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Office of
Inspector General

Semiannual
Report to the
Congress

OCTOBER 2001-MARCH 2002

WORKING WITH OTHERS TO PROMOTE, PRESERVE &
PROTECT THE NATION'S WELL-BEING

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Message from the Inspector General

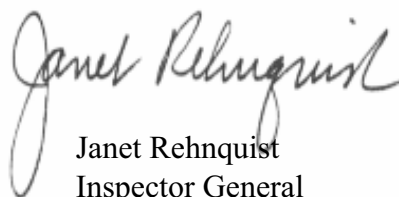
Reflecting on the events of September 11, it is with pride that I acknowledge the contributions of our staff to the law enforcement response to the terrorist attacks—assisting the FBI, serving as liaison to a joint terrorism task force command center in New York City, and working as air marshals. In the wake of those horrific events, our first priority is to review concerns about departmental vulnerabilities, the readiness and capacity of government responders at all levels, and security at federal and other laboratories. We have become increasingly proactive in our efforts to secure sensitive HHS facilities and products.

As we move forward from that national tragedy, we are focusing on additional priorities for the coming year as well. Among them, the need to revise the method by which Medicare and Medicaid pay for prescription drugs. Flaws in the current method of payment—based on a list price reported by drug manufacturers—cost Medicare and Medicaid millions in excess payments. We are working closely with other entities to achieve payment methods equitable to all parties, and we believe that significant progress is being made.

With the anticipated growth in the nursing home population over the next several decades, also among our priorities is doing everything we can to ensure a safe environment for our Medicare and Medicaid beneficiaries in the nursing home environment. Not only are we examining inefficiencies in the payment systems for nursing home care, we are evaluating the role of the nursing home director, family experience with nursing home care, and quality assurance committees in nursing homes.

There are many other areas—administration of grants, child support enforcement, abuse of the federal share of Medicaid, to name a few—upon which we will concentrate during the coming months. The results of our efforts in all of these endeavors will be shared in our reports which are available to the public on the OIG Internet site.

As we move into our next reporting period, I thank those many providers who have worked willingly with us to build a stronger relationship and to seek ways to eliminate fraud and abuse. As a result of our collaborative efforts, I feel confident that we will find increasing success in meeting the ever-changing, increasingly complex needs of our beneficiaries.



Janet Rehnquist
Inspector General

Highlights

Statistical Accomplishments

For the first half of Fiscal Year 2002, OIG reported savings of over \$13 billion comprised of over \$12 billion in implemented recommendations and other actions to put funds to better use, \$248.7 million in audit disallowances and \$780.8 million in investigative receivables. (Details pp. 58, 61 and Appendix A.)

Also for this reporting period, OIG reported exclusions of 1,366 individuals and entities for fraud or abuse of the federal health care programs and/or their beneficiaries, 250 convictions of individuals or entities that engaged in crimes against departmental programs, and 106 civil actions. (Details pp. 15 and 61.)

Significant Investigative Results

- TAP Pharmaceutical Products Inc. paid more than \$875 million in a global settlement with the Federal Government, as well as state governments, to resolve criminal and civil liability relating to the sales and marketing of its prostate cancer drug, Lupron. (Details p. 18.)
- KPMG, LLP, formerly KPMG Peat Marwick, LLP, agreed to pay the Federal Government \$9 million, plus interest, to settle allegations that it prepared false hospital cost reports that were submitted to the Medicare and Medicaid programs. (Details p. 18.)

Inspector General's Open Letter

- The Inspector General issued an Open Letter to the provider community announcing new criteria for assessing whether and when a corporate integrity agreement will be appropriate. The letter also modified the billing review procedures required of providers operating under corporate integrity agreements, thereby reducing the burden of these requirements. (Details p. 20.)

Financial Accountability

- In its audit of the Department's FY 2001 financial statements, OIG again issued a "clean" opinion, which means that the statements continued to fairly and reliably present financial information. However, serious internal control weaknesses were noted in the financial systems and processes used to produce financial statements and in Medicare information systems. (Details p. 54.)

Nursing Home Quality of Care

- To address nursing home quality of care issues, OIG participated in forming a Nursing Home Steering Committee headquartered in Washington, DC. The purpose of the Steering Committee—comprised of representatives from OIG, CMS and DOJ—is to deter fraud, improve resident care, and coordinate government action in nursing home bankruptcy and other financial and litigation matters. This reporting period, the efforts of the Steering Committee contributed to the coordination and success of an OIG-sponsored event, entitled "Nursing Facility Quality of Care: Improving Government Enforcement Efforts." At this symposium, federal and state prosecutors, investigators and regulators convened in Washington, DC, to exchange ideas on how various federal and state agencies can work together to identify and solve quality of care failures in the nation's long term care facilities. (Details p. 7.)

Retail Food Safety

- In a study on retail food safety, OIG found that the industry and local, state and federal agencies embrace the model Food Code and recommended National Retail Food Regulatory Program Standards as blueprints for developing future inspection practices. However, there were many concerns about implementing these standards, and OIG offered numerous suggestions for both FDA and states. (Details p. 38.)

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Performance Measure ❖❖

Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program 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 items. 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.

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 reports on the audits of the 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, auditors assess compliance with Medicare laws and regulations and the adequacy of internal controls.

FINANCIAL STATEMENT AUDIT ❖❖

In the audit report on its Fiscal Year (FY) 2001 financial statements, CMS sustained the unqualified audit opinion first issued on the FY 1999 financial statements. Auditors found that the statements presented fairly, in all material respects, the financial position of CMS as of September 30, 2001, and 2000, and its net costs for the years then ended, as well as the changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for FY 2001. However, the audit found continuing material weaknesses in financial systems and regional and central office oversight and in Medicare electronic data processing (EDP) controls.

The Medicare contractors improved their maintenance of supporting records for Medicare activities and year-end balances. However, because they lacked an integrated accounting system to accumulate and report financial information, they continued to use ad hoc, labor-intensive reports, which increased the risk of human error, material misstatement or omission. The audit also revealed numerous and continuing weaknesses in EDP processing controls at the Medicare contractors, as well as certain application control weaknesses at a contractor shared system. Such weaknesses increase the risk of unauthorized access to and disclosure of sensitive information, malicious changes that could interrupt data processing or destroy files, improper Medicare payments, and disruption of critical operations.

Officials at CMS concurred with the recommendations and are in the process of taking corrective action. Most importantly, they are continuing efforts to implement the Healthcare Integrated General Ledger Accounting System. The new system, expected to be fully operational in 2007, will incorporate contractors' financial data, including claims activity, into CMS' internal accounting system. (A-17-01-02001)

DELINQUENT MEDICARE DEBT

Despite CMS' significant progress in managing debt, especially at Medicare contractors, serious problems remain. The OIG identified an estimated \$670 million (absolute value) in misstated and misclassified delinquent Medicare debt in information reported to the Treasury Department. Misstatements included \$450 million in reconciliation errors, \$68 million in unsupported or unrecorded transactions, and \$152 million in classification errors regarding the debt's eligibility for referral to Treasury for collection. Further, CMS did not have an adequate process for pursuing debt using the required demand letters.

The OIG made specific recommendations for improving supporting documentation, periodic reconciliations, and supervisory review of delinquent debt activities. The CMS concurred with the recommendations. (A-17-01-02003)

STATE HEALTH INSURANCE ASSISTANCE PROGRAM

A study assessing State Health Insurance Assistance Program (SHIP) performance in providing information to Medicare beneficiaries found that SHIPs target programs to meet the needs of the local community. Beneficiaries are interested in SHIP services, yet most are unaware of the program's existence.

The OIG made several recommendations to enhance the usefulness of SHIPs in the broader context of the entire set of information and referral sources which CMS provides for Medicare beneficiaries. (OEI-07-00-00580)

COMMUNITY BENEFICIARIES

Medicare home health beneficiaries who begin receiving services without having first been discharged from a hospital are known as “community” home health beneficiaries. Prior to this study, not much was known about their needs and access to home health care or how they have been affected by recent changes in the Medicare payment methodology. The OIG found that about 40 percent of Medicare home health beneficiaries do not have a prior hospital or nursing home stay. Through reliance on their physicians, family and the aging network, they appear to be getting access to Medicare home health care. (OEI-02-01-00070)

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS

The Consolidated Omnibus Budget Reconciliation Act of 1985 required CMS to establish Unique Physician Identification Numbers (UPINs)—one assigned to each physician who provides services to Medicare beneficiaries. The CMS contracts with one company to maintain the UPIN Registry that contains relevant data on all UPINs. During this reporting period, OIG issued the two following reports regarding UPINs and registry data.

Invalid Equipment/Supply UPINs

The OIG found that Medicare paid \$32 million for medical equipment and supply claims with invalid UPINs in 1999. In addition, OIG found that Medicare allowed \$59 million in 1999 for medical equipment and supply claims with UPINs

that were inactive on the date of service. The OIG also found that a small number of suppliers accounted for a significant share of allowed charges for claims with invalid or inactive UPINs.

The OIG recommended that CMS revise claims processing edits to ensure that UPINs listed on medical equipment and supply claims are valid and active. The OIG also recommended that CMS emphasize to suppliers the importance of using accurate UPINs when submitting claims to Medicare. The CMS agreed. (OEI-03-01-00110)

Inaccuracy of Provider Data

In this report, OIG examined inaccuracies in CMS' UPIN Registry. The OIG identified

incorrect addresses for 28 percent of sample providers during the course of an inspection assessing the appropriateness of Medicare Part B payments for outpatient mental health services. Even the Medicare carriers did not have accurate addresses for all of these providers. The OIG estimates that Medicare paid about \$35 million (\pm \$17 million) in 1998 for outpatient mental health services billed by providers with inaccurate mailing addresses.

The Health Insurance Portability and Accountability Act of 1996 requires CMS to establish unique identifiers for all health care providers. OIG, therefore, recommended that CMS take steps to validate and update UPIN Registry data prior to implementation of the new provider identifier system. The CMS concurred and has taken steps to update the registry. (OEI-03-99-00131)

EDITS FOR UNAUTHORIZED LABORATORY TESTS

This report found that the CMS' Common Working File (CWF) edits, designed to detect and prevent payment of unauthorized laboratory tests, appear to work well. They successfully identified and correctly processed 998 out of every 1,000 services billed to Medicare by laboratories holding a Clinical Laboratory Improvement Amendment of 1988 Certificate of Waiver or Certificate for Provider Performed Microscopy Procedures. (OEI-05-00-00050)

AMBULATORY SURGERY CENTERS

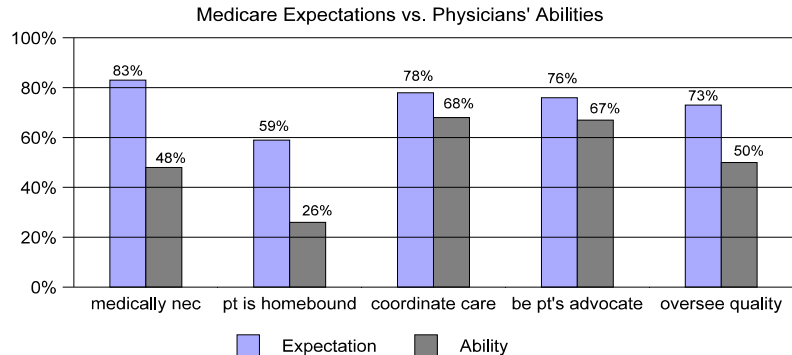
A series of OIG reports assessed how state agencies and accreditors oversee ambulatory surgical centers (ASCs) and how CMS holds them accountable. The ASCs have experienced explosive growth, more than doubling in number from

1990 to 2000. During the same time period, the volume and complexity of procedures performed in ASCs has increased dramatically, from 12,000 to over 101,000 major procedures annually. For these reasons, oversight is more important than ever. However, Medicare's system of quality oversight is not up to the task. States have not recertified nearly a third of ASCs in 5 or more years, and CMS does little to monitor the performance of state agencies and accreditors.

The report made recommendations to CMS to strengthen its quality oversight of ASCs. While CMS responded positively to the report, it did not fully commit itself to a number of the recommendations, particularly those calling for a minimum survey cycle and a more accessible complaint process. (OEI-01-00-00450; OEI-01-00-00451; OEI-01-00-00452)

PHYSICIANS' ROLES IN HOME HEALTH

Based on interviews with physicians and analysis of CMS' claims data, OIG found that physicians are currently playing a key role in initiating, certifying and monitoring the care for Medicare home health beneficiaries. However, they are doing so despite limited knowledge of Medicare home health rules and in discomfort with CMS' expectations. At present, the availability of reimbursement for their oversight role does not seem to have significant impact on physicians who care for Medicare home health patients.



In order to address physician concerns and improve the Medicare home health services, OIG recommended that CMS establish a working group within CMS' Physician Regulations Issues Team to improve communication and to consider modifying the physician home health oversight role. (OEI-02-00-00620)

HOME HEALTH PROVIDERS

The objective of this report was to determine if CMS enrolled home health agencies who are excluded from Medicare by OIG or debarred from government

participation by the General Services Administration; felons; or undercapitalized parties. The OIG independently reviewed a sample of home health agencies, owners and managers enrolled in Medicare between October 1, 1997, and September 30, 2000. Based on this review, OIG found that CMS processes seem to have effectively prevented enrollment of such parties. (OEI-04-00-00550)

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, as in the following examples:

- In Texas, three former owners of an HHA were sentenced for conspiracy, health care fraud, money laundering, mail fraud and kickbacks to respective terms of 17 years, 14 years, and 8 years and 1 month imprisonment. They were also jointly ordered to pay close to \$4.3 million in restitution. The investigation found that during their operation of the HHA, the owners submitted fraudulent costs on their 1994 through 1997 Medicare cost reports.
- Lifeline Health Care of Southwest Florida, Inc., an HHA, and The Lifeline Health Group, Inc. agreed to pay the government \$3.1 million, plus interest, for allegedly submitting false claims to the Medicare program for home health services that were not medically necessary, were provided to patients who were not homebound, and were not properly documented. As part of the settlement, the HHA entered into a comprehensive 5-year corporate integrity agreement.
- Two owners of an Arizona HHA were sentenced for theft of public money, property or records and embezzlement. The co-owners were charged with billing Medicare for services not rendered or not medically necessary and for creating and submitting false documents. The court set special conditions prohibiting one of the owners from ever holding a position requiring billing public or private entities. The other owner was ordered to surrender her license as a registered nurse and to pay \$20,100 in fines. Both agreed to lifetime exclusions from federal health care programs.

NURSING HOME FRAUD

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. In addition to protecting federal health care programs from these improper billing schemes, OIG also strives to protect the health, well-being and safety of nursing home residents. Investigations of improper billing and quality of care issues resolved during this reporting period follow.

- In California, Covenant Care agreed to pay the government \$3.65 million to settle allegations that the company—operating approximately 45 nursing homes—significantly inflated and overcharged the amount of nursing hours provided to Medicare patients. Covenant Care also entered into a corporate integrity agreement.
- In Louisiana, Twin Oaks Nursing Home, Inc. (Twin Oaks), agreed to pay the government \$100,000 to resolve allegations of failing to provide appropriate care. Issues included deficiencies in documentation, improper staffing levels, inadequate supplies and deteriorated equipment. Twin Oaks also agreed to enter into a 5-year corporate integrity agreement that includes a quality monitor requirement.
- A licensed practical nurse at a Pennsylvania nursing home was sentenced to 10 months incarceration and lost her nursing license for falsifying a patient's record after a medication error was discovered. The patient later died as a result of the mistake.

NURSING FACILITY QUALITY OF CARE: IMPROVING ENFORCEMENT

During the past few years, OIG has conducted a number of evaluations and investigations focusing on nursing facility quality of care matters. One of OIG's foremost priorities is to continue its involvement in nursing facility quality of care issues. As part of this ongoing effort and to better coordinate involvement in quality of care issues, on January 31-February 1, 2002, OIG sponsored a symposium, "Nursing Facility Quality of Care: Improving Government Enforcement Efforts," in Washington, DC.

