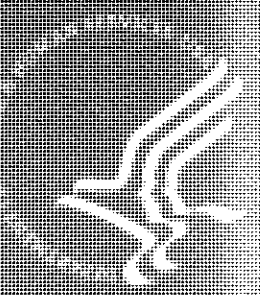


Semiannual Report

Office of Inspector General

October 1, 2021 – M

June Gibbs B
Inspector Ge

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 98-502	Single Audit Act of 1984
P.L. 99-499	Superfund Amendments and Reauthorization Act of 1986
P.L. 100-504	Inspector General Act Amendments of 1988
P.L. 101-121	Governmentwide Restrictions on Lobbying
P.L. 101-576	Chief Financial Officers Act of 1990
P.L. 102-486	Energy Policy Act of 1992
P.L. 103-355	Federal Acquisition Streamlining Act of 1994
P.L. 103-356	Government Management Reform Act of 1994

Office of Management and Budget Circulars:

A- 21	Cost Principles for Educational Institutions
A- 25	User Charges
A- 50	Audit Follow-up
A- 70	Policies and Guidelines for Federal Credit Programs
A- 73	Audit of Federal Operations and Programs
A- 76	Performance of Commercial Activities
A- 87	Cost Principles for State and Local Governments
A- 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-123	Internal Controls
A-127	Financial Management Systems
A-128	Audits of State and Local Governments
A-129	Managing Federal Credit Programs
A-133	Audits of Institutions of Higher Education and Other Nonprofit Institutions

General Accounting Office "Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

Title 26, United States Code, section 7213

Title 42, United States Code, sections 261, 263a(l), 274e, 290dd-3, 300w-8, 300x-8, 406, 408, 707, 1320a-7b, 1320b-10 and 1383(d), the Social Security and Public Health Service Acts

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

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

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

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

A MESSAGE FROM THE SECRETARY

In 1995, we have marked the mid-point in this Administration's efforts to give the American public a Government that works better and costs less. We must not only ensure that the Department of Health and Human Services' (HHS) programs provide quality service to the public, but that they give the American people a greater return on their investment. Even with the improvements and savings we have made or plan to make through streamlining and consolidations, we must ensure that the taxpayers' dollars are not lost to fraud, waste, and abuse.

The Office of Inspector General (OIG) has proven to be one of our soundest investments, returning $80 for every budget dollar invested in it. Last year, OIG's work resulted in $8 billion in savings, fines, penalties and recoveries — the largest amount in HHS history.

Building on that outstanding record, we will step up our attack against fraud, waste, and abuse. We are doing this with the help of a new, innovative demonstration program. The OIG and its partners in the Department's Health Care Financing Administration and Administration on Aging, as well as the Department of Justice and State Medicaid agencies and Fraud Control Units, are using a multidisciplinary approach to fighting health care fraud through coordinated and targeted investigations, audits, evaluations and sanctions. This project should also demonstrate the benefits of providing stable and reliable resources for these efforts through recoveries and penalties collected from those who defraud or abuse HHS programs.

I am confident that our efforts will prove exceptionally successful, and commend the Inspector General and her staff for their commitment to new and innovative ways to protect the taxpayers' dollars and the vital services on which they rely.

Donna E. Shalala

FOREWORD

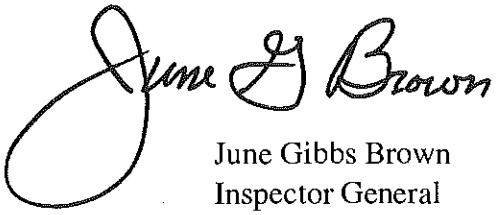
I am pleased to present this semiannual report of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) describing our accomplishments during the 6-month period ending March 31, 1995.

