care Corp., September 1999, \$36,935
 CIN: A-07-98-53295 Winnebago Tribe of Nebraska, September 1998, \$36,808
 CIN: A-10-00-63008 State of Idaho, March 2000, \$36,800
 CIN: A-08-00-65136 State of South Dakota, June 2000, \$36,380
 CIN: A-07-98-02030 DOSHI - CPA Report, November 1997, \$35,703
 CIN: A-03-00-00010 PSU Geisinger HMO/Institutional Status/Medicare, January 2001, \$35,639
 CIN: A-02-00-65502 Abyssinian Development Corp., August 2000, \$34,737
 CIN: A-07-97-01218 DOSHI - Utah/Nevada FMC, March 1997, \$33,752
 CIN: A-04-00-60897 State of Florida, March 2000, \$33,397
 CIN: A-03-99-00004 PSU-Geisinger/Phy Credit Balances/Medicare, December 1999, \$32,165
 CIN: A-07-97-01199 BCBS New Mexico Unfunded Pension Cost, February 1997, \$31,372
 CIN: A-09-96-42547 Maricopa County Arizona, April 1996, \$30,766
 CIN: A-03-00-63919 Mingo County Economic Opportunity Commission Inc., March 2000, \$30,453
 CIN: A-05-97-48015 NA-Hoosier Valley Economic Opportunity Corp., May 1997, \$29,004
 CIN: A-03-98-03301 AAUAP - Incurred Cost Review - HHS 105-95-7011, April 1998, \$28,289
 CIN: A-03-00-64076 National Medical Association, April 2000, \$27,106
 CIN: A-10-96-41391 Klamath Family Head Start, April 1996, \$26,530
 CIN: A-05-00-60452 St. Croix Chippewa of Wisconsin, December 1999, \$26,363
 CIN: A-03-92-00033 Blue Cross of West Virginia Termination, November 1992, \$25,200
 CIN: A-06-00-00020 Rev of Infusion Therapy Claims @ Vista Continuing, June 2000, \$25,008
 CIN: A-10-00-58628 NA-Kuigpagmiut Inc., November 1999, \$24,596
 CIN: A-04-00-64117 State of Alabama, April 2000, \$23,911
 CIN: A-03-00-00004 Guthrie Clinic/Physician Credit Balances/Medicare, December 1999, \$23,759
 CIN: A-08-00-60654 Spirit Lake Tribe, January 2000, \$22,031
 CIN: A-07-99-01288 Wellmark Medicare Admin Costs, November 1999, \$21,513
 CIN: A-04-00-01206 BCBS NC - Medicare Part A Admin Cost Audit-Carmichael, September 2000, \$21,302
 CIN: A-03-00-65163 George Washington Univ., September 2000, \$20,879
 CIN: A-07-99-01290 Moh Admin Costs, November 1999, \$20,548
 CIN: A-05-96-43041 NA-Hoosier Valley Economic Opportunity Corp., June 1996, \$20,438
 CIN: A-10-01-67141 State of Idaho, December 2000, \$20,000
 CIN: A-04-97-01163 Vimi Medicare Pro Contract Audit, September 1997, \$18,758
 CIN: A-03-00-61948 Mingo County Economic Opportunity Commission Inc., January 2000, \$18,703
 CIN: A-03-00-00200 Guthrie Clinic/Physician Credit Balances/Medicaid, December 1999, \$18,318
 CIN: A-05-93-21928 Wright State Univ., July 1993, \$18,308
 CIN: A-01-00-61896 Jewish Family Service of Stamford Inc., December 1999, \$18,027
 CIN: A-03-99-00201 PSU-Hershey/Phy Credit Balances/Medicaid, December 1999, \$17,584