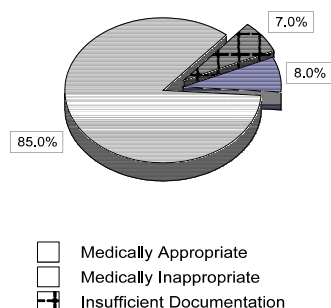
The objective of the symposium was to improve the government's nursing facility quality of care enforcement efforts through an analysis of the current

methods utilized by the government when pursuing these kinds of cases. The symposium included a series of case studies presented by attorneys and investigators who had successfully conducted quality of care cases. The meeting included participants from CMS, DOJ, United States Attorneys Offices, Medicaid Fraud Control Units, state survey officials and OIG.

NURSING HOME PSYCHOTROPIC DRUG USE

The OIG released this report, along with a companion report, on the use of psychotropic drugs in nursing homes. Conducted in response to concerns expressed by the Senate Special Committee on Aging about the use of psycho-

Nursing Home Residents' Psychotropic Drug Use



tropic drugs as inappropriate chemical restraints, OIG found that there is not a pervasive problem in this regard. Where there are problems, they are related to chronic use, inappropriate dosage, a lack of documented benefit to the resident, and unnecessary duplicate drug therapy. In some cases, a lack of adequate documentation for residents' psychotropic drug use was noted.

The OIG suggested that CMS consider educating providers to better document the use of these drugs. The CMS agreed and is acting upon the suggestion. (OEI-02-00-00490; OEI-02-00-00491)

RURAL HEALTH CLINIC CLAIMS

This report identified potential Medicare overpayments, totaling approximately \$2.8 million, paid to rural health clinics in 13 states for Calendar Years 1997 through 1999. The potential overpayments included \$2.6 million in Part B billings for individual services that were covered and paid on the basis of an all-inclusive rate per visit and \$0.2 million in duplicate claims for services provided to the same beneficiaries, for the same dates of service, and with the same diagnoses.

In addition to recommending financial adjustments, OIG recommended that CMS implement Common Working File edits to detect claims that contain Part B services paid under the all-inclusive rate. The OIG also recommended that CMS require the fiscal intermediaries to develop effective procedures and computer system edits to detect duplicate claims. The CMS agreed with almost all of the recommendations. (A-07-00-00108)

UNIVERSITY HOSPITAL MEDICARE BAD DEBT

The OIG found that \$5.4 million of the \$7.2 million claimed as bad debts by an Alabama university hospital on its FY 1997 cost report was unallowable, primarily because the hospital had not developed its patient accounts receivable system to properly accumulate complete, accurate and timely Medicare bad debts. As a result, the hospital relied on a consultant to prepare its bad debt listing but did not verify the accuracy of the work.

In addition to recommending a financial adjustment, OIG recommended that the hospital improve its accounts receivable systems and controls. The hospital generally agreed. (A-04-00-06005)

INCORRECTLY REPORTED HOSPITAL INPATIENT TRANSFERS

This report pointed out a continuing significant problem with incorrect hospital reporting of inpatient prospective payment system (PPS) transfers as discharges. Since 1992, the number of incorrectly reported transfers has trended downward, but remains high. The OIG identified over 153,000 claims for incorrectly reported transfers from January 1992 through June 2000 with potential overpayments totaling nearly \$233 million. Contributing causes include misapplication of the PPS transfer policy by the CMS regional offices and the fiscal intermediaries, problems with computer system interfaces at hospitals, and breakdowns in communication between hospitals' medical and billing staffs.

The OIG recommended, among other things, that CMS issue clarifying instructions to hospitals and fiscal intermediaries regarding the PPS transfer policy and initiate collection of the overpayments identified to date. The CMS agreed to collect overpayments for the 4-year period specified in regulations regarding the reopening of Medicare claims. (A-06-00-00041)

POSTACUTE TRANSFER CARE

In this report, OIG pointed out that CMS has no controls in place to prevent excessive payments to inpatient prospective payment system (PPS) hospitals for erroneously coded patient discharges that are followed by postacute care, such as care in a skilled nursing facility or by a home health agency. Medicare policy calls for inpatient payment rates to be reduced when PPS hospitals discharge beneficiaries in 10 specified diagnosis related groups (DRG) to such settings. However, OIG

estimates, based on a statistical sample, that Medicare paid approximately \$52.3 million nationwide in excessive DRG payments to inpatient PPS hospitals as a result of erroneously coded discharges.

In addition to recommending recovery of overpayments, OIG recommended that CMS, as a long-term remedy, establish edits in its Common Working File to compare inpatient claims potentially subject to the postacute care policy with subsequent claims. This will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim. The CMS officials concurred. (A-04-00-01220)

OUTPATIENT PSYCHIATRIC SERVICES

In this report, OIG found that many of the outpatient psychiatric services claimed by a Maryland medical center for FY 1997 were not allowable. Based on the results of a sample review of claims, OIG estimated that the center overstated its charges by at least \$957,500.

The OIG recommended that the center strengthen procedures to ensure that charges are for covered and properly documented services. The center did not agree. (A-03-99-00012)

HOSPITAL INVESTIGATIONS

The following are significant examples of hospital-related cases resolved during this period:

- In Connecticut, Danbury Hospital agreed to pay the government \$7.5 million to settle allegations that it violated the False Claims Act with respect to its 1986 cost report. Based upon a review by OIG, the government found that the hospital was overpaid by the fiscal intermediary when the fiscal intermediary attempted to manipulate cost reports in order to increase its performance score. The hospital did not enter into a corporate integrity agreement because it demonstrated that it had extensive and effective compliance programs in place. The government did **not** waive its permissive exclusion authority as part of the settlement agreement in this case.
- Kaweah Delta Health Care District (Kaweah), a subdivision of the State of California, agreed to pay the government \$475,000 to resolve its potential

liability under the Civil Monetary Penalties Law for the submission of false claims. This payment is in addition to the \$270,006 that Kaweah paid to the fiscal intermediary in 1999, representing a total recovery of \$745,006. The settlement covers two separate violations: 1) for submitting separate claims to Medicare for laboratory services that were included in the composite rate, and 2) for presenting claims for the technical component of services under inappropriate billing codes resulting in a higher rate of reimbursement.

- York Hospital of York, Pennsylvania, paid \$270,000 to resolve its civil monetary penalty liability. York presented claims to Medicare for certain Emergency Department services that it represented were personally and identifiably provided by faculty physicians to Medicare beneficiaries when, in fact, York did not possess sufficient documentary evidence to establish the presence of the physicians during the performance of these services.
- The former chief executive officer (CEO) of a New Jersey hospital was sentenced to 3 months incarceration and ordered to pay \$211,572 in restitution and a fine of \$5,000 for tax evasion. From 1992 through 1996, the CEO caused the hospital to pay for some personal expenses, which were not reported as income on his tax returns. The CEO also caused the hospital to charge Medicare for personal expenses not related to patient care. In 1996, the hospital dismissed the CEO after an internal investigation revealed the scheme; the hospital also made an adjustment to its Medicare cost report to cover the loss incurred by Medicare as a result of the CEO's actions.

MEDICARE ADMINISTRATIVE APPEALS

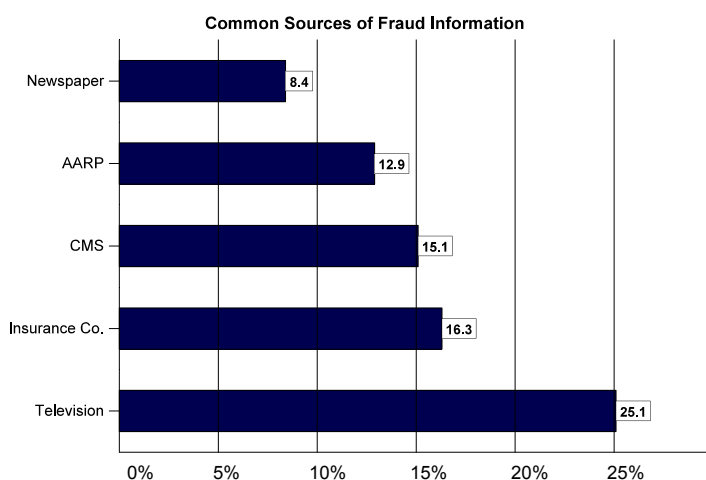
The OIG examined the impact of amendments made by the Benefits Improvement and Protection Act of 2000 (BIPA) to the Medicare appeals system. The amendments, effective October 1, 2002, could negatively affect the already backlogged and overwhelmed appeals process. An earlier OIG report detailed fundamental weaknesses in the Medicare appeals process, many of which could be exacerbated by the implementation of the BIPA amendments. For example, short time frames called for by BIPA could result in appeals cases being prematurely accelerated to higher, more expensive levels of appeal—reducing the quality of decisions and adversely affecting the financing and administration of the Medicare program.

To resolve these problems while still meeting the intent of the BIPA amendments, this report offers recommendations to restructure and improve the administration of the system, including the establishment of an administrative

appeals process that is dedicated to Medicare and adjustments to the mandated time frames. The Department generally agreed with the recommendations.
(OEI-04-01-00290)

BENEFICIARY AWARENESS OF FRAUD

This follow-up report addresses current Medicare beneficiaries' level of awareness of fraud and compares it to levels reported in 1998. The OIG found that outreach activities designed to educate beneficiaries about Medicare fraud are meeting most of their goals. In 2001, beneficiaries were more knowledgeable



about Medicare fraud and were significantly more likely to receive information about fraud than they were 3 years ago. Additionally, beneficiaries are reporting suspected fraud using an approach consistent with the three-step process which directs them to first contact their health care provider, then their Medicare insurance company, and finally the OIG hotline.
(OEI-09-00-00590)

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 and, in appropriate cases, 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 Texas woman was sentenced to 17.5 years incarceration and ordered to pay over \$9.3 million in restitution and over \$3,000 in special assessments after being convicted on 32 counts of health care fraud. The woman defrauded Medicare, Medicaid and several private insurance companies by

billing for services not rendered through multiple companies she established. The billing scheme defrauded health insurance programs, negatively affected beneficiaries and compromised the identities of physicians whose provider numbers she used to falsely bill the programs. Although first indicted on 17 counts of health care fraud in April 2000, the woman continued her false billings and as a result, was indicted on 15 additional counts of health care fraud in May 2001. Evidence submitted showed that the woman, even after two indictments, still continued to falsely bill health care programs for services not rendered.

- A California physician, who also owned and operated a clinic, was sentenced to 5 years in prison and ordered to pay \$2.87 million in restitution. The physician was convicted of multiple felony counts, including mail fraud, wire fraud, bankruptcy fraud and making false statements. Evidence proved the physician deliberately misdiagnosed patients as suffering from a rare vascular disease that requires patients to obtain expensive pumps, braces and other medical devices. The physician was also convicted of making false statements when he filed for bankruptcy in 1996.
- A New York woman was sentenced to 18 months incarceration and ordered to pay a total of \$565,230 in restitution for health care fraud. As the billing clerk and bookkeeper for her husband's dental practice, the woman improperly billed insurance companies for nonrendered services. The woman admitted that she "shopped" around by submitting claims for different services to find out which insurance companies would reimburse the most and which companies would require the least amount of documentation.
- In Maine, the chief financial officer (CFO) of a nonprofit organization providing housing and 24-hour care to Medicaid recipients with disabilities was sentenced to 27 months in prison and ordered to pay \$392,992 in restitution for health care fraud. The CFO used his position to access the nonprofit's operating account from which he cut extra payroll checks for himself, then provided false statements to Medicaid in an attempt to hide the scheme. The CFO used the stolen money to build an addition to his home and to purchase a home theater system.
- In Ohio, a husband and wife were sentenced for stealing health care funds from their former employer. The husband was sentenced to 19 months incarceration and his wife to 13 months. The couple was also ordered to pay a total of \$189,304 in restitution and to undergo drug treatment and counseling. While working for a company that provides billing and other management services to health care providers, the couple engaged in a scheme through which they diverted health care payment checks to accounts established for their own personal use.

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 authorizes penalties against 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. (Section 1128B(b) of the Social Security Act, 42 U.S.C. § 1320a-7b)

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 are examples of anti-kickback enforcement actions:

- In Tennessee, three pharmacy benefits management (PBM) company owners agreed to pay the government \$1.3 million for allegedly engaging in a kickback scheme to obtain PBM business for their company. After obtaining the PBM business, the owners diverted money from the health care program for their personal benefit in the form of loans, consulting fees, dividends and bonuses. As part of the settlement, the PBM owners agreed to be excluded from participating in the federal health care programs for 15 years.
- OB-GYN Associates of Cookeville, Tennessee, and several individual physicians paid \$109,900 to resolve their civil monetary penalty liability for violations of the physician self-referral (Stark) statute and the kickback provisions of the Civil Monetary Penalties Law. From 1997 through 2000, the physicians had a financial relationship with a mobile ultrasound company from which they received referral fees—ostensibly in the form of rent—in return for referring Medicare beneficiaries to the company for ultrasound studies and diagnostic testing.
- A New York man was ordered to pay \$18,000 in restitution and a \$5,000 fine for violating the anti-kickback statute. As the security director for a hospital, one of his responsibilities included arranging ambulance transportation for hospital patients. In 1995, the man began accepting kickbacks from the

owner/operator of an ambulance company in exchange for Medicare and Medicaid referrals to the company.

FRAUD AND ABUSE SANCTIONS

During this reporting period, OIG administered 1,472 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

Section 1128 of the Social Security Act (42 U.S.C. § 1320a-7) provides several grounds for excluding individuals and entities from participation in Medicare, Medicaid and other federal health care programs. Exclusions are required for individuals and entities convicted of the following types of criminal offenses: 1) Medicare or Medicaid fraud; 2) patient abuse or neglect; 3) felonies for other health care fraud; and 4) felonies for illegal manufacture, distribution, prescription or dispensing of controlled substances. The OIG has the discretion to exclude individuals and entities on several other grounds, including: misdemeanors for other health care fraud (other than Medicare or Medicaid) or for illegal manufacture, distribution, prescription or dispensing of controlled substances; suspension or revocation of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; and submission of false or fraudulent claims to a federal health care program.

During this reporting period, OIG excluded 1,366 individuals and entities. The following are examples of exclusions that were administered:

- A Missouri transportation company owner/operator was excluded for 15 years after he was convicted of submitting or causing the submission of false claims for ambulance services provided to patients. Additionally, he entered into a \$325,000 settlement agreement in a parallel civil suit.

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.

- In Colorado, two certified nurse aides (CNAs) were convicted in a time-card fraud scheme that lasted more than a year and resulted in a loss to

Medicaid of approximately \$63,000. Additionally, one of the CNAs had previously been convicted and had violated his parole. Both CNAs were excluded for 10 years.

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 and has available space and qualified personnel to treat the individual. In addition, the transferring hospital must effect 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 from a responsible physician for each negligent violation of any of the section 1867 requirements and, in some circumstances, may exclude a responsible physician.

Between October 1, 2001, and March 31, 2002, OIG collected \$109,000 from 4 hospitals for patient dumping violations. The following is a sampling of the alleged violations involved in the Patient Anti-Dumping statute settlements from this reporting period:

- A Victor Valley Community Hospital in California agreed to pay \$40,000 to resolve allegations that it had violated section 1867 of the Social Security Act on seven occasions. One patient did not receive stabilizing treatment or an appropriate transfer and another experienced a delay in treatment until her insurance company agreed to pay for treatment. Five patients did not receive appropriate medical screening examinations; four resulting from the hospital calling the patients' insurance companies for payment authorization which was denied. The settlement amount reflected the hospital's limited ability to pay.
- Englewood Hospital in New Jersey agreed to pay \$15,000 to resolve allegations that it violated section 1867 of the Social Security Act. The OIG found that the hospital failed to provide medical examinations to

several people who came to the hospital emergency room for evaluation and treatment. The hospital discharged the patients and sent them to private physicians' offices.

