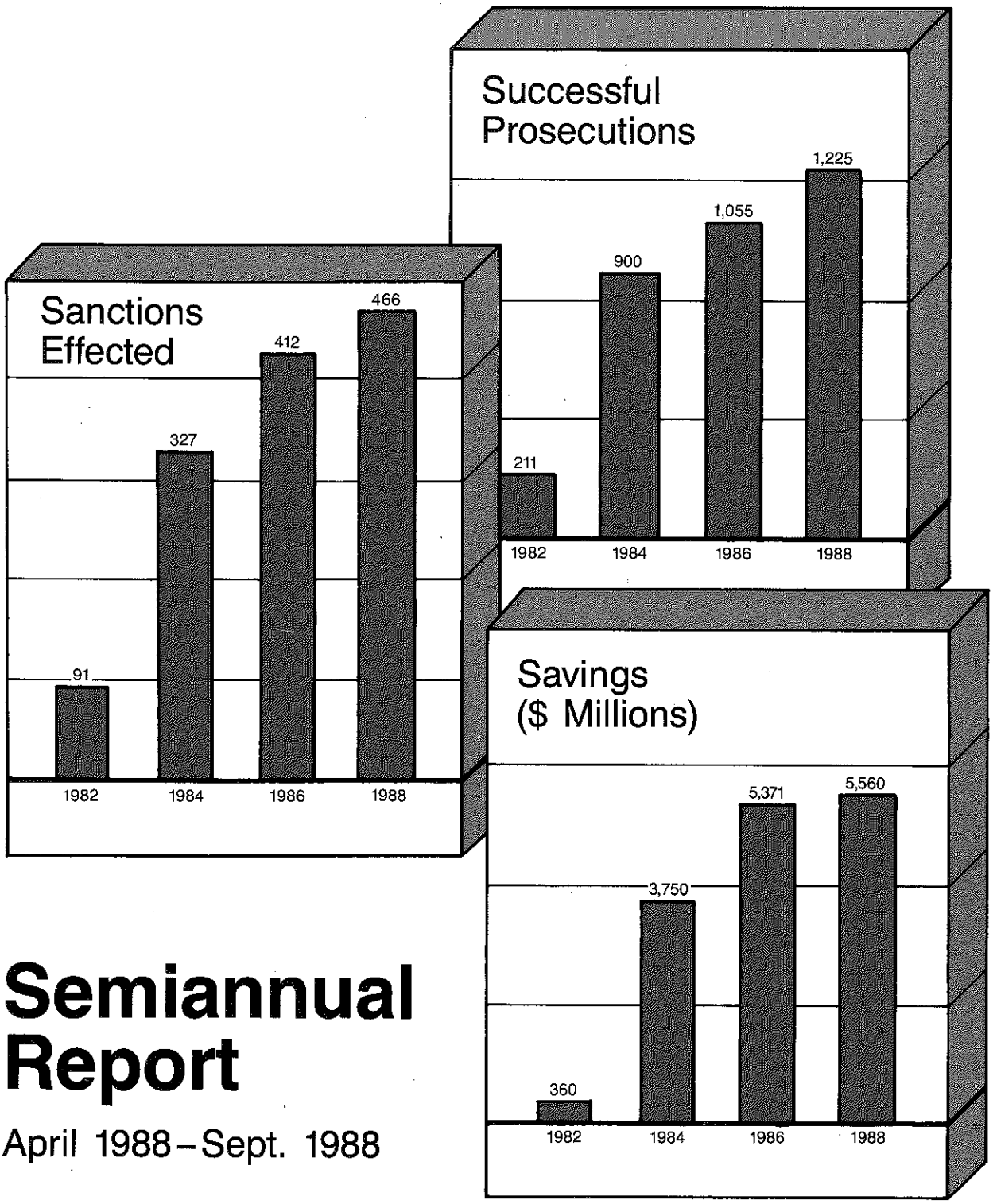
Department of Health and Human Services
Richard P. Kusserow
Inspector General

OFFICE OF INSPECTOR GENERAL



Semiannual Report

April 1988–Sept. 1988

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

The Office of Inspector General was created by Public Law 94-505, as amended by Public Law 97-375, which set forth specific semiannual reporting requirements to the Secretary and the Congress. A selection of other statutory and administrative reporting and enforcement responsibilities are listed below:

AUDIT AND MANAGEMENT REVIEW RESPONSIBILITIES

P.L. 96-304 Supplemental Appropriations and Rescissions Act of 1980
P.L. 97-365 Debt Collection Act of 1982
P.L. 98-502 Single Audit Act of 1984
P.L. 97-255 Federal Managers' Financial Integrity Act

CRIMINAL INVESTIGATIVE RESPONSIBILITIES: Violations of the following statutes as they pertain to Department programs

The Social Security Act
The Public Health Service Act
The Federal Food, Drug and Cosmetic Act
Title 18, United States Code, entitled "Crimes and Criminal Procedure"

CIVIL MONETARY PENALTY AND SANCTION AUTHORITIES

P.L. 92-603 Social Security Amendments of 1972
P.L. 95-142 Anti-Fraud and Abuse Amendments of 1977
P.L. 97-248 Peer Review Improvement Act of 1982
P.L. 97-258 Omnibus Budget Reconciliation Act of 1981
P.L. 98-369 Deficit Budget Reduction Act of 1984
P.L. 99-272 Consolidated Omnibus Budget Reconciliation Act of 1985
P.L. 99-509 Omnibus Budget Reconciliation Act of 1986
P.L. 99-660 Health Care Quality Improvement Act of 1986
P.L. 100-93 Medicare and Medicaid Patient and Program Protection Act of 1987
P.L. 100-203 Omnibus Budget Reconciliation Act of 1987
P.L. 100-360 The Medicare Catastrophic Coverage Act of 1988

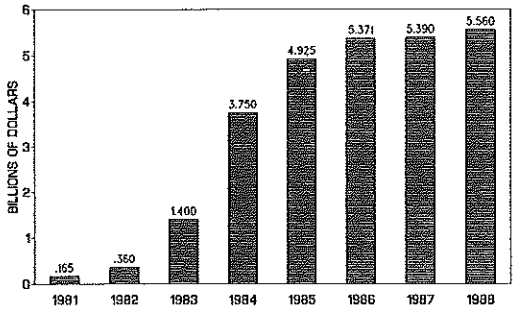
OFFICE OF MANAGEMENT AND BUDGET CIRCULARS

A-21 Cost Principles for Educational Institutions
A-25 User Charges
A-50 Audit Follow-up
A-70 Policies and Guidelines for Federal Credit Programs
A-76 Performance of Commercial Activities
A-87 Cost Principles for State and Local Governments
A-88 Indirect Cost Rates, Audit, and Audit Follow-up at Educational Institutions
A-102 Uniform Administrative Requirements for Assistance to State and Local Governments
A-110 Uniform Administrative Requirements for Grants and Other Agreements With Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations
A-122 Cost Principles for Nonprofit Organizations
A-128 Audits of State and Local Governments
A-129 Managing Federal Credit Programs

REPORT HIGHLIGHTS

Dollar Results - During Fiscal Year (FY) 1988, $5.56 billion in settlements, fines, restitutions, receivables and savings resulted from Office of Inspector General (OIG) activities and implementation of OIG recommendations.[1]

COST SAVINGS 1981-1988



The following items highlight OIG findings and recommendations made during the second half of the fiscal year which, if implemented, will result in significant cost savings.

- The OIG estimated that unreported beneficiary marriages in five States resulted in $5.2 million in Social Security overpayments. Another $2.8 million would have been paid over the next 5 years to 288 individuals if computer aided matching had not detected their marriages. (See page 11.)

- Medicare could save about $4 billion over the next 5 years by ending disproportionate share payments without redistributing the funds to the prospective payment system (PPS). These payments were found to be financially unjustified in an OIG study. (See page 23.)

- Medicare could reduce indirect medical education payments by $920 million in FY 1989 because teaching hospitals have been receiving larger than normal profits. (See page 22.)

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[1] For more detail on savings classifications, see Appendices A-D.

- Savings to Medicare would total about $635 million if reimbursement rates to rural referral centers (RRCs) were based on the relationship of costs of RRC to costs of urban and other rural hospitals; rather than being based on the cost of urban hospitals alone. (See page 23.)

- Intermediaries paid at least $28 million to PPS hospitals for nonphysician services already covered by diagnosis related group (DRG) payments. (See page 24.)

- Physicians incorrectly received approximately $73.6 million from Medicare in 1985; the primary cause of the overpayments was inaccurate documentation of consultation services. (See page 31.)

- Medicare paid $20.8 million for claims that should have been covered by the health plans of beneficiaries. (See page 34.)

- As much as $1.9 billion can be saved over the next 5 years by eliminating Federal sharing in premiums States pay to enroll Medicaid recipients in the Medicare Part B program. (See page 36.)

- An OIG study found that State Medicaid programs have not taken full advantage of transfers of assets, liens and estate recoveries to pay for long term care services, and could save $589 million annually if recovery programs were more effective. (See page 37.)

- An estimated $11.9 million in Medicaid costs were claimed by Arkansas for youth psychiatric patients without the required certification of need for care. (See page 39.)

- About $31 million a year can be saved by solving longstanding systemic procurement problems at the National Institutes of Health. (See page 47.)

- California claimed $9.9 million in Federal funds for services provided to children not eligible for the Aid to Families with Dependent Children Foster Care program. (See page 62.)

- Several States claimed $54 million in Federal financial participation in FY 1985 for State sales taxes. The OIG recommended that the Office of Management and Budget (OMB) revise Circular A-87 to deny payments for sales taxes levied by States on themselves. (See page 68.)

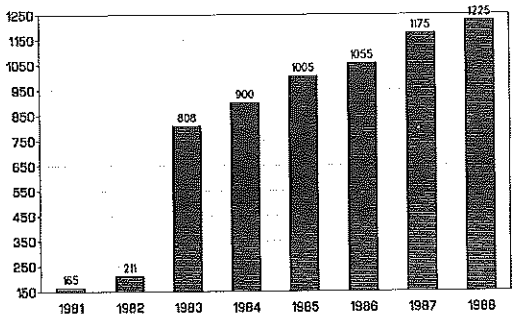
- About $517 million can be saved over the next 5 years and the Department of Health and Human Services' (HHS) programs would receive a one-time

savings of $360 million by accelerating deposits of payroll taxes under Federal grants, contracts and other agreements. (See page 68.)

- About $1.3 billion could be saved annually by disallowing interest costs charged by State and local governments on their unfunded pension liabilities. (See page 70.)

Successful Judicial Prosecutions - As a result of investigations by OIG, a total of 1,225 individuals and entities were convicted for engaging in crimes against HHS programs during 1988.

SUCCESSFUL PROSECUTIONS 1981-1988



The following items highlight OIG investigative activities during the second half of FY 1988.

- Convictions resulting from investigations of Medicare and Medicaid fraud by OIG and federally supported State Medicaid Fraud Control Units totaled 291, with financial recoveries and savings of over $26 million. (See page 20.)

- Five ambulance companies and their owners were convicted, two of them for misrepresenting routine transportation of nursing home patients to doctors' offices and hospitals as emergency services. (See page 25.)

- A total of 518 persons were found guilty of crimes related to one or more of the programs administered by the Social Security Administration. (See page 7.)

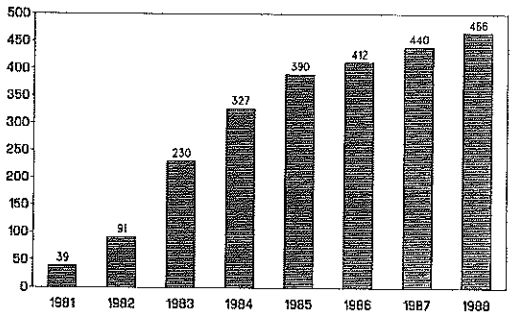
- Of the total, more than 200 persons were convicted of misuse of Social Security numbers in the commission of various crimes, including credit card fraud and illegal purchase of handguns. (See page 9.)

- In one project completed during this reporting period, eight persons were convicted for illegally obtaining AFDC benefits in two neighboring States; 18 were convicted during the 2-year life of the project. (See page 57.)

- Successful action on OIG cases yielded more than $35 million in returns of departmental funds in the form of fines, recoveries, restitutions, settlements and savings, and an additional $8.1 million in returns to non-departmental entities. (See page 15 and Appendix D.)

Administrative Sanctions - A total of 466 health care providers and suppliers or their employees were administratively sanctioned during FY 1988 for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries.

ADMINISTRATIVE SANCTIONS EFFECTED 1981-1988



The following items highlight OIG administrative sanctions imposed during the second half of the fiscal year.

- A total of 289 persons or entities were administratively sanctioned, through exclusion or monetary penalties, for defrauding Medicare, Medicaid or other health care payers or for providing substandard care or excessive services. (See page 26.)

- One hundred and eighty-one of these health care providers or their employees were excluded from program participation under the Medicare and Medicaid Patient and Program Protection Act on the basis of program-related convictions. (See page 26.)

- Under the civil monetary penalty authorities, another 48 providers were assessed a total of $5 million in fines and penalties for filing false Medicare or Medicaid claims. (See page 28.)

- Thirteen persons were excluded from the programs because of convictions related to controlled substance abuse. (See page 26.)

- Six health care providers were sanctioned upon the recommendation of peer review organizations on the basis of failure to meet professional standards of quality of care, or for performing unnecessary services. (See page 27.)

- Under the "patient dumping" authorities of the Consolidated Omnibus Budget Reconciliation Act of 1985, penalties amounting to $5,000 were collected from a hospital that had inappropriately transferred an indigent patient who was in labor and had an emergency medical condition. (See page 21.)

The following items pertaining to quality of care and the welfare of beneficiaries highlight OIG findings, recommendations and activities during the second 6 months of the fiscal year.

- A follow-up survey on the quality of service provided to Social Security clients found that 87 percent of the respondents rated the Social Security Administration's (SSA) services as good or very good. (See page 8.)

- An OIG inspection found that inadequate record-keeping and reporting procedures have made measurement of the magnitude of patient dumping difficult. The OIG recommended that reporting of suspected cases of patient dumping should be made a condition of participation in the Medicare program. (See page 20.)

- Fifteen individuals or organizations were administratively sanctioned by exclusion from the Medicare and Medicaid programs because of convictions for patient abuse or neglect. (See page 26.)

- State dental boards tend to be seriously understaffed and, as a result, the effectiveness of both licensure and discipline of operations is compromised. (See page 47.)

- In light of the Public Health Services' (PHS) 1985 findings that a type of bypass surgery has no proven medical value, PHS should reconsider its 1978 recommendation that this procedure be covered by Medicare. (See page 48.)

- After making an assessment of nursing homes, OIG recommended that the Health Care Financing Administration (HCFA) should produce for the public an informative document that contains easily accessible and objective information pertaining to nursing homes. (See page 40.)

- An OIG report on youth drug education found a consensus among those involved that drug education should be comprehensive and start at an early age, and that more parental involvement is needed in the programs. (See page 48.)

- In a report on minority adoptions, OIG concluded that despite substantial progress, adoption agencies have not yet succeeded in recruiting enough minority families for older and more handicapped minority children. (See page 61.)

- Two unlicensed physicians were convicted for intent to distribute controlled substances, practicing without a certificate and misrepresentation in billing Medicare. (See page 32.)

TABLE OF CONTENTS

INTRODUCTION

This report summarizes the Department of Health and Human Services' (HHS) Office of Inspector General major activities, initiatives and results for the 6-month period ending September 30, 1988. Under Public Law 94-505, enacted in 1976, the Office of Inspector General (OIG) has a statutory responsibility to protect the integrity of HHS programs which serve 56 million beneficiaries. Three primary components comprise OIG — the Office of Audit, the Office of Investigations, and the Office of Analysis and Inspections. Through a comprehensive program of audits, investigations, inspections and program evaluations, OIG reduces the incidence of fraud, waste, abuse and mismanagement, and promotes the economy, efficiency and effectiveness of HHS programs which are estimated to cost nearly $400 billion in Fiscal Year (FY) 1988.

The OIG's activities cover all five operating divisions of the Department. The Social Security Administration (SSA) manages the Nation's retirement, disability and Supplemental Security Income (SSI) and Part B of the Special Benefits to Disabled Coal Miners (Black Lung) programs. The Health Care Financing Administration (HCFA) administers the Medicare and Medicaid programs. The Public Health Service (PHS) promotes biomedical research, disease prevention, safety and efficacy of marketed food and drugs and other activities designed to ensure the general health and safety of American citizens. The Family Support Administration (FSA) provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. The Office of Human Development Services (HDS) provides a variety of social services to American children, families, older Americans, native Americans and the Nation's disabled. The subsequent chapters of this report are devoted to OIG activities in each operating division of the Department.

The tables on the next two pages summarize the Department's actions on OIG's recommendations to recover funds or put them to better use. Recommended recoveries that program management have agreed to implement are item C(i) on the table pertaining to recommendations involving questioned costs which is on page 2. The table covers current period activity, while management's collection of these and previously recommended recoveries for the year are summarized in the "Audit Disallowances" table on page 3. Appendix C details recommended recoveries agreed to by management during the current period.

The OIG recommendations to put funds to better use are summarized in the second table on page 2. The table depicts implemented recommendations as well as those under advisement. Legislative and programmatic actions on OIG recommendations are detailed in Appendices A and B respectively.

RESOLVING AUDIT RECOMMENDATIONS

The following chart summarizes the Department's responses to OIG's audit recommendations for the recovery or redirection of expenditures. This information is provided in accordance with the Supplemental Appropriations and Recissions Act of 1980 (Public Law 96-304). In addition, the chart provides expanded information on audit resolution identified in separate legislation passed by the House and Senate.

OIG RECOMMENDATIONS INVOLVING QUESTIONED COSTS
(in millions)

	Number	Amount
A. Reports pending management decision at the start of the reporting period.	162	$30.2
B. New reports issued during period with questioned costs (including unsupportable and ineligible).	253	213.7
C. Recommendations for which management decisions were made during reporting period.		
(i) amounts agreed to be recovered and added to accounts receivable (See Appendix C)	292	85.6
(ii) amounts not sustained	103	8.3
D. Reports for which no management decision has been made at the end of the reporting period.	198	150.1
E. Reports for which no management decision has been made within 6 months after the date the report was issued.	1	0.01

OIG RECOMMENDATIONS INVOLVING BUDGETARY SAVINGS AND FUNDS PUT TO BETTER USE (in millions)[1]

	Number	Amount
A. Reports with recommendations at the start of the reporting period.	7	316.3
B. Reports containing recommendations that were issued during reporting period.	53	1,232.7
C. Recommendations that were decided by management during the period.	24	805.8
D. Reports pending action at end of reporting period		
(i)legislative (See Appendix E (1))	15	5,280.5
(ii)management (See Appendix E(2))	22	3,063.0
E. Reports for which no management decision has been made within 6 months after the date the report was issued.	0	0.0
F. Prior management decisions implemented in the period		
(i) legislative action (See Appendix A)	11	2,343.7
(ii)management action (See Appendix B)	3	22.4

FOOTNOTE
1. All reports with significant financial recommendations computed for annual savings except those related to items in Appendix A.

COLLECTION OF AUDIT DISALLOWANCES

The OIG monitors the Department's debt collection activities to ensure its compliance with Federal debt reporting requirements. The operating divisions are reviewed on a rotating basis. During this fiscal year, OIG evaluated SSA's activities, including actions taken to meet the Office of Management and Budget's (OMB) and the Department of Treasury's reporting requirements. This information was included in our report titled "Examination of Social Security Administration's Financial Statements for Fiscal Year Ended September 30, 1987," which was discussed in the previous semiannual report.

A portion of the Department's outstanding debt results from the Department's acceptance of recommended audit recoveries. When the Department agrees with audit recommendations to recover questionable charges to HHS programs, accounts receivable are recorded by the operating divisions. The OIG then monitors these debt collection activities. The following chart summarizes the Department's recovery activity.