Appendix D

CIN: A-03-97-00007 NE Health Care Quality Foundation/CCAS/N Hampshire, March 1997, \$17,045
CIN: A-07-00-00117 Rev. of Pension Costs for Med. Reimb. BCBS of ND, January 2001, \$16,863
CIN: A-01-99-55594 State of Vermont, November 1998, \$16,623
CIN: A-01-97-44143 Brandeis Univ., January 1997, \$16,602
CIN: A-05-00-60814 Childrens Hospital of Michigan Inc., November 1999, \$16,191
CIN: A-01-00-65091 State of Vermont, July 2000, \$15,853
CIN: A-10-00-59080 Norton Sound Health Corp., December 1999, \$15,000
CIN: A-04-99-01200 OIG-HCFA Joint Review of Gem Physical Therapy Inc., December 1999, \$14,604
CIN: A-03-97-00008 NE Health Care Quality Foundation/CCAS/Vermont, March 1997, \$14,596
CIN: A-09-00-00104 State of Nebraska, July 1999, \$14,209
CIN: A-06-98-54189 City of Houston Texas, July 1998, \$14,146
CIN: A-09-96-00050 CFO - HCFA 1996, November 1997, \$13,924
CIN: A-10-00-63684 Hoh Indian Tribe, April 2000, \$13,602
CIN: A-07-95-01175 Mutual of Omaha - Admin Costs, August 1996, \$13,564
CIN: A-07-99-57985 State of Kansas, February 1999, \$13,550
CIN: A-09-01-66137 Tohono O Odham Nation, November 2000, \$13,329
CIN: A-05-95-36498 Hoosier Valley Economic Opportunity Corp., April 1995, \$13,116
CIN: A-03-98-50338 National Medical Association, February 1998, \$12,968
CIN: A-09-01-67471 Catholic Charities of San Jose, January 2001, \$12,420
CIN: A-09-99-59787 Palau Community Action Agency, June 1999, \$12,326
CIN: A-09-00-61853 Fresno Indian Health Association Inc., March 2000, \$11,963
CIN: A-03-01-66421 American Association of Community Colleges, November 2000, \$11,811
CIN: A-04-99-59501 Chapel Hill-Carrboro City Board of Education, June 1999, \$11,256
CIN: A-08-00-56759 South Dakota Urban Indian Health Inc., November 1999, \$10,933
CIN: A-09-00-62572 NA-Fresno Indian Health Association Inc., February 2000, \$10,720
CIN: A-07-00-63881 Santee Sioux Tribe of Nebraska, April 2000, \$10,187
CIN: A-10-97-00002 Group Health Institutionalized, November 1997, \$9,769
CIN: A-05-01-66410 Hutzel Hospital (Subsidiary of the Detroit Medic), November 2000, \$9,455
CIN: A-10-00-62578 State of Alaska, February 2000, \$9,159
CIN: A-02-01-66887 Puerto Rico Administration of Children & Families, February 2001, \$9,000
CIN: A-07-97-01231 Prowest-DOSHI Washington, June 1997, \$8,027
CIN: A-05-00-63666 Ho-chunk Nation, February 2000, \$7,851
CIN: A-03-00-00020 Health Personnel, Inc. PA, February 2001, \$7,809
CIN: A-03-91-02004 W. VA B/C Admin Cost FY 85/90 and Term. Cost, November 1992, \$7,556
CIN: A-03-96-38803 Skyline Government Services Corp., November 1995, \$7,285
CIN: A-03-98-00045 Temple Univ/Physician Credit Balances/Medicare, July 1999, \$7,280
CIN: A-01-97-49174 Brandeis Univ., August 1997, \$7,068
CIN: A-09-01-65778 Indian Health Council Inc., October 2000, \$7,032
CIN: A-01-00-61715 State of Vermont, October 1999, \$6,766
CIN: A-06-96-40858 CADD0 Community Action Agency Inc., February 1996, \$6,557
CIN: A-09-00-58580 Tohono O Odham Nation, November 1999, \$6,456
CIN: A-04-99-56945 Quitman County Development Organization Inc., March 1999, \$6,142
CIN: A-07-95-01167 Pension Costs Claimed Nebraska BCBS, January 1996, \$6,075
CIN: A-06-97-48062 SER-Jobs for Progress National Inc., May 1997, \$5,924
CIN: A-05-00-58003 Community Unit School District No. 300, October 1999, \$5,858
CIN: A-08-99-56446 Sisseton-Wahpeton Sioux Tribe, May 1999, \$5,843
CIN: A-08-00-59899 South Dakota Urban Indian Health Inc., November 1999, \$5,496
CIN: A-02-99-56463 Virgin Islands Advocacy Agency Inc., November 1998, \$5,089
CIN: A-09-97-48829 Community Action Commission of Santa Barbara Count, August 1997, \$4,809
CIN: A-01-00-60299 Indian Township Tribal Government Passamaquoddy Tr, January 2000, \$4,597
CIN: A-05-01-67790 Chicago Family Health Center Inc., January 2001, \$4,462