Civil Penalties for False Claims

Under the Civil Monetary Penalties Law (CMPL), section 1128A of the Social Security Act, 42 U.S.C. § 1320a-7a, a person is subject to penalties, assessments, and exclusion from participation in federal health care programs for engaging in certain activities. For example, a person who submits to a federal health care program a claim for items and services that the person knows or should know is false or fraudulent is subject to a penalty of up to \$10,000 for each item or service falsely or fraudulently claimed, an assessment of up to three times the amount falsely or fraudulently claimed, and exclusion. For the purposes of the CMPL, "should know" is defined to mean that the person acted in reckless disregard or deliberate ignorance of the truth or falsity of the claim. The CMPL also authorizes actions for a variety of other violations, including submission of claims for items or services furnished by an excluded person, requests for payment in violation of an assignment agreement, and payment or receipt of remuneration in violation of the anti-kickback statute (42 U.S.C. § 1320a-7b(b)). The authority to bring CMPL cases has been delegated to the Inspector General.

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 exclusions 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.

Under the federal civil False Claims Act (FCA), 31 U.S.C. §§ 3729-3733, a person or entity is liable for up to treble damages and up to \$11,000 for each false claim it knowingly submits or causes to be submitted to a federal program. Similarly, a person or entity is liable under the FCA if it knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid. The FCA defines "knowing" to include not only the traditional definition, but also instances when the person acted in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information. Under the FCA, no specific intent to defraud is required. Further, the FCA contains a *qui tam* or whistleblower provision that allows private individuals to file suit on behalf of the United States and entitles that whistleblower to a percentage of any fraud recoveries.

The government, with the assistance of OIG and often the FBI and other law enforcement agencies, recouped more than \$728.7 million through both Civil and Monetary Penalties Law and False Claims Act civil settlements related to the Medicare and Medicaid programs during this reporting period.

Examples of civil penalties for false claims include the following:

- TAP Pharmaceutical Products Inc. (TAP) paid more than \$875 million to resolve criminal and civil liability resulting from sales and marketing of its prostate cancer drug, Lupron. TAP pled guilty to conspiring to violate the Prescription Drug Marketing Act by causing the sale of free samples and paid \$290 million in criminal fines—the largest criminal fine ever in a health care fraud prosecution. On the civil side, TAP paid \$585 million, plus interest, to the Federal Government and the states for damages suffered by the Medicare, Medicaid and Tricare programs. The settlement followed a lengthy investigation into TAP’s pricing, sales and marketing practices for Lupron. As part of the civil settlement, TAP also entered a comprehensive 7-year corporate integrity agreement that requires that TAP report certified pricing information to the federal and state government and requires, for the first time, an outside audit of TAP’s sales and marketing practices.
- KPMG, LLP (KPMG), formerly KPMG Peat Marwick LLP, agreed to pay \$9 million, plus interest, to the Federal Government to resolve allegations of submitting false hospital cost reports to the Medicare and Medicaid programs on behalf of Basic American Medical, Inc. (BAMI) and Columbia Hospital Corporation (now known as HCA, Inc.). The government alleged that KPMG, acting as a reimbursement consultant and preparer of the hospital cost reports, knowingly made claims that were false, exaggerated or ineligible for payment and concealed errors from the government, thereby enabling BAMI and HCA to falsely retain funds. KPMG also prepared “reserve” cost reports detailing non-allowable expenses and allocations contained in the filed cost reports and estimated the reimbursement impact in the event that these nonallowable expenses and allocations were detected on audit.
- Raytel Cardiac Services, Inc.(RCS) and Raytel Medical Corporation (collectively, Raytel) agreed to pay the government \$11.5 million, plus interest, and to enter into a 5-year corporate integrity agreement to resolve the corporation’s liability for the submission of false claims and false statements to the government. The \$11.5 million settlement figure is comprised of \$5 million in restitution based on a guilty plea by RCS to obstruction of a criminal investigation and \$6.5 million to resolve Raytel’s civil liability under the False Claims Act. A corporation with locations in New York, Connecticut and New Jersey, Raytel is one of the Nation’s largest providers of trans-telephonic pacemaker monitoring. The allegations in the case centered around Raytel’s failure to fully complete all necessary steps in performing the monitoring services, as well as conducting the monitoring for the required length of time.

- In New York, Impath, Inc. (Impath), agreed to pay the government \$9 million to settle allegations of improperly billing Medicare for diagnostic pathology services. A *qui tam* alleged that from 1992 to 1998, Impath, a large clinical laboratory with facilities in New York, California and Arizona, presented improper Medicare claims and supporting records to the government. The settlement also contains compliance provisions.
- Molina Healthcare of California, Inc., doing business as Molina Medical Centers (Molina), a Medicaid managed care plan in California, paid \$600,000 to resolve its civil monetary penalty liability for furnishing false and misleading information to Medicaid beneficiaries. Molina sent over 17,000 false and misleading letters—stating that if the beneficiaries did not re-enroll with Molina they would lose access to their primary care physicians—to Medicaid beneficiaries enrolled in its plan. These letters appeared as though they were sent directly from the beneficiaries’ physicians; in reality, they were sent by a mailing house at the request and direction of Molina.

Compliance Activities

Because the great majority of providers are honest and wish to avoid fraud and abuse issues, OIG is 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://oig.hhs.gov> in the “Compliance Tools” and “Fraud Detection & Prevention” sections.

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.

In addition to developing compliance program guidance that 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. These compliance obligations are typically negotiated through an agreement commonly referred to as a corporate integrity agreement (CIA). Presently, OIG is monitoring approximately 324 corporate integrity agreements.

***Inspector General's
Open Letter***

Please Note: The following is a synopsis of the Inspector General's Open Letter. The full text of the letter can be found on the Internet at <http://oig.hhs.gov>.

On November 20, 2001, the Inspector General issued an "Open Letter to Health Care Providers" in which she announced modifications to CIAs in response to concerns from the provider and enforcement community regarding the civil settlement process. These modifications addressed two major, but related, areas.

The first area addressed concerns the resolution through a CIA of OIG's administrative exclusion authority in connection with a fraud settlement. The Inspector General noted that there were a limited number of cases where it would be appropriate to resolve a provider's permissive exclusion liability separately or subsequent to resolution of the False Claims Act case and that, in certain cases, it may be appropriate to release OIG's administrative exclusion authorities without a corporate integrity agreement. The Open Letter listed eight criteria OIG will consider when determining whether a CIA is appropriate.

The second major area concerned OIG's modification to the CIA claims review procedures. In part because of provider concerns about the costs of the CIA billing review requirements, OIG modified the billing review procedures by requiring a full, statistically valid random sample of claims only if the provider's initial sample of claims indicated an error rate at or above 5 percent. This modification would be offered both for all future CIAs and current CIAs, where appropriate.

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://oig.hhs.gov> 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 131 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 30 recoveries and 15 settlements collectively totaling over \$46.5 million. Successful resolution to provider self-disclosure is demonstrated in the following example:

- Summa Health System Hospitals (Summa), an Ohio health care provider, agreed to pay the government \$770,000 to resolve its False Claims Act liability for the improper billing of dialysis services. As part of the settlement, Summa also agreed to maintain its current compliance program for 3 years. The settlement stemmed from Summa's self-disclosure under the OIG Provider Self-Disclosure Protocol.

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 October 1, 2001, through March 31, 2002, OIG accepted 21 advisory opinion requests and issued 5 advisory opinions. On December 4, 2001, OIG issued a final safe harbor regulation for ambulance restocking arrangements. Also, in accordance with the Health Insurance Portability and Accountability Act of 1996, OIG solicited proposals (via *Federal Register* notice) for modifying existing safe harbors to the anti-kickback statute. The OIG received 22 timely filed responses to the December 19, 2001, notice.

**ADMINISTRATIVE COSTS INCLUDED IN
ADJUSTED COMMUNITY RATE PROPOSALS**

Through adjusted community rate (ACR) proposals, managed care organizations (MCOs) present to CMS an initial rate that represents the “commercial premium” that the MCO would charge its non-Medicare enrollees for services included in the managed care plan. This rate is then adjusted by various factors described in the regulations, including the relative costs to Medicare beneficiaries. Administrative costs are one component of the ACR. At the request of the former CMS Administrator, OIG completed several reviews of administrative costs included in ACR proposals. The results are being shared with CMS so that appropriate legislative changes can be considered.

Nine-State Review

This report pointed out that the CMS methodology for developing ACR proposals still results in Medicare paying a disproportionate share of administrative costs. Audits of the proposals prepared by 10 MCOs in 9 states showed that \$97.1 million of base-year costs would have been recommended for disallowance had the MCOs been required to follow the Medicare program’s general principle of paying only reasonable costs. Because there is no statutory or regulatory authority governing the allowability of costs in the ACR process, the MCOs were not required to adhere to this principle. (A-03-01-00017)

Mid-Atlantic MCO

This review (part of the nine-state review) of ACR proposals submitted by a Mid-Atlantic MCO was made to determine if the administrative costs were reasonable, necessary and allocable when compared with Medicare’s general principle of paying only reasonable costs. The OIG found that \$36.4 million in costs were 1) related-party costs for management fees that were based on a percentage of premium revenues rather than actual costs; 2) unallocable costs consisting of commissions paid to brokers who sell non-Medicare insurance policies; 3) related to such items as bad debts, travel and entertainment, promotions, donations, and tax penalties; 4) unsupported and undocumented; or 5) apportioned to Medicare using an allocation method that would have been inappropriate under Medicare’s cost-based criteria. (A-03-01-00002)

MEDICARE CONTRACTOR ADMINISTRATIVE COSTS

Under an agreement with CMS, an Indiana contractor processes and pays claims for Medicare Parts A and B services, as well as for durable medical equipment. Based on a review of the contractor's administrative costs claimed for FYs 1998 and 1999, OIG recommended a financial adjustment of \$4.7 million, including over \$3 million in pension and post retirement health benefit costs that were charged to Medicare based solely on accrual accounting entries rather than actual cash contributions. The contractor agreed with some of the recommended adjustments. (A-05-01-00023)

TERMINATED MEDICARE CONTRACTOR

A contractor in Pennsylvania processed and paid Medicare claims until the contractual relationship with CMS was terminated in 1997. 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 \$2.9 million in excess pension assets that the contractor should remit to Medicare. The contractor did not agree with this recommendation. (A-07-01-00132)

PAYMENTS FOR BENEFICIARIES REPORTED AS INSTITUTIONALIZED

Medicare pays a higher capitation rate to MCOs for Medicare beneficiaries who are institutionalized than for those who are not. Based on a statistical sample, OIG estimated that a California MCO received Medicare overpayments of at least \$2 million for beneficiaries who were incorrectly classified as institutionalized in February 1998. The MCO did not agree with the recommendations to refund the identified overpayments and to review additional payments for possible overpayments. (A-09-01-00056)

DIALYSIS FACILITIES PERFORMANCE ♦♦

An OIG inspection examined how the five major dialysis corporations use clinical performance measures to hold their facilities accountable for the quality of

care they provide. These five corporations provide treatment to about 70 percent of dialysis patients nationwide, the majority of which are Medicare beneficiaries. The OIG found that these corporations rely heavily on facility-specific clinical performance measures and have gained considerable knowledge on how to use them effectively. They collect over 14 measures and generate timely facility-specific reports that compare the performance of facilities.

The CMS is actively engaged in efforts to improve the use of clinical performance measures. Based on the lessons that these corporations have learned, OIG made several recommendations for CMS to consider as it strengthens its use of dialysis facility performance measures. The OIG also provided two supplemental reports with detailed information on these performance measures to CMS. (OEI-01-99-00052; OEI-01-99-00053; OEI -01-99-00054)

RENAL BENEFICIARY AND UTILIZATION SYSTEM PROBLEMS ❖❖

The CMS describes the Renal Beneficiary and Utilization System as “...a mission critical system that is used by CMS and the renal community to perform their duties...” This report indicated that data sets within the system were out-of-date, incomplete and inaccurate—resulting in duplication of effort, delays and program vulnerabilities—and were created from a lack of resources, historical complications and an outdated system.

The suggestions OIG offered to CMS include focusing on developing a strategic plan to address ESRD data management and establishing short-and long-term targets; assessing data needs of end-users; ensuring efficient data distribution; and enhancing communication. The OIG also recommended that CMS coordinate with the Social Security Administration to address data errors in basic beneficiary information. The CMS is working to correct these problems. (OEI-07-01-00250)

FRAUD INVOLVING DURABLE MEDICAL EQUIPMENT SUPPLIERS

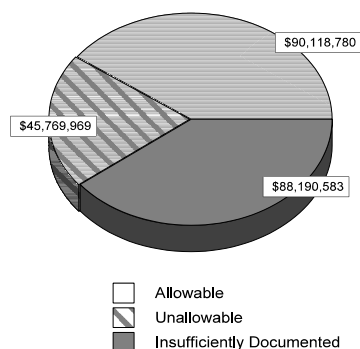
The durable medical equipment (DME) industry suffers from waves of fraudulent schemes in which federal health care programs are billed for equipment never delivered, higher-cost equipment than that actually delivered, unnecessary equipment or supplies, or equipment delivered in a state different from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

- In Kentucky, American HomePatient, Inc., (AHP), agreed to pay the government \$7 million to resolve its liability under the False Claims Act and the Civil Monetary Penalties Law for submitting false claims to Medicare, Medicaid and TRICARE. From January 1995 through December 1998, AHP allegedly billed the government for DME supplied to patients around the country that did not meet the applicable reimbursement requirements. In addition, AHP allegedly provided free or discounted services to physicians and hospitals for referrals of patients to AHP.
- Lincare Holdings, Inc. and Lincare, Inc. (collectively, Lincare) agreed to pay the government \$3.15 million to settle its potential False Claims Act liability. Lincare is a nationwide provider of DME, primarily home oxygen and related supplies and drugs. The investigation involved the operation of two Lincare centers in northern California that allegedly submitted false claims related to home oxygen therapy.
- In Georgia, a DME company owner was ordered to pay \$626,838 in restitution for fraudulent concealment. The owner and his company submitted bills to Medicare for incontinence care supplies that were never provided. They then created false receipts in an effort to conceal their scheme from Medicare.
- In New Jersey, three individuals were sentenced for conspiring in a Medicare fraud scheme with two DME company owner/operators. The operators, already sentenced for their roles in the scheme, owned three New Jersey based companies that provided wound and incontinence care kits to nursing home residents in Puerto Rico. Two of the individuals sentenced included a doctor and a nursing home owner in Puerto Rico who received illegal kick-backs in return for medically unnecessary and excessive DME referrals to the companies. The third individual, an office manager for the company owners, was sentenced for his role in attempting to cover up the scheme. The investigation found that many of the supplies paid for by Medicare were never used or were diverted to non-Medicare patients residing in the Dominican Republic.

INHALATION DRUG PAYMENTS

This report pointed out significant potentially improper payments by a durable medical equipment regional carrier to suppliers for inhalation drugs. Based on a statistical sample, OIG estimates such payments totaled \$134 million for the 12-month period ended September 30, 1999. Claims were unallowable because

Total Reimbursements = \$224,079,332



documentation was insufficient, payments were for drugs billed without a prescription, or the items or supplies were not reasonable and necessary for the beneficiary's condition.

The OIG recommendations call for improvements to procedures and controls and financial adjustments. The CMS concurred. (A-06-00-00053)

ELECTROCONVULSIVE THERAPY REIMBURSEMENT

In this report, OIG indicated that Medicare allows almost one-half million dollars annually for a form of electroconvulsive therapy (ECT) that is not clinically recommended. A 1985 National Institutes of Health Consensus Development Conference Statement and more current research indicate that the use of multiple monitored ECT is not effective and can pose a risk to patients. The OIG recommended that CMS take action to assure that the Medicare coverage policy for ECT is consistent with clinical guidelines. The CMS concurred. (OEI-12-01-0450)

TRANSPORTATION FRAUD

Common Medicare and Medicaid fraud schemes associated with transportation and ambulance companies involve the submission of claims for transporting patients to a hospital when patients are really taken to other facilities for which claims are non-reimbursable. Other schemes include billing singly for patients who were transported as a group and falsely claiming reimbursement for ambulatory patients. The following examples of transportation fraud were resolved during this reporting period:

- Two co-owners of an Arkansas ambulance company were sentenced for conspiracy and health care fraud. A federal trial jury found the two guilty of submitting false claims for medically unnecessary transportation of dialysis patients. The co-owners were each sentenced to 46 months imprisonment and were jointly ordered to pay over \$1 million in restitution to Medicare and Medicaid. In addition, the company's former general manager was sentenced for his part in the conspiracy to 9 months confinement in a halfway house.