AUDIT DISALLOWANCES [1]

October 1, 1987 to August 31, 1988
(In Millions)

	Total	OS	HDS	PHS	FSA	HCFA	SSA
Beginning Receivables	**$170.43**	$7.86	$15.00	$6.49	$48.69	$87.71	$4.68
New Receivables	**323.10**	12.40	26.60	53.80	3.50	225.80	1.00
Payments of Receivables	**(12.64)**	(0.15)	(3.41)	(0.67)	(6.89)	(1.11)	(0.41)
Payments In Offsets	**(168.56)**	0.00	0.00	(0.12)	0.00	(167.94)	(0.50)
Reclassified Amount	**57.21**	0.00	(0.30)	(3.53)	(30.75)	95.08	(3.29)
Written Off	**(5.53)**	0.00	0.00	0.00	0.00	(5.53)	0.00
Ending Receivables	**364.01**	20.11	37.89	55.97	14.55	234.01	1.48

1 *Data is drawn from OIG Audit, Inspections Management System (AIMS). Includes sustained disallowances of HCFA's Bureau of Quality Control. Amounts shown are not final and may be subject to change as a result of decisions by Grants Appeal Board, the Courts, etc.*

SOCIAL SECURITY ADMINISTRATION

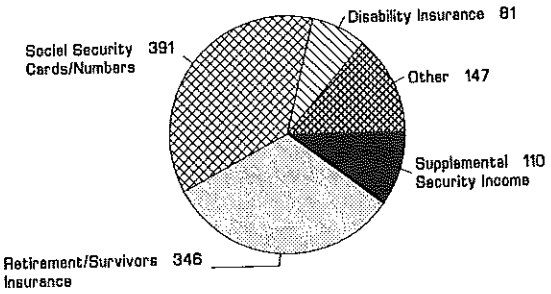
CHAPTER I

SOCIAL SECURITY ADMINISTRATION

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

The Social Security trust funds could save billions with the implementation of Office of Inspector General legislative and programmatic recommendations. Investigations resulted in a total of 518 convictions during this reporting period for a total of 1,075 for the year.

SOCIAL SECURITY
Successful Judicial Prosecutions
FY 1988



In addition, audit and investigative receivables and programmatic savings exceeded $26 million.

Fifty years ago, the Social Security Act established a national system that would collect a share of workers' earnings and pay them benefits in old age. The national Retirement, Survivors, and Disability Insurance (RSDI) program, popularly called Social Security, is the largest of the Social Security Administration (SSA) programs. In FY 1988, SSA will pay RSDI benefits estimated at $214.5 billion. The program is financed through payroll taxes paid by employees, their employers and the self-employed. Benefits are paid for retired and disabled workers, spouses, certain divorced spouses, children and disabled children of retired and disabled workers; and to widows and widowers, certain surviving divorced spouses, children, and dependent parents of deceased-worker beneficiaries.

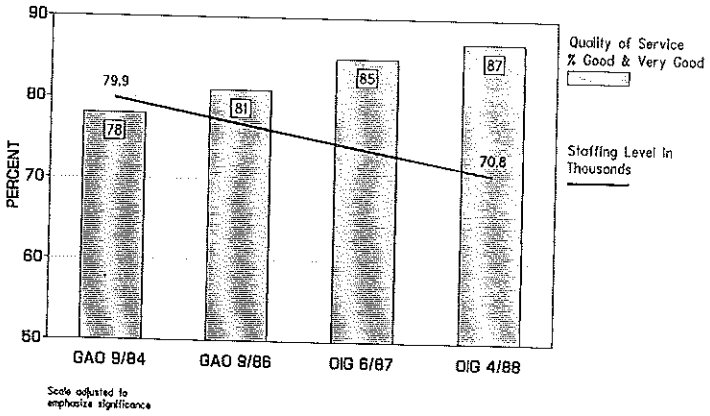
In 1974, the Supplemental Security Income (SSI) program consolidated under Federal administration various earlier State-run programs assisting the blind, disabled and elderly. The program, financed by general revenues, provides monthly payments to persons age 65 or older who meet a means test and to disabled and blind persons of any age who meet tests of both disability and means. In FY 1988, SSA will pay SSI benefits totaling $11.2 billion. In addition, program expenditures under the Black Lung program will approach $1.6 billion. These monies are expended to pay compensation, medical and survivor benefits to eligible miners and their survivors, where mine employment terminated prior to 1970 or where no mine operator can be assigned liability.

SOCIAL SECURITY CLIENT SATISFACTION

An OIG inspection entitled "Social Security Client Satisfaction: FY 1988" was conducted to follow up on concerns that the quality of service provided to Social Security clients may be declining as a result of staff reductions at SSA. The survey was originally designed by the General Accounting Office (GAO) and was replicated in a FY 1987 OIG inspection. The sample for the FY 1988 inspection consisted of 640 randomly selected individuals who visited or telephoned SSA offices during the last week of January or the first week of February 1988.

Based on a 72 percent survey response rate, OIG determined that 87 percent of the respondents rate SSA services as good or very good. The ratings from the three prior surveys were: 78 percent for the September 1984 sample, 81 percent for the September 1986 and 85 percent for the June 1987 sample as illustrated in the chart below:

SSA Staffing Levels Vs. Quality of Service
Comparison of Four Studies



The current survey shows a statistically significant increase in the rating for client satisfaction over the first GAO survey. Consequently, OIG concluded that the 11 percent staff reduction that has occurred since the first GAO survey has not had an adverse effect on the clients' satisfaction with SSA services. (OAI-02-88-00660)

ACCESS TO ATTORNEYS

An OIG inspection was conducted to determine whether claimants who appealed RSDI determinations had problems in obtaining representation by attorneys.

The OIG found that the vast majority of RSDI claimants who request hearings do not have difficulty in retaining attorneys. Lawyer referral agencies indicated no decrease in the number of attorneys handling SSA cases and no reports of instances where attorneys were unwilling to accept SSA claimants. By more than two to one, claimants prefer having attorneys represent them rather than representing themselves or using nonattorney representatives. There was some confusion among claimants about SSA attorney fee arrangements, resulting in costly hearing delays and postponements.

The OIG recommended that SSA continue to support its current attorney fee payment policy which is less costly to claimants than a legislative proposal that would mandate automatic 25 percent fees. Also, to save time and money in the appeals process, SSA should assure that all hearing offices properly inform claimants about their rights to attorneys and about attorney fee arrangements. The SSA will consider the OIG findings and recommendations and continue to seek ways to ensure that claimants know and understand their rights to representation and attorney fee arrangements. (OAI-09-88-00520)

FALSE IDENTIFICATION AND SOCIAL SECURITY NUMBERS

Use of false identification is a multi-billion dollar problem affecting both Government and business. Congressional estimates place the cost to the American public and business from crimes involving false identification at $24 billion annually. Along with birth certificates and drivers' licenses, the Social Security number (SSN) or card is a foundation document in creating false identifications. (For a discussion on birth certificate fraud see page 73.)

A. Undocumented Alien-Related Fraud

The sale of SSNs to illegal aliens, a thriving business, is illustrated in the following OIG investigative cases:

- A foreign national was sentenced to 1 year in prison for using an alias and an SSN not assigned to him to open a savings account at a Wisconsin financial institution. Similar incidents in which other foreign nationals had been involved resulted in losses in excess of $100,000 to various Wisconsin

federally insured institutions. This case was a joint investigation with the Federal Bureau of Investigation (FBI) and the local police department.

- In Ohio, an undocumented alien was sentenced to jail for stealing his 11-year-old nephew's Social Security card and assuming his identity to obtain employment and to register a stolen vehicle.

B. Bank Fraud Using SSNs

The use of fraudulent SSNs has a significant impact on the entire credit system of the United States. Because of its responsibilities for assuring the integrity of the SSN system, OIG frequently assists the FBI, Secret Service and other Federal law enforcement agencies in a myriad of investigations. The following cases are examples of investigations in which OIG was involved:

- In Delaware, an individual was sentenced to a total of 9 years in prison for mail, bank and SSN fraud. He had applied for credit cards under a fictitious name and submitted false tax returns to validate the fraudulent applications, then defrauded nine banks of $132,000. The case was investigated jointly by OIG, the Postal Service and the Secret Service.

- A former broker with a prominent investment firm was convicted in Rhode Island for money laundering and false representation of an SSN. Between 1982 and 1984, the broker used false SSNs and names to open bank accounts into which customers deposited checks which were used to make investments. Because the checks were for less than $10,000, the bank was not required to report the transactions to the Internal Revenue Service (IRS). The investment firm was charged with conspiracy and money laundering and fined $1 million.

- An Ohio woman was sentenced to 5 years in prison for misuse of an SSN and to 3 concurrent 2-year sentences for fraud and computer-related violations. She had used more than 10 aliases and SSNs to obtain bank loans, merchandise and credit from a variety of stores and financial institutions.

C. Student Loan Fraud

The following cases, which involved the use of false SSNs to obtain student loans, were resolved during this period.

- Four employees of a beauty school in New York City were each sentenced to 3 years probation and 250 hours of community service. They also were each fined $2,000, and one employee was ordered to pay $7,000 in restitution. They had used fictitious names and SSNs to obtain student grants. The checks to the fictitious students were sent to the addresses of friends and relatives, who turned them over to the conspirators. Other beauty school employees or

officials are suspected to be involved, with the total amount of illegal gains expected to exceed $100,000. The investigation is being conducted jointly with the Department of Education and the FBI.

- An Indiana woman was given a 3-year suspended sentence for student loan fraud. She and her husband, who was sentenced in 1987, had used false SSNs in applying for student loans. The case was worked jointly with the FBI.

UNREPORTED MARRIAGES

The OIG concluded that State computerized marriage records can be successfully matched with SSA's master beneficiary record (MBR) file to identify unreported beneficiary marriages. The SSA relies primarily on beneficiaries to voluntarily report any changes in marital status that might affect their entitlement status. (For example, marriages of those entitled as a surviving mother or father, child, or divorced spouse may terminate benefits.) However, these changes are often not reported to, or detected by, SSA.

An OIG computerized match of SSA's MBR file with State marriage records in five States found that overpayments estimated at $5.2 million were made to beneficiaries who married between 1980 and 1985. The OIG also estimated that another $2.8 million would have been paid during the next 5 years to 288 individuals if the match had not detected their marriages.

The OIG recommended that SSA periodically obtain computerized marriage records from the five States identified in the report and match those records with the MBR to detect unreported marriages and investigate and take appropriate action on the cases we identified. In addition to exploring the possibility of acquiring State marriage records, SSA is also assessing various alternative approaches to detecting unreported marriages. In addition, SSA has initiated administrative action on the unreported marriages identified. (CIN: A-09-87-00052)

TAXES ON NONRESIDENT ALIEN BENEFICIARIES

As of December 31, 1986, SSA was paying approximately $1.2 billion annually to some 346,000 beneficiaries residing outside the United States. Approximately 151,000 of these beneficiaries were nonresident aliens subject to tax withholding. They are legally entitled to benefits as a result of coverage earned while working in the United States, working for a United States corporation overseas, or serving in the United States armed services.

A. Resolution of Overpayment and Underpayment Issues

Since 1984, SSA has attempted to develop policies for processing overpayments and underpayments involving nonresident alien benefits. Because of the absence of formal policy guidelines, a backlog existed of approximately 7,900

unprocessed cases. These cases involved approximately $12.4 million in overpayments and $2.6 million in underpayments.

The OIG recommended that SSA fully adopt its role as withholding agent under the Internal Revenue Code and thus maximize the use of existing automated procedures and simplify the processing of beneficiary cases. The SSA agreed with the spirit and intent of our recommendations and will study ways that corrective measures may be most effectively put into place. (CIN: A-13-86-62631)

B. Collection of Retroactive Taxes

The OIG found that from January 1984 through November 1986 over $4.4 million in nonresident alien taxes had not been withheld from benefits paid to 17,566 nonresident alien beneficiaries.

The OIG recommended that SSA use its automated systems to identify retroactive nonresident alien taxes due and develop procedures to facilitate collection by SSA's automated systems. (CIN: A-13-86-62658)

MULTIPLE PAYMENTS

An OIG examination found that improvements are needed in SSA's controls and procedures to detect beneficiaries who are improperly receiving more than one SSA benefit check per month. The OIG developed and applied computer programs to detect such payments using the beneficiaries' mailing addresses as the key match criteria. Overpayments identified totaled $572,600. Investigations concluded that in 15 cases beneficiary claims were fraudulent. Nationwide, an estimated $2.7 million in overpayments could be identified by using the computer programs and approximately $612,000 could be realized in cost savings by eliminating these unauthorized payments over the next 12 months.

Recovery of identified overpayments has already begun by SSA. Also, SSA will test and evaluate the detection routines before deciding on their future use. (CIN: A-04-87-03001)

DISABILITY BENEFITS FRAUD

By concealing work activities and other information from SSA, certain individuals fraudulently obtain Social Security benefits. The following are examples of successful judicial prosecutions of cases involving disability benefits fraud:

- In Texas, an individual was sentenced to 20 months in prison, ordered to make restitution of $119,000 and fined $50 for receiving Social Security disability payments while working under another SSN. He had made several false statements to SSA regarding his work and earnings.

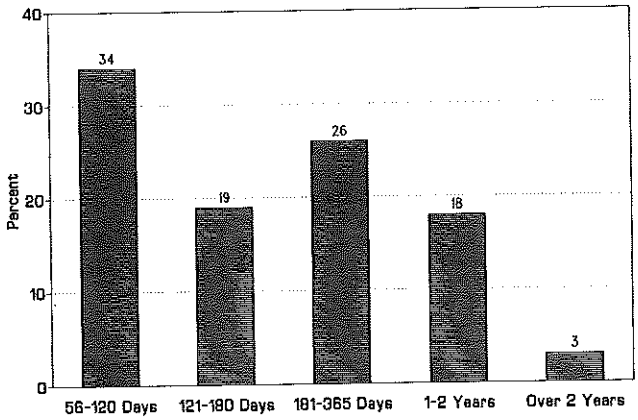
- A Pennsylvania man employed by the State liquor control board was given a suspended sentence and ordered to repay $28,000 to SSA. He had hidden his income to obtain disability benefits.

- An Arkansas man had to repay $40,000, in $200-a-month payments, because he worked under his wife's SSN while receiving disability and Medicare payments.

COLLECTION OF SSI OVERPAYMENTS

The OIG's review of the collection of SSI overpayments from current recipients found an ongoing backlog of uncollected overpayments. In these cases, SSA had issued reminder alerts (also called B8 diary alerts) to field offices regarding the overpayments. These alerts are intended to initiate collection actions on prior overpayments when recipients become reentitled to SSI benefits or in cases where recoveries are not being made on current pay recipients. Timely action is critical because the recipients' pay status could change, thus making collection efforts much more difficult.

AGE OF UNCOLLECTED OVERPAYMENT CASES



During 1986, SSA was unable to reduce the backlog of uncollected overpayment cases (about 3,100 cases on average) because the work was assigned a low priority. The OIG estimated that the backlog averaged about $2.4 million and recommended that SSA assign sufficient priority to collecting overpayments to prevent a buildup in the future. The SSA is taking action to reduce the backlog. (CIN: A-09-87-00045)

MEDICAL EVIDENCE DEVELOPMENT BY DDS

This study analyzed selected medical evidence procurement and other administrative management procedures to identify cost efficient practices for potential utilization by other disability determination services (DDS). Administrative

policies or practices that are barriers to efficient administration or that needlessly increase program costs and lead to more inconsistency were also reviewed. The SSA, jointly with the States, administers two national disability programs: Social Security Disability Insurance and Supplemental Security Income. State DDSs make determinations of disability on the basis of regulations, standards and guides issued by SSA. The SSA pays 100 percent of the costs incurred by the States in performing this function.

The OIG found that the program operations manual system guidelines are adequate to assure accurate development of medical evidence; however, several areas require additional SSA guidance. The DDSs have made special efforts to improve and/or enhance the quality and timeliness of the medical evidence of record. The OIG recommended that SSA catalog all DDS efforts, and after careful review, publish and distribute to all DDSs those efforts identified as most effective. While all DDSs have reportedly developed consultative examination (CE) management plans, not all SSA regional offices are conducting annual CE reviews. The OIG recommended that SSA require regional offices to conduct reviews to assure that CE management plans are being implemented in a cost-effective manner. The OIG also recommended that SSA adopt the Medicare national laboratory fee schedule for use by the DDSs. The SSA agreed with a majority of the recommendations. (OAI-06-88-00820)

DECEASED BENEFICIARIES

Benefits may continue to be sent to deceased persons, either because the person's death goes unreported to SSA or because relatives or friends deliberately conceal it from SSA. Deliberate concealment of beneficiaries deaths to use their benefits constitutes fraud against SSA programs.

A. Medicare Usage Data

An OIG report analyzed the advisability of employing Medicare usage data to identify Social Security payments made to deceased beneficiaries. Although SSA uses several techniques to learn of beneficiaries' deaths, OIG analysis indicated more could be done.

Of 518 beneficiaries in Texas age 96 or older who had not used Medicare since 1984, OIG identified payments to 12 deceased beneficiaries. These payments to deceased beneficiaries totaled about $300,000. The SSA concurred with OIG's recommendation that SSA conduct a review in another State to determine whether matching techniques OIG developed should be used on a broad scale. (CIN: A-12-87-02655)

B. Fraud Cases

One of the ways fraud involving deceased beneficiaries is identified is through matches of State death records against SSA beneficiary rolls. The following are examples of successfully concluded cases resulting from this kind of match, or

from referral by other organizations:

- A woman in New York was sentenced to a year in prison and ordered to repay $19,000 for converting her deceased father's benefits for almost 4 years. Although the fraud was uncovered after SSA received a State death alert match, upon questioning the woman had claimed her father was alive but was visiting friends.

- A match of California death records with SSA rolls led to a 6-month jail sentence and restitution of more than $6,000 for a woman who used benefits intended for her deceased father-in-law.

- A State death alert match and timely referral to OIG by SSA also led to the quick conviction and sentencing of an Ohio woman. She has to serve 3 years probation and repay the $12,000 she illegally obtained by negotiating her deceased father's benefit checks.

- A local radio station newscaster, also in Ohio, had to sell her deceased mother's house to repay the $11,000 she had obtained by negotiating her mother's benefit checks. Bank agents alerted OIG to her illegal actions.

- An elderly woman was not prosecuted in New York because of her age and physical condition. However, she had to repay $28,000 she collected because she did not inform SSA of the death of a woman for whom she was a representative payee.

ASSISTANCE TO OTHER LAW ENFORCEMENT AGENCIES

A great many Federal, State and local law enforcement and regulatory agencies depend on OIG expertise for assistance in false SSN use related to a broad range of illegal activities, including licensing and income tax fraud, drug trafficking and racketeering. During this 6-month period, we identified $8.1 million in non-HHS funds ordered recovered through OIG assistance. The following results are examples of some of these cases.

- The OIG provided evidence and testimony in an Ohio case which resulted in the conviction of a man from a Caribbean country for drug trafficking, money laundering, conspiracy and firearms violations. He had assumed the SSN of a juvenile to get a driver's license, then continued to use it in renting an apartment, arranging mail drops and other activities requiring identification.

- An OIG investigation resulted in a Minnesota man's being sentenced to 2 years incarceration for SSN fraud after Minneapolis police had asked assistance in identifying him. Suspected of being the serial killer of 3 Indiana

women, the man was about to be paroled from prison where he was serving a 10-year term for rape.

- Assistance to local Ohio police in identifying a man suspected of receiving stolen property led to a 6-month jail sentence. He was involved in automobile and automobile parts theft and drug sales and distribution, and possessed weapons when arrested.