In the first half of Fiscal Year (FY) 1995, we have been part of several pivotal changes. As of March 31, 1995, the Social Security Administration (SSA) became an independent agency with its own OIG formed of staff from the HHS OIG. In the next reporting period, SSA OIG will report its own accomplishments. Under the provisions of the Social Security Independence and Program Improvements Act of 1994, and at the request of Commissioner Shirley Chater, (while continuing as HHS Inspector General) I will serve as interim Inspector General of SSA until an Inspector General is nominated and confirmed. It is a pleasure to work with Commissioner Chater and her excellent staff, and I commend all of the outstanding accomplishments by both HHS and SSA staff in the transition to an independent SSA.

Within HHS OIG, we are continuing to streamline our operations while maintaining our vigorous pursuit of fraud, waste and abuse. As examples of our streamlining efforts, we completed early-out and buyout programs targeted at reducing management positions (Senior Executive Service through General Schedule-13) and closed 17 out of 65 field offices. The OIG also reduced administrative costs by increasing teleconferencing to conduct audit conferences and report reviews, making more efficient use of other electronic communications, pursuing more cost-effective in-house training and redesigning basic work processes.

Under Secretary Shalala's leadership, we have launched a major program integrity project, "Operation Restore Trust," with the Health Care Financing Administration, Administration on Aging, Department of Justice, State Medicaid Fraud Control Units and others working against health care fraud. Its purpose is to model an approach for attacking health care fraud through focused intergovernmental teams. We will target our initial partnership efforts to investigations, audits, evaluations and administrative sanctions in home health agencies and nursing homes, two industries we have identified as particularly vulnerable to fraud and abuse. The ultimate objective is to protect the integrity, quality and access of our health care programs.

These innovations and cost-cutting efforts underscore OIG's record as a good investment, returning $80 in savings for each dollar invested in it in FY 1994 or an average of $6.4 million per OIG employee. With the support of the Department and the Congress, we will continue to fulfill our mission and strengthen the Department's ability to serve the public.



June Gibbs Brown
Inspector General

HIGHLIGHTS

In this first half of Fiscal Year 1995, the Office of Inspector General (OIG) has undertaken several major initiatives to protect the integrity of departmental operations and programs and the health and well-being of the beneficiaries served by those programs. Some of OIG's most significant accomplishments during this period are identified below.

The OIG and the Health Care Financing Administration (HCFA) initiated a project to develop an innovative, multidiscipline Federal and State approach to preventing and detecting fraud in home health agencies and nursing homes in five States. (See page 23)

Other initiatives include:

Reducing Unnecessary Spending:

- Joint work by OIG and HCFA is resulting in annual savings of $8 million and recovery of $219 million in overpayments caused by transfers between prospective payment system hospitals that were erroneously reported and paid as discharges. (See page 5)

- The OIG found that, in 1992, $10.8 million in improper payments were made on behalf of Medicare beneficiaries in nursing homes for durable medical equipment. (See page 21)

- Based on its finding that Federal employees and retirees owe the Social Security Administration (SSA) $15.2 million, OIG recommended that SSA submit a legislative proposal to implement Federal salary offset for overpayments. (See page 28)

Preventing and Detecting Fraud and Abuse:

- New York State agreed to pay almost $27 million to settle charges of false claims to the Federal Government. (See page 65)

- A Michigan carrier agreed to pay $27.6 million to settle a qui tam suit initiated by a former employee and $24 million to settle charges of violating Medicare secondary payer laws. (See page 16)

- The OIG found that over 75 percent of the reimbursement claims filed by a home health agency were inappropriate, resulting in an overpayment of $25.9 million. (See page 6)

- The OIG found that questionable billing practices may account for nearly half of the Medicare allowances for incontinence supplies in 1993. (See page 20)

- A woman who owned two vascular testing clinics and a durable medical equipment company in Florida and three of her employees were given lengthy jail sentences and ordered to repay more than $2.2 million for paying individuals to submit to tests and falsely billing Medicare and Medicaid. (See page 8)

- A Massachusetts carrier paid $2.75 million in settlement for submitting false Medicare reports for a number of New England States. (See page 16)