- A California-based medical transportation provider and its president were sentenced for health care fraud. The president was sentenced to 15 months incarceration and ordered to pay \$445,631 in restitution jointly with the company. The company and its president submitted fraudulent medical transportation claims to a Medicare HMO for services not rendered. Some of the claims included dates of service for beneficiaries who were already deceased.
- In New Jersey, an ambulance company owner was sentenced to 15 months incarceration and ordered to pay \$431,000 in restitution for mail fraud in connection with a scheme to defraud Medicare. The owner routinely billed Medicare for ambulatory patients and inflated mileage. She also billed for oxygen when none was provided, billed for ambulance services when a van was used, and misstated diagnoses and places of service on claims. In some instances, she billed Medicare for patients who were actually being transported for local shopping trips.

PRESCRIPTION DRUG FRAUD

Working jointly with such partners as 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 Medicare or Medicaid programs in order to obtain the drugs under false pretenses for their personal use or for resale. Participants in these often complex 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 Medicare and Medicaid programs from making improper payments. The following are examples of prescription drug fraud cases:

- ***Georgia***—A woman was sentenced to 18 months incarceration, ordered to pay \$30,805 in restitution and to seek drug and alcohol treatment for theft or embezzlement in connection with health care. The woman stole a Medicare beneficiary card and used it at numerous emergency rooms and hospitals in order to obtain prescriptions for narcotics.
- ***Pennsylvania***—A pharmacy employee was sentenced to 28 months incarceration and ordered to pay \$5,000 in restitution for conspiracy to distribute controlled substances and possession of bank robbery proceeds. Through an arrangement with the pharmacist/pharmacy owner, the employee bought controlled substances without lawful prescriptions in order to distribute them for cash.

- **Washington, DC**—A woman was sentenced to 10 months in prison for unlawful distribution of methadone. Along with other individuals including doctors and pharmacists, the woman participated in a scheme involving Medicaid fraud and drug diversion.

This period, OIG also continued to focus specifically on the illegal use and distribution of the controlled and highly addictive time-release medication OxyContin, as demonstrated in the following example:

- **Maine**—In an ongoing investigation involving Medicaid fraud and the illegal acquisition and distribution of OxyContin, seven additional individuals were sentenced to an average incarceration of close to 30 months and were ordered to pay a total of \$30,305 in restitution. All were members of a group in southern Maine who used Medicaid to pay for illegally acquired OxyContin which was then illegally distributed. Of the 21 people charged to date, 20 have pled guilty and one has been found guilty in a jury trial; 19 have been sentenced.

MEDICAID PRESCRIPTION DRUG PRICING

The OIG found that 30 states were using at least some of the revised average wholesale prices that First DataBank began reporting as a result of DOJ investigations. However, the method by which these states implemented the revised prices varied considerably. States reported both advantages and disadvantages to using the revised prices. States that use the revised prices believe they will lead to short-term cost savings, but are unsure of the long-term impact. States' concerns about the revised prices reinforce OIG's conclusion that the current system's reliance on reported average wholesale prices as the basis for drug reimbursement is fundamentally flawed. (OEI-03-01-00010)

MEDICAID PHARMACY ACQUISITION COSTS

Most states use average wholesale price (AWP) minus a percentage discount, which varies by state, as a basis for reimbursing pharmacies for drug prescriptions. The objective of these reviews in eight states was to develop an estimate of the discount below AWP at which pharmacies purchase brand name and generic drugs. The OIG determined that there was a significant difference between AWP and pharmacy acquisition costs for generic drugs and brand name drugs. The OIG recognizes that acquisition cost is just one factor of many that must be considered in pharmacy reimbursement policy. However, a change in any of the factors affecting such reimbursement could have a major impact on program expenditures.

The OIG believes that the difference between the AWP and pharmacy acquisition costs is significant enough to warrant consideration in any evaluation of the states' Medicaid programs and, therefore, recommends that the states consider the results of these reviews. (A-06-01-00001; A-06-01-00002; A-06-01-00003; A-06-01-00004; A-06-01-00005; A-06-01-00006; A-06-01-00007; A-06-01-00008)

MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

The Medicare, Medicaid and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 increased public hospitals' Medicaid disproportionate share hospital (DSH) reimbursement from 100 percent to 175 percent of uncompensated care costs—a change expected to increase federal spending by \$380 million during FYs 2003 through 2005. Based on recent and ongoing reviews, OIG believes that the reimbursement increase may not be warranted. The DSH payments are not always retained by public hospitals, are often returned to the states for other uses, and are not always calculated correctly.

The OIG recommended that CMS seek legislation to at least delay, if not repeal, the implementation of the increase in DSH payments until the need for and use of DSH funds for direct care of uninsured patients can be sufficiently reviewed. If the new limit is implemented, OIG recommends additional legislative reform to ensure that DSH funds remain at the hospitals to provide care to vulnerable populations. The CMS initially concurred with the recommendations. However, when commenting on the final report, CMS said that it currently had no plans to seek a legislative change. (A-06-01-00069)

CLAIMS FOR RESIDENTS OF INSTITUTIONS FOR MENTAL DISEASES

The objective of these reviews was to determine if controls were in place to effectively preclude states from claiming federal Medicaid funding for 21- to 64-year-old residents of psychiatric hospitals that are institutions for mental diseases (IMD). The OIG found that controls were not adequate to preclude the states examined from making inappropriate claims.

Virginia

This review found that from July 1, 1997, through December 31, 2000, Virginia paid Medicaid claims of \$2.7 million (\$1.4 million federal share) for 21- to 64-year-old IMD residents. Recommendations called for making

financial adjustments and changing the Medicaid Management Information System to deny crossover payments to private IMDs. The state generally agreed. (A-03-00-00212)

Texas

The OIG found that from September 1, 1997, through August 31, 2000, Texas improperly claimed \$425,000 in federal funds for IMD residents aged 21 to 64 who were temporarily released to general acute care hospitals for medical treatment. In addition to recommending financial adjustments, OIG recommended that the state cease claiming federal funds for these clients and develop controls or edits to detect and prevent such claims. The state agreed with the recommendations. (A-06-00-00074)

***MEDICAID CLINICAL LABORATORY
SERVICES: VIRGINIA***

Under Medicaid requirements, reimbursement to providers for clinical laboratory services may not exceed what the Medicare program recognizes as reimbursement for the same services. This follow-up review in Virginia found that controls did not exist to prevent the state from claiming federal funding for out-patient clinical laboratory services in excess of Medicare amounts. The report noted that the state was overpaid \$446,000 in federal funds for Calendar Years (CY) 1996, 1997, and 1998. The overpayments related to unbundling (paying for panel tests at the higher individual services amount rather than the lesser amount for the panel), duplicate services, and state laboratory fees above the Medicare carrier fees. As of the start of this audit, the state had not yet refunded the \$724,000 federal share of overpayments related to CYs 1993 and 1994 identified in a prior OIG audit.

The OIG recommended that the state make a financial adjustment for the overpayments identified and install and revise edits to detect and prevent payments for unbundled and duplicate services. The state generally agreed with the recommendations and stated that it had completed an offset against federal funds for the CYs 1993 and 1994 overpayment. (A-03-00-00204)

***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 reviews 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 25 states. Reports issued to date have resulted in identifying over \$229 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.

New York

A joint audit with a New York State agency determined that Medicaid might have inappropriately paid between \$33 million and \$37.1 million for certain diagnostic and special education services for eligible students from January 1, 1997, through December 31, 1999. Most of the overpayments were attributed to a control weakness by the agency responsible for submitting claims to Medicaid. While officials corrected the weakness prior to the audit, they did not take steps to repay the overpayments. The report recommended, among other thing, that the state recoup inappropriate Medicaid payments and establish procedures to eliminate Medicaid billings for duplicate claims. (A-02-01-01024)

Delaware

An audit conducted with the Delaware State Auditor indicated that a state agency had overpaid Medicaid MCOs and other health care providers \$364,000 for services rendered on behalf of deceased recipients. The overpayments resulted because of major weaknesses in internal controls. The state agreed with recommendations to recover the overpayments and has begun to strengthen internal controls. (A-03-00-00205)

Arizona

A partnership audit conducted by the Arizona Office of Program Integrity identified potential Medicaid overpayments of about \$3.4 million (federal share, \$2.2 million) for end stage renal disease (ESRD) services during the period January 1, 1996, through June 30, 1999. The potential overpayments included claims with separate charges for laboratory tests already in the composite rates (unbundling), services and charges exceeding authorized amounts and frequency limits without appropriate medical documentation, and billing for laboratory tests without Clinical Laboratory Improvement Amendments certification. The report recommended, among other things, that the state recoup erroneous payments and review and/or update controls related to ESRD services. (A-09-01-00095)

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 2002, OIG is providing oversight for and administration of approximately \$116.9 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, as demonstrated by the following examples:

- **Minnesota MFCU**—Allina Health System, a large integrated health care organization operating a variety of medically-related facilities and businesses, agreed to pay more than \$16 million to settle allegations that it had submitted false claims to the Medicare, Medicaid and TRICARE programs between 1994 and 2001. The settlement agreement resolves two *qui tam* suits that alleged that the organization performed audits showing that it owed the federal health programs substantial overpayments and knowingly failed to return the overpayments. The settlement agreement also resolves a number of other issues. As part of the settlement, the organization agreed to enter into a comprehensive 5-year corporate integrity agreement covering all its lines of business.
- **New York MFCU**—A psychiatrist was ordered to pay \$786,585 in restitution, a \$50,000 fine and to undergo mental health treatment for mail fraud. The psychiatrist billed Medicare, Medicaid and a private insurer for services he did not perform and for inflated amounts of therapy time. In some instances, he billed for more than 24 hours of psychotherapy provided in a single day.

- **California MFCU**—A laboratory owner was sentenced to 6 months in jail and ordered to pay \$551,724 in restitution for health care fraud. He was one of three laboratory owners involved in a scheme to bill Medicare and Medi-Cal improperly for oxygen laboratory tests. The laboratories routinely changed dates of service, altered test results, and billed for tests not rendered.
- **Montana MFCU**—The former acting administrator at a nursing home was sentenced to 15 months imprisonment and ordered to pay \$15,277 in restitution for theft from a health care facility, embezzlement and theft, and theft from an Indian tribal organization. The administrator conspired with an administrative assistant at the nursing home to steal Medicare, Medicaid, Social Security and other funds intended for nursing home residents. The funds were deposited into a bank account under their control and withdrawn for their own use. The administrative assistant was also sentenced for theft from a health care facility to 12 months imprisonment and ordered to pay \$18,537 in restitution.
- **Ohio MFCU**—A former home health care nurse was ordered to pay \$1,100 in fines and to undergo periodic drug testing while on probation for creating false documents in connection with health care benefits. The nurse admitted to documenting patient visits which did not occur, forging patient signatures on log sheets, and creating false nursing notes. As a result of her actions, the HHA improperly billed Medicare and Medicaid for services not rendered.

Public Health Agencies

The activities conducted and supported by HHS public health agencies 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 2001 FINANCIAL STATEMENT AUDITS

In support of its audit of the consolidated HHS-wide financial statements for FY 2001, OIG audited, through contracts with independent public accounting firms, the financial statements of the major operating divisions. Agency officials are taking corrective actions on most of the recommendations.

- NIH: The accounting firm issued an unqualified opinion on the NIH FY 2001 financial statements and noted a repeated material weakness for lack of an integrated financial system and sufficient financial analyses and reviews. A new material weakness was noted in the area of investment in management systems due to inadequate and inconsistent documentation to support decisions regarding new systems and to support the tracking of financial activities. (A-17-01-00009)
- CDC and ATSDR: The accounting firm issued an unqualified opinion on the CDC and ATSDR FY 2001 financial statements and noted no material weaknesses. (A-17-01-00010)
- FDA: The FDA received an unqualified opinion on the FY 2001 financial statements. No material weaknesses were noted in the system of internal controls. (A-17-01-00008)

LABORATORY SECURITY

As part of a major initiative to address bioterrorism issues, OIG is reviewing laboratory security at departmental, federal grantee and private-sector locations. The objective of this work is to ensure that laboratories working with select agents—substances that could potentially be used in bioterrorism attacks—are adequately secured. To assess physical security, OIG is using DOJ standards, developed in 1995 following the Oklahoma City bombing, that focus on perimeter security, entry security, interior security and security planning. The OIG is also reviewing laboratories' compliance with CDC regulations on the transfer of select agents and with the U.S.A. Patriot Act of 2001, which restricts certain individuals' access to such agents. Reviews have been completed or are underway at CDC, NIH, FDA and numerous grantees and private businesses. (Various CINs)

***NATIONAL INSTITUTE OF ENVIRONMENTAL
HEALTH SCIENCES SUPERFUND***

Through an agreement with the Environmental Protection Agency, the National Institute of Environmental Health Sciences (NIEHS) received Superfund money to carry out health-related and other activities. As required by statute, OIG audited the NIEHS Superfund obligations and disbursements for FY 2000. The audit found that these funds were generally administered in accordance with applicable laws and regulations; however, discrepancies between the Time and Attendance System and employees' earnings and leave statements were noted. The NIEHS agreed with the recommendations to resolve these discrepancies. (A-04-01-04000)

***ORGAN DONOR REGISTRIES:
A USEFUL, BUT LIMITED, TOOL***

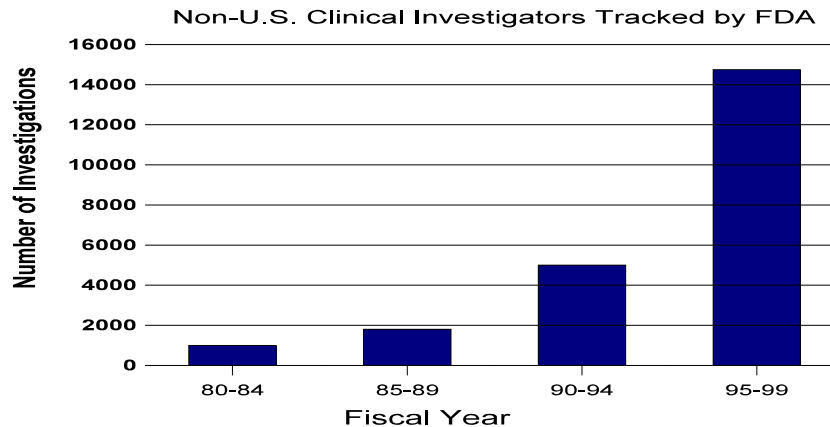
In response to the Secretary's request, made at the time he announced his Organ Donor Initiative, OIG assessed the value of donor registries as a strategy for increasing organ donation. The study found that registries have provided some assistance to organ procurement efforts, but that there are limitations to the contribution that registries can make to increasing the number of donors. For example, their use appears to increase consent rates for families, but so far registries contain only a limited number of donors. The OIG identified a number of practices that could take fuller advantage of the opportunities that registries offer.

The OIG recommended that HRSA establish a mechanism to disseminate information on donor registries and to support research projects that seek to maximize the impact that registries can have. The HRSA concurred with the recommendations. (OEI-01-01-00350)

***HUMAN SUBJECT PROTECTION
IN CLINICAL TRIALS***

Inspecting the growth of foreign clinical trials for new drug applications, OIG found that clinical trials in foreign countries have increased dramatically, and FDA cannot assure the same level of protection as it can for domestic trials. An increasing number of these trials are being conducted in countries wherein institutional review boards (IRBs) have limited experience in protecting human subjects. Entities

familiar with international research have raised concerns about the ability of some inexperienced foreign IRBs to adequately protect human subjects.