- In an investigation into a health care organization, the New York Medicaid Fraud Control Unit found that a man appeared to have used several names and SSNs. The OIG investigation led to his conviction for income tax evasion. His secretary was convicted for lying to a grand jury on his behalf.

MEDICARE INQUIRIES AT SSA

An OIG inspection examined SSA field office problems in handling beneficiary inquiries relating to Medicare claims. The review determined that SSA is overextended in its commitment to assist beneficiaries with their inquiries related to Medicare claims. The SSA field offices lack the capacity to effectively answer most inquiries about Medicare claims because they do not have access to carrier data and the staff lacks experience with the complex processes and rules of Medicare.

The OIG recommended that both SSA and HCFA take actions to advise the public that it is primarily HCFA's responsibility to respond to beneficiary Medicare inquiries. This recommendation is consistent with the Department's policy on catastrophic health care coverage, which places primary responsibility with HCFA to resolve beneficiary problems. The SSA and HCFA agreed with the recommendations and are working to accomplish these goals. (OAI-02-87-00002)

HEALTH CARE FINANCING ADMINISTRATION

CHAPTER II

HEALTH CARE FINANCING ADMINISTRATION

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

The Medicare and Medicaid programs will save more than $2.3 billion as a result of actions taken on Office of Inspector General recommendations during the second half of Fiscal Year 1988. During this period, OIG identified program areas where legislative action, more efficient management and tightened internal and fiscal controls could result in significant additional savings. An additional $69 million in program expenditures were questioned as to their allowability under law, regulations or cost principles. In these instances, recommendations for financial adjustments and appropriate procedural changes were made.

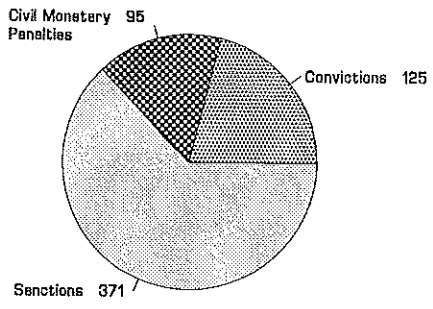
In FY 1988, the Medicare and Medicaid programs, administered by the Health Care Financing Administration, provided health care coverage for more than 52 million of the Nation's elderly, poor and disabled. Total Federal Medicare payments for FY 1988 are estimated at $87.7 billion. Medicare hospital insurance (Part A) provides, through direct payments for specified use, hospital insurance protection for covered services to persons 65 or older and to certain disabled persons. Medicare Part A is financed by the Federal hospital insurance trust fund.

Medicare supplementary medical insurance (Part B) provides, through direct payments for specified use, insurance protection against most of the costs of health care to persons 65 and older and certain disabled persons who elect this coverage. The services covered are medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services, and certain other medical and health services. Medicare Part B is financed by participants and general revenues.

Federal grants to States for medical care for nearly 25 million low-income people will total $30.7 billion in FY 1988. Federal matching rates are determined on the basis of a formula which measures relative per capita income in each State. Eligibility for the Medicaid program is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). States may also cover certain individuals who are not eligible for SSI or AFDC.

Fraud and abuse of the Medicare and Medicaid programs or their beneficiaries may result in criminal, civil, and/or administrative actions against the perpetrators. During this period, OIG was responsible for a total of 346 successful actions against wrongdoers which resulted in $22.7 million in fines, savings, restitutions and settlements. Successful actions for the year totaled 591.

JUDICIAL & ADMINISTRATIVE ACTIONS
FY 1988



In addition, State Medicaid Fraud Control Units, for which OIG has oversight responsibility, reported 234 successful actions for the period. Total OIG and State Medicaid Fraud Control Unit monetary returns in fines, penalties, restitutions, recoveries and savings amounted to over $26.7 million.

HOSPITAL PATIENT DUMPING

Under Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), OIG has responsibilities related to penalizing hospitals for inappropriate transfer of patients seeking medical treatment in a hospital emergency room. An amendment to COBRA, that took effect on August 1, 1986 (Public Law 99-509), established criteria for the appropriateness of transfer from one hospital emergency room to another of critically ill or injured patients, and women in active labor. Hospitals which fail to comply with these provisions are subject to termination or suspension and a civil monetary penalty of up to $50,000 for each violation.

A. Incidence and Perspectives

An OIG inspection sought to determine whether objective measurement of the extent of patient dumping could be made using existing records. Perspectives of health care professionals were solicited to identify vulnerabilities in the current process of identifying and reporting alleged cases.

Current record-keeping by hospitals made objective measurement of the problem difficult. The hospitals in our sample could not uniformly or consistently

identify all patients transferred to their emergency room (ER) from other ERs. Due to the difficulty in objectively measuring the incidence of dumping, confusion exists as to the actual extent of the problem. A significant number of hospitals in our sample did not have procedures or reporting mechanisms to effectively deal with patient dumping. Some seemed unaware of mechanisms; where they were aware of them, they were reluctant to use them. Practices, such as diversion of patients during ambulance transportation persist which, at minimum, subvert the intent of COBRA even though they may not directly violate its provisions.

The OIG recommended that reporting of suspected cases of patient dumping be made a condition of participation in the Medicare program or part of a hospital's provider agreement. All Medicare-participating hospitals should post notices in their ERs which inform patients of their rights and indicate a local or toll-free number for reporting of suspected dumping instances. The COBRA regulations should require that all ER records clearly identify all transferred patients to and from other ERs. In an effort to clarify physicians' responsibility under COBRA, HCFA should clarify the definition of what constitutes "stabilization" and "emergency condition." The Public Health Service, the Office for Civil Rights and HCFA generally agreed with the report's findings and recommendations, although HCFA expressed reservations concerning our recommendations for increased record-keeping and further definition of critical terms. (OAI-12-88-00830)

B. Patient Dumping Enforcement

The OIG and HCFA issued proposed regulations addressing the patient dumping provisions in June 1988 (53 FR 22513). Under the proposed rulemaking, HCFA would have responsibilities for enforcing the patient dumping provisions of the Medicare conditions of participation. The HCFA would send notices of proposed termination to offending hospitals, which then would have 30 to 90 days to comply with the Medicare conditions of participation or be terminated. If there is evidence of a "dumping," HCFA is to refer the case to OIG for further investigation and possible imposition of administrative sanctions or civil penalties. The OIG and HCFA are currently developing final regulations on patient dumping.

During this reporting period, 130 referrals for further investigations involving potential sanctioning were initiated. The OIG imposed sanctions on one hospital that had inappropriately transferred an indigent patient who was in labor and had an emergency medical condition.

PPS PAYMENT RATES

In 1983, Medicare began using a new method of paying most hospitals called the prospective payment system (PPS). Under this system, Medicare makes

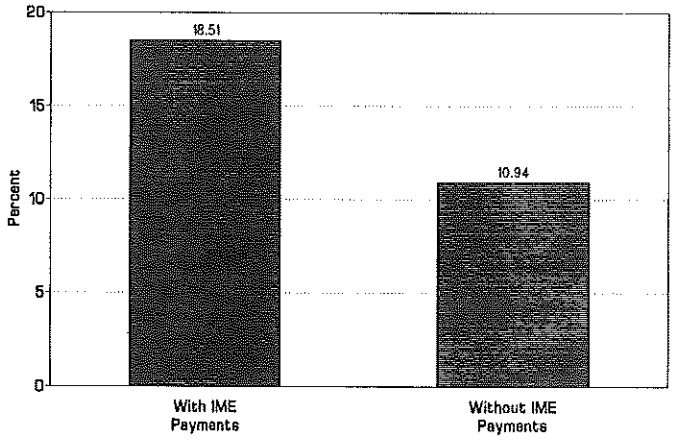
payments to hospitals based on the average cost for treating a particular illness or injury. Generally, each time a hospital treats a Medicare patient with the same type of diagnosis, that hospital receives the same predetermined payment.

Currently, Medicare participates in the funding of formal and informal medical education expenditures at teaching institutions through payment for direct medical education costs and payment of an indirect medical education (IME) allowance to teaching institutions participating in PPS. Also, certain PPS hospitals receive "disproportionate share" payments because they serve a large proportion of low-income patients. There was an implicit belief that low-income patients generally were more severely ill and stayed longer in hospitals and therefore were more costly to treat.

A. Indirect Medical Education

The OIG studied 310 of 860 hospitals (36 percent) that received IME payments in the second year of PPS and found that IME payments were a major factor in teaching hospitals continuing to earn large profits. The average net profit margin for teaching facilities rose to 18.51 percent from 18.27 percent in the first year. The 18.51 percent level exceeded the profit margin of 15.27 percent earned by all hospitals. The 860 teaching facilities earned an estimated $3.3 billion in profits, or an average of $3.9 million a facility. Payments for IME accounted for $1.2 billion, or 37 percent of these profits.

PROFITS WITH & WITHOUT IME PAYMENTS

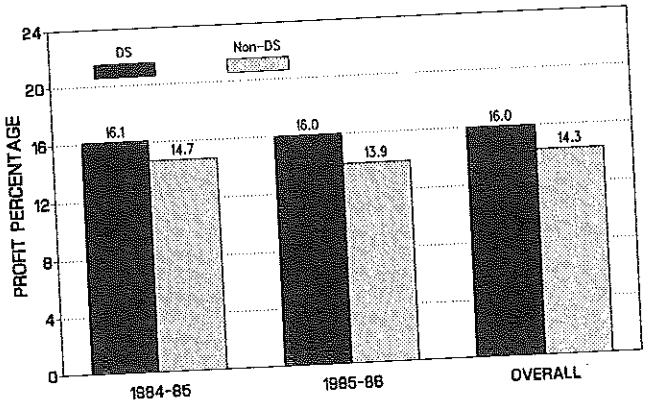


The large profits disclosed by this study further support prior OIG recommendations for reducing IME payments and the current proposal in the President's FY 1989 budget to cut the IME adjustment factor to 4.05 percent. Estimated first year savings for FY 1989 are $920 million. (CIN: A-09-87-00100)

B. Disproportionate Share Hospitals

An OIG report determined that significant differences do not exist between disproportionate share eligible hospitals and non-disproportionate share hospitals in terms of Medicare profit margins, costs per discharge, and durations of patient hospitalization. Medicare profit margins for disproportionate share (DS) and non-DS hospitals averaged about 16 percent and 14.3 percent, respectively, for the initial 2 years under PPS.

PPS PROFIT MARGINS
DS & Non-DS Hospitals

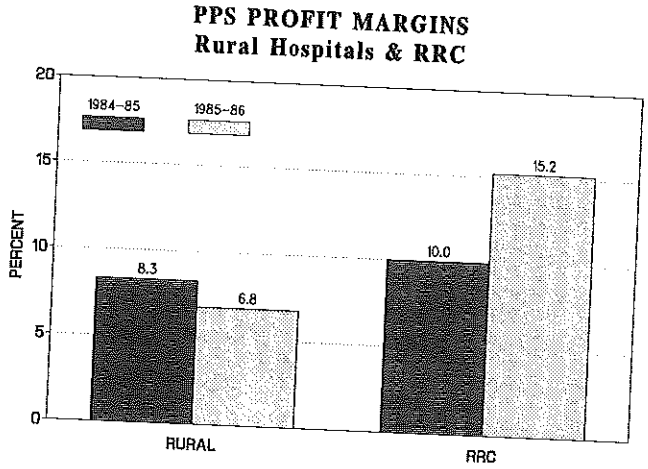


For the first 2 PPS years, DS hospitals were 1.7 percent more profitable than non-DS hospitals, as illustrated in the chart above. The findings do not substantiate the necessity of DS payments. Payments under PPS adequately compensate hospitals for services provided to Medicare patients, including low-income patients. Therefore, OIG recommended that DS payments be eliminated without redistribution of funds to PPS hospitals. Ending these payments would save about $800 million a year and a total of $4 billion over the next 5 years. The HCFA officials agreed with the results of our analysis. However, they did not believe that the Congress would be receptive to the total repeal of the DS adjustment. The Administration has sent the Congress a proposed bill containing a provision which would eliminate periodic interim payments for certain hospitals that have a disproportionate share of low-income patients. (CIN: A-04-87-01004)

C. Rural Referral Centers

The HCFA could reduce payments to rural referral centers (RRCs) by about $635 million over a 5-year period by setting the PPS reimbursement rate for RRCs at the midpoint between the urban and rural rates. At the time of our audit, HCFA reimbursed RRCs at the urban hospital rate rather than the lower rate reimbursed to other rural hospitals, on the premise that RRC costs are similar to costs of urban hospitals. An OIG review determined that this premise was incorrect.

Although more expensive to operate than other rural hospitals, RRCs are not as costly to operate as urban hospitals. Review of thousands of hospital cost reports revealed that the average cost per Medicare discharge for RRCs fell within 1 percent of the midpoint between the average discharge cost of urban hospitals and the average discharge cost of other rural hospitals. The RRCs received excess payments because RRC reimbursements were based on the relationship of RRC costs to costs of urban and other rural hospitals rather than being based on the cost of urban hospitals alone.



The OIG recommended that HCFA discontinue reimbursing RRCs at the urban rate and base reimbursement on the midpoint between urban and rural rates. The OIG also recommended that HCFA seek legislative authority to accrue the savings to the Medicare program rather than reallocate it to all eligible hospitals. The HCFA agreed only that reimbursing RRCs at the urban rate should be discontinued. (CIN: A-03-87-00001)

IMPROPER PAYMENTS FOR NONPHYSICIAN SERVICES

An OIG audit report determined that intermediaries made improper payments of at least $28 million to PPS hospitals from October 1983 to January 1986. These payments were for nonphysician services provided to Medicare beneficiaries either on the day before admission or during an inpatient stay. The OIG supplied HCFA with computer listings of the claims paid improperly. The HCFA recovered over $24 million and expects to make additional recoveries based on this information. Under the law and regulations applicable to PPS, hospitals cannot bill separately for nonphysician services. Costs for these services were already included as inpatient operating costs in developing the predetermined PPS payment rates.

Improper payments were made because intermediaries had not established adequate computer edits within their claims processing systems. Also, HCFA advised us that these edits covering this issue were not evaluated routinely during annual contractor performance evaluation program reviews. We believe these weaknesses in internal controls are material and should be reported in accordance with the Federal Managers' Financial Integrity Act (FMFIA).

The OIG recommended that HCFA ensure that intermediaries implement needed computer edits and controls over payments for nonphysician services. In addition, HCFA should recover funds spent improperly. The HCFA indicated that corrective action has been initiated on most of the recommendations. The HCFA, however, did not agree that the weakness in internal controls met FMFIA's definition of materiality. (CIN: A-01-86-62024)

MISCODING TRANSFERS

An OIG report entitled "Miscoding Patient Transfers: Effect on Medicare Payment" focused on the effectiveness of the prospective payment procedures which pertain to the reduction of diagnosis related group (DRG) payments when a patient is transferred from one short term general hospital to another. The OIG estimated that a total of $39 million was overpaid on 21,000 claims by Medicare in 1985 nationwide.

The OIG recommended systems changes to detect miscoded transfers and facilitate payment adjustments. Increased peer review organization review of readmissions within 1 day of discharge as well as a clarification of the definition of a transfer in the Medicare Hospital Manual was also recommended. The HCFA agreed to implement the recommendations concerning definitions and payment adjustments. The HCFA is also making changes in the peer review organization scope of work to improve the detection and resolution of miscoded transfers. (OAI-06-87-00043)

AMBULANCE SERVICE FRAUD

Several investigations of ambulance companies and their owners were successfully concluded during this reporting period. Most of the fraud uncovered followed a pattern of billing Medicare for ambulance transportation when what had been provided was essentially taxi service. One case involved contractor kickbacks.

- The largest ambulance company in Massachusetts was fined $28,000, and its owner $10,000, for giving a former city hospital official a kickback of a station wagon and a sports car in return for ensuring that the company received a lucrative hospital contract. The hospital official was fined $1,000.

- A Virginia ambulance company and its owner had to pay $26,000 in restitution to the Medicare and Medicaid programs and $5,000 in fines. They had billed patients for more than the agreed amount under the State Medicaid program and inflated the mileage claimed to Medicaid. They had also resubmitted claims which had been denied by Medicare because deductibles had not been met, using fictitious dates after the deductible had been met, and billed both Medicare and Medicaid for same-day transportation of nursing home patients to doctor's offices and the hospital. Two company office assistants were also convicted in the case, which was worked jointly with the State Medicaid Fraud Control Unit.
- The owner of an ambulance company in Ohio, who was also the local full-time fire chief, was sentenced to a year in jail and ordered to pay $34,000 in restitution. He and his company had filed Medicare claims for emergency transportation of patients who had to be hospitalized, when they had actually performed nothing more then taxi runs for nursing home patients who were not hospitalized.
- The part-owner of a California ambulance company was fined $16,000 for instructing drivers and attendants to bill Medicare for services never rendered.

SANCTION AUTHORITIES

During this reporting period, OIG successfully imposed 289 sanctions in the form of monetary penalties or exclusions from the Medicare and Medicaid programs.

A. Patient and Program Protection Sanctions

Public Law 100-93, the Medicare and Medicaid Patient and Program Protection Act (MMPPPA), vastly expanded the sanction authorities contained in section 1128 of the Social Security Act. In addition to excluding individuals and entities convicted of program-related crimes, those convicted of crimes such as fraud against a private health insurer, obstruction of an investigation or abuse of a controlled substance can be excluded. The MMPPPA also consolidated all of the Inspector General's sanction authorities, except for those relating to the PRO process, under section 1128. Thus, the authority to exclude an individual or entity for filing claims for excessive charges, providing services of a poor quality, or providing unnecessary services is now included as part of this section. The following cases are examples of some of these sanctions:

- A New York physician, convicted of defrauding the Medicare program over a 6-year period and causing financial damage in excess of $194,000 to the program, was excluded for 20 years.
- A licensed practical nurse in Utah, convicted of patient abuse, was excluded for 5 years.

- Convicted of conspiracy to unlawfully distribute controlled substances, an Indiana pharmacist was excluded for 5 years.

- A Louisiana husband and wife team of physicians, a surgeon and obstetrician/ gynecologist, respectively, were each excluded for 5 years after their convictions for billing Medicaid for services not performed.

- The operator of a Nevada medical clinic who was convicted of filing false claims with Medicare and obstruction of justice was excluded for 20 years. The clinic operated by this woman offered alleged cures for various terminal illnesses regardless of the patient's actual medical condition.

- A corporation of Massachusetts psychiatrists, convicted of defrauding the Medicaid program of over $30,000, was excluded for 7 years.

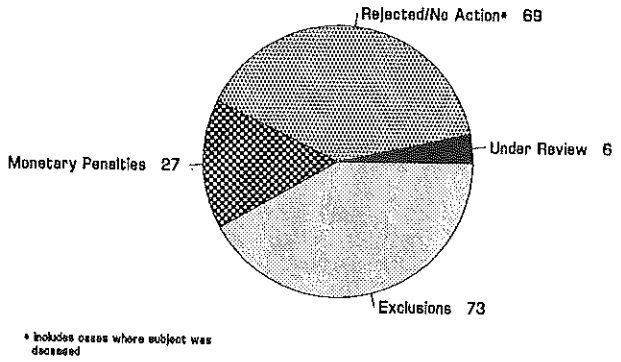
- After a determination that services such as laboratory and diagnostic testing had been furnished substantially in excess of the needs of his patients, a California physician was excluded for 10 years.

B. PRO Sanctions

Peer review organizations (PROs) are groups of practicing doctors and other health care professionals who are paid by the Federal Government to review the hospital care of Medicare patients. The PRO designated for each State has responsibility for deciding whether care is reasonable and necessary, is provided in the appropriate setting and meets the standards of quality accepted by the medical profession. Health care providers can be excluded or required to pay a monetary penalty as a result of a PRO determining that the provider furnished unnecessary services, failed to provide services that met professionally recognized standards of care or failed to document the services as required by the PRO.