- A Texas man and his wife were sentenced to prison for 48 and 30 months, respectively, for a scheme in which he faked his own death so she could collect insurance and Social Security survivors benefits. (See page 31)

- An administrative law judge determined that a California oncologist should be permanently excluded from participation in the Medicare and State health care programs. (See page 15)

- An Alaska physician was excluded for 15 years for sexual assaults he committed during physical examinations of his patients. (See page 14)

Identifying Systemic Management Problems:

- The OIG presented five alternative options to improve the system for reimbursement of administrative costs in the Medicaid, Aid to Families with Dependent Children and Food Stamp programs, some of which could save hundreds of millions of dollars. (See page 54)

- Audits by OIG in five States identified numerous instances where child care facilities did not comply with States' health and safety standards. The OIG recommended that the Administration for Children and Families (ACF) provide States' identified "best practices" to improve health and safety conditions in the Nation's child care programs. (See page 52)

- After OIG found that 75 percent of all hospitals in the United States had never reported an adverse action taken against practitioners, the Public Health Service (PHS) and HCFA agreed to work together to encourage the Joint Commission on Accreditation of Healthcare Organizations to devote

greater attention to hospital compliance with the National Practitioner Data Bank law. (See page 47)

- As an upfront control over the quality of contract bids, OIG recommended that HCFA include, in its requests for bids from peer review organizations, OIG's recently issued Proposal Guidance Book that instructs bidders on the documentation needed to support proposed costs. (See page 7)

Promoting Improved Service Delivery:

- In an inspection on oxygen concentrator services, OIG found that Medicare policies have contributed to a wide variation in these services provided to beneficiaries, and that many of the services provided were not endorsed by national organizations. (See page 20)

- The OIG determined that the use of competitive contracts or negotiated agreements to purchase consultative examinations could result in considerable savings for SSA, and improve the timeliness and quality of these examinations. (See page 36)

- In response to a PHS request, OIG determined that the Office of Research Integrity (ORI) is properly staffed and identified opportunities for ORI to improve its operations by making better use of existing staff. (See page 46)

- The OIG found that the Administration on Aging and ACF could take advantage of the benefits of intergenerational activities by encouraging the voluntary colocation of programs, such as Head Start and senior centers. (See page 58)

Developing and Assessing Performance Measures:

- Upon finding that there was considerable confusion as to congressional intent regarding the Supplemental Security Income (SSI) disability program for children, particularly those with mental impairments, OIG recommended revisiting the purpose of these payments and the method of determining eligibility for them. (See page 36)

- The OIG found that PHS's numerous evaluations of its programs performed each year provide useful information but do not necessarily measure program results. Current PHS systems, with some reorganization and redirection, could better produce information to measure performance. (See page 48)

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

During this reporting period, the following items have been labeled as performance measures:

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Chapter II SOCIAL SECURITY ADMINISTRATION

Chapter V GENERAL OVERSIGHT

Health Care Financing Administration

Chapter I

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare and Medicaid programs. Medicare Part A provides hospital and other institutional insurance for persons age 65 or older and for certain disabled persons. Financed by the Federal Hospital Insurance (HI) Trust Fund, Fiscal Year (FY) 1995 expenditures for Medicare Part A are expected to exceed $110 billion. Medicare Part B (Supplementary Medical Insurance, or SMI) is an optional program which covers most of the costs of medically necessary physician and other services. Financed by participants and general revenues, FY 1995 expenditures for Medicare Part B are estimated at $64 billion.

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

The Office of Inspector General (OIG) has devoted significant resources to monitoring and investigating the Medicare and Medicaid programs. These activities have helped ensure the cost-effective delivery of health care, improved the quality of health care and reduced the potential for fraud, waste and abuse.

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

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

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

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

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 the first half of the fiscal year, OIG was responsible for a total of 905 successful actions against wrongdoers in these programs.