Among other things, OIG recommended that FDA obtain more information about the foreign IRBs, encourage greater sponsor monitoring, and that the Office for Human Research Protections encourage accreditation. The FDA generally concurred with the recommendations. (OEI-01-00-00190)

RETAIL FOOD SAFETY

Members of the retail food industry, state and local agencies, and the Federal Government overwhelmingly agreed that FDA has demonstrated its support for the model Food Code and the voluntary Recommended National Retail Food Regulatory Program Standards. All embrace the Food Code and the Standards as blueprints for developing future retail food inspection practices. Respondents at every level, however, expressed concern about issues of implementation. For example, the frequency of revisions to the Food Code may act as a drawback to adopting the most recent Food Code.

In this study, OIG recommended that FDA develop strategic plans which map out future actions for both FDA and the states, and OIG offered numerous suggestions for developing these plans. The FDA agreed with the recommendations, noting that some of them can be implemented with current resources, but others will be implemented as resources become available. On January 15, 2002, FDA responded to OIG's request for *FDA's Implementation Plan* in which the agency set forth its current thinking about enhancing food safety and security at the retail level, provided time- line projections and identified where resources will be needed for an orderly comprehensive implementation of the recommendations. (OEI-05-00-00540)

FDA'S ESTABLISHMENT INVENTORY ❖❖

The FDA has regulatory responsibility for more than 100,000 firms, which it must inspect to ensure product quality and safety. These firms are listed on an official establishment inventory, which FDA uses to plan inspections, justify existing resources, and request additional resources should its workload increase. Based on a review of the inventory's accuracy, OIG estimated that 16 percent of the establishments were no longer in business. The OIG recommended that FDA take appropriate steps to ensure that the inventory is complete, accurate and up-to-date. The FDA generally agreed. (A-15-01-20001)

STORAGE AND HANDLING OF EQUIPMENT EXPOSED TO HAZARDOUS MATERIAL

The purpose of this review was to determine whether NIH maintains adequate controls over the handling and storage of laboratory equipment potentially exposed to hazardous material. Although NIH stated that improvements had been made since the issuance of a 1998 Federal Occupational Health report, OIG remains concerned about a lapse in documenting equipment exposed to hazardous material. The NIH agreed with OIG's recommendations—to appropriately tag equipment and to file paperwork accordingly—and completed their implementation. (A-15-01-00040)

FACULTY LOAN REPAYMENT PROGRAM

The Faculty Loan Repayment Program run by HRSA provides degree-trained health professionals from disadvantaged backgrounds with loan repayments of up to \$20,000 per year. In exchange, these individuals agree to serve as faculty members at academic medical or health-related institutions for at least 2 years. Program goals include the development of a diverse faculty that can serve as effective role models and mentors for disadvantaged students. Under the statute, the academic institution is required to match the federal loan repayment, unless it can demonstrate a financial hardship, in which case it can request a waiver. This report found that waivers are routinely granted without an in-depth review of the institution's financial condition.

The OIG recommended that HRSA develop detailed policy guidance for evaluating waiver requests. The OIG believes that one effect of doing this would be to maximize the reach of federal dollars to assist more disadvantaged faculty applicants. The agency agreed. (OEI-12-01-00510)

***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, 287 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 debts.

After being excluded for nonpayment of their HEAL debts, a total of 1,618 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. This figure includes the 156 individuals who have entered into such a settlement agreement or completely repaid their debts during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals over \$112 million. Of that amount, over \$9.7 million is attributable to this reporting period. In the following examples, each individual entered into a settlement agreement to repay the amount indicated:

- An Illinois physician—\$403,324
- A California physician—\$230,344
- A Colorado dentist—\$179,610
- A Michigan osteopath—\$176,650

CONTROLS OVER ETHICS AND TRAVEL POLICIES

The object of this review was to determine whether adequate controls existed to ensure that HRSA adhered to regulations and policies regarding outside activities, financial disclosure, appointment of staff fellows and expert consultants, and travel. The review revealed no evidence of substantive violations of ethics or travel policies. However, OIG identified technical lapses related to the timeliness and completeness of certain forms and an inappropriate policy regarding the supervisory approval chain for travel. The HRSA officials stated that they had already taken action in some areas and planned to take action in the remaining areas in accordance with OIG's recommendations. (A-03-01-00351)

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, 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 Government, and state and local governments; and to strengthen states' financial management practices.

FY 2001 FINANCIAL STATEMENT AUDIT

In support of its audit of the consolidated Departmentwide financial statements for FY 2001, OIG contracted with an independent accounting firm to audit ACF's financial statements. The ACF received an unqualified opinion on its financial statements, with no weaknesses considered to be material. (A-17-01-0003)

AFDC OVERPAYMENTS AND COLLECTIONS

Under the former Aid to Families with Dependent Children (AFDC) program, state agencies administering the Title IV-A program were obligated to recover overpayments to recipients. Although the program was repealed and replaced by the Temporary Assistance to Needy Families (TANF) program, the requirement to recover AFDC overpayments remains in effect. States are still obliged to recover these overpayments and to return the proportionate federal share of the overpayments they collect to the U. S. Treasury. Some states have improperly retained these funds.

During this reporting period, OIG conducted reviews in Illinois, Texas, and Louisiana to determine the process used by each to identify and return the federal share of AFDC overpayments collected. Approximately \$31 million was identified as the federal share of the unremitted collections, which OIG recommended be refunded. (A-05-01-00030; A-06-01-00035; A-06-01-00073)

CHILD SUPPORT TO FAMILIES EXITING TANF

This inspection revealed that states pay some families less in TANF cash assistance than they collect in child support on their behalf. The OIG also found that, after leaving TANF, 8 percent of custodial parents in 5 in-depth site visits experienced delays in receiving their child support payments and 3 percent were underpaid. Eleven states reported that they were not always able to accurately distribute child support. Additionally, in the states visited, there was no systematic oversight of the child support distribution process.

The OIG recommended that the Office of Child Support Enforcement (OCSE) and the Office of Family Assistance ensure that the state child support enforcement and TANF systems effectively share information about their joint caseload and

accurately and efficiently disburse payments to TANF leavers by providing technical assistance and state use of Special Improvements Project grants to facilitate needed changes. The ACF generally concurred with the findings. (OEI-05-01-00220)

SUPPORT FOR CHILDREN ON TANF

This report demonstrates a strong correlation between payment compliance of non-custodial parents and their income. If payment requirements are out of synch with income and resources, payment compliance is low—raising particular problems for low-income parents. The OIG found that the level of payment required in child support orders for non-custodial parents with earnings below poverty was 69 percent of their reported earnings.

By way of contrast, the average for all non-custodial parents was 40 percent. Overall compliance with the support order over a 32-month period was 38 percent. However, this ranged from 17 percent for parents with earnings below poverty to 62 percent when earnings were two times the poverty line. Thus, if support order payment levels are properly correlated to income at the early stages of support orders, compliance rates can be improved with support levels increasing as income rises. The ACF agreed with OIG's findings and is taking action accordingly. (OEI-05-99-00392)

FEDERAL CHILD SUPPORT CASE CLOSURE REGULATIONS ♦♦

Appropriate child support case closures can help states concentrate resources on those cases where there is a greater likelihood of successful enforcement and collection. This process, implemented by states, is subject to federal regulations. This OIG study found an estimated 32 percent national error rate among child support case closures. Three types of errors comprised the error rate: 10 percent of cases did not meet a federal closure reason; 25 percent of cases requiring notice of closure did not have notice provided; and 11 percent of

Allowable Closure Reasons Under Federal Regulations

Notice Required

No Enforceable Order and Arrearages Less Than \$500
Noncustodial Parent is Deceased
Paternity cannot be Established
Noncustodial Parent's Location is Unknown
Noncustodial Parent is Disabled, Institutionalized or Incarcerated
Noncustodial Parent is a Foreign Citizen
Agency has Lost Contact with a Non-TANF Client
A Non-TANF Client is Non-cooperative
An Initiating State is Non-responsive in an Interstate Case

Notice Not Required

Agency has Completed Locate-only Services in Non-TANF Cases
Non-TANF Custodial Parent Requests Closure
A Good Cause Exception has Been Granted

cases that received notice of closure were closed before the required 60 days had elapsed. Closing cases that do not meet a closure reason effectively halts enforcement action in workable cases. When clients are not provided advance notice of closure, they are likely unaware of the closure action and miss the intended prompt to supply additional information that could lead to successful enforcement. The OIG suggested that OCSE work with states to reduce the error rate. The agency generally agreed. (OEI-06-00-00470)

INCREASED HEALTH CARE COVERAGE FOR UNINSURED CHILDREN ❖❖

The OIG estimated that, during the 12 months ended February 2001, an additional 13,100 uninsured children in Connecticut could have been enrolled in the State Children's Health Insurance Program (SCHIP) if the State Child Support Enforcement agency had been included in the enrollment process. Noncustodial parents unable to provide other health insurance (e.g., because it was not available or too costly) and residing in the state could have contributed \$11 million of the SCHIP premiums for 11,600 of these children. Noncustodial parents residing in other states could have contributed 83 percent of the premiums for 1,500 of the uninsured children.

The OIG recommended that the state SCHIP and Child Support Enforcement agencies improve coordination of their efforts to ensure that uninsured children eligible for SCHIP are enrolled and that noncustodial parents contribute toward the premiums when possible. (A-01-01-02500)

CHILD SUPPORT PRIVATIZATION IN MARYLAND ❖❖

In a limited-scope review of selected performance criteria during the first year of a 3-year Child Support Enforcement privatization contract, OIG found that the contractor's performance and reporting generally did not meet the terms and requirements of the contract. The contractor's quality assurance function did not provide effective oversight of child support operations, and the contractor did not perform all services or abide by all representations included in its response to the request for proposal. The OIG's report included several recommendations to the state agency to better monitor the contractor's performance. (A-03-01-00223)

CHILD SUPPORT ENFORCEMENT IN MARYLAND AND WEST VIRGINIA

The OIG evaluated Maryland's and West Virginia's processes and procedures to ensure that noncustodial parents' obligations are determined and met before public funds are used to cover their children's medical needs. Policies and procedures were found to be generally satisfactory, and the respective state laws and regulations appeared to comply with Title IV-D of the Social Security Act. However, neither state had legislation authorizing a decisionmaker, such as a judge or Family Law Master, to order noncustodial parents to contribute toward the state's cost of providing coverage under the Medicaid program. (A-03-01-00217; A-03-01-00218)

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, 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 1,705 investigations of child support cases nationwide which have resulted in 529 convictions and court-ordered criminal restitution and settlements of over \$29.5 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 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 10 task force regions appear in a table on the following page.

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 4,350 cases from the states.

As a result of the work of the task forces, 193 federal arrests have been executed and 161 individuals sentenced. The total ordered amount of restitution related to federal investigations is close to \$7 million. There have been 307 arrests on the state level and 276 convictions or civil adjudications to date, resulting in \$10.7 million in restitution being ordered.

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, Minnesota, Ohio, Wisconsin
Northeast	New York, New York	New Jersey, New York, Puerto Rico
Southeast	Atlanta, Georgia	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
Southwest	Dallas, Texas	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
West Coast	Sacramento, California	Arizona, California, Hawaii, Nevada
New England	Boston, Massachusetts	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Great Plains	Topeka, Kansas	Iowa, Kansas, Missouri, Nebraska, North Dakota, South Dakota
Rocky Mountains	Denver, Colorado	Colorado, Montana, Utah, Wyoming
Pacific North	Olympia, Washington	Alaska, Idaho, Oregon, Washington

Investigations

During this period, OIG investigations of child support cases, nationwide, resulted in 74 convictions and court-ordered criminal restitution of over \$3.6 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:

- **Oklahoma**—A man was sentenced to 5 years supervised probation and ordered to pay \$71,678 in restitution. In 1981, the man married using a false identity and, soon after, left his wife prior to the birth of their child and with no means of support. Since that time, the man has attempted to avoid paying child support by moving frequently and using various assumed names and social security numbers to hide his true identity.

Another man was sentenced to 15 months in prison and ordered to pay \$66,526 in restitution. A jury convicted the man after he refused an offer allowing him to plead to a misdemeanor if he paid the arrearage owed while serving probation. Although he earned approximately \$50,000 a year working with a railroad company, he never made a voluntary child support payment.

- **New York**—A man was sentenced to 3 years probation and ordered to pay \$17,361 in restitution. In addition to being forbidden to possess a firearm, he must participate in a substance abuse program, submit to random drug testing and report to probation on a schedule set by that agency. In addition to being convicted at the federal level, he was also convicted and sentenced on a state charge of failure to pay child support in April 2001. In order to avoid paying support, the man earned unreported income for several years; he also used fictitious addresses in order to hide his assets and whereabouts.

Another man was sentenced in state court to 6 months incarceration for contempt of court stemming from his failure to pay child support. The man fathered a child as the result of an affair; his daughter from that affair suffers from disabilities. The proprietor of an advertising agency, the man has claimed an annual income of up to \$7.8 million in the past. Based upon his subsequent guilty plea to failure to pay child support, he will be sentenced at the federal level upon his release from state jail.

- **Louisiana**—A man was sentenced to 2 years imprisonment, 1 year probation and ordered to pay \$84,536 in restitution. A computer programmer with an annual salary of \$65,000, the man failed to pay support for the past 15 years.

- **Michigan**—A physician was sentenced to over 7 months in jail, 5 years probation and ordered to pay \$62,359 in restitution for failure to pay child support, desertion and abandonment, and aggravated stalking. In addition, he was ordered to pay over \$1,000 in extradition fees and to undergo mental health counseling. At the time of his arrest, he was working as an emergency room physician at a hospital in Oklahoma.

- **Ohio**—A man was sentenced to 2 years probation and ordered to pay \$37,800 in restitution. Prior to his prosecution, he was living in New York with a girlfriend and assisting her operation of a Web site for children's stories. While residing in New York, the man also worked as a truck driver and as a satellite television installer.
- **Montana**—A man was sentenced to almost 7 months time served and ordered to pay \$6,315 in restitution for failure to pay child support, misuse of a social security number, and false statements. In an effort to avoid his child support obligations, he used his son's social security number when applying for employment. After his sentencing, the man, who is a citizen of the United Kingdom, was remanded into the custody of federal law enforcement for deportation.

MISUSE OF GRANT FUNDS

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

- A Rhode Island man was sentenced to 10 years imprisonment (with 7 years suspended) and ordered to pay \$244,334 in restitution for obtaining money under false pretenses. While serving on a city council addressing drug and alcohol abuse, the man embezzled \$244,334, a portion of which came through an HHS grant by the SAMHSA. He funneled money through the city and several community centers into the bank accounts of two fictitious companies. The funds were disguised as payments for services purportedly provided by the companies.
- Based on the findings of a joint OIG audit and investigation, the former executive director and former fiscal director of an ACF grantee in New York were sentenced for conspiracy to defraud the government through their misuse of Head Start program funds. The former executive director was sentenced to 6 months imprisonment and ordered to pay \$8,674 in restitution. The former fiscal director was sentenced to 24 months imprisonment and ordered to pay a total of \$34,684 in restitution. In 1999, ACF advised the grantee that as mother and daughter, the relationship between the executive director and the fiscal director created an unacceptable conflict of interest. In response, the mother paid her daughter \$151,000 in unauthorized severance pay. Later, the daughter fraudulently obtained a mortgage by misrepresenting that she was still an employee of the Head Start grantee.

DISCRETIONARY GRANTS ♦♦

The OIG reviewed a sample of 30 discretionary grants awarded by 3 ACF components and issued reports to 25 grantees during this reporting period. The purpose of these grants included economic/community development, job creation for low-income/unemployed residents, runaway youth assistance, and refugee services. The OIG found that about half of the grantees in the sample did not achieve or only partially achieved the grant objectives. The OIG also noted that about half of the grantees, including some that had achieved their grant objectives, had fiscal and/or internal control weaknesses. The OIG is continuing its review by assessing ACF's internal monitoring and oversight of these grantees. (Various CINS)

CONNECTICUT'S CLAIMS FOR FOSTER CARE ADJUSTMENTS

For the quarters ended December 1996 through September 1999, Connecticut claimed a total of \$22.6 million in federal funds for retroactive Title IV-E foster care adjustments. However, the state was not able to provide proper support for about \$2 million of the amount claimed. Also, the state could not fully support its claim for one quarter when it was transitioning to a new computer system. Therefore, OIG set this amount (\$11 million) aside until the state and ACF reach a workable solution.