Since May 1985, when the PROs were authorized to recommend sanctions, OIG has received 175 recommendations from PROs, and sanctions have been effected in 41 States. Of the 175 recommendations, 165 have been processed and released. The status of the PRO referrals are indicated in the following chart:

STATUS OF PRO REFERALS



Action was taken in six instances on the basis of PRO recommendations during this period, of which the following cases are examples:

- A physician in North Carolina who failed to provide services that met professionally recognized standards in the care of seven Medicare beneficiaries was excluded for 3 years.

- Another North Carolina physician was excluded for 5 years on the basis of his failure to provide services that met professionally recognized standards of care and his failure to document the services as required by the PRO.

- An administrative law judge affirmed an OIG monetary penalty assessment against a physician. The physician was assessed the penalty in lieu of exclusion from the Medicare program, on the basis of findings of the PRO for Washington State. A second physician who co-managed the patient's care failed to pay his portion of the monetary penalty and has been excluded from participation in the Medicare program.

C. Civil Monetary Penalty Settlements

Under the civil monetary penalty (CMP) authorities provided by the Congress, health care providers can be assessed thousands of dollars in fines and penalties for each false item claimed against Medicare and Medicaid. The following cases are examples of some of the more significant settlements made during the past 6 months:

- A medical center had to pay $225,000 in restitution and penalties for billing Medicare for noncovered services. The OIG determined that the center had

billed surgical assists performed by physician assistants and inpatient psychiatric evaluations performed by nonphysicians.

- Over a period of years, a hospital repeatedly billed Medicare and Medicaid for inpatient psychiatric hospital days when the patients were actually on leave from the hospital. It had to pay restitution and penalties totaling $300,000 to OIG and the State.

- A physician who violated the physician freeze provisions of the Deficit Reduction Act of 1984 had to pay $9,000. The OIG identified 263 instances where he had overcharged Medicare beneficiaries for EKG procedures.

- As part of a comprehensive settlement, a chiropractor had to pay restitution and penalties of $120,000 for billing for services not rendered. He also pled to a Medicare fraud charge and received a 35-year exclusion from Medicare and Medicaid participation.

- A settlement of $455,000 was reached in a suit against a medical group for preparing false Medicare billings for one of its ophthalmologist members. An OIG investigation had shown that the group had exercised little or no control over billing submitted for the ophthalmologist and had entered without questioning his coding of nonsurgical procedures as surgical procedures. In addition, the ophthalmologist was said to have subjected patients to dangerous procedures not approved by Medicare which were billed as reimbursable surgical operations.

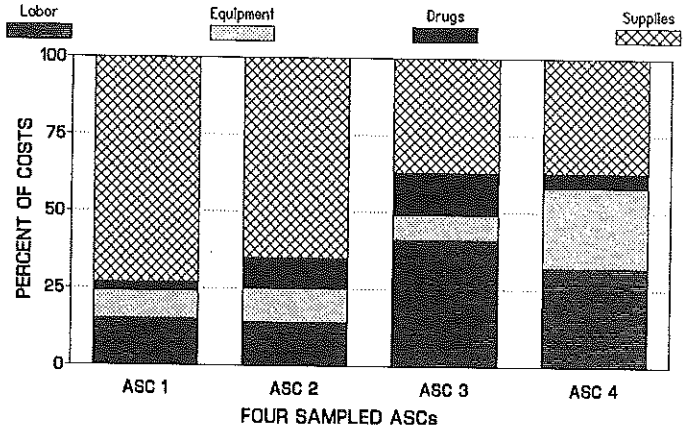
AMBULATORY SURGICAL CENTERS

An OIG report entitled "Medicare Certified Ambulatory Surgical Centers, Cataract Surgery Costs and Related Issues" was conducted to advise HCFA on appropriate ambulatory surgical center (ASC) facility payment policy and reimbursement rates for the July 1988 update.

The study determined that cataract extraction with implant is not a multiple procedure. Cataract extraction with an intraocular lens (IOL) implant is currently considered a multiple procedure in which ASCs receive separate payment for the IOL. However, none of the ASCs reported any additional facility costs when the extraction and implant were done during the same operation. Also, discounts, rebates and incentives are routinely offered by lens manufacturers and their sales representatives which are not reflected in Medicare payments for IOLs. In addition, the problems with IOL payments, as discussed in an OIG March 1986 report on Medicare cataract surgery, have not been resolved. Facility costs vary significantly; supply and equipment costs can be

reduced by group purchasing and comparison shopping; and the ASCs rarely provide routine laboratory tests for cataract surgery patients.

FOUR COMPONENTS OF ASC COSTS



The OIG recommended that HCFA classify cataract extraction with IOL implant as one procedure and reimburse it at 100 percent of the appropriate facility payment rate effective July 1988. A national Medicare Part B reimbursement cap of $200, with a handling fee not to exceed 10 percent ($20), for any IOL billed to Medicare should be established. The HCFA agreed with a majority of the recommendations. (OAI-09-88-00490)

CONVENTIONAL EYE WEAR

An OIG follow-up review found that HCFA had not implemented GAO's 1984 recommendations to discontinue Medicare Part B coverage of conventional eye wear for beneficiaries with intraocular lens implants. Although HCFA concurred with GAO's recommendations, the necessary regulation had not been implemented and payments continued. In 1985, payments for conventional eye wear after cataract surgery with an IOL totaled about $60 million. These and subsequent Medicare payments for conventional eye wear could have been prevented had HCFA acted promptly on GAO's recommendations.

Although Medicare does not pay for most routine eye care and conventional eye wear, it does pay for conventional eye wear following an IOL implant—even though the IOL implant functions like the natural lens and does not require special eye wear.

The HCFA had reservations about OIG's recommendation to develop regulations to specifically preclude Medicare from paying for eye wear to correct

refractive errors to beneficiaries with an IOL implant. The HCFA noted that some patients cannot have their vision fully restored after cataract surgery without wearing conventional eyeglasses. While HCFA plans to review this issue further, they have no immediate plans for regulatory changes. The HCFA also did not agree with our recommendation to require carriers to enforce payment exclusion through the use of prepayment edits and postpayment reviews. (CIN: A-04-88-02039)

PHYSICIAN CONSULTATION SERVICES

An OIG inspection on "Medicare Physician Consultation Services" determined that carriers incorrectly paid approximately $73.6 million in 1985 for physician consultations. The primary cause of overpayments was physicians billing at a higher level of intensity than documented in medical records. The OIG also identified weaknesses in the prepayment controls utilized by the carriers.

For 1985, HCFA reported more than $404 million in allowed charges to physicians for consultations performed in the hospital. Varying definitions of a physician consultation contribute to confusion of physicians and Medicare carriers as to accurate and appropriate billing practices.

The OIG recommended that HCFA develop a uniform definition for consultations and effectively convey that definition to the medical community. In addition, HCFA should reduce the number of procedure codes and require their use by all carriers. Although HCFA agreed with these recommendations, they believed that the recommendation to adopt specific reimbursement criteria should be left to the discretion of the carriers. (OAI-88-02-00650)

HEALTH MAINTENANCE ORGANIZATION INVESTIGATION

The owner-operator of two Florida clinics was sentenced to 18 months incarceration in connection with pre-screening Medicare patients, billing the Medicare program for the prescreening, refusing Health Maintenance Organization (HMO) enrollment to those who were ill and persuading those enrolled who became ill to disenroll. His former office manager, who was convicted for destroying applications of Medicare patients who sought HMO enrollment, was given 25 years probation and 200 hours of public service. The clinics had been affiliated with one of the Nation's largest HMOs which had a multi-million-dollar contract to provide services to Medicare patients in exchange for monthly payments from HCFA.

PHYSICIAN KICKBACKS

Earlier this year, an elaborate scheme involving four diagnostic laboratories and their two owners was uncovered by a task force, led by the U.S. Attorney in Philadelphia, in which OIG participated. Laboratory representatives had approached hundreds of physicians, offering to provide a series of diagnostic tests in exchange for patient referrals and the use of their offices. The labs billed

Medicare for the tests and paid the physicians $50 for each patient referral. After the labs and owners had been convicted, the U.S. Attorney issued letters to 360 physicians who had accepted payments, demanding repayments in settlement of civil liabilities. To date, more than $500,000 has been collected from 334 physicians. The case and its results have received wide publicity, serving as a warning to other medical care professionals against engaging in similar illegal activities. The dismantling of the scheme not only meant savings and recoveries for the Medicare program but also ended testing which was of a questionable quality. Experts have stated that the quality was generally poor, largely because the persons administering the tests (which included secretaries and cocktail waitresses) were poorly trained.

INTERMEDIARY DATA PROCESSING ACTIVITIES

Numerous policies, directives, guidelines and laws have been established requiring Federal agencies to develop disaster recovery and contingency plans to recover files and records in the event they are lost or destroyed. Our reviews of 16 of the 50 Medicare intermediaries disclosed that none have taken the necessary action to ensure continued processing and payment of Medicare claims should their computer processing capabilities be rendered partially or totally inoperative for an extended period of time. Fifteen of the 16 intermediaries reviewed stated that they were totally dependent on computer support for operations and would not be able to fulfill their mission if their data processing capabilities were partially destroyed. The 16 intermediaries accounted for the processing of 20 million claims (40 percent of total) valued at about $16.5 billion (33 percent of $50 billion paid) in FY 1987.

The OIG recommended that HCFA take a more active leadership role in directing and exploring the development and implementation of a national contingency plan. The HCFA agreed with these recommendations. (CIN: A-14-87-02661)

PRACTICING WITHOUT A LICENSE

Physicians who practice medicine without a license and bill Medicare not only illegally obtain program funds but also pose a threat to the unwitting patients. Two unlicensed physicians were convicted during this period.

- An unlicensed California physician was sentenced to 3 1/2 years in prison for intent to distribute controlled substances. He had also submitted claims to the Medicare and Medicaid programs for services not performed.

- A podiatrist in Ohio was convicted of practicing without a certificate from the State medical board and for misrepresentation in billing Medicare.

PROGRAM INTEGRITY FUNCTIONS

A national inspection of Medicare carriers' performance of program integrity functions was conducted to determine whether existing HCFA policies and procedures were effective, whether carriers were appropriately applying these policies and procedures, whether funding levels for these functions were adequate, and where changes were needed.

Current HCFA policies and procedures concerning carriers' program integrity functions are not adequate in several key areas, and carriers are not applying them as intended by HCFA in all instances. As we recommended, HCFA plans to implement new program integrity guidelines at all carriers and to increase its monitoring efforts in this area.

The level of funds available for the performance of carrier program integrity functions appears to be adequate; however, the allocation of such funds away from traditional program integrity activities is a concern. The OIG recommended that HCFA create a separate program integrity budget category and that each function currently being performed by the carriers be analyzed to ensure that available funds are being used in the most efficient manner possible. In response to this recommendation, HCFA had indicated its willingness to modify analysis of the effectiveness and efficiency of carrier program integrity efforts. (OAI-04-88-00710)

DURABLE MEDICAL EQUIPMENT

Medicare pays for some durable medical equipment (DME) items, such as oxygen equipment, wheelchairs, home dialysis systems and seat-lift chairs which physicians prescribe for home use. Medicare also helps pay the approved rental costs if the equipment is rented.

A. Reimbursement to HHAs

An OIG report entitled, "Medicare Intermediary Reimbursement to Home Health Agencies for Durable Medical Equipment" was undertaken to assess Medicare payment vulnerabilities. The study produced four major findings:

- Intermediaries' review of bill and payment processes were ineffective in controlling DME costs. Claims often lacked sufficient description of the DME supplied and/or failed to include charge data on individual items.

- Billing arrangements between DME suppliers and home health agencies (HHAs) often compromise HCFA's payment safeguards. Intermediary reimbursement to HHAs for DME may be as much as 88 percent higher than the amount carriers would have paid.

- When HHA-discharged patients still require DME, the usual HHA-supplier billing arrangements no longer apply; suppliers then bill carriers under the Part B benefit.

- Beneficiary coinsurance liability can be substantially more than it would have been had claims been processed by carriers. In our review, if the intermediaries had applied the carrier allowed-charge limits, total beneficiary coinsurance liability would have been 110 percent less.

The OIG recommended that HCFA shift the claims adjudification responsibilities to Medicare carriers for DME furnished by HHAs. This change would assure consistency in program coverage and payment decisions and eliminate the potential for unwarranted beneficiary coinsurance liability amounts. However, HCFA did not concur. Both the President's FY 1988 and FY 1989 budget and legislative programs included proposals to reduce unnecessary expenditures for DME. (OAI-02-87-00016)

B. DME Fraud

The following cases are examples of successful actions taken against DME suppliers who defrauded the Medicare and Medicaid programs.

- A DME supplier in Georgia was sentenced to 6 months incarceration and more than $94,000 in restitution and fines for a variety of schemes to collect money illegally from Medicare. He billed for oxygen concentrator repairs never made, for rental while the repairs were being made, for equipment sold to deceased persons and for the sale of "new" equipment which patients had rented for years. He also falsified forms for obtaining equipment for people who did not need it, and billed Medicare for services by a laboratory company which did not exist. He has been suspended from participating in the Medicare and Medicaid programs.

- A California supplier was given 3 years probation, fined $2,500 and ordered to serve 300 hours of community service for defrauding Medicare of $3,744. Rather than getting appropriate authorization from physicians for DME sales, he had filled out false physician telephone orders.

- An Ohio supplier had to pay restitution of $86,500 and was fined $4,500 for billing Medicare and Medicaid for oxygen equipment and enteral feeding supplies and equipment never provided or nonreimbursable, for mileage when deliveries were not emergencies and for multiple deliveries when several cylinders were delivered at the same time. The case was investigated jointly with the State Medicaid Fraud Control Unit.

MEDICARE AS SECONDARY PAYER

The OIG's review found that Medicare often paid for claims when beneficiaries had other health benefits available. For the period September 1, 1983 through November 30, 1985, an estimated $20.8 million was inappropriately paid by

Medicare because fiscal intermediaries were not always performing retroactive examinations of paid claims when other potential payment sources were identified and the beneficiary was not always telling providers that other health benefits were available.

As recommended, HCFA revised the Medicare Intermediary Manual to require retroactive examination of paid claims for 27 months or longer, if cost effective, but not prior to January 1, 1983. The HCFA also agreed to forward our listings of potential overpayments to the intermediaries for appropriate recovery action.

The HCFA agreed to require providers to identify third party insurance coverage, using the most cost effective means for that particular institution. The HCFA also planned to strengthen the current requirement for obtaining detailed information about third party payers by incorporating the requirement into the provider agreement. The President's FY 1989 budget and legislative program included a proposal to strengthen enforcement of secondary payer collections. (CIN: A-10-86-62005)

BAD DEBTS OF ESRD FACILITY CHAIN

A national chain of end stage renal disease (ESRD) facilities overstated its claim for reimbursable bad debts of 81 facilities by $2 million for 1985. This occurred because the facilities' claims included unallowable costs charged by the parent company.

Under the ESRD composite rate reimbursement system, ESRD facilities are reimbursed 100 percent of their allowable bad debts (unpaid deductible and coinsurance) up to their unreimbursed Medicare reasonable costs. However, if the facility's Medicare revenue exceeds its Medicare costs, it has no unrecovered cost and is not eligible to receive payment for Medicare bad debts. The OIG audit showed that the parent company charged approximately $19 million in unallowable costs to these 81 facilities. Accordingly, we adjusted the bad debt calculations for the unallowable costs and determined that the reimbursable bad debts were overstated by $2 million.

The HCFA generally agreed with OIG recommendations that it instruct the appropriate fiscal intermediaries to: (1) extend home office cost adjustments and recalculate the reimbursable bad debts for the 81 facilities in question; (2) review the allowability of claimed bad debts for those facilities which have significant bad debts remaining, considering the facilities' due diligence in attempting to collect debts from beneficiaries; (3) recover any overpayments made for unallowable amounts reimbursed; and (4) suspend future reimbursement of bad debts to these facilities until the home office's cost report has been audited. (CIN: A-01-87-00504)

FALSE CLAIMS Conviction of individual health care practitioners and suppliers for fraud most commonly results from prosecutions relating to the filing of false claims against the Medicare program, as illustrated in the following cases:

- A Florida chiropractor was sentenced to serve 10 years in prison, and his wife and son 6 years each, for criminal schemes related to several health care clinics they owned and operated. Through the claims offset process, the Medicare carrier recovered almost $900,000 of the more than $2 million overpayment they had received. Earlier they had been assessed a CMP of $1.7 million and given a 25-year suspension from the Medicare and Medicaid programs. They were convicted on a wide range of charges including filing false claims with Medicare, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), private insurers and individual patients, and operating a criminal enterprise in violation of racketeering laws.

- A podiatrist in the State of Washington was sentenced to 15 months in prison and had to pay $75,000 after being convicted of mail fraud and false statements to the Medicare program. He had billed for debridement of toenails of nursing home patients, some of whom were amputees.

- The owner of a clinic in California was sentenced to 4 months in jail and ordered to pay more than $90,000 in fines and restitution. An investigation established that he had billed Medicare for services not covered.

BUY-IN PROGRAM The buy-in program enables States to enroll eligible Medicaid recipients in the Medicare Part B program, thus shifting to the Federal Government some of the financial burden of providing health care to the Nation's elderly and poor. Under this program, States "buy-in" Medicare coverage for their elderly Medicaid population by paying the Medicare premium, deductible and coinsurance.

A. Federal Financial Participation The OIG conducted a follow-up to a 1985 review to determine the actions taken by HCFA to reduce the Federal cost of the buy-in program. The OIG previously recommended that HCFA seek legislation to eliminate Federal financial participation (FFP) in monthly premiums paid by States in view of the basic financial incentive buy-in provides (i.e., shifting of health care costs from Medicaid to Medicare). Such actions could reduce Federal Medicaid expenditures by as much as $1.9 billion over a 5-year period. In addition, HCFA should seek legislation to apply a late enrollment surcharge of buy-in enrollees. This surcharge would generate an additional $79.4 million for the Medicare Part B trust fund over a 5-year period. The HCFA agreed in principle with our

recommendation but deferred action pending the outcome of proposed legislation to reduce the overall growth of Medicaid.

In response to our follow-up report, HCFA again agreed that the elimination of FFP in monthly premiums paid by State agencies was a reasonable cost reduction measure but, again deferred action because it intends to pursue legislation similar to its earlier proposal. We believe that a legislative proposal eliminating FFP should be developed so that HCFA can react quickly in the event the Congress rejects the Medicaid fixed payment concept. (CIN: A-03-86-62019)

B. State Agency Premiums

An OIG audit determined that the Supplementary Medical Insurance (SMI) trust fund was losing significant revenue because HCFA was not billing State agencies for premiums of all Medicaid recipients enrolled in the Medicare buy-in program.

The HCFA reacted timely and effectively to a 1987 OIG alert of the billing problem. With the cooperation of SSA, HCFA reconciled its records with SSA's (SSA maintains records on Medicare coverage) and identified 13,789 buy-in enrollees for whom premiums were not billed to the State agency. The HCFA collected over $7.7 million from State agencies for the previously unbilled premiums and began billing the premiums on a current basis. The OIG estimated that adding the premiums for the 13,789 enrollees to current billings will generate an additional $11.5 million in trust fund revenues over a 5-year period.

The billing problem may resurface, however, since neither HCFA nor SSA was able to specifically identify its cause. We, therefore, recommended that HCFA and SSA periodically reconcile records until they are assured that the billing problem is eliminated. Both SSA and HCFA agreed to a periodic reconciliation to ensure that States are properly billed for buy-in premiums. (CIN: A-03-86-62013)

MEDICAID ESTATE RECOVERIES

This study evaluated State implementation of asset control authorities granted in the Tax Equity and Fiscal Responsibility Act (TEFRA). The study found that State Medicaid programs have not taken full advantage of transfers of Medicaid beneficiaries' assets, liens and estate recoveries to pay for long term care services.