CIN: A-07-95-01123	Review of CPA Adm. Cost - BCBS of Kansas City, May 1995, \$4,045
CIN: A-04-97-01162	HMSA Medicare Pro Contract Audit, September 1997, \$3,871
CIN: A-02-01-67330	Cornell Cooperative Extension of Madison County, January 2001, \$3,803
CIN: A-02-00-64365	NA-Municipality of Ponce Puerto Rico, May 2000, \$3,788
CIN: A-09-95-39056	Hawaii Dept. of Health, September 1995, \$3,601
CIN: A-04-99-59126	Sequatchie Valley Planning & Development Agency, September 1999, \$3,360
CIN: A-03-01-03303	Johns Hopkins University/KPMG/NIDA/N01da-3-7301, February 2001, \$3,347
CIN: A-08-00-65151	Rocky Boy School District No. 87J & L, July 2000, \$3,309
CIN: A-06-00-65029	State of Louisiana, July 2000, \$3,162
CIN: A-02-01-66889	Puerto Rico Administration of Children & Families, February 2001, \$3,103
CIN: A-03-95-03318	Trans-Management Systems 105-92-1527 (CCO), May 1996, \$3,016
CIN: A-02-01-66888	Puerto Rico Administration of Children & Families, February 2001, \$2,883
CIN: A-07-98-02502	CT BCBS Pension Costs Claimed, March 1998, \$2,725
CIN: A-03-98-51505	Alliedsignal Technical Services Corp., April 1998, \$2,722
CIN: A-02-97-49366	Seneca Nation of Indians, September 1997, \$2,655
CIN: A-01-97-45487	ABT Associates Inc., January 1997, \$2,596
CIN: A-08-00-61852	Native American Services Agency Inc., February 2000, \$2,575
CIN: A-03-97-43996	Actuarial Research Corp., October 1996, \$2,561
CIN: A-06-00-58523	Osage Nation of Oklahoma, October 1999, \$2,247
CIN: A-04-01-67492	Berean Baptist Church Head Start, January 2001, \$2,141
CIN: A-03-96-44076	St. Pauls College, August 1996, \$2,029
CIN: A-10-96-38114	State of Washington, February 1996, \$2,000
CIN: A-07-97-01232	Prowest - DOSHI Alaska, June 1997, \$1,473

Notes to Table 2

¹The opening balance was adjusted to reflect an upward revaluation by \$248 million.

²Management decision has not been made within 6 months of issuance on 12 reports:

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

CIN: A-03-00-00203	PA/Intergovernmental Transfers/Medicaid, February 2001, \$3,700,000,000
CIN: A-07-98-02534	Empire BCBS Pension Plan Termination, March 2000, \$38,626,351
CIN: A-04-97-00109	Emergency Assistance Claims - NC, July 1998, \$13,000,000
CIN: A-01-99-00506	Follow-up Review of Seprtly Billable ESRD Lab Tests, January 2001, \$12,200,000
CIN: A-07-96-01177	Medicare Post Retirement Claim BC Mich, November 1996, \$8,978,998
CIN: A-01-97-02506	Review of the Avail of Medical Coverage/CSE Support, June 1998, \$5,704,585
CIN: A-04-98-01188	Review Admin. Costs @ Medicare Managed Risk Plan, August 1999, \$2,559,357
CIN: A-09-95-00095	Health Services Advisory Group, Inc (HSAG), December 1995, \$1,389,723
CIN: A-03-99-00038	Edgewater Psyc Hospital, March 2001, \$208,731
CIN: A-07-97-01230	OFMQ - DOSHI Oklahoma, June 1997, \$203,510
CIN: A-09-00-60029	Cocopah Indian Tribe, December 1999, \$20,830
CIN: A-01-97-00526	Psychiatric Outpatient Services, March 1998, \$7,245

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 are no data to report under a particular requirement, this is indicated as “none.” A complete listing of audit and inspection reports is being furnished to the Congress under separate cover. Copies are available upon request.

<i>Section of the Act</i>	<i>Requirement</i>	<i>Page</i>
Section 4(a)(2)	Review of legislation and regulations	64
Section 5		
(a)(1)	Significant problems, abuses and deficiencies	Throughout
(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	Throughout
(a)(3)	Prior significant recommendations on which corrective action has not been completed	Appendices B and C
(a)(4)	Matters referred to prosecutive authorities	66
(a)(5)	Summary of instances where information was refused	None
(a)(6)	List of audit reports	Under separate cover
(a)(7)	Summary of significant reports	Throughout
(a)(8)	Statistical Table 1-Reports with Questioned Costs	62
(a)(9)	Statistical Table 2-Reports With Recommendations That Funds Be Put To Better Use	63
(a)(10)	Summary of previous audit reports without management decisions	Appendix D
(a)(11)	Description and explanation of revised management decisions	Appendix D
(a)(12)	Management decisions with which the Inspector General is in disagreement	None

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

Pursuant to section 205 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, the Inspector General is required annually to solicit proposals (via *Federal Register* notice) for modifying existing safe harbors to the anti-kickback statute and for developing new safe harbors and special fraud alerts.