The OIG recommended that the \$2 million be returned to ACF. However, the state believes that the full \$13 million (\$11 million plus \$2 million) should be referred to ACF for final resolution. (A-01-01-02501)

HEAD START REVIEWS

At ACF's request, OIG reviewed financial practices at Head Start programs in two states and Puerto Rico.

Pennsylvania

The OIG's review of selected financial and program management practices in FY 2000 revealed internal controls and management practices in need of improvement. The grantee expended Head Start funds on programs or activities that were unallowable, inappropriate or unreasonable. Financial reports, including the required independent audits and financial

status reports, were not prepared, submitted late, or submitted with incorrect information. The grantee could not provide required documentation for all major procurements, and actual enrollment was consistently below the funded enrollment level. Further, the grantee did not equitably charge administrative costs to benefitting programs, resulting in overcharges to the Head Start program. (A-03-01-00555)

West Virginia

The OIG reviewed selected financial and management practices following allegations of questionable financial transactions. The review disclosed questionable short-term transfers of Head Start funds in 1998 to programs with funding difficulties. The OIG also found that program disallowances were repaid to ACF primarily using residual federal fund balances from dormant programs and that the grantee's executive director used the grantee's building as collateral for a personal loan. The review also disclosed that the grantee did not properly allocate costs to benefitting programs, which could result in funding the program for a far greater number of children than were actually served, and charged Head Start for the full cost of surplus items distributed to the general population. (A-03-01-00510)

Puerto Rico

The OIG determined the allowability, allocability and reasonableness of \$3.6 million claimed by a grantee for personnel services for FY 1999. The OIG found that the grantee's practice of charging support service employees arbitrarily to Head Start and other programs it administered was not appropriate because these costs should be allocated to the programs that benefit. The reallocation resulted in a downward adjustment of \$1.2 million of compensated personnel services. Further, the grantee improperly claimed \$39,000 for health insurance and \$76,000 for cost-of-living adjustments for support service employees. The grantee officials generally agreed with the findings and recommendations. (A-02-99-02005)

General Oversight

The Office of the Assistant Secretary for Budget, Technology and Finance (ASBTF) is responsible for developing and executing the Department of Health and Human Services' (HHS) budget; ensuring that HHS performance measurement and reporting are in compliance with the Government Performance and Results Act; establishing and monitoring departmental policy for financial management (including debt collection, audit resolution, cost policy and financial reporting); and developing and monitoring HHS information technology policy (including IT security). The Assistant Secretary is the Department's Chief Financial Officer and oversees the Department's Chief Information Officer. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that many outside entities, such as state and local governments, charge for administering HHS and other federal programs.

The Office of the Assistant Secretary for Administration and Management (ASAM) is responsible for HHS policies regarding human resources, grants and acquisitions management. This office also oversees the Program Support Center, which provides a range of administrative services, such as human resources, financial management and administrative operations.

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 the cognizant agency to audit the majority of 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. The OIG is also responsible for auditing the Department's financial statements.

FINANCIAL STATEMENT AUDIT OF THE DEPARTMENT ❖❖

As required by the Government Management Reform Act of 1994, OIG audited the Department's consolidated/combined financial statements for FY 2001. This audit encompassed individual audits of 10 operating divisions' financial statements and reviews of 4 service organizations. The audit report, which appears in the Department's FY 2001 Accountability Report, included a "clean," or unqualified, opinion on the financial statements. This means that, for the third consecutive year, the statements were reliable and fairly presented.

However, the audit report noted two continuing material internal control weaknesses, which are those problems that are systemic across a number of operating divisions, as well as significant dollar issues affecting only one division. First, the Department continued to have serious weaknesses in its financial systems and processes for producing financial statements. These weaknesses included non-integrated financial management systems, insufficient financial analyses and reporting, and grant accounting issues. Second, Medicare information systems controls remained inadequate. Access controls, systems software controls and entity-wide security programs were the most troublesome areas. (A-17-01-00001)

DEPARTMENTAL SERVICE ORGANIZATIONS

In support of its audit of the consolidated HHS-wide financial statements for FY 2001, 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 concluded that controls were suitably designed and operating with sufficient effectiveness. No significant exceptions were noted. (A-17-01-00012)
- Human Resources Service: The firm examining the Human Resources Service concluded that controls were suitably designed and operating with sufficient effectiveness. No significant exceptions were noted. (A-17-01-00014)

- Division of Payment Management: According to the firm contracted to examine the Division of Payment Management, controls were suitably designed and operating with sufficient effectiveness. No significant exceptions were noted. (A-17-01-00013)
- Division of Financial Operations: The firm concluded that controls were suitably designed, except for noted deficiencies related to entity-wide security planning and management, access controls, application software development and change control, and segregation of duties. Also, the controls were operating effectively with the exceptions that separation procedures were not always followed, the contingency plan had not been updated since December 1999, and the Business Continuity and Contingency Plan had not been tested since October 1999. (A-17-01-00011)

DEPARTMENTAL CHILD SUPPORT OBLIGATIONS

Some departmental employees were delinquent in meeting their child support obligations and their wages are not being withheld for that purpose. In most cases, states did not know that delinquent obligors were departmental employees and, therefore, had not notified the Department of the required withholding action. More than half of these were Indian Health Service employees. The Department enters all income withholding orders which are received; however, some data entry errors did occur.

The OIG recommended that the Department undertake a series of steps to address these issues. The OCSE, PSC and IHS agreed with OIG's findings and recommendations and took appropriate action. To strengthen its efforts to make HHS itself a model employer with regard to child support enforcement, a senior official was appointed to oversee departmental compliance with these matters. (OEI-05-00-00300)

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 first

half of FY 2002, OIG's National External Audit Review Center reviewed about 1,076 reports that covered \$439 billion in audited costs. Federal dollars covered by these audits totaled \$103.1 billion, about \$45.8 billion of which was HHS money.

The OIG's oversight of the nonfederal audit activity not only provides Department managers with assurances about the management of federal programs but also identifies any significant areas of internal control weakness, noncompliance and questioned costs that require formal resolution by federal officials. 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. The nonfederal audit reports reviewed and issued during this reporting period fall into the following categories:

<i>Reports issued:</i>	
<i>Without changes or with minor changes</i>	<i>1,041</i>
<i>With major changes</i>	<i>31</i>
<i>With significant inadequacies</i>	<i><u>4</u></i>
<i>Total</i>	<i>1,076</i>

The 1,076 reports included recommendations for HHS program officials to take action on cost recoveries totaling \$2.8 million, as well as 4,083 recommendations for improving management operations. In addition, these audit reports provided information for 47 special memoranda which identified concerns for increased monitoring by departmental management.

RESOLVING RECOMMENDATIONS

The tables that appear on pages 58 and 59 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. 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	444	\$1,208,429,000	\$185,235,000
Issued during the reporting period	120	\$355,697,000	\$64,276,000
Total Section 1	564	\$1,564,126,000	\$249,511,000

Section 2			
For which management decision was made during the reporting period ^{2,3}			
Disallowed costs		\$248,730,000	\$14,917,000
Costs not disallowed		\$107,028,000	\$90,832,000
Total Section 2	148	\$355,758,000	\$105,749,000

Section 3			
For which no management decision had been made by the end of the reporting period			
Total Section 1 minus Total Section 2	416	\$1,208,368,000	\$143,762,000

Section 4			
For which no management decision was made within 6 months of issuance ⁴	302	\$876,468,000	\$87,647,000

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	39	\$63,258,602,000
Issued during the reporting period	8	\$1,004,867,000
Total Section 1	47	\$64,263,469,000

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	2	\$55,497,000,000
Based on proposed legislative action		
Value of recommendations that were not agreed to by management	0	0
Total Section 2	2	\$55,497,000,000

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	45	\$8,766,469,000

**LEGISLATIVE AND REGULATORY
REVIEW AND 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.

Development Functions

The OIG is responsible for the development and public announcement of a variety of sanction regulations addressing civil money penalty and program exclusion authorities administered by the Inspector General, as well as advisory opinions and safe harbor regulations related to the anti-kickback statute. During this reporting period, OIG:

- Published final regulations setting forth a new safe harbor to protect certain arrangements involving hospitals or other receiving facilities that replenish drugs and medical supplies used by ambulance providers when transporting patients to hospitals. (66 FR 62979; December 4, 2001)
- Developed and cleared final rulemaking addressing a series of revisions and technical corrections to OIG fraud and abuse authorities set forth in 42 CFR, Chapter V and continued to develop proposed regulations that will codify the new and revised Medicare+Choice and Medicaid managed care civil money penalty provisions.
- Published several *Federal Register* notices that set forth OIG policy and procedures in various areas. These included the annual solicitation notice for new safe harbors and Special Fraud Alerts (66 FR 65460; December 19, 2001). This notice solicited recommendations and proposals for developing new and modifying existing safe harbors, as well as developing new OIG Special Fraud Alerts.

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 OIG employee for conspiracy to commit access device fraud. She was sentenced to 4 months incarceration, 4 months in a halfway house and was ordered to pay \$48,925 in restitution. As part of a conspiracy to commit credit card and bank fraud, the employee misused her position to access and obtain the personnel information of other OIG employees. She then turned the information over to her co-conspirators, who subsequently used this information to open fraudulent credit card accounts and purchase goods and services throughout the metropolitan area of Washington, DC.
- In South Dakota, a former IHS employee was sentenced and ordered to pay \$6,746 in restitution for theft or embezzlement from a health care benefit program. As an accounting technician with the IHS, the employee was responsible for scheduling vendor payments using the electronic certification system. Several times during 1998 through 1999, the employee diverted funds from vendor bank accounts into her own checking account by changing the bank routing information.

INVESTIGATIVE PROSECUTIONS

During this semiannual reporting period, OIG investigations resulted in 250 successful criminal actions. Also during this period, 696 cases were presented for criminal prosecution to DOJ and, in some instances, to state and local prosecutors. Criminal charges were brought by prosecutors against 312 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over \$780.8 million 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.

Appendices

Appendix A
Savings Achieved Through Policy and Procedural Changes Resulting From Audits,
Investigations and Inspections
October 1, 2001, through March 31, 2002

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 \$12,015 million for this period.

OIG Recommendation	Implementing Action	Savings (millions)
Centers for Medicare and Medicaid Services		
Reforming Medicaid Disproportionate Share Payments: Disproportionate share payments to hospitals should be related to costs incurred in treating Medicaid and indigent patients to correct the inequities and abuses in current payment methodologies. (CIN: A-06-90-00073; CIN: A-04-92-01025)	Section 4721 of the BBA of 1997 reformed disproportionate share payments under state Medicaid programs by placing limitations on federal financial participation.	\$4,070
Medicare Part A Payments for Skilled Nursing Facilities: Services should be bundled into Medicare and Medicaid's payments to nursing homes; Part B payments for services normally included in the extended care benefit should continue to be examined for appropriateness; and a legislative recommendation should be developed to prohibit entities other than the skilled nursing facility (SNF) from seeking coverage on behalf of persons in part A covered SNF stays for enteral nutrition, incontinence care, and surgical dressings, and limit Medicare coverage of these services to Part A. In 1997 congressional testimony, OIG supported establishing a prospective payment <i>continued—</i>	Section 4432 of the BBA of 1997 (as amended by the BBRA of 1999) required a PPS for SNF care. Covered services include Part A SNF benefits and all services for which payment may be made under Part B (except physician and certain other professional services) during the period when the beneficiary is provided covered SNF care.	2,410

Appendix A

<p>Medicare Part A Payments for Skilled Nursing Facilities Continued— system (PPS) and consolidated billing. (OEI-03-94-00790; OEI-06-92-00863; OEI-06-92-00864; CIN: A-17-95-00096; CIN: A-14-98-00350)</p>		
<p>Medicare Secondary Payer Extensions: Establish a centralized database of information about private insurance coverage of Medicare beneficiaries. Extend the Medicare secondary payer (MSP) provision to include end stage renal disease (ESRD) beneficiaries as long as the individual has employer based coverage available. (OEI-07-90-00760; OEI-03-90-00763; CIN: A-10-86-62016; CIN: A-09-89-00100; CIN: A-09-91-00103; CIN: A-14-94-00391; CIN: A-14-94-00392))</p>	<p>The database capacity was achieved through the authorization of a data exchange between the Social Security Administration and the Centers for Medicare and Medicaid Services (CMS) and between the Internal Revenue Service and CMS. Section 4631 of the BBA of 1997 permanently extended current MSP policies for beneficiaries who are disabled and have ESRD. For ESRD beneficiaries, the statute also increased the time period Medicare is secondary payer from 18 to 30 months.</p>	<p>2,000</p>
<p>Capital-Related Costs of Hospital Services: Extend congressionally mandated reductions in hospital costs. The CMS should seek legislative authority to continue mandated reductions in capital payments; excess capacity was not considered in the capital cost policy. (CIN: A-09-91-00070; CIN: A-07-95-01127)</p>	<p>Section 4402 of the BBA of 1997 provided for rebasing of capital payment rates for an additional reduction in the rate of 2.1 percent.</p>	<p>1,160</p>
<p>Medicare Payments for Oxygen: The CMS should reduce Medicare payments for oxygen concentrators and ensure that beneficiaries receive necessary care and support in connection with their oxygen therapy. (OEI-03-91-00711, OEI-03-91-001710)</p>	<p>Section 4552(a) of the BBA of 1997 reduced Medicare reimbursement for oxygen 25 percent until 1999 and by 30 percent for each subsequent year; section 4552(c) mandated that the Secretary develop service standards for oxygen provided in the home.</p>	<p>600</p>
<p>Medicare Laboratory Reimbursements: In July 1989, OIG recommended that CMS take advantage of economies of scale present in the laboratory industry by considering competitive bidding or making reductions to the fee schedule amounts. In January 1990, OIG recommended that CMS seek legislation to allow across the board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices which laboratories charge physicians in a competitive marketplace. In a January 1996 follow-up, OIG found that Medicare continued to pay more to clinical laboratories than physicians for the same tests. Although the Omnibus Budget Reconciliation Act of 1993 reduced the fee schedule to 76 percent of the average in 1996, OIG recommended that CMS periodically evaluate the national fee schedule to ensure that it is in line with the prices <i>continued—</i></p>	<p>Section 4553 of the BBA of 1997 provided for reducing fee schedule payments by lowering the cap to 74 percent of the median for payment amounts, with no inflation update for 1998 through 2002.</p>	<p>600</p>

Medicare Laboratory Reimbursements Continued— physicians pay for the same clinical laboratory services. (OEI-02-89-01910; CIN: A-09-89-00031; CIN: A-09-93-00056)		
State Enhanced Payments Under Medicaid Upper Payment Limit Requirements: States are allowed to make enhanced payments to local government providers as long as aggregate state payments for each class of service do not exceed the amount that would have been paid under Medicare cost principles. The OIG found that states' use of intergovernmental transfers maximized federal Medicaid reimbursements. The OIG also found that enhanced payments were not based on the cost of providing the service nor did OIG find a direct relationship in the use of these funds to increase the quality of care. (CIN: A-03-00-00216)	On January 12, 2001, CMS issued revisions to the upper payment limit regulations which, among other things, created new payment limits for local government-owned providers. This final rule will significantly affect a state's ability to reap windfall revenues by reducing the available funding pool from which to make enhanced payments to local government-owned providers.	600
Payments for Durable Medical Equipment: Excessive Medicare Part B payments for enteral and parenteral nutrition, equipment and supplies should be reduced, or competitive acquisition strategies should be employed. (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230; OEI-06-92-00861)	Section 4316 of the BBA of 1997 froze Medicare payments for enteral and parenteral nutrition and supplies for 1998 through 2002 and simplified the process used to reduce inherently unreasonable prices by 15 percent.	300
Medicare Payments to Hospitals for Bad Debt: The CMS should seek legislative authority to modify the bad debt payment policy. (CIN: A-14-90-00039)	Section 4451 of the BBA of 1997 reduced bad debt payment to providers by 25 percent in FY 1998, 40 percent in FY 1999, and 45 percent in later years. The Benefits Improvement and Protection Act of 2000 subsequently reduced the reduction to 30 percent.	140
Medicaid Drug Rebates-Sales to Repackagers Excluded from Best Price Determinations: Medicaid rebates were lost because sales to HMOs were improperly excluded from drug manufacturers' best price determinations in FYs 1998 and 1999. The CMS should require drug manufacturers who excluded sales to HMOs from their best price calculations to repay the rebates and evaluate the policy guidance relating to exclusion of sales to other (non-HMO) repackagers from best price determinations. (CIN: A-06-00-00056)	The CMS issued Medicaid Drug Rebate Program Release #47 in July 2000 to make it clear to manufacturers to not inappropriately exclude other prices from best prices, as required by section 1927 of the OBRA of 1990.	80.7
Medicare Payments for Prescription Drugs: The CMS should reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. (OEI-03-95-00420; OEI-03-94-00390; OEI-03-97-00290)	Section 4556 of the BBA of 1997 reduced Medicare payments for drugs, which are paid based on the average wholesale price, by 5 percent.	30