Only 23 States and the District of Columbia recover Medicaid benefits which were incorrectly paid. Many of these recovery programs are inefficient. The Medicaid program could recover $589 million nationally each year if all States recovered at the same level of effectiveness as Oregon.

The study recommended stronger programmatic initiatives on estate recoveries by HCFA. The study also encouraged statutory changes to enhance asset control and recovery activities. A departmental work group is reviewing our recommendations in order to respond to a congressional requirement to report on activities in this area by December 1988. (OAI-09-86-00078)

MEDICAID ELIGIBILITY ERRORS

In FY 1986, misspent funds resulting from eligibility errors in the Medicaid program cost Federal and State governments $1.1 billion. The OIG conducted a national inspection to identify the reasons some States are more successful than others in reducing and maintaining a low rate of eligibility errors. The inspection also highlighted the best practices of States that have successfully reduced Medicaid error rates.

The OIG determined that the threat of fiscal disallowances has assisted in the reduction of States' error rates. However, more actions must be taken to further reduce the error rate. A 0.5 percent decrease in the Medicaid eligibility error rate nationally, based on 1988 Medicaid cost projections, would result in savings to Federal and State governments of $250 million. The OIG found that no formal network exists for States to share information on mechanisms to improve Medicaid eligibility determinations. The HCFA needs to take a more active role with States to reduce and contain these errors which result in misspent funds. The OIG recommended that HCFA (1) alert State officials annually of Federal and State dollars misspent in each State, (2) develop and coordinate strategies where one State can help another, and (3) reward States with error rates below the 3 percent level. The HCFA did not concur. (OAI-04-87-00014)

IMPROPER MEDICAID CLAIMS

The Federal Government pays part of the costs incurred by the States for providing medical services to persons unable to pay for such care. The States are required to set forth their service options, modifications, and other details of their program in a State Medicaid plan approved by HCFA. Occasionally, States claim costs which are unallowable expenditures under Federal guidelines.

A. Undocumented Aliens

One county in California claimed $2.4 million Federal cost sharing in medical services provided to undocumented aliens who were later found to be illegal aliens or had failed to prove their legal residence. Under Federal law, Medicaid funds are available for emergency medical services provided to illegal aliens but not routine medical care.

The OIG recommended that the State (1) revise its procedures to ensure that Medicaid claims for Federal cost sharing on behalf of undocumented aliens are limited to emergency medical services, (2) refund $2.4 million for services

improperly provided to undocumented aliens in the county reviewed, and (3) estimate improper claims for Federal cost sharing on behalf of undocumented aliens under Medicaid in other counties and make the appropriate refund. The HCFA concurred with our finding and recommendations. (CIN: A-09-87-00122)

B. Youth Psychiatric Services

Arkansas claimed $11.9 million Federal cost sharing for inpatient services provided to youth psychiatric patients without having a certification of need for care. The certification of need, issued by a team of health professionals, indicates the need for the treatment and that the treatment can reasonably be expected to improve the youth's condition. Federal financial participation is prohibited without the certification.

The OIG recommended that Arkansas make a financial adjustment of $11.9 million and implement controls to adequately monitor the inpatient psychiatric services provided to youths. The HCFA agreed with our findings and recommendations. (CIN: A-06-87-00040)

C. Abortion Costs

An OIG review evaluated the corrective action taken by the District of Columbia's Medicaid agency in response to our prior audit of the agency's FY 1984 payments for abortion claims. The OIG found that the District had, in error, claimed Federal funds for abortion costs because its Medicaid Management Information System (MMIS) did not identify all claims for abortion services submitted by physicians.

Our current review found that FY 1985 claims also included physician claims for abortion services because the agency's MMIS was not modified until the start of FY 1986. Although the system was effective in identifying abortion costs related to inpatient hospital stays, financial adjustments had not been made as of the close of our audit to reduce claimed costs for the unallowable amounts identified.

The OIG recommended that the agency make a financial adjustment totaling $978,154. The agency generally agreed and adjustments of $798,877 had already been made by the time our report was issued. (CIN: A-03-86-60222)

MEDICAID OVERPAYMENTS

The Medicaid program authorized FFP in costs incurred by the States in providing medical services to recipients of public assistance and to other low-income individuals. Medical assistance under Medicaid includes services to recipients residing in various types of long term care facilities.

A. Long Term Care Facilities

California did not return the Federal share ($7.8 million) of Medicaid overpayments made to community hospitals and long term care facilities during the period October 1, 1973 through September 30, 1985.

Adjustments had not been made because the State agency deferred crediting the Federal account until overpayments were recovered from providers. The Departmental Grant Appeals Board has ruled in similar cases that the Department has the right to collect the Federal share of these payments, even if recoveries have not been made. The HCFA concurred with OIG's recommendations that the State return $7.8 million and develop procedures to return the Federal share of identified overpayments. (CIN: A-09-87-00059)

B. Intermediate Care Facilities

Illinois improperly received about $20.3 million in Federal funds because State intermediate care facilities for the mentally retarded (ICF/MR) were not certified in accordance with Medicaid requirements. The OIG's findings included instances where provider agreements had expired or were invalid because of retroactive certifications and no written justifications were maintained to indicate that deficiencies identified did not jeopardize the patient's health and safety, nor seriously limit the facility's capacity to give adequate care.

In addition to procedural changes, OIG recommended financial adjustments totaling $20.3 million. The HCFA and State concurred with the findings and recommendations. (CIN: A-05-86-60219)

NURSING HOME ASSESSMENT

The HCFA is planning to publish information on approximately 16,000 nursing homes that care for Medicare or Medicaid patients to assist consumers in the evaluation and selection of a nursing home. The HCFA requested that OIG assess the opinions of potential users of this information at the local level including discharge planners, senior citizens, family members of nursing home residents, physicians, and staff members of the area agencies on aging, rating each of the indicators according to its perceived importance. Respondents made suggestions about nursing home information not currently collected by HCFA, and the need for easily accessible and objective information on nursing homes. All items related to patient characteristics ranked lower in importance than those related to quality indicators. (OAI-12-88-01240)

STATE MEDICAID FRAUD CONTROL UNITS

From 1978 to 1988, Medicaid vendor payments have increased from $18 billion to more than $45 billion annually. The State Medicaid Fraud Control Units (MFCUs), which have increased from 17 to 38 in number during that period, are responsible for investigating fraud for more than 91 percent of the Medicaid vendor payments annually.

The MFCUs have broad authorities beyond fraud investigations. They are also responsible for investigating complaints of abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan. Many of the units have been instrumental in obtaining State legislation to protect the elderly from neglect and abuse, and have vigorously prosecuted offenders under the new statutes.

The MFCUs have worked closely with local survey and utilization review units of the State intermediaries in the drafting of clear regulations governing providers, to ensure that the regulations will stand up in a court of law. They also work with professional associations to help identify "bad actors" and maintain high levels of service and professionalism.

During FY 1988, OIG administered approximately $45 million in grants to the MFCUs and conducted eleven recertification and technical assistance visits to nine States. During this period, the MFCUs reported 234 convictions and $4 million in fines, restitutions and overpayments collected.

PUBLIC HEALTH SERVICE

CHAPTER III

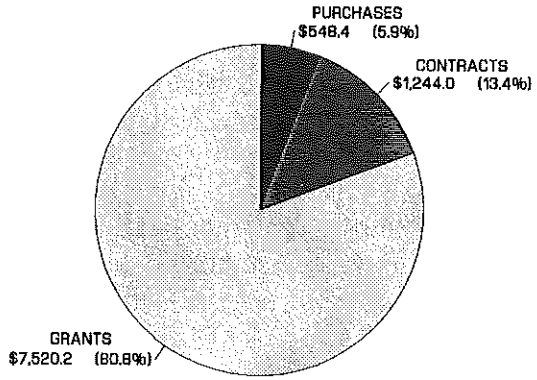
PUBLIC HEALTH SERVICE

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

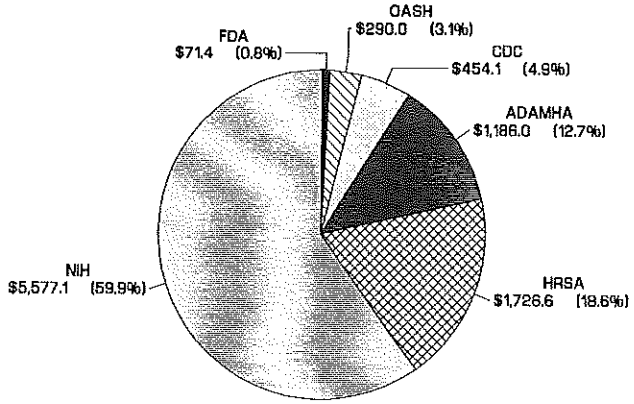
During the second half of Fiscal Year 1988, the Office of Inspector General identified questionable charges to the Public Health Service (PHS) programs totaling $2.1 million.

The PHS encompasses: National Institutes of Health (NIH); Food and Drug Administration (FDA); Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); Centers for Disease Control (CDC) and Health Resources and Services Administration (HRSA). Through these agencies, funds are provided to advance knowledge through research. About $10 billion is expected to be awarded in FY 1988. Most of the grants and contracts will be awarded to educational institutions and State and local governments.

DISTRIBUTION BY FUNDING MECHANISM
(Dollars in Millions)



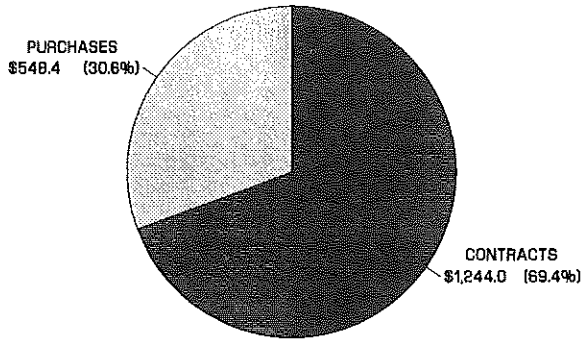
DISTRIBUTION BY AGENCY
(Dollars in Millions)



The activities conducted and supported by PHS represent this country's primary defense against acute and chronic diseases and disabilities and provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people.

The OIG has audit cognizance for 95 percent of the colleges and universities and about 50 percent of the State and local governments.

DISTRIBUTION OF PROCUREMENT DOLLARS
PHS Total: $1,792.4
(Dollars in Millions)



Funds are also provided to protect food sources and to assure safe and effective drugs and medical devices; to combat communicable diseases and protect the public health; to assist States, local governments and community organizations in delivering health care; to uncover the physiological and behavioral bases for understanding, preventing and treating mental illnesses and alcohol and other substance abuse; and to support, through financial assistance, the development of our future generation of health care providers.

This year, OIG is responding to commitments made to the Secretary and the Congress to increase audit emphasis of PHS programs by establishing a PHS audit division headed by a Deputy Assistant Inspector General for Audit. The audit division will evaluate audit emphasis on PHS programs such as Acquired Immune Deficiency Syndrome (AIDS), drug abuse, alcohol and research funding. Staffing of the division is now underway and when completed will provide resources to conduct internal and external reviews promoting effective and efficient program operations, compliance with laws and regulations, financial accountability and detection as well as prevention of fraud, waste and abuse.

PURCHASING AT NATIONAL INSTITUTES OF HEALTH

The OIG reported that NIH has experienced serious, longstanding, systemic procurement deficiencies. These deficiencies which OIG, PHS and the Assistant Secretary for Management and Budget (ASMB) have been reporting for 5 years, significantly undermine required safeguards against waste, loss and unauthorized use of appropriated funds. Little or no action had been taken to correct the deficiencies reported. The procurement system for small dollar purchases could not be certified because the system lacked necessary internal controls and direction. Weak controls also opened the procurement system to other problems. For example, we found instances where drugs and hypodermic needles were fraudulently purchased through the procurement system for personal use.

Significant waste occurred because NIH did not negotiate discounts for supplies commensurate with NIH's purchasing power; purchasing clerks were inefficiently used on a part-time basis; and unnecessary inventory costs were incurred when the material was already on hand in the warehouse. As a result of NIH's failure to exercise proper fiduciary responsibility, OIG estimated that $124.4 million had been wasted over the past 6-year period. This represents, in dollars, a lost opportunity for awarding a significant number of grants for important biomedical research considering the current dollar amount of the average grant award.

Based on FY 1987 experience, OIG estimated that $31 million could be saved annually by correcting the procurement deficiencies. The PHS agreed that prompt and decisive actions were needed. The procurement office has been reorganized, has developed a corrective action plan and is in the process of implementing the plan to remedy these deficiencies. (We note that PHS has negotiated discounts which could result in nearly $2 million *more* savings than our estimate.) (CIN: A-12-88-00016)

LICENSURE AND DISCIPLINE OF DENTISTS

An OIG report entitled "State Licensure and Discipline of Dentists" analyzed information obtained from representatives of dental boards in the 50 States and the District of Columbia and various national organizations. It will be followed shortly by similar reports focusing on chiropractors, optometrists, and podiatrists.

The OIG found that State dental boards are seriously understaffed and, as a result, the effectiveness of both licensure and discipline operations is compromised and State board disciplinary actions against dentists have increased only slightly during the past 3 years.

The OIG recommended that State governments assure that State dental boards have sufficient resources to carry out their responsibilities effectively. It was also recommended that PHS assist the American Association of Dental Examiners to carry out a more effective leadership role in working with its member boards. The PHS concurred with this recommendation. (OAI-01-88-00580)

ARTERIAL BYPASS SURGERY

Medicare continues to cover surgery that a 1985 PHS funded study determined had no proven medical benefit. The HCFA consults PHS in determining the efficacy of medical procedures for Medicare coverage. In 1978, PHS recommended coverage of extracranial-intracranial (EC/IC) bypass surgery, a procedure thought to improve blood flow and reduce the risk of stroke. The procedure had been covered by Medicare since 1979. In 1985, 790 of these EC/IC surgeries were performed at a cost to Medicare of about $10.7 million.

In November 1985, results of a PHS funded study were published that demonstrated a lack of benefit from the bypass surgery. One month later, in December 1985, HCFA asked PHS to reconsider its 1978 recommendation. The PHS attributed the delay in responding to conflicting professional views on the merit of the NIH funded study.

The OIG recommended that PHS promptly reconsider its 1978 recommendation and that HCFA take action to clarify coverage of this procedure upon receipt of PHS's response. The PHS responded to HCFA's request in August 1988 and recommended that Medicare coverage be withdrawn for EC/IC bypass surgery when used to treat ischemic cerebrovascular disease of the internal carotid or middle cerebral arteries. (CIN: A-09-87-00005)

YOUTH DRUG EDUCATION

The OIG conducted a review entitled "National Youth Drug Education Programs" to describe the local level implementation of three national youth drug education programs (Just Say No, Boys Clubs of America, and National Federation of Parents for Drug-Free Youth) as perceived by program administrators, participating parents and children, and independent professionals. The OIG found a consensus that drug education should be comprehensive and start early. Participants like the programs but desire more parental involvement. Most programs are in schools and are concerned with drugs which lead to other substance abuse, particularly alcohol. Finally, professionals want an assessment of what works.

The OIG recommended that the Department of Education and ADAMHA develop long and short term evaluations of the implementation and effectiveness of youth drug education programs; assure effective dissemination of available research findings, clearinghouse information, and other networking

activities; and give special consideration to funding comprehensive youth drug education programs which target children at early ages. (OAI-02-88-00080)

URBAN INDIAN HEALTH PROGRAM

The statute authorizing health care services to urban Indians provides for assistance in gaining access to existing health resources and direct health care where it is unavailable or inaccessible. However, most of the urban Indian health clinics are operated in cities where numerous other facilities are available. Two complementary reports were issued following an OIG review of the urban Indian health program funded by IHS.

A. Direct Health Care Services

The IHS should eliminate or curtail providing direct health care services under its urban Indian health program unless it can demonstrate that the services do not duplicate other services available in the community, and unless the extent of Indian utilization supports their need. Under Federal regulations, the provision of direct health care services by urban Indian clinics is justified only if they do not duplicate other services available in the community. The IHS could not provide us with such justification for clinics currently operated.

Also, the low utilization of some of the clinics by Indian clients raises questions as to their need. Many of the clinics were, according to IHS statistics, providing direct health care services to only a small percentage of the Indian population residing in their service areas, which for 20 percent of the clinics was less than 5 percent. Furthermore, some of the clinics provide services to more non-Indians than to Indians.

The OIG estimated that, if IHS eliminated all direct health care services from its urban Indian projects, approximately $5.6 million could be saved annually. Substantial savings could also be realized if direct health services were only partially eliminated or reduced. (CIN: A-09-86-63001)

B. Access and Use of Facilities

The inspection, entitled "A Bridge to Mainstream Health Care Delivery" was conducted to determine, in select communities, the extent to which community health services, other than the urban Indian health program (UIHP), are available and accessible to low-income and indigent urban Indians, the extent of Indian and non-Indian utilization and the factors influencing utilization.

The OIG noted the lack of uniform national criteria for monitoring projects and inconsistent management oversight of the UIHP. Budgetary decisions are not necessarily based on documented need or organizational effectiveness. This has resulted in inequitable and fluctuating funding of some projects, which hamper their ability to plan or provide consistent levels of service. Finally, IHS provides only limited technical assistance to the projects.

The PHS should strengthen management of the UIHP by (1) implementing a monitoring and evaluation system with uniform national criteria for all area offices, (2) completing an updated standardized national needs assessment (based on a standardized updated needs assessment in each local area) and (3) continuing the effort to improve the collection and dissemination of uniform national aggregate and comparative statistics. In addition, PHS should use needs assessment and evaluation data to decide future funding allocations and individual project-level funding. Finally, PHS should provide more explicit guidelines concerning adequate information and referral programs, including assistance in gaining access to Medicaid, other medical assistance programs and mainstream health providers. The PHS concurred with all of the OIG recommendations and has taken steps to implement the recommended changes. (OAI-09-87-00027)

IHS STAFF QUARTERS

An OIG report disclosed that rents and utilities for IHS staff quarters were not always being charged as required by regulation. In addition, some rental and utility rates were incorrectly computed by local service units. Based on review of 1986 rental data, OIG estimated that IHS could increase rental revenues by over $490,000 annually if correctly computed rental and utility rates were used.

In addition, when IHS contracted with a health corporation in September 1980 to manage quarters in one State, no provision was made for forwarding the rental income to the IHS area office. As a result, the health corporation inappropriately retained over $409,000 in rental income.

The IHS should begin collecting rent on quarters occupied rent free by non-IHS employees and seek Office of General Counsel guidance in determining the feasibility of collecting unpaid rent from current and prior IHS tenants, including the health corporation. Furthermore, all adjustments to rental and utility rates should be independently verified. The IHS should assign top priority to implement corrective actions. Officials at PHS generally agreed with our findings and recommendations in response to a preliminary report on the results of this review. (CIN: A-09-87-00113)

EMBEZZLING PHS FUNDS

The OIG investigated several cases involving embezzlement of money from local health care centers which received a major portion of their funding from PHS. The following convictions were obtained during this period:

- A controller of a California community health center supported by PHS was sentenced for embezzling money from the center between 1980 and 1987. He had added to his pay cards hours he had not worked, and had gotten

unauthorized advances through the payroll system and had written them off to a center expense account. He was ordered to make restitution of more than $92,000, confined to a halfway house for 90 days and ordered to serve 5 years probation.

- A bookkeeper in a Pennsylvania health systems agency largely funded by PHS had to repay $56,500 he embezzled over a period of 4 years. He created fictitious bills for which he made out payment checks, and after obtaining the necessary signature he erased the payee name and inserted his own.

- A Mississippi woman was convicted of embezzling money from a community service center which was funded by PHS. Besides acting as bookkeeper for the center, she served as secretary to the executive director. In this capacity she prepared vouchers for the director's approval and made out checks for payment. After the director signed the checks, she changed them to be payable to herself. Loss to the center was about $13,000.