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

In response to the 2000 annual solicitation, OIG received three timely filed responses which contained the following proposals related to safe harbors:

<i>Proposal</i>	<i>OIG Response</i>
New safe harbor for sale of durable medical equipment (DME) by sleep disorder centers.	The OIG will not adopt this suggestion. There is no basis for safe harbor protection for the provision of DME by sleep disorder clinics. There is no comparable safe harbor under the anti-kickback statute for other providers. Arrangements for the sale or distribution of DME can be abusive, depending on the circumstances.
Modify the language of the existing rental and services safe harbors that requires aggregate compensation to be set in advance so as to accommodate “per use” fees.	The OIG will not adopt this suggestion. The arrangements that use “per use” or similar “per click” fees are often abusive under the anti-kickback statute.
Modify the employment safe harbor to include a “bright line” definition of the term “employee.”	The OIG will not adopt this suggestion. The existing safe harbor defines “employee” with reference to Internal Revenue Service rules for purposes of consistency. It would not be feasible for OIG to develop a different definition.
Modify the group practice safe harbor to conform it to the final regulations under the physician self-referral statute published by CMS on January 4, 2001.	The OIG has this proposal under consideration.

Appendix G

Statutory and Administrative Responsibilities

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

Audit and Management Review Responsibilities and Office of Management and Budget Circulars

- P.L. 96-304 Supplemental Appropriations and Rescissions Act of 1980
- P.L. 96-510 Comprehensive Environmental Response, Compensation and Liability Act
- P.L. 97-255 Federal Managers' Financial Integrity Act
- P.L. 97-365 Debt Collection Act of 1982
- P.L. 99-499 Superfund Amendments and Reauthorization Act of 1986
- P.L. 101-576 Chief Financial Officers Act of 1990
- P.L. 102-486 Energy Policy Act of 1992
- P.L. 103-62 Government Performance and Results Act of 1993
- P.L. 103-355 Federal Acquisition Streamlining Act of 1994
- P.L. 103-356 Government Management Reform Act of 1994
- P.L. 104-156 Single Audit Act Amendments of 1996
- P.L. 104-191 Health Insurance Portability and Accountability Act of 1996
- P.L. 104-193 Personal Responsibility and Work Opportunity Act of 1996
- P.L. 104-208 Federal Financial Management Improvement Act of 1996
- P.L. 106-398 Government Information Security Reform Act
- P.L. 106-554 Report on Federal Agencies' Monitoring of Personal Information Through "Cookies"
- P.L. 106-554 Report on Water/Sewer Services Provided by the District of Columbia

Office of Management and Budget Circulars

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

General Accounting Office Government Auditing Standards

Criminal and Civil Investigative Authorities

Criminal investigative authorities include:

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

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

- Title 31, United States Code, sections 3729-3733, (the False Claims Act) and 3801-3812 (the Program Fraud Civil Remedies Act)
- Title 42, United States Code, sections 1320a-7, 1320a-7a (Civil Monetary Penalties Law), 1320b-10, 1320c-5, 1395l, 1395m, 1395u, 1395dd ("Patient Anti-Dumping" Act) and 1396b

Office of Inspector General Components

Office of Audit Services (OAS)—provides all auditing services for HHS, either through its own resources or by overseeing audit work of others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.

Office of Counsel to the Inspector General (OCIG)—provides legal services to OIG, rendering advice and opinions on HHS programs and operations, imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, and renders advisory opinions on sanctions to the health care community.

Office of Evaluation & Inspections (OEI)—conducts short-term management and program evaluations that focus on issues of concern to the Department, the Congress and the public. The OEI generally focuses on programs with significant expenditures of funds and services to program beneficiaries or in which important management issues have surfaced. The findings and recommendations contained in the reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability and effectiveness of departmental programs.

Office of Investigations (OI)—conducts criminal, civil and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. Investigative efforts lead to criminal convictions, administrative sanctions or civil monetary penalties. The OI serves as liaison to the Department of Justice on all matters relating to investigations of HHS programs and personnel. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Management and Policy (OMP)—provides mission support services to the IG and other components. The OMP formulates and executes the budget, develops policy, disseminates OIG information to the news media and public, liaises with the Department, Congress, and external organizations and manages information technology resources. The OMP also conducts and coordinates reviews of existing and proposed legislation and regulations to assess implications and economic consequences for HHS programs and operations.

U.S. Department of Health
and Human Services

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