Various Public Health Agencies

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.	24.4
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Appendix B
Unimplemented Office of Inspector General Recommendations
To Put Funds to Better Use

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

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

OIG Recommendation	Status	Savings (millions)
Centers for Medicare and Medicaid Services		
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)	In responding to OIG's report, CMS agreed with the recommendation to mandate Medicare coverage for all state and local government employees. However, this proposal was not included in the President's FY 2003 budget. The CMS did not agree with the recommendation to make Medicare the secondary payer.	\$1,559
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)	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.	1,600
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)	The CMS initially 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.	1,130*

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

Appendix B

<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 reduced capital payments, it did 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>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>In responding to OIG's report, CMS agreed with the recommendation to include a bad debt factor in the DRG rates. The BBA of 1997 provided for some reduction of bad debt payments to providers. The Benefits Improvement and Protection Act (BIPA) of 2000 subsequently increased bad debt reimbursement. However, additional legislative changes are needed to implement the modifications that OIG recommended.</p>	<p>340</p>
<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 and the BBRA of 1999 contained 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>	<p>157.3</p>
<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, 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>The CMS concurred with OIG's recommendations. The Administration's proposal for both FY 2002 and 2003 would assess a \$1.50 fee on most, but not necessarily all, paper claims. Also, under the CMS Claims Processing User Fee Act of 2001, significant outreach to providers will be conducted.</p>	<p>126</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>	<p>Disagreeing with the recommendation, CMS believes that savings will be achieved through the President's budget proposal to enact a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug</p>	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>	<p>The CMS did not concur with the recommendation, and no legislative proposal was included in the President's FY 2001 budget.</p>	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>	<p>The CMS agreed with OIG's findings but stated that further analysis would be required before any legislative changes could be supported.</p>	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>	<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 final rule in the <i>Federal Register</i> in February 2002.</p>	47
<p>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-02-99-0 01 20)</p>	<p>The CMS generally concurred. However, CMS did not agree to set specific standards for suppliers of custom-molded and custom-fabricated devices.</p>	43
<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 rate currently paid during the first 3 months of rental. (CIN: A-06-91-00080; OEI-07-96-00221; OEI-07-96-00222) <i>continued—</i></p>	<p>The CMS concurred and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency is examining payment allowances and methodologies at other payers and is reviewing data to determine if Medicare payments are excessive. However, the</p>	40

Appendix B

<p>Reimbursement for Hospital Beds Continued—</p>	<p>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. The BIPA of 2000 increased DME payments by 3.7 percent for 2001.</p>	
<p>End State 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)</p>	<p>The CMS agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities, and the BBA of 1997 required the Secretary to audit the cost reports of each dialysis provider at least once every 3 years. 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. The BIPA of 2000 increased the rate for services provided in 2001 by 2.4 percent and required the Secretary to develop a composite rate that includes, to the extent feasible, payment for clinical diagnostic laboratory tests and drugs that are routinely used in dialysis treatments but are currently separately billable.</p>	<p>22*</p>
<p>Medicaid Reimbursement for Clinical Laboratory Services: State agencies should install edits to detect and prevent payments for clinical laboratory services that exceed the Medicare limits and billings that contain duplicate tests, recover overpayments, and make adjustments for the federal share of the amounts recovered. (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; 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; A-03-00-00204; A-01-01-00003)</p>	<p>The CMS wrote to all state Medicaid directors in January 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. The OIG is conducting several follow-up reviews in this area.</p>	<p>17.8</p>

**This estimate represents annual program savings of \$22 million for each dollar reduction in the composite rate, given the population of ESRD beneficiaries at the time of OIG’s review.*

<p>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)</p>	<p>The FY 2002 and 2003 budgets did not include this type of legislative proposal.</p>	<p>9.1</p>
<p>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)</p>	<p>The CMS agreed with the recommendation, and the BBA of 1997, as amended by the BBRA of 1999, reduced 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.</p>	<p>TBD*</p>
<p>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)</p>	<p>The CMS was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. The OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare for old age or disability. At that point, Medicare would become the primary payer.</p>	<p>TBD</p>
<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-04-99-01195)</p>	<p>Although the BBA of 1997 included provisions to restructure home health benefits, CMS still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. Subsequent to the BBA, OIG's four-state review found that unallowable services continued 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. Also, CMS established additional payments for physician care plan oversight and undertook efforts to educate physicians and beneficiaries.</p>	<p>TBD</p>

*To Be Determined

Appendix B

<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 agreed to pursue a change in the rebate program similar to that recommended. The President's FY 2003 budget proposes a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug.</p>	<p>TBD</p>
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Various Public Health Agencies

<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. However, the proposal was not included in the President's FY 2003 budget.</p>	<p>8.2</p>
<p>Recharge Center Costs: The Assistant Secretary for Administration and Management 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. This suggestion was forwarded to OMB for consideration.</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).

OIG Recommendation	Status
Centers for Medicare and Medicaid Services	
<p>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)</p>	<p>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 a notice of proposed rulemaking in FY 1996.</p>
<p>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)</p>	<p>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 President's FY 2001 budget included funding to establish financial management controls at the contractors and to hire contractor staff to implement the controls. For the long term, CMS is developing an integrated general ledger system as the cornerstone of its financial management controls.</p>
<p>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)</p>	<p>Although CMS initially concurred with some specific recommendations, the agency believes that section 4706 of the BBA of 1997 sets forth congressional expectations on this issue in specifically requiring managed care organizations to meet the solvency standards established by the state for private health maintenance organizations. The CMS expected to publish regulations implementing the solvency standards in the spring of 2002.</p>

Appendix C

<p>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 which would protect the interests of the government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)</p>	<p>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>
<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. However, 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, 2002.</p>
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Appendix D

Notes to Tables 1 and 2

Notes to Table 1

¹The opening balance was adjusted downward \$6.1 million.

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

CIN: A-09-93-00083	Child Support Intercept Programs-California: The State does not concur with finding, they agree they earned interest on the collections, but contend that the IRS intercepts are AFDC related income which was offset by an acceptable substitution methodology related to financing. Amended amount of Cost question for \$380,533.
CIN: A-09-00-62228	Placer Community Action Council Inc.: Procedures were established to ensure bank deposits in excess of the FDIC insured limits have sufficient Collateral. All reasonable care was taken to safeguard Cost Question funds in the amount of \$69,506.
CIN: A-10-97-41196	Confederated Tribes and Bands of The Yakama Indian: Grantee supplied documentation to support Question Cost for \$122,934
CIN: A-10-00-58628	NA-Kuigpagmiut Inc.: Grantee supplied documentation to support Question Cost for \$38,889.

³Included are management decisions to disallow \$17.5 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-06-00-00056	MEDICAID DRUGS-REVIEW OF REPACKAGED DRUGS EX FROM, MARCH 2001, \$108,000,000
CIN: A-04-98-00123	REVIEW FOSTER CARE PMTS-CHILD CARE IN NC, APRIL 2001, \$48,183,445
CIN: A-01-00-00538	NATIONAL IDENTIFICATION OF SNF CONSOLIDATED BILLING, JUNE 2001, \$47,633,686
CIN: A-01-00-00509	M/C PART B PMTS FOR DME PROVIDED TO SNF PATIENTS, JULY 2001, \$35,000,000
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 HLTH, SEPTEMBER 1999, \$25,993,849
CIN: A-07-99-01279	OP PSYCH, JANUARY 2001, \$18,515,190
CIN: A-06-00-00051	AUDIT OF MEDICARE REHAB AGENCY COSTS IN TX, RHS, I, JUNE 2001, \$18,394,465
CIN: A-05-94-00064	MI BLUE CROSS/BLUE SHIELD, AUDIT OF ADMIN COSTS, JUNE 1996, \$15,609,718
CIN: A-01-01-02502	REVIEW OF UNCOLLECTED AFDC OVERPAYMENTS, AUGUST 2001, \$12,400,000
CIN: A-07-96-01176	MEDICARE EXCESS PENSION ASSETS - BC MICH, NOVEMBER 1996, \$11,904,263
CIN: A-07-01-02616	REVIEW OF MUTUAL'S OVERSIGHT OF PIP, AUGUST 2001, \$11,336,867
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

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CIN: A-01-00-00506	DIAGNOSIS-RELATED GROUP PAYMENT WINDOW, JULY 2001, \$5,042,207
CIN: A-01-97-00516	ADMIN. COSTS-PART A&B, RAILROAD RETIRE BOARD, JUNE 1999, \$4,939,184
CIN: A-03-99-00009	IBC ADMIN FY 96-97 AND NON-RENEWAL, JULY 2001, \$4,644,602
CIN: A-07-96-02001	MEDICARE PART B ADMIN COSTS AT BC/BS 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-03-00-00002	TRIGON PT-A AND TERMINATION, SEPTEMBER 2001, \$3,464,705
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-07-99-01298	DATE OF DEATH - 2, MAY 2001, \$3,200,000
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
CIN: A-01-01-00517	REVIEW OF MEDICARE OUTLIER PAYMENTS AT ROGER WILLIAMS HOSPITAL, JUNE 2001, \$3,100,000
CIN: A-06-99-00057	AUDIT OF MEDICARE REHAB AGENCY SRVCS IN TX, RHS,IN, JANUARY 2001, \$3,097,201
CIN: A-05-93-00013	MI-BLUE CROSS/BLUE SHIELD-CONTRACT MEDICARE AUDIT, APRIL 1993, \$3,010,916
CIN: A-09-98-50183	STATE OF CALIFORNIA, MARCH 1998, \$3,000,000
CIN: A-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-02-91-01006	BLUE SHIELD OF WESTERN NY MEDICARE ADM CTS PORTER, SEPTEMBER 1991, \$2,379,239
CIN: A-04-00-01209	OUTPATIENT PSYCHIATRIC SRVCS AT HOLLYWOOD PAV.HOSP, APRIL 2001, \$2,366,287
CIN: A-03-99-00038	EDGEWATER PSYC HOSPITAL, MARCH 2001, \$2,348,604
CIN: A-04-97-01166	REV. HOME HLTH SRVCS BY STAFF BUILDERS HOME HLTH, APRIL 1999, \$2,300,000
CIN: A-04-97-01170	REVIEW HOME HLTH SRVCS BY MEDCARE HOME HLTH SRVCS, APRIL 1999, \$2,200,000
CIN: A-07-00-00112	MEDICARE CONTRACT AND SEG. CLOSING - HCSC, JULY 2001, \$2,148,287
CIN: A-07-01-68554	STATE OF NEBRASKA , JUNE 2001, \$2,113,388
CIN: A-04-00-02162	REVIEW TREATMENT OF QUALIFIED DISCHRGs @ FCSO, FEBRUARY 2001, \$2,042,060
CIN: A-02-00-02502	UNIVERSITY OF MEDICINE & DENTISTRY CONTRACT AUDIT, APRIL 2001, \$2,002,011
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 SRVCS BY MEDTECH HOME HLTH SRVCS, APRIL 1999, \$1,900,000
CIN: A-06-96-00009	NEW MEXICO BCBS ADMIN COST - CONTRACTED, NOVEMBER 1997, \$1,879,366
CIN: A-04-01-68839	STATE OF FLORIDA , JUNE 2001, \$1,818,236
CIN: A-05-97-00014	GROUP HEALTH PLAN INC.(HEALTHPARTNERS) INST. BENES, JUNE 1998, \$1,808,308
CIN: A-05-95-00059	AUDIT OF ADMINISTRATIVE COSTS--BCBS MICHIGAN, JANUARY 1997, \$1,787,345
CIN: A-03-00-00007	REVIEW OF 1-DAY DISCHARGES--PA., APRIL 2001, \$1,649,411
CIN: A-04-97-02143	REVIEW THERAPY SRVCS 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 BC/BS ADMINISTRATIVE COSTS, NOVEMBER 1999, \$1,615,063
CIN: A-04-99-01196	OIG-HCFA JOINT REVIEW OF JMV MEDICAL CORP., DECEMBER 2000, \$1,600,417
CIN: A-03-96-00012	BCBSM PT-B NON-RENEWAL COSTS, AUGUST 1998, \$1,557,459
CIN: A-05-93-00057	MI-BLUE CROSS & BLUE SHIELD 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-07-01-00128	PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT BY HEALTH CARE SERVICE CORPORATION (HCSC), MAY 2001, \$1,292,114
CIN: A-04-00-66032	STATE OF FLORIDA, AUGUST 2000, \$1,210,637
CIN: A-05-00-00004	NEW CENTER COMMUNITY MENTAL HEALTH CENTER, JUNE 2000, \$1,181,000
CIN: A-05-00-00049	PARTNERSHIP PLAN - IL HOSPITAL TRANSFERS, JUNE 2001, \$1,150,113
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 RVW IN PR - SAN GERMAN - 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-05-01-00037	BC/BS OF MN. ADMIN COSTS-LEON SNEAD & CO., JUNE 2001, \$1,037,090
CIN: A-04-99-01199	REV. PSYCHIATRIC OUTPATIENT SRVCS-CORAL GABLES HOS, APRIL 2001, \$1,031,497
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-BCBSGA, 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 PRORAM (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 BLUE CROSS BLUE SHIELD, DECEMBER 1999, \$817,487
CIN: A-02-98-01040	NIAGARA CTY DEPT. OF HLTH-#337001-HHS ELIG REVIEW, DECEMBER 1999, \$807,679
CIN: A-03-99-00008	BLUE CROSS BLUE SHIELD 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-09-00-00103	PACIFICARE HMO - MEDICARE DUAL ELIGIBLES, MAY 2001, \$720,858
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-05-00-64226	NA-ILLINOIS DEPT. OF PUBLIC AID, MAY 2000, \$654,017
CIN: A-01-98-00503	PSYCHIATRIC OUTPT SERVICES AT THE FRANKLIN MED CTR, NOVEMBER 1998, \$646,517
CIN: A-01-99-00535	AUDIT OF M/C PART A ADMIN COSTS-ANTHEM BC/BS CT, AUGUST 2000, \$621,256
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 M'CARE P. B BCBSSC, JULY 1994, \$594,092
CIN: A-04-93-01069	MONITORG ADMIN COST AUDIT MCARE PART A BCBSSC, JULY 1994, \$590,844
CIN: A-09-00-00067	COLLEGE HOSPITAL - O/P PSYCH SVCS, APRIL 2001, \$567,888
CIN: A-04-00-61620	STATE OF NORTH CAROLINA, MARCH 2000, \$528,952
CIN: A-05-00-00011	LIBERTYVILLE MANOR SNF - THERAPY SERVICES, SEPTEMBER 2001, \$506,937
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.HLTH CARE'S PART. HOSPITALIZ, DECEMBER 1999, \$452,928
CIN: A-06-00-00011	FINAL ADMINISTRATIVE COST PROPOSAL - AR BC/BS, NOVEMBER 2000, \$442,177
CIN: A-07-01-00120	REVIEW OF UNFUNDED PENSION COCST AT BCBS OF OK, JULY 2001, \$413,800
CIN: A-05-97-00013	ACIFICARE OF CA-HMO INSTITUTIONAL STATUS PROJECT, APRIL 1998, \$407,784
CIN: A-02-01-67912	STATE OF NEW YORK, MARCH 2001, \$389,622