- The chief fiscal officer of a Florida center for health care to the needy was convicted of embezzling center funds, including receipts from patients and Medicare and Medicaid checks.

COMMERCIAL COMPUTER SERVICES

A follow-up review of actions taken by ASMB and PHS to discontinue using costly commercial time-sharing computer services was conducted by OIG. The OIG found that ASMB had successfully transferred the preparation of the entire Department's budget to microcomputers. However, PHS continues to use the commercial time-sharing service in preparing its detailed budget requests and maintaining its real property management system.

In the prior OIG report, "Alternatives to Use of Costly Commercial Time-Sharing Services Could Save Millions" (ACN: 15-62683), dated July 31, 1986, OIG noted that use of available alternatives to commercial time-sharing services could save HHS at least $2.6 million over the next 5 years. The commercial time-sharing services contract used at the time of our initial review, cost HHS $3.2 million over a 3-year period.

In FY 1987, PHS initiated a 3-year plan for the development of microcomputer software that would enable it to process both of the above systems in a microcomputer environment. The current PHS projection is that these systems will be fully operational by FY 1990. The PHS officials stated that they will continue using commercial timesharing services during the interim 3-year period at an estimated cost of $1.2 million. The OIG recommended that ASMB

help PHS contract for the services of additional computer programmers to assure an earlier completion of this software development project.

In its reply to our draft report, PHS stated they recently contracted for technical assistance in moving towards a microcomputer-based system. They also said that substantial portions of the system have been removed from the commercial time-sharing contract. (CIN: A-12-87-02668)

FAMILY SUPPORT ADMINISTRATION

CHAPTER IV

FAMILY SUPPORT ADMINISTRATION

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

The Family Support Administration (FSA) provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. These programs include the Aid to Families with Dependent Children (AFDC) which is the fifth largest in HHS with a Federal cost in 1988 of almost $10 billion.

The AFDC program is a cooperative program among Federal, State and local governments which will reach 3.8 million families consisting of 11 million individuals each month in 1988. The Child Support Enforcement (CSE) program provides grants to States to enforce obligations owed by absent parents to their children by locating absent parents, establishing paternity when necessary, and obtaining child support. The Low Income Home Energy Assistance (LIHEA) program provides block grants to the States to help offset the increased cost of fuel for recipients of AFDC, food stamps, supplemental security income, as well as certain other individuals. Other programs include Emergency Assistance (EA), Refugee and Entrant Assistance, Community Services and Work Incentive programs. Expenditures for these FSA programs will total $14.1 billion in Fiscal Year 1988.

The Office of Inspector General continues to direct audit emphasis to reviewing recipient eligibility, determining the fairness of program benefits, and evaluating the economy and efficiency of operations. During this reporting period, OIG recommended recovery of $0.5 million in questionable grantee charges. Programmatic savings and audit and investigative receivables totaled in excess of $3 million.

EFFECT OF UNVERIFIED SSNs ON AFDC

Implementation of three modifications to SSA's enumeration verification system (EVS) could save $10.7 million annually, and reduce unverified SSNs by 47 percent, according to a recent OIG inspection. In 1986, SSA returned more than 4 million unverified SSNs to State agencies responsible for determining eligibility for AFDC and other benefit programs.

The objective of our review was to determine the effectiveness of SSA's automated verification process in identifying incorrect SSNs on AFDC payment accuracy, and potential improvements in the verification process. The Deficit

Reduction Act of 1984 required States to develop and implement EVS. The major thrust of this computer system is interprogram and interstate sharing of wage and benefit information relating to welfare recipients. States are required to use the SSN for record identification and must attempt to verify each SSN with SSA. The EVS—the primary SSN verification system—historically has failed to verify 15 to 18 percent of queried SSNs.

In addition to the three system modifications, the report recommended that SSA terminate the agreements now held with some States to process NUMIDENT corrections and assume full responsibility for the maintenance of the NUMIDENT file. The SSA should also make its requirements for the release of information more consistent among the query systems it maintains. The SSA and FSA generally agreed with the recommendations. (OAI-09-88-00068)

STANDARD FILING UNIT

An OIG report entitled "Impact of New Requirements: AFDC Standard Filing Unit" determined that few cases (5 percent) are affected by the standard filing unit (SFU) changes mandated in the Deficit Reduction Act of 1984. Prior to these changes, household family members eligible for AFDC were not required to file for benefits as a single SFU. However, savings from counting SSA and child support payments and consolidating multiple SFUs are offset by adding mothers over age 17 and children with no resources to the welfare rolls. The only cases resulting in any reduction of eligibility fell into two categories: families with SSA survivor or disability benefits and excluded teenage mothers under age 18 living with parents where only the teenager's baby was receiving AFDC benefits.

Although the Department had projected that the SFU changes would result in savings of $143 million for FY 1985 and $439 million over a 5-year period, we believe that savings are at best negligible for AFDC. Significant savings would be realized, however, through child support collections for children previously excluded from the SFU. The OIG recommended continued aggressive child support collection consolidation of multiple SFUs within a household. These actions would result in increased savings to the Department. (OAI-09-87-00003)

AFDC STATES BENEFITS PROJECT

In 1981, OIG initiated a project to assist State and local agencies in California in the prosecution of fraud against Federal and State income maintenance and benefit programs. The project was established in response to the perception on the part of the agencies that successful completion of their cases was frustrated by the amount of time it took to obtain necessary information and documents from Federal agencies. The OIG developed a mechanism for State and local investigators and prosecutors to verify SSNs, get information about Social

Security payments and obtain photocopies of the checks. The success of the project led OIG to expand it nationwide in 1983. Close to 14,000 requests for assistance have been received from hundreds of State, county and municipal jurisdictions. Their reporting to OIG on the outcome of cases is sometimes sporadic, but at least 1,100 convictions and an estimated $10 million in monetary returns have been obtained. At present OIG is processing about 600 requests for assistance each month.

OTHER WELFARE FRAUD PROJECTS

The OIG is actively involved in investigative projects in several States where computer matches or other sources have indicated large-scale AFDC fraud.

- In a recently completed project which resulted from a computer match, OIG and State officials investigated instances where individuals were receiving AFDC benefits from both the Indiana and Wisconsin programs. During this reporting period, eight persons were convicted and more than $100,000 ordered in restitution. Convictions and restitutions since the advent of the project in early 1987 have totaled 18 and $200,000, respectively.

- A project begun in early 1987 in Illinois and consisting of 90 welfare cases, investigated by a task force under the direction of the U.S. Attorney, has to date resulted in 46 convictions and more than $348,000 in fines and restitutions. Five of these convictions occurred during this reporting period.

ESSENTIAL PERSON

The essential person (EP) provision of Title IV-A of the Social Security Act allows States to include in the AFDC grant people living in the same household as AFDC recipients, for the provision of services essential to the AFDC recipients. Our review, which concentrated on three States' implementation of the provision, showed that, for the most part, individuals who provided no essential services or benefits to the AFDC recipients were routinely designated as EPs, contrary to program purpose. We even found one child who had been designated an EP at the age of 7 days old. The cause of this problem can be traced directly to the Federal regulations. They lack the specificity and clarity needed to assure that program intent is carried out. If the regulations are changed to preclude such abusive designations, approximately $42 million annually or $210 million over a 5-year period in Federal AFDC expenditures could be saved.

The FSA agreed with our recommendations to revise regulations to clarify the intent of the program and has proposed regulations which would preclude States from including individuals as EPs who do not provide an essential benefit or service to an AFDC family. (CIN: A-02-87-02006)

LOAN REPATRIATION PROGRAM

An OIG review disclosed that FSA had not taken sufficient action to recoup loans made under the repatriation program. This program provides loans to citizens who are returned to the United States because of such situations as destitution or an international crisis. The State and local governments who administer this program do not bill FSA in a timely manner and FSA is slow to approve these payments. Furthermore, OIG noted material internal control weaknesses in the accountability over Federal program funds.

The OIG recommended that the FSA assess its responsibilities for the timely collection of Federal debt and the prompt payment of Federal indebtness, and evaluate existing procedures for improving the accountability over Federal program funds. The FSA concurred with our findings and recommendations and indicated that corrective actions are being taken. (CIN: A-12-87-03087)

DISALLOWANCE OF EMERGENCY ASSISTANCE CHARGES

An FSA review of costs claimed for the emergency assistance program in 14 counties in one State for the year ending September 1985, disclosed allowable costs claimed by the State of $8.9 million. The OIG staff designed the sampling plan used in the review and provided FSA with the appraisal of the results.

The FSA indicated that the State has agreed to the method of costing a case and to other items including determination of the unallowable proportion of cases which were partially allowable. The FSA informed OIG that the agreement with the State is in writing (memorandum dated April 27, 1988).

REVIEW OF SELECTED AFDC COSTS

An OIG review indicated that Connecticut needs to strengthen existing procedures and implement new procedures to ensure that only eligible costs are claimed under the AFDC program. Over the 5-year period ending September 30, 1986, the State claimed $3.6 million ($1.8 million Federal share) for child day care and other services which were not eligible under the AFDC program. These claims occurred because Connecticut uses a single account to make payments for AFDC and other Federal and State programs. In preparing the AFDC claim, however, not all ineligible payments were removed.

The OIG recommended that Connecticut reduce the next AFDC quarterly claim for the ineligible costs and revise its procedures to ensure the removal of ineligible costs from future claims. State agency officials agreed with the finding and recommendations. (CIN: A-01-88-02007)

OFFICE OF HUMAN DEVELOPMENT SERVICES

CHAPTER V

OFFICE OF HUMAN DEVELOPMENT SERVICES

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

During this reporting period, the Office of Inspector General (OIG) identified questionable grantee charges to the Office of Human Development Services (HDS) programs of over $4.5 million.

The HDS oversees a variety of programs that provide social services to the Nation's children, youth and families, disabled, older Americans and native Americans. The Head Start program provides grants and contracts to public or not-for-profit agencies to supply educational, nutritional, health and social services to preschool children of the poor. Foster Care and Adoption Assistance is an entitlement program that provides grants to States to assist with the cost of foster care and special needs adoptions maintenance, administrative costs to manage the program, and training for staff. The goal of this program is to strengthen families in which children are at risk, reduce inappropriate use of foster care, and to facilitate the placement of hard to place children in permanent adoptive homes when family reunification is not feasible.

MINORITY ADOPTIONS

An inspection report entitled "Minority Adoptions" focused on current practices by adoption agencies to increase adoptions by minority families and on obstacles to such efforts. A review of minority adoption practices in five cities determined that agencies regularly serving minority foster children have generally incorporated special techniques to recruit and match minority families with waiting children. However, agencies serving few minority children reportedly did not use many of these techniques.

Many minority children wait in foster care because most families want younger, healthier children. Other obstacles to minority adoptions include some agency practices, traditional staff attitudes, and community myths and fears. Best practices in overcoming such obstacles included interagency coordinating mechanisms, personalized presentations of children, use of adoptive parents and counselors, and encouragement of single parent and foster parent adoptions.

The report concluded that despite substantial progress, adoption agencies have not yet succeeded in recruiting enough minority families for the older and more handicapped minority children. (OAI-02-88-00640)

INELIGIBLE FOSTER CARE CLAIMS

Title IV-E of the Social Security Act provides for the care and protection of children in the Aid to Families with Dependent Children program who have been removed from the homes of relatives and placed in foster care. An OIG review in California disclosed ineligible foster care claims for FFP totaling $9.9 million. For the cost of care to qualify for Federal reimbursement, the child must have been (1) receiving or eligible for AFDC assistance at the time of removal from the home, (2) removed from the home of a specified relative by either a voluntary placement agreement or a judicial determination and (3) placed in an eligible foster family home or institution. California regulations were inconsistent with Federal eligibility requirements.

The OIG recommended that the State process a financial adjustment of $9.9 million, revise the State regulations to conform with Federal eligibility requirements and encourage the counties to document AFDC eligibility in the service files.

The HDS was in full agreement with the findings and recommendations. (CIN: A-09-87-00077)

HEAD START FUNDS EMBEZZLEMENT

In Alabama, the executive director and the fiscal manager for a community action program were found guilty in a jury trial of conspiracy and embezzlement of funds from the local Head Start program. They had used the funds to finance various enterprises, including a restaurant, a wholesale grocery and a service station. Both were given jail sentences and fined a total of $15,000.

HHS AND GOVERNMENT-WIDE OVERSIGHT

CHAPTER VI

HHS AND GOVERNMENT-WIDE OVERSIGHT

INTRODUCTION

This chapter is devoted to OIG departmental management and Government-wide responsibilities. The Office of the Secretary will spend an estimated $225 million to provide overall direction for departmental activities and to provide common services such as accounting and payroll to departmental operating divisions. The OIG's oversight of these areas includes review of debt management activities, grants and controls, audit resolution, implementation of the Federal Managers' Financial Integrity Act, and participation in the President's Council on Integrity and Efficiency projects. Special reviews requested by the Secretary, the Congress and other departmental policy makers are also conducted. Reviews are directed at ways to strengthen all areas of departmental management.

Participation in the President's Council on Integrity and Efficiency also carries significant responsibilities for involvement in Government-wide efforts to reduce fraud, abuse, waste and mismanagement. The OIG's role typically involves participation on task forces to address developing programmatic or management approaches where the potential for fraud, abuse or mismanagement has been identified. The President's Council on Integrity and Efficiency's activities involve multiagency efforts to uncover fraud and abuse across programmatic lines.

In addition, OIG has oversight responsibility for audits conducted of Government grantees by nonfederal auditors, principally public accounting firms and State auditor organizations. As a result of the Office of Management and Budget (OMB) assignment of audit oversight responsibilities under OMB Circulars A-73, A-87, A-88, A-110 and A-128, OIG is responsible for audits of about 50 percent of all Federal funds awarded to State and local governments, hospitals, colleges and nonprofit organizations.

NONFEDERAL AUDITS

Approximately half of Federal funds awarded State and local governments and colleges and universities comes from HHS programs. The OIG is assigned cognizance at 95 percent of all colleges and universities. A major portion of this oversight responsibility is accomplished by relying on audit work performed by certified public accountants and State audit organizations. The OIG analyzes audit reports for indicators of grantee noncompliance with Federal regulations,

initiates audit resolution procedures on reported recommendations and maintains a quality control review process to identify substandard audit work.

The OIG also continues an active role in the implementation of the Single Audit Act. A major component of OIG's work load has been to assist State and local governments and their auditors with planning and performing single audits. The OMB has assigned HHS audit cognizance of 18 State and 906 local governments, which have submitted single audit reports.

The magnitude of HHS funding to State and local governments gives OIG a special interest and concern regarding compliance with the Single Audit Act. The Department provides about $50 billion a year to the 50 States and the 80,000 units of local government. All but 3 of the 50 States receive more funds from HHS than from any other department.

A. Local Government Compliance

In view of the impact this level of funding has on the operations of the audited entities, OIG's concern for the quality of single audit reports and the adequacy of the Federal Government's system to properly identify those State and local governments in noncompliance with the Single Audit Act goes far beyond the 924 governments for which OIG is presently assigned cognizance. The OIG is working with the States for which it is assigned cognizance to establish systems to assure compliance of local governments with the Single Audit Act. Such systems complement the monitoring system at the Bureau of the Census by filling the gap in the Government's knowledge on compliance by local governments.

B. Quality Control

To ensure that all audits meet generally accepted Government auditing standards, uniform procedures are used to review nonfederal audit reports. During this reporting period, OIG reviewed and processed 1,200 nonfederal audit reports containing $31 million in recommended cost recoveries. The reports also identified many opportunities for improving management operations. The following table summarizes these results.

Reports issued without changes or with minor changes	1,519
Reports issued with major changes	349
Reports with significant inadequacies	22
Total audit reports processed	1,890

Of those reports with significant inadequacies, four were referred to State officials and professional organizations for appropriate action. Several other

referrals are pending. In addition, work is continuing with professional auditing associations and State boards of accountancy to improve audit quality.

C. Potential Recoveries

Following are examples of three statewide single audit reports issued during this reporting period. The reports recommended financial adjustments totaling about $13.3 million.

- One audit report recommended financial adjustments of $5.5 million applicable to HHS funds. About $3 million of the recommended recovery related to State overpayments to Medicaid providers. The State improperly claimed the overpayments for Federal reimbursement. (CIN: A-03-88-06041)

- A second audit report contained about $4.3 million in recommended financial adjustments applicable to PHS funds, of which $3.4 million related to claimed expenditure amounts for which there was no documentation and $0.9 million related to unallowable claims for indirect costs. (CIN: A-08-88-05664)

- A third audit report contained about $3.5 million in recommended financial adjustments applicable to HHS funds, of which about $2.7 million related to claimed expenditures (principally involving public assistance programs) for which there was no documentation. (CIN: A-03-88-06140)

GOVERNMENT-WIDE ISSUES

Each year, State and local governmental entities receive over $100 billion in Federal grant funds. The OIG estimated that at least $6 billion is related to administrative costs, much of which relates to all Federal agencies.

A major OIG initiative was begun to look for ways to improve the accounting process, strengthen Government cost principles and identify cost containment areas that contribute to Government-wide savings. The cost principles governing the charging of costs by State and local governments have not changed substantially for about 20 years.

The OIG identified 13 areas in need of improvement in OMB Circular A-87 (cost principles). To date, OIG issued audit reports containing recommendations for improvements as well as cost recoveries and savings totaling about $2 billion. We have also issued a nationwide summary report to OMB on internal service fund activities identifying opportunities for savings of over $100 million if procedural recommendations are implemented.

A. Sales Tax On Federal Programs

The Federal Government could have saved $54 million if sales tax generated from self-taxing States was considered an unallowable cost for Federal financial participation (FFP). Six of the 50 States require their own agencies to pay State sales tax, 39 States do not. The remaining five States have no sales tax. The OIG reviewed the effects of State sales tax on programs receiving Federal financial assistance in the six self-taxing States. The OIG determined that during the fiscal year ended June 30, 1985, the Federal Government paid $54 million on expenditures under Federal agreements. An additional $74.5 million in increased Federal expenditures could occur if two other States in our review were to begin taxing themselves.

The OIG contends that State sales tax applied to expenditures under Federal agreements and claimed for FFP is unallowable because it does not constitute an actual cost to the State. Pursuant to our recommendations on draft revisions to Circular A-87, OMB has proposed that FFP be denied on sales taxes levied by States on themselves. (CIN: A-04-87-00040)

B. Payroll Taxes

The OIG identified an opportunity for Federal interest savings through accelerated deposit of payroll taxes related to Federal grants, contracts and other agreements. Under OIG's proposal, the Government would save the interest costs on payroll "float" by requiring recipients of Federal funds to deposit payroll taxes at the time Federal funds are drawn down to meet payroll needs. The OIG estimated that by doing so savings could be as much as $517 million over 5 years and a one-time savings of some $360 million for HHS activities. This amount could be substantially increased if expanded Government-wide.

We believe that such a change would not require new legislation, but could be made by regulatory or administrative action. With speedy implementation, this proposal would generate savings which could be applied to the expected budget deficit in FY 1989. In addition to outlay savings as a result of reduced interest payments, this change may also increase the Government's revenues by moving payroll tax payments forward and allowing the Government to invest those payments. (CIN: A-12-88-00110)

C. FICA Sick Pay Credit

An OIG review disclosed that States were not properly crediting Federal programs for Federal Insurance Contributions Act (FICA) refunds. Amendments to the Social Security Act effective January 1, 1982, provide that payments made for sickness or accident disability, with some limited exceptions, are considered wages for Social Security purposes. Conversely, related FICA contributions prior to January 1, 1982 could be excluded from the wage base. The changes permitted employers to file retroactive claims for credit or refund back to January 1, 1979.