Internal Control Structure and Compliance with Laws and Regulations: Fiscal Year 1993

The HCFA is responsible for the adequacy of the internal control structure at the 81 Medicare contractors who pay claims to beneficiaries and are responsible for the related recording and reporting of accounting transactions. In a review conducted in accordance with the CFO Act, OIG identified significant areas of weakness in the internal control structure and compliance with applicable laws and regulations at HCFA and/or its Medicare contractors. As a result of these weaknesses, OIG was unable to express an opinion on HCFA's FY 1993 and FY 1994 financial statements.

Although OIG noted improvements throughout the year at contractor operations, it continued to find significant problems with contractor recording and reporting of accounts receivable and accounts payable. The HCFA has reported Medicare contractor accounts receivable as a material weakness since 1993. The OIG recommended that HCFA take action to ensure that Medicare contractors: establish an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable and accounts payable information; improve reporting controls to ensure that accounts receivable and accounts payable amounts are accurately summarized and appropriately valued; develop control procedures to provide independent checks by management on the validity, accuracy and completeness of the amounts reported to HCFA; and strengthen

existing internal controls related to the segregation of duties. Further, OIG proposed that HCFA improve its methodology for estimating the amount of the allowance for uncollectible accounts receivable to comply with generally accepted accounting principles. (CIN: A-14-93-03027)

Medicare Secondary Payer: Blue Cross Blue Shield of Michigan

The OIG has estimated that the Medicare program may be paying out as much as $1 billion a year unnecessarily because Medicare fiscal intermediaries (FIs) and carriers do not always identify the primary payers, and because insurers, underwriters and third party administrators often do not pay as primary payers when they are required to do so. This problem, which was first identified as a high risk area in 1989, has been addressed through several initiatives, including proposals for legislative remedies and legal actions against noncomplying insurers.

While extensive efforts have been made to correct this complex problem, HCFA, the Department and the Office of Management and Budget have determined that it would be inadvisable to close this material weakness/high risk area prior to the establishment of more effective systems for preventing inappropriate primary payments by Medicare, managing the backlog of recoveries and strengthening HCFA's accounts receivable system.

During this reporting period, OIG issued a report on Blue Cross Blue Shield of Michigan's (BCBSM's) compliance with the Medicare secondary payer (MSP) provisions of the Social Security Act. The audit was conducted to determine the amount of the overpayment made to BCBSM by the Medicare program based on BCBSM's failure to comply with the MSP requirements. The Department of Justice had initiated legal action against BCBSM in 1989 and the Government's claims were recently settled for $24 million (see page 16). (CIN: A-05-93-00061)

Medicare Administrative Costs: King County Medical Blue Shield

The HCFA contracts with private insurance companies (FIs and carriers) to process and pay Medicare claims. The OIG reviews the allowability of costs claimed for reimbursement by these contractors.

During this reporting period, OIG reviewed about $64 million in Medicare Part B administrative costs claimed by King County Medical Blue Shield for FYs 1991 through 1993. The OIG recommended that the contractor adjust its final administrative cost proposal for this period by approximately $600,000 to eliminate unallowable and unallocable costs charged to the Medicare program. The contractor concurred with substantially all of the findings. The HCFA has not made a final management decision on the recommendations. (CIN: A-10-95-00001)

Fringe Benefit Costs: Former Humana Hospital San Antonio

At the request of the House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, OIG performed a follow-up review at Humana Hospital San Antonio (HHSA). The OIG report includes the results of reviews by the FIs having responsibility for the approximately 80 former Humana hospitals regarding their employee health care fringe benefits (FBs).