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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-09-98-00095	BLUE SHIELD OF CALIFORNIA, OCTOBER 1999, \$378,191
CIN: A-06-99-58928	ARKANSAS OFFICE OF CHILD SUPPORT ENFORCEMENT, APRIL 1999, \$367,273
CIN: A-01-99-00518	PSYCHIATRIC OUTPATIENT SVCS AT DANBURY HOSPITAL, MAY 2000, \$342,168
CIN: A-02-01-68556	ALBANY COUNTY OPPORTUNITY INC., MAY 2001, \$339,237
CIN: A-02-00-01000	GHI MEDICARE ADMIN. COSTS (CARMICHAEL & CO., CPA), APRIL 2001, \$338,392
CIN: A-02-00-01023	LONG ISLAND JEWISH MEDICAID OUTPATIENT MENTAL SRVS, AUGUST 2001, \$319,130
CIN: A-02-01-65217	PUERTO RICO DEPT. OF THE FAMILY, DECEMBER 2000, \$317,042
CIN: A-04-01-68747	STATE OF NORTH CAROLINA , JUNE 2001, \$281,636
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-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-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-12-00-00012	REVIEW OF OCS GRANT TO BROWN MAGNOLIA, APRIL 2001, \$221,889
CIN: A-05-99-00067	WPS PART B ADMINISTRATIVE COSTS, NOVEMBER 2000, \$221,644
CIN: A-05-96-00052	ORT ASSIST-ANCILLARY COSTS-NW COM. HOSP., JUNE 1997, \$206,508
CIN: A-02-00-01032	REVIEW OF MEDICAID OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY SAINT BARNABAS HOSPITAL, FORDHAM-TREMONT COMMUNITY MENTAL HEALTH CENTER FOR FISCAL YEAR ENDED SEPTEMBER 30, 1999, JULY 2001, \$205,100
CIN: A-06-96-00064	ORT SNF RESEARCH AT METHODIST HOSPITAL, JANUARY 1997, \$200,000
CIN: A-03-01-00555	PDPI INC. -- HEAD START, JUNE 2001, \$185,577
CIN: A-06-01-68876	STATE OF LOUISIANA, JUNE 2001, \$175,494
CIN: A-03-99-00007	FOREST AMBULANCE SERVICE - EXTERNAL, DECEMBER 1998, \$173,189
CIN: A-02-00-01020	BCBS OF WESTERN NY (CARMICHAEL & CO., CPA, APRIL 2001, \$171,631
CIN: A-07-99-01287	WELLMARK ADMIN COSTS 98, NOVEMBER 1999, \$160,626
CIN: A-03-98-00034	FREESTATE HP/INSTITUTIONAL STATUS/MEDICARE, MARCH 1999, \$156,987
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	I PRO CLOSEOUT AUDIT - CPA CONTRACT MONITORING, DECEMBER 1998, \$135,492
CIN: A-05-00-00060	MEDICA FOLLOW-UP, REIMB. RATES FOR INSTI. BENES, JUNE 2001, \$133,795
CIN: A-06-00-00014	REV OF INFUSION THERAPY CLAIMS @ DOCTORS HEALTHCAR, JUNE 2000, \$132,238
CIN: A-04-01-68784	STATE OF SOUTH CAROLINA, JUNE 2001, \$129,884
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-03-01-00001	EASTERN SHORE AMBULANCE CO., AUGUST 2001, \$110,417
CIN: A-06-01-68039	PUEBLO DE SAN FELIPE, APRIL 2001, \$109,446
CIN: A-01-00-62266	STATE OF MAINE, MARCH 2000, \$106,500
CIN: A-03-01-69502	CHILD WELFARE LEAGUE OF AMERICA INC., AUGUST 2001, \$102,852
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	NAT-WIDE REF OPNT PSYCH SVC AT ACUTE CARE HOSPITALS, MARCH 2000, \$94,716
CIN: A-10-97-00003	BCWAAK-ADM COSTS REMOTE NETWORK ACTIVITIES FY 93 & 94, FEBRUARY 1998, \$94,643
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-01-01-00503	REVIEW OF O/P MEDICAL SUPPLIES AT MERCY HOSPITAL, JULY 2001, \$88,904
CIN: A-07-00-00118	REVIEW OF KANSAS RURAL HEALTH CENTER, MAY 2001, \$87,493
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-10-01-67562	KENAITZE INDIAN TRIBE, MARCH 2001, \$79,533
CIN: A-04-94-02080	FINALIZATION OF BCBSFL DATA MATCH, JUNE 1995, \$79,316
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	OVELOCK PAIUTE TRIBE, DECEMBER 1999, \$74,187
CIN: A-01-00-00503	REVIEW OF MEDICARE OUTLIER PAYMENTS-MASS GENERAL, DECEMBER 2000, \$73,019
CIN: A-09-00-60444	OMBA 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	I 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-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-04-00-64899	NA-STATE OF TENNESSEE, JULY 2000, \$55,129
CIN: A-07-97-01206	PENSION - WASHINGTON/ALASKA - UNFUNDED, MARCH 1997, \$54,000
CIN: A-06-99-56489	STATE OF LOUISIANA, JANUARY 1999, \$53,963
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-09-01-65664	NA-LOVELOCK PAIUTE TRIBE, DECEMBER 2000, \$50,473
CIN: A-05-00-00059	TITLE XIX - MEDICAID ESCHEATED WARRANTS, MARCH 2001, \$50,162
CIN: A-09-95-00095	HEALTH SERVICES ADVISORY GROUP, INC (HSAG), DECEMBER 1995, \$49,585
CIN: A-03-93-03306	URVEY RESEARCH ASSOC. CACS NO1-ES-45067, DECEMBER 1993, \$48,779
CIN: A-09-01-68898	STATE OF ARIZONA, JUNE 2001, \$46,237
CIN: A-07-00-00106	PENSION SEGMENTATION AUDIT AT BCBS OF OKLAHOMA, JULY 2001, \$45,508
CIN: A-03-99-03307	UNIV OF PENN/NIH/GRANT EXPENDITURES REVIEW, MAY 2001, \$44,403
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-07-01-00121	REV. OF PEN. COSTS FOR MED. REIMB. FOR BCBS OF OK, JULY 2001, \$42,463
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-01-01-00507	OUTPATIENT PHARMACY SVCS AT LAWRENCE MEMORIAL HOSP, SEPTEMBER 2001, \$41,210
CIN: A-02-95-34279	PUERTO RICO DEPT. OF HEALTH, JUNE 1995, \$40,207
CIN: A-05-00-00017	INDIANA MEDICAID TRANSPORTATION SERVICES, MARCH 2001, \$39,735
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

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CIN: A-08-00-65136	STATE OF SOUTH DAKOTA, JUNE 2000, \$36,380
CIN: A-03-00-00010	PS GEISINGER HMO/INSTITUTIONAL STATUS/MEDICARE, JANUARY 2001, \$35,639
CIN: A-02-00-65502	ABYSSINIAN DEVELOPMENT CORP., AUGUST 2000, \$34,737
CIN: A-04-00-60897	STATE OF FLORIDA, MARCH 2000, \$33,397
CIN: A-09-01-00050	BALBOA NEPHROLOGY MEDICAL GROUP, APRIL 2001, \$32,568
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-03-00-00209	STATE SURVEY AND CERTIFICATION COSTS - VA, AUGUST 2001, \$29,298
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-05-00-60452	ST. CROIX CHIPPEWA OF WISCONSIN, DECEMBER 1999, \$26,363
CIN: A-06-00-00020	REV OF INFUSION THERAPY CLAIMS @ VISTA CONTINUING, JUNE 2000, \$25,008
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-04-00-00133	ESCHEATED WARRANTS - FLORIDA, MAY 2001, \$21,517
CIN: A-04-00-01206	BCBSNC - M'CARE PART A ADMIN COST AUDIT-CARMICHAEL, SEPTEMBER 2000, \$21,302
CIN: A-10-01-67141	STATE OF IDAHO, DECEMBER 2000, \$20,000
CIN: A-04-01-67441	CATAWBA INDIAN NATION, APRIL 2001, \$19,204
CIN: A-04-97-01163	VIMI M'CARE PRO CONTRACT AUDIT, SEPTEMBER 1997, \$18,758
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-03-97-00007	NE HEALTH CARE QUALITY FOUNDATION/CCAS/N HAMPSHIRE, MARCH 1997, \$17,045
CIN: A-07-00-00117	REV. OF PENSION COSTS FOR MED. REIMB. BC/BS 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-06-01-68297	NATIVE AMERICAN CENTER OF RECOVERY INC., MAY 2001, \$16,314
CIN: A-10-00-59080	ORTON SOUND HEALTH CORP., DECEMBER 1999, \$15,000
CIN: A-03-97-00008	NE HEALTH CARE QUALITY FOUNDATION/CCAS/VERMONT, MARCH 1997, \$14,596
CIN: A-09-00-00104	PACIFICARE OF CALIFORNIA - INSTITUTIONAL STATUS, MARCH 2001, \$14,278
CIN: A-07-99-60332	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-07-99-57985	STATE OF KANSAS, FEBRUARY 1999, \$13,550
CIN: A-09-01-66137	TOHONO O ODHAM NATION, NOVEMBER 2000, \$13,329
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-08-99-60402	STATE OF SOUTH DAKOTA, JULY 1999, \$11,774
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-02-01-66887	PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEBRUARY 2001, \$9,000
CIN: A-05-01-67360	MICHIGAN FAMILY INDEPENDENCE AGENCY, FEBRUARY 2001, \$8,708
CIN: A-09-01-68177	INDIAN HEALTH COUNCIL INC., MARCH 2001, \$8,257
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-05-01-68270	LAKE COUNTY COMMUNITY ACTION PROJECT, MAY 2001, \$7,614
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-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 BC/BS, JANUARY 1996, \$6,075
CIN: A-06-97-48062	SER-JOBS FOR PROGRESS NATIONAL INC., MAY 1997, \$5,924
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-09-97-48829	COMMUNITY ACTION COMMISSION OF SANTA BARBARA COUNT, AUGUST 1997, \$4,809
CIN: A-09-01-67778	LOVELOCK PAIUTE TRIBE , JUNE 2001, \$4,693
CIN: A-01-00-60299	INDIAN TOWNSHIP TRIBAL GOVERNMENT PASSAMAQUODDY TR, JANUARY 2000, \$4,597
CIN: A-07-95-01123	REVIEW OF CPA ADM. COST - BCBS OF KANSAS CITY, MAY 1995, \$4,045
CIN: A-04-97-01162	HMSA M'CARE PRO CONTRACT AUDIT, SEPTEMBER 1997, \$3,871
CIN: A-02-00-64365	NA-MUNICIPALITY OF PONCE PUERTO RICO, MAY 2000, \$3,788
CIN: A-09-01-00067	EAST BAY NEPHROLOGY MEDICAL GROUP, AUGUST 2001, \$3,418
CIN: A-03-01-03303	JOHNS HOPKINS UNIVERSITY/KPMG/NIDA/N01DA-3-7301, FEBRUARY 2001, \$3,347
CIN: A-09-01-68929	COLUSA INDIAN COMMUNITY COUNCIL, AUGUST 2001, \$3,306
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. BC/BS 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-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 downward revaluation by \$134 million.

²Management decision has not been made within 6 months of issuance on 32 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-05-00-00056	MEDICAID INTERGOVERNMENTAL TRANSFERS - IDPA, MARCH 2001, \$1,870,000,000
CIN: A-06-00-00023	MEDICAID PHARMACY/PHYSICIAN ACTUAL ACQUISITION COS, AUGUST 2001, \$1,080,000,000

Appendix D

CIN: A-10-00-00011	MEDICAID INTERGOVERNMENTAL TRANSFERS - WA STATE, MARCH 2001, \$475,000,000
CIN: A-01-99-00507	NAT-WIDE REF OPNT PSYCH SVC AT ACUTE CARE HOSPITLS ,MARCH 2000, \$224,466,692
CIN: A-04-00-02165	REVIEW OF AL MEDICAID INTERGOVERNMENTAL TRANSFERS, MARCH 2001, \$147,500,000
CIN: A-04-00-02169	REV. AL M'CAID INTERGOV'TAL TRANSFERS-HOSPITAL ENHANCE, MAY 2001, \$63,000,000
CIN: A-01-99-00530	NATIONWIDE REV OF O/P PSYCH SVCS @ PSYCH HOSPITALS, DECEMBER 2000, \$56,936,287
CIN: A -07-98-02534	EMPIRE BC/BS PENSION PLAN TERMINATION, MARCH 2000, \$38,626,351
CIN: A-02-01-67912	STATE OF NEW YORK ,MARCH 2001, \$19,000,000
CIN: A-04-97-00109	EMERGENCY ASSISTANCE CLAIMS - NC, JULY 1998,\$13,000,000
CIN: A-01-99-00506	FOLLOW-UP REVIEW OF SEPRTRY BILLABLE ESRD LAB TESTS, JANUARY 2001, \$12,200,000
CIN: A-06-99-00060	REVIEW OF AN HMO UNDERPAYMENT CLAIM OF 21 MILLION, JUNE 2001, \$12,191,579
CIN: A-01-00-00502	REV OF EXORBITANT MEDICARE PMTS FOR O/P SVCS, MAY 2001, \$12,100,000
CIN: A-03-91-00552	INDEPENDENT LIVING PROGRAM -- NATIONAL, MARCH 1993, \$10,161,742
CIN: A-07-96-01177	MEDICARE POST RETIREMENT CLAIM BC MICH, NOVEMBER 1996, \$8,978,998
CIN: A-03-00-00007	REVIEW OF 1-DAY DISCHARGES--PA.,APRIL 2001, \$6,300,000
CIN: A-01-97-02506	REVIEW OF THE AVAIL OF MEDICAL COVERAGE/CSE SUPORT, JUNE 1998, \$5,704,585
CIN: A-04-98-01188	REVIEW ADMIN. COSTS @ M'CARE 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-07-99-01298	DATE OF DEATH - 2,MAY 2001, \$700,000
CIN: A-03-00-00001	OPS GEISINGER HMO/INSTITUTIONAL STATUS/MEDICARE, JANUARY 2001, \$306,269
CIN: A-05-01-00074	REVIEW OF BID PROPOSAL RFP HCFA-01-0003, JUNE 2001, \$282,049
CIN: A-03-99-00038	EDGEWATER PSYC HOSPITAL, MARCH 2001, \$208,731
CIN: A-07-97-01230	FMQ - DOSHI OKLAHOMA, JUNE 1997, \$203,510
CIN: A-07-97-01231	PROWEST-DOSHI WASHINGTON, JUNE 1997, \$163,552
CIN: A-02-96-02001	INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JANUARY 1998, \$90,528
CIN: A-07-97-01232	PROWEST - DOSHI ALASKA, JUNE 1997, \$21,218
CIN: A-09-00-60029	COCOPAH INDIAN TRIBE, DECEMBER 1999, \$20,830
CIN: A-05-96-00069	CPA AUDIT OF HOOPER HOLMES HHA G&A -OI CASE OPEN, FEBRUARY 1998, \$17,555
CIN: A-07-95-01164	MEDICARE ADMIN COSTS - GENERAL AMERICAN,DECEMBER1995, \$16,632
CIN: A-01-97-00526	PSYCHIATRIC OUTPATIENT SERVICES, MARCH 1998, \$7,245
CIN: A-01-98-00506	PSYCHIATRIC OUTPATIENT AT NEWTON-WELLESLEY HOSPITAL, MARCH 1998, \$1,120

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	60
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 & C
(a)(4)	Matters referred to prosecutive authorities	61
(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	58
(a)(9)	Statistical Table 2—Reports With Recommendations That Funds Be Put to Better Use	59
(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

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-56, 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" statute) 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

Office of Inspector General
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