- The State of Michigan claimed a refund of $8.4 million and identified $1.1 million as having been paid from Federal program funds. The OIG reviewed the State's calculation of the Federal share and determined a more appropriate amount to be $1.2 million. The OIG recommended that the State of Michigan refund to the Government $1.2 million.

Approximately 27 States have claimed refunds or credits under the changes permitted by Public Law 97-123. We are reviewing other States to assure that Federal funds are being refunded appropriately. (CIN: A-05-87-00098)

D. Self-Insurance Funds

To date, OIG's nationwide review of States' insurance funds has resulted in the recommended recovery of $17.6 million in Federal funds. This is in addition to future savings resulting from recommended changes to OMB Circular A-87.

Self-insurance funds provide reserve type self-insurance for State activities and properties administered by State, county and municipal governments. The cost of insurance, or premiums, is billed to the appropriate government agencies. Excess reserves result from premiums collected and interest earned in excess of claims and operating expenses. These excess reserves should be credited back to the fund users or used to reduce premiums in subsequent years. The OMB Circular A-87, Cost Principles for State and Local Governments, precludes the charging of excess reserve balances to Federal programs.

Our reviews disclosed that contrary to Circular A-87 cost principles, States were improperly charging excessive self-insurance costs to Federal programs. For example:

- Kentucky accumulated over $12 million ($5.4 million Federal share) from its self-insurance fund which was transferred to its general fund. (ACN: 04-60450)

- Oregon accumulated a surplus of $9.7 million ($2.2 million Federal share) more then recommended by an outside actuary in its self-insurance fund. (CIN: A-10-86-60450)

- Pennsylvania's self-insurance fund earned $7.7 million in interest ($1.3 million Federal share) on its self-insurance fund reserve which was credited to its general fund. (ACN: 03-61451)

- Florida over-charged users of its self-insurance fund and accumulated excess reserves of $43.6 million (Federal share $8.7 million). (CIN: A-04-88-00060)

In addition to financial adjustments for these overcharges, OIG recommended that the States take steps to avoid future excesses and ensure that self-insurance funds are properly accounted for in future statewide cost allocation plans.

The OIG also recommended that OMB Circular A-87 be revised to specifically address excess reserves in self-insurance funds. The OMB has included our recommendations in its proposed revision to Circular A-87. (CIN: A-04-87-00038)

E. Contingency Reserve Fund

An OIG review disclosed that California did not reduce Federal program expenditures for applicable credits amounting to approximately $3.9 million. The State legislature required that surplus balances of the Public Employees' Contingency Reserve Fund for the years ended June 30, 1984 and 1985 be returned to contributing State agencies. The reversion was recorded as an increase to each agency's fund balance. Federal expenditure accounts were not adjusted and Federal expenditure reports were not amended to report the refund.

Federal cost principles require that expenditures claimed under Federal programs be net of all applicable credits. Based on the proportion of Federal program expenditures to total State expenditures, a financial adjustment of about $3.9 million should be made to the Federal Government.

The OIG recommended that California make a refund for the Federal share of the returned surpluses. Procedural recommendations were not made because the State budget acts of 1985 and 1986 discontinued contributions for contingency reserves. State officials agreed that the Federal Government should receive a refund for its share of the reversion. However, they believed that the refund should be reduced by over $326,000. (CIN: A-09-86-60465)

F. Pensions

Many State and local governments have pension plans with unfunded actuarial liabilities, which occur when the assets of the pension plan are less than the total amount of benefits that are expected to be paid current and future retirees. Interest is an expense of unfunded actuarial liabilities, essentially consisting of the interest that would have been earned had the pension plan been fully funded. Federal programs would be allocated a share of this interest expense even though Federal cost principles (OMB Circular A-87) state that interest is not allowable for reimbursement under Federal grants. This is because the cost principles do not require that interest included in pension expenses be separately identified and excluded from grant claims. If pension interest incurred was specifically disallowed for reimbursement, approximately $1.3 billion in administrative costs could be saved each year.

Based on three studies on the funding position of governmental pension plans, OIG estimated that unfunded actuarial liabilities totaled approximately $146 billion. With interest rates varying from 6 to 9 percent, annual interest cost ranged from $8.8 billion to $13.1 billion. The Federal Government funds approximately 15 percent of all State and local government expenses. Applying this rate, the gross Federal share of pension interest expense ranged between $1.3 billion and $2 billion.

The effect of pension interest can be significant to individual grantees as well as to individual programs. For example, one State reported an unfunded actuarial liability of $6 billion at June 30, 1986. Annual interest expense on this amount was approximately $510 million and the Federal share was $76.5 million. For three HHS programs operated by the State, pension interest expense totaled an estimated $1.13 million annually. Federal assistance available for direct program services was reduced by the amounts spent on pension interest.

To minimize the effect of pension interest expense on the Federal Government and its grantees, OMB Circular A-87 should be clarified. We have brought the need for this clarification to the attention of OMB and requested that it be considered in the revisions to the circular currently proposed. (CIN: A-09-87-00031)

PCIE ACTIVITIES

The President established the President's Council on Integrity and Efficiency (PCIE) in 1981 to coordinate Government-wide activities to attack waste and fraud and improve management processes. The PCIE and its member Inspectors General focus on interagency projects which enhance the Federal Government's overall ability to combat fraud, abuse and waste.

A. Review Of Guaranteed Loan Programs

The PCIE is coordinating a three phase Government-wide review of Federal guaranteed loan programs. Our review at HHS focused on the Health Education Assistance Loan (HEAL) program, which is the Department's principal guaranteed program. As of September 30, 1987, HHS has guaranteed about $1.6 billion for over 93,000 HEAL loans issued by private lenders.

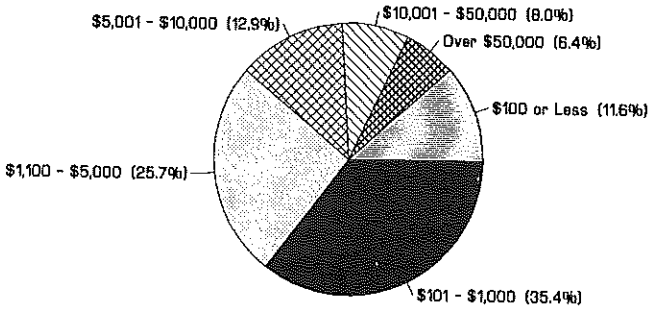
In the first segment of the review, OIG reported on PHS's progress in implementing OMB's nine point credit management program relating to guaranteed loans. The PCIE committee is finalizing a consolidated report to be issued to OMB, which summarizes the recommendations made by the participating OIGs to their respective agencies to improve the effectiveness of credit management initiatives.

In the second segment of the review, the results of various HHS OIG audits, investigations, and agency reviews will be "rolled up" into a consolidated report evaluating the management of Federal loan guarantee programs. The final segment will be an assessment of the implementation of the guaranteed loan provisions of OMB Circular A-70, Policies and Guidelines for Federal Credit Programs. (CIN: A-05-87-00061)

B. Civil Monetary Penalties

A PCIE study on civil monetary penalties found a total of 311 different CMP amounts being assessed, ranging from $10 to $1 million. The report surveyed all agencies with statutory Inspectors General, plus the Departments of Treasury and Justice and the smaller agencies represented by the PCIE Coordinating Conference. The Internal Revenue Service and the tax code were not included.

CIVIL MONEY PENALTY AMOUNTS



Senate Bill 1014, the Federal Civil Penalties Inflation Adjustment Act of 1987, would provide a regular inflation adjustment for each CMP and require annual reporting of the number of CMPs imposed and the status of collections. Although many penalties were established or have been updated since 1981, some penalties date back to as early as 1793. Consequently, the effect of Senate Bill 1014 is negligible in about 40 percent of the cases, but would increase older CMPs by as much as 1,089 percent. The Congress may want to consider future reductions or consolidations in CMPs or add sunset provisions rather than automatic increases.

PROGRAM FRAUD CIVIL REMEDIES ACT

The Program Fraud Civil Remedies Act (PFCRA), passed in October 1986, established administrative penalties for anyone who makes a false claim or written false statements to a Federal agency. It was modeled after the CMP law for the Medicare and Medicaid programs, which OIG has been responsible for enforcing since its enactment 5 years ago. Under PFCRA, any person who

makes a claim or statement to the Department, knowing — or having reason to know — that it is false, fictitious or fraudulent, may be held liable in an administrative proceeding for a penalty of up to $5,000 per claim or statement. In addition, that person may be subject to an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims or statements, and for reporting at the end of each fiscal year investigations completed under PFCRA and referred for administrative action. In April 1988, OIG published final rules for implementing PFCRA.

BIRTH CERTIFICATES

Birth certificates, which are issued by the individual States, are the key to opening many doors in our society—from citizenship privileges to Social Security benefits. These certificates can be used as "breeder" documents to obtain drivers licenses, passports, Social Security cards or other documents used to create a false identity.

A. Birth Certificate Fraud

An OIG report entitled, "Birth Certificate Fraud" was completed to identify fraud vulnerabilities in birth certificate forms and issuance procedures. The OIG found that nearly 7,000 local offices issue an estimated 10,000 varieties of birth certificate forms, seals and signatures. The lack of standardization makes it difficult for user agencies to identify fraudulent certificates. Ten States allow open access to public records and others require little identification. Poor security and lack of "safety paper" are common problems. More States, however, are matching birth and death records which increases fraud detection. The Immigration Reform and Control Act of 1986 requires employers to check employee documents and requires State benefit agencies to verify alien status. These new requirements add increased pressure to secure birth certificates against fraud.

The OIG recommended that States standardize birth record forms and procedures, increase security and restrict access to records. (OAI-86-02-00001)

B. Birth Certificate Fraud Cases

The following are examples of investigative cases involving birth certificate fraud:

- In Texas, two men were sentenced to a total of 11 years in prison for misusing Social Security numbers to obtain income tax refunds. Through visiting cemeteries and reviewing old newspapers, the two individuals had identified deceased children with a date of birth close to their own. Posing as distant relatives of the deceased, they obtained birth certificates and SSNs to establish new identities. Using the names and SSNs, along with a real company's name and the company's employer identification number, they filed false

income tax returns with false W-2 forms attached. This case was a joint investigation with the Internal Revenue Service and the U.S. Postal Service.

- In New York, a woman has been convicted for defrauding the Aid to Families with Dependent Children program of more then $100,000. An illegal alien, she had obtained counterfeit Puerto Rican birth certificates to get Social Security cards under four fictitious identities. She was also working and collecting AFDC benefits under her own identity.

EMPLOYEE FRAUD Continuous surveillance over Department programs to ensure against employee-related crimes is a significant OIG responsibility. Most of the roughly 123,000 persons employed full time by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities. During this reporting period, 20 employees had to be disciplined by the Department or the courts, of which the following are examples:

- A hearings clerk with the Office of Hearings and Appeals in Utah received a suspended prison sentence, was given 3 years probation and was told to make restitution of $2,300 obtained in bank loans. The individual had used a friend's SSN and given false information to obtain checks from three banks, then posed as an employee of the IRS when cashing the checks. He has since resigned his Federal position.

- A claims representative, formerly working in an Alabama SSA office, was found guilty of embezzling money from a Social Security beneficiary. Learning that the beneficiary would receive a large check because of a reversal ruled by an administrative law judge, the claims representative told her that she owed a Supplemental Security Income overpayment of $550. He went to her home to collect the money but never gave her a receipt. She subsequently gave him $100 for being so helpful. When he went to her home again to ask for $200 for "cancer treatment" in New York (where he was being transferred), she became suspicious and called her attorney. Incarceration for the representative was suspended pending his repaying the beneficiary.

APPENDICES

APPENDIX A

SAVINGS FROM ENACTED LEGISLATION NOT PREVIOUSLY REPORTED OR CLAIMED

This schedule documents the budgetary savings resulting from OIG recommendations that have been implemented through legislation. The amounts shown, totaling $2,343.7 million for this period, represent funds or resources that will result in budgetary savings.

RECOMMENDATION	LEGISLATIVE ACTION	SAVINGS IN MILLIONS
Cataract Surgeons Fees: The OIG recommended that HCFA reduce surgeons fees and establish global fees for cataract surgery. The HCFA complied and initiated regulatory changes, the substance of which were then incorporated into the Omnibus Budget Reconciliation Act of 1986. (OAI-85-09-00046)	Section 9343 of OBRA FY 1986 reduced prevailing charge levels for cataract surgery in FY 1987 by 10 percent and 12 percent thereafter. NOTE: The OIG had previously deferred reporting savings for FY 1989-91 due to continuing congressional and departmental efforts to further reduce cataract surgery fees. At this time, OIG is reporting these savings which were developed by HCFA's Office of the Actuary. For additional legislative action on cataract surgery, see page 78.	$600
PPS Hospital Profits: Reports and testimony by OIG have recommended that PPS payments should take into account large Medicare profits being earned by hospitals. (ACN: 09-62021 and CIN: A-08-87-00003)	Section 4002 of OBRA 1987 prevented PPS rates from increasing a scheduled 2.7 percent, rising only 0.4 percent from 11/21/87-4/1/88. From 4/2/88-9/30/88 rates rose 3 percent for rural hospitals, 1.5 percent for large city hospitals and 1 percent for all other PPS hospitals. Savings for the period 4/1/88-9/30/88 are based on Congressional Budget Office (CBO) estimates.	589

RECOMMENDATION	LEGISLATIVE ACTION	SAVINGS IN MILLIONS
Capital Related Costs: Discontinue inappropriate Medicare PPS payments for hospital capital costs (ACN: 14-52083, 09-52032, 09-52002, 09-52020)	The OBRA of 1986 reduced capital-related payments to PPS hospitals by 3.5 percent for FY 1987 cost reporting periods; by 7 percent for FY 1988 reporting periods; and by 10 percent for FY 1989 reporting periods. Section 4006 of OBRA 1987 increased these percentage reductions requiring that capital payments be reduced by 12 percent for cost reporting periods beginning January 1, 1988, and by 15 percent for FY 1989 reporting periods. Savings are based on CBO estimates (FY 1988-90).	$450
CABG Surgery Fee: Limitations should be placed on reasonable charges for the primary surgeon's fee for CABG surgery. (OAI-09-86-00076)	Section 4045 of OBRA 1987 establishes a formula for reducing prevailing charge levels for 12 overpriced procedures including CABG surgery. Savings are based on an OIG estimate (FY 1988-92) generated from a CBO savings estimate for the 12 procedures.	163.2
Cataract Surgery Fee: Medicare should pay a single professional fee to cover all professional staff associated with cataract surgery. (OAI-85-09-00046)	Section 4045 of OBRA 1987 establishes a formula for reducing prevailing charge levels for cataract surgery. Savings are based on an OIG estimate (FY 1988-92) generated from a CBO savings estimate for the 12 overpriced procedures including cataract surgery.	541.5

APPENDIX B

PROGRAMMATIC SAVINGS
APRIL 1988 THROUGH SEPTEMBER 1988

This schedule documents savings to programs resulting from regulatory actions or policy determinations of management on behalf of OIG recommendations. Savings are calculated using departmental figures for the year in which the change was effected. Total programmatic improvements during the period amounted to $22.4 million.

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Reducing Overpayments Caused by Excess Earnings:		
The SSA should require certain beneficiaries to respond to the direct mail follow-up regarding estimated earnings and reduce or suspend benefits for failure to respond. (CIN: A-09-87-00045)	The SSA introduced a modification in the 1987 mid-year mailer.	$13.4
Purdue University: Research Indirect Cost Rates:		
Reduce organized research indirect cost rate from 52 percent of modified total direct cost for on-campus research activity to 45.1 percent. (CIN: A-05-86-67000)	The University agreed to an organized research rate of 46 percent of modified total direct cost.	6.0
Low Income Home Energy Assistance:		
Indiana should institute procedures to discontinue energy assistance to households ineligible because their income exceeded the maximum allowable to qualify for the State's emergency assistance program. (CIN: A-05-86-60551)	Corrective action was taken by the State to implement OIG recommendations, including the creation of an autonomous quality assurance unit.	3.0

APPENDIX C

AUDIT RECEIVABLES
APRIL 1988 THROUGH SEPTEMBER 1988

This schedule represents significant examples of the dollar amounts placed in accounts receivable for recoupment during this reporting period as a result of management determinations in favor of audit findings and recommendations. Audit receivables[1] for this period totaled $167.5 million.[2]

	DOLLARS IN MILLIONS
• Illinois improperly claimed costs for intermediate care facilities for the mentally retarded that were not certified according to Medicaid criteria. (CIN: A-05-86-60219)	$20.3
• California did not return the Federal share of uncollected Medicaid overpayments to community hospitals and long term care facilities. (CIN: A-09-87-00059)	7.8
• The HCFA was failing to bill State agencies for premiums of some buy-in enrollees. (CIN: A-03-86-62013)	7.7
• Three independently owned and operated intermediate care facilities had the overall character of institutions for mental diseases and therefore did not qualify for Medicaid payments. (CIN: A-05-86-60214)	6.6
• Twenty-three nursing homes were overpaid by the Missouri State Medicaid Agency and subsequent refunds were not returned to the Federal Government. (CIN: A-07-87-00023)	5.4
• A nonfederal audit of South Carolina's Health and Human Services Finance Commission disclosed that emergency job funds were inappropriately transferred and expenditures were not adequately documented. (CIN: A-04-88-05005)	4.5
• Massachusetts understated collections and credits applicable primarily to the Medicaid program. (CIN: A-01-86-60255)	4.4

[1] Includes $81.9 million in receivables resulting from recommendations by HCFA's Bureau of Quality Control.
[2] Subject to reduction as a result of appeal and/or uncollectibility.

	DOLLARS IN MILLIONS
• California did not reduce Federal program expenditures for applicable credits. (CIN: A-09-86-60465)	$3.9
• New York improperly claimed Federal funds for more than one outpatient mental health service per day for certain patients. (CIN: A-02-86-60230)	2.3
• Noncovered extra eye wear was paid for by one intermediary. (CIN: A-04-87-01000)	1.6
• Unallowable costs for personnel and other fixed costs were included in amendments to an intermediary's contract for processing Medicare claims. (CIN: A-02-86-62015)	1.3
• Medicare overcontributed to the pension costs of an intermediary primarily because of the abnormal forfeiture that occurred when the Medicare contract ended. (CIN: A-07-86-62005)	1.0
• The computerized marriage records of several States were matched with SSA files to detect unreported marriages. (CIN: A-09-87-00052)	1.0
• The District of Columbia claimed Medicaid costs for ineligible abortions. (CIN: A-03-86-60222)	1.0
• An intermediary's administrative costs exceeded approved budget levels. (CIN: A-03-88-05554)	0.9
• Medicaid overpayments, that South Carolina later collected, were not credited to the Federal Government. (CIN: A-04-88-02033)	0.9
• An intermediary's administrative costs exceeded approved levels and other items were unallowable. (CIN: A-02-87-01005)	0.8
• Massachusetts did not limit Medicaid payments for outpatient clinical diagnostic laboratory tests to the levels set in the Medicare fee schedules. (CIN: A-01-87-00011)	0.8
• Maine did not limit Medicaid payments to the Medicare fee schedules for hospitals' outpatient clinical diagnostic lab tests. (CIN: A-01-87-00018)	0.6

	DOLLARS IN MILLIONS
• A university did not credit the Federal Government for interest earned on deposited Federal funds. (CIN: A-06-86-61202)	$0.5
• Minnesota claimed AFDC foster care payments for ineligible children. (CIN: A-05-86-60552)	0.5
• Inadequate documentation and improper judicial determinations made claims for foster care in New York City unallowable. (CIN: A-02-86-60257)	0.4
• Shared service and training costs at a health center were not adequately supported. (CIN: A-02-87-06071)	0.4
• North Carolina's charges for medical reviews exceeded its actual costs. (CIN: A-04-88-05020)	0.3
• New York charged the HDS for excessive fringe benefit and rent costs. (CIN: A-02-87-07059)	0.3
• Mathematical errors and unsupported costs resulted in an excessive claim by a Medicare carrier. (CIN: A-05-86-62016)	0.3
• Minnesota erroneously reimbursed counties in excess of their authorized allocation for administrative aides and attempted to correct this error by inappropriately transferring maintenance allocation funds. (CIN: A-05-87-05765)	0.2
• An intermediary charged unallowable transportation, insurance, and training, costs to Medicare. (CIN: A-05-86-62028)	0.2
• Medicare was charged for pension costs while the retirement plan was fully funded and while no additional funding occurred. (CIN: A-05-86-62031)	0.2
• Other audit determinations (complete listing available upon request).	9.5

HCFA Program Disallowances	DOLLARS IN MILLIONS
• Medicaid reimbursement claimed during periods of invalid provider agreement.	$8.8
• Medicaid reimbursement to intermediate care and skilled nursing facilities at rates higher than approved State plans.	10.1
• Medicaid payments for ineligible patients under the home and community based care waiver.	1.5
• State claimed from Medicaid an excessive share for retroactive payments made to intermediate care facilities.	4.1
• Overpayment by Medicaid of States management system costs.	16.4
• States improperly claimed non-personal services and training costs under the Medicaid program.	1.0
• Medicaid reimbursement claimed for suspended payments to providers suspected of fraud and abuse activities.	10.3
• Recoupments collected from third parties and other sources not returned to Medicaid fund.	8.0
• Nonqualifying contributions were included in Medicaid program claims.	10.0
• Claims of excessive per diem rates for Medicaid patients in State owned intermediate care facilities for the mentally retarded.	6.5
• Nonsupportable claims for payments made directly to recipients under the Medicaid program.	0.9
• Overstated Medicaid claim for cost recovery of mechanized claims processing and information retrieval system.	1.8
• Other determinations	2.5

APPENDIX D

INVESTIGATIVE RECEIVABLES
APRIL 1988 THROUGH SEPTEMBER 1988

This schedule represents the dollar amount of fines, savings, restitutions, settlements and recoveries determined through judicial or administrative processes in support of OIG investigative findings. These figures include both actual and ordered recoupments for the Treasury of the United States, the Social Security and Medicare trust funds and departmental programs victimized by fraud and abuse. Receivables of $35.1 million are reported for this period.

Fines and Restitutions:

• Texas man drew disability payment while working under another SSN.	$ 119,500
• Woman in New York used false SSNs to obtain AFDC benefits.	104,800
• Pharmacist in Illinois billed Medicaid for prescriptions never filled.	50,000
• DME supplier in Georgia used a variety of schemes to fraudulently collect from Medicare for oxygen equipment.	94,700
• DME supplier in Ohio billed Medicare and Medicaid for equipment and service not provided or not covered.	91,000
• California man receiving disability payment did not tell SSA he was working.	50,100
• California woman receiving disability benefits did not tell SSA she had returned to work.	64,700
• Maryland man cashed deceased grandfather's checks.	53,400
• Minnesota man concealed employment as a carpenter while collecting disability benefits.	92,400
• Woman in Oregon concealed remarriages to continue to collect SSA survivors benefits.	59,600

OIG RECOMMENDATION	STATUS	SAVINGS
Medicare Deductibles: Raise the Medicare Part B deductible to $100 and appropriately index it. (ACN: 09-52043)	The President's FY 1989 budget does not include a proposal to index the deductible to the Medicare Economic Index.	$ 280
Rounding Medicare Premiums: Round Medicare Part B premiums up to the next higher dollar. (ACN: 09-52008 and CIN: A-08-87-00003)	The proposal was not included in the President's FY 1989 budget and legislative program.	175
Hospital DRG Rates: Rebase Medicare hospital PPS rates to correct for inclusion of overstated operating costs. (ACN: 09-62021 and CIN: A-08-87-00003)	This proposal has not been included in the President's FY 1989 budget and legislative program. However, this report has been generally available and has been considered by the Congress in setting annual updates to the PPS rates in recent years.	378
Medicare Round Down: Round down to the next whole dollar Medicare Part B and other payments for Medicare services. (ACNs: 03-62006 and 14-52085)	The OIG has submitted a second report; however, this proposal has not been included in the President's FY 1989 budget and legislative program.	63.0
IME Adjustments: Reduce the Medicare PPS adjustment factor for indirect medical education costs and thus limit the large profits being earned by teaching hospitals. (ACN: 09-62003)	As in prior years, a proposal to reduce the adjustment factor has been included in the President's FY 1989 budget and legislative program.	380
Buy-In Program: Eliminate Federal financial participation in monthly Part B premiums paid by States on behalf of Medicaid recipients eligible for Medicare (Buy-in program). (ACN: 03-50228 and CIN: A-03-86-62019)	The proposal is not included in the President's FY 1989 budget and legislative program.	380

OIG RECOMMENDATION	STATUS	SAVINGS
Nursing Home Per Diem: Revise Medicare regulations to prohibit suppliers from billing directly for urological and enteral therapy supplies and require that nursing homes include the cost of such products in their per diem rates. (ACN: 06-42002)	The proposal was not included in the President's FY 1989 budget and legislative program.	$ 17.0
Crossover Claims: Limit Medicaid "buy-in" payments for Medicare deductible and coinsurance to the Medicaid fee schedule. (ACN: 02-60202)	The proposal is not included in the President's FY 1989 budget and legislative program.	100
User Fees: The OIG identified three premarketing approval functions where FDA has not proposed a user fee. (CIN: A-01-87-02522)	The PHS included these fees and proposed other fees for premarket reviews of human drugs, medical devices, animal drugs, and food and color additive petitions.	2.8
Viability of HEAL SLIF Fund: Selling "cured loans"; eliminating the current 8 percent ceiling on insurance premiums over life of loan; linking insurance premium assessments to risk categories; 20 percent cost-sharing by lenders; permitting lenders to require cosigners; eliminating Federal guarantee for loan amounts in case of death or disability; and imposing a lender's processing fee for default claims filed. (ACN: 12-73276)	Proposed legislation currently pending in the Congress.	74.7

II. PROGRAMMATIC RECOMMENDATIONS - This schedule represents $3,063 million in estimated savings, based on annual savings or a one-time recovery, that would result from positive determinations in favor of OIG recommendations. Savings are based on preliminary OIG estimates and reflect economic assumptions which are subject to change. The magnitude of the savings may also increase or decrease as some of the proposals could have interactive effects if enacted together.

OIG RECOMMENDATION	STATUS	SAVINGS
Overpayments: The SSA needs to recover or otherwise resolve 124,039 incorrect payments or overpayments (amounting to $72.5 million) which were recorded as incorrect payments. (CIN: A-03-86-62600)	The SSA agreed and expects to implement the recommendation in the near future.	$ 53.7
Overpayments: The SSA did not follow procedures to collect from other beneficiaries on the same record as the overpaid beneficiary. (ACN: 03-62601)	The SSA agreed to develop a computer application to identify such cases and conduct annual reviews until completion of the National Debt Management System.	6.3
Supplemental Security Income: Instead of a blanket write-off, the SSA should initiate efforts to recover SSI overpayments previously written off for all except the known deceased debtors in the backlogged debt population. (OAI-12-87-00030)	The SSA is conducting a study to determine whether pursuing backlogged debt cases is cost effective, with a decision to be made in the near future.	28.0
Supplemental Security Income: The SSA should negotiate with the IRS for income tax refund offset to recover outstanding debts owed by former SSI recipients who are under age 65. (OAI-12-86-00065)	The SSA has indicated that actions geared to use of income tax refund offset for recovering SSI overpayments from former recipients are underway.	58.5

OIG RECOMMENDATION	STATUS	SAVINGS
Supplemental Security Income: The SSA should aggressively pursue voluntary cross program adjustments to collect outstanding debts owed by former SSI recipients who are current RSDI beneficiaries. (OAI-12-87-00029)	The SSA has indicated it will explore the cost effectiveness of reopening previously terminated debt including cases where voluntary cross program adjustments might be applicable.	$ 7.3
Nonpayment for Broken Consultative Examinations: The SSA should not pay State agencies for consultative examinations that are canceled or otherwise not kept. (CIN: A-01-87-02004)	The SSA has drafted proposed regulatory changes that prohibit SSA from paying State agencies for examinations that are canceled or otherwise not kept.	1.5
National DRG Validation Study - Unnecessary Admissions: The HCFA should strengthen the role of the PROs and reconcile differences between PRO and Super PRO data to reduce the nearly $1 billion in unnecessary Medicare hospital payments identified in this report. (OAI-09-88-00880)	The HCFA is considering our recommendations.	938
Medicare Physician Consultation Services: A uniform definition for consultation for carriers and physicians should be developed and specific reimbursement criteria regarding initial and follow-up should be adopted. (OAI-02-88-00650)	The HCFA disagreed with the recommendations concerning reimbursement criteria.	73.6
Miscoding Patient Transfers: Systems changes should be made to detect miscoded transfers, facilitate payment adjustment and increase PRO review of readmissions within 1 day of discharge. (OAI-06-87-00043)	The HCFA has agreed to implement the recommendations concerning payment adjustments.	39.9

OIG RECOMMENDATION	STATUS	SAVINGS
Multiple Surgical Procedures: All carriers should uniformly limit reimbursement for second surgical procedures to 50 percent of reasonable charge. (CIN: A-03-86-62008)	The HCFA has no plans to establish a national limit for multiple surgical procedures at this time, but has agreed to call our findings to the attention of the carrier involved.	$ 5.2
Multiple Visits in SNFs: Apply the "multiple visit" concept to Medicare payments for physician visits to patients in skilled nursing homes and hospitals. (ACN: 03-42005)	The HCFA has not adopted the multiple visit concept.	240
Pacemaker Monitoring: Reclassify pacemaker monitoring under Medicare from the current physician-assisted service to the lower-paying routine service. (ACN: 08-52017)	The HCFA issued guidelines as part of studies mandated by the Deficit Reduction Act of 1984, and is exploring alternative approaches to the problem.	6.0
Medicare as Secondary Payer - Automobile Accident Related Claims: Under the provisions of the MSP program, HCFA should ensure identification of all beneficiaries involved in automobile accidents and covered by auto or liability insurance. (OAI-07-86-00092)	The HCFA has concurred with OIG findings and is in general agreement with OIG recommendations.	15.2
Child Support Enforcement - Absent Parent Medical Liability: The FSA should enforce the provisions in regulations that require petitioning of courts for insurance coverage of dependent children. (OAI-07-86-00045)	The FSA has concurred with OIG findings and is in general agreement with OIG recommendations.	33.0
Medicare as Secondary Payer - End Stage Renal Disease: Under the provisions of MSP, HCFA should ensure identification of all ESRD beneficiaries covered by employee group health plans, and that proper billing for services has been made. (OAI-07-86-00092)	The HCFA has concurred with OIG findings and recommendations and is developing instructions to fiscal intermediaries.	19.6

OIG RECOMMENDATION	STATUS	SAVINGS
Ambulatory Surgeries: Increase use of outpatient facilities for elective surgeries under Medicaid. (ACN: 09-50205)	The HCFA is preparing a proposed rule which will encourage the use of outpatient surgery.	$ 110
Mandatory Second Opinion: Mandate that Medicaid beneficiaries obtain second surgical opinions for selected surgeries. (ACN: 03-30211)	The HCFA's expected regulations will be delayed until a report required by the Omnibus Budget Reconciliation Act of 1986 is submitted to the Congress.	63.0
Premature Admissions: Minimize premature admissions for Medicaid elective surgeries. (CIN: A-09-86-60213)	The HCFA is developing a proposed rule which will encourage the use of preadmission testing and preadmission review systems.	18.5
Child Support Enforcement: The FSA should require States to annually match SSNs of absent parents of AFDC children without support orders, with low support orders or in arrears against SSA's earnings records. Cases where the absent parent earns in excess of $10,000 would be reopened. (OAI-05-86-00097)	The FSA has agreed with OIG's findings. The FSA is arranging with IRS for States to obtain the required information where earnings information cannot be matched at the State level.	103.4
Access of Dialysis Patients to Kidney Transplantation: The OIG sent to HCFA a series of recommendations that would help ensure that dialysis patients are afforded a full and fair opportunity to receive a kidney transplant. (OAI-01-86-00107)	Both HCFA and PHS are collaborating with professional societies to develop guidelines for patient transplant suitability.	18.3

OIG RECOMMENDATION	STATUS	SAVINGS
National DRG Validation Study - Poor Quality Care: The HCFA needs to issue regulations to implement the 1985 COBRA provisions giving PROs authority to deny Medicare reimbursement for patients receiving substandard medical care. (OAI-09-00880)	The HCFA is currently developing regulations.	$1,200
Medicare Payment For Physician Services-Inpatient Dialysis: The HCFA should issue instructions that require each carrier to use a visit code method to reimburse providers for services provided to beneficiaries in need of inpatient dialysis. (OAI-06-88-00370)	The HCFA disagreed with our recommendations.	24.0

APPENDIX F

OIG NONMONETARY FINDINGS THROUGH SEPTEMBER 1988

This schedule represents recent OIG findings and recommendations that resulted in or which, if implemented, would result in substantial benefits. The benefits primarily relate to effectiveness rather than cost efficiency.

OIG RECOMMENDATION	STATUS
Medicare Reimbursement for At-Home Oxygen Care: The HCFA should issue immediately a uniform medical necessity certification form. Included on this form should be a strong physician attestation statement. This attestation places the responsibility with the physician for the accuracy of the information contained on the certification form. (OAI-04-87-00071)	The HCFA is developing, but has not issued a medical necessity certification form and attestation statement.
Medical Licensure and Discipline: The HCFA should amend the PRO regulations and the Medicare carrier instructions to require more extensive and timely reporting to State medical boards of cases involving physician misconduct or incompetence. (OAI-01-86-00064)	The HCFA has agreed to include a regulatory provision to require PROs to report cases involving misconduct or incompetence to medical boards.
Unauthorized Activities On Official Time: The ASPER should issue a general policy statement which requires the departmental operating divisions and staff divisions to issue more specific instructions for documenting situations where employees routinely perform duties away from their official duty station. (MAR-88-00001)	The ASPER revised the Department Personnel Manual to indicate AWOL will be charged in instances of misuse and to remind managers to establish appropriate systems for overseeing these particular instances.

OIG RECOMMENDATION	STATUS
Lack Of Controls In Issuing Underpayment Checks: The SSA should develop procedures to require that all RSDI underpayments resulting from suspension of 1 year or more be subject to prepayment review. (MAR-88-00002)	The SSA issued a program circular reminding agents to make certain that all eligibility factors (both disability and nondisability) continue to be met before reinstating RSDI benefits to a person in suspense.
Infrequent Contact With Disability Beneficiaries: The SSA should institute annual mail contacts with RSDI disability beneficiaries most likely to return to work to prevent overpayments. (MAR-88-00003)	The SSA developed a profile of those beneficiaries, and a mass mailer requesting up-to-date work information has been sent to approximately 60,000 disability beneficiaries.
Postings To SSA's Master Earning File: The SSA should install a mechanism to prevent the postings of earnings to the master earnings file subsequent to an individual's date of death and create an alert if the SSN is being used by another person subsequent to the death of the account holder. (MAR-88-00004)	The SSA agreed and will include these recommendations in the functional requirements for the redesigned master earnings file.
Define "Material Weakness" Under the Federal Managers' Financial Integrity Act (FMFIA): The ASMB should develop a generally accepted definition of the term "material weakness" for use departmentwide and establish a mechanism for timely resolution of disagreements over materiality of audit findings. (CIN: A-12-87-03085)	The ASMB issued departmentwide instructions that provided guidance on defining a material weakness which will be used on a trial basis for Fiscal Year 1988 and formed a task force to further study material weakness issues.
Increase Financial Viability of Rural Hospitals Subject to PPS: The HCFA should consider budget-neutral legislative proposals to assist rural hospitals subject to PPS.	The HCFA believes that additional legislative relief is not necessary. They believe that it is prudent to await the impact of current legislation.

OIG RECOMMENDATION	STATUS
Specify in PRO Contracts Excess Profit Clauses—Medicare: The HCFA should consider both PRO and non-PRO business of all prospective PRO contractors when evaluating offerors' estimated costs for future PRO contracts.	The HCFA commented that due to the firm fixed-price nature of the contracts, there is no basis for adjusting the contract price based on the PRO's cost experiences.
Uniform Application Form for Obtaining Medicare Provider Numbers: The HCFA should require carriers to obtain comprehensive information on a provider, collected by a uniform application form, before issuing a Medicare provider number. The forms should be certified by the provider, over a penalty clause, and the number issued should be a unique identifier. A national data base of providers should be established, which carriers must query before issuing a number. (HQ #88-001)	The HCFA is establishing a national registry to assign a unique physician identification number, but feels the information OIG recommended be collected was too voluminous and would place too heavy a burden on HCFA and the carriers.
Death Record Search and Verification of Birth Certificates of Applicants for Original SSNs at Age 18 or Over: The SSA should require a death record search and additional documentation which pre-dates recently obtained birth records. Before processing applications for original applications for Social Security numbers for applicants age 18 and over, SSA should conduct a death record search and require additional documentation which pre-dates recently obtained birth records. (MIR #87-077)	The SSA issued a program circular instructing field offices to conduct face-to-face interviews with applicants, verify birth or baptismal records issued within the past year and initiate death record searches for questionable authenticity.
National Youth Drug Education Programs: The Department of Education and ADAMHA should develop evaluations of the implementation and effectiveness of the youth drug education program and assure effective dissemination of available research findings, clearinghouse information, and other networking activities. (OAI-02-88-00080)	The ADAMHA is working with the Department of Education to implement our recommendations.

OIG RECOMMENDATION	STATUS
Home Health Aides: The HCFA should require State survey agencies to take a series of actions to insure that all necessary tasks are performed by home health aides, because substantial deficiencies exist in the orientation of aides to patient needs. (OAI-02-86-00010)	The HCFA agreed to revise the Medicare conditions of participation to include a home health aide training requirement.
Nursing Home Assessment: The HCFA should assign high priority in developing a release of information on nursing homes that contains easily accessible and objective information on the subject. (OAI-12-88-01240)	The HCFA is proceeding with the publication and is dedicated to providing valuable information on the subject.

ACRONYMS

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
AFDC	Aid to Families with Dependent Children
ASMB	Assistant Secretary for Management and Budget
CABG	coronary artery bypass graft
CBO	Congressional Budget Office
CE	consultative exam
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMP	civil monetary penalty
COBRA	Consolidated Omnibus Budget Reconciliation Act
CSE	Child Support Enforcement
DDS	disability determination service
DME	durable medical equipment
DRG	diagnosis related group
DS	disproportionate share
EA	emergency assistance
EP	essential person
ER	emergency room
ESRD	end stage renal disease
EVS	Enumeration Verification System
FDA	Food and Drug Administration
FFP	Federal financial participation
FICA	Federal Insurance Contributions Act
FMFIA	Federal Managers' Financial Integrity Act
FSA	Family Support Administration
FY	fiscal year
GAO	General Accounting Office
HDS	Human Development Services
HEAL	Health Education Assistance Loan
HHA	home health agency
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IME	indirect medical education
IRS	Internal Revenue Service
LIHEA	Low Income Home Energy Assistance
MBR	master beneficiary record
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
MMPPPA	Medicare and Medicaid Patient and Program Protection Act
MSP	Medicare secondary payer
NIH	National Institutes of Health
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
OS	Office of the Secretary
PCIE	President's Council on Integrity and Efficiency
PFCRA	Program Fraud Civil Remedies Act
PPS	prospective payment system
PRO	peer review organization
RRC	rural referral center
RSDI	Retirement, Survivors, and Disability Insurance
SFU	standard filing unit
SMI	Supplemental Medical Insurance
SSI	Supplemental Security Income
SSN	Social Security number
TEFRA	Tax Equity and Fiscal Reform Act

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