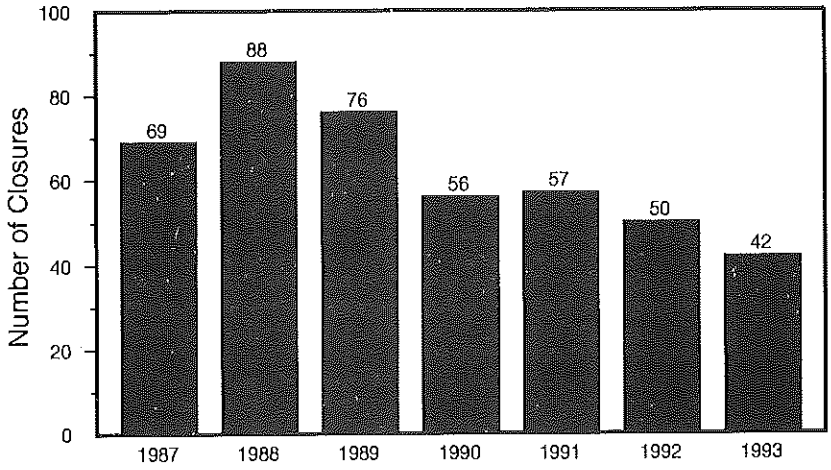
The OIG found that Humana corporate headquarters had improperly reported to the Medicare program a portion of its employee health care FB costs at HHSA for the fiscal year ended August 31, 1990. Further, Humana had incorrectly reported these costs for all of its hospitals for the 3 fiscal years ended August 31, 1990. The OIG brought this matter to the attention of Humana's Medicare FI, which subsequently identified other types of errors affecting the bases used to allocate allowable costs to Medicare. The net effect of these adjustments on Medicare reimbursement to Humana hospitals will not be known until each of the individual hospitals' and the corporate headquarters' Medicare cost reports are revised.

The OIG recommended that HCFA monitor the resolution of these adjustments by the FIs and ensure that appropriate cost recoveries are made for the employee health care FB costs improperly claimed by the former Humana hospitals. Further, OIG recommended that HCFA reemphasize the need for all of its FIs to carefully review whether hospitals or hospital chains are properly reporting their employee health care FB costs in situations where the services are directly rendered by the provider or a related organization. In its response to the draft report, HCFA agreed with OIG's findings and recommendations. (CIN: A-06-93-00094)

Hospital Closure: 1993

The OIG previously released six reports describing the nationwide phenomenon of hospital closure in years 1987 through 1992. The OIG found that the extent, characteristics and impact of hospital closings in 1993 were similar to those identified for hospitals that closed in the previous 6 years. Forty-two hospitals closed in 1993, continuing a downward trend in the annual number of closures.

HOSPITAL CLOSURE



Most were small and had low occupancy rates, and few patients were affected by the closings. Although residents of a few communities had to travel greater distances for hospital care, all but eight communities had emergency and inpatient medical care available within 20 miles of a closed hospital. (OEI-04-94-00120)

Medicare Patient Transfers

This report is the result of OIG's review of transfer recovery projects undertaken jointly by OIG, HCFA and Medicare FIs. The projects identified overpayments that occurred because transfers of patients between PPS hospitals were erroneously reported and paid as discharges. In total, these projects resulted in Medicare Part A trust fund recoveries totaling $219 million and annual savings totaling $8 million. In addition, it is estimated that $22 million will be recovered by FIs from transfer transactions that warrant further resolution.

The HCFA concurred with OIG's recommendations that it place a high priority on recovering the remaining overpayments, including those over 4 years old, and that it inform OIG of the final resolution of the remaining unresolved cases. (CIN: A-06-93-00095)

End Stage Renal Disease Payments to Health Maintenance Organization

The OIG assessed the appropriateness of the payments made to the health maintenance organization (HMO) Humana Medical Plan in Florida for Medicare beneficiaries classified as end stage renal disease (ESRD) status. In addition to a regular monthly capitation payment, HMOs receive a monthly payment for beneficiaries classified as ESRD status. From a total of 212 beneficiaries classified as ESRD status enrolled with Humana in September 1992, OIG identified 25 who were inappropriately classified. As a result,

Humana received overpayments of more than $1.6 million between October 1, 1990 and December 31, 1993.

The OIG recommended that Humana: monitor the monthly HCFA special status beneficiary report and notify HCFA of beneficiary status changes where appropriate; refund the $1.6 million in overpayments; identify and refund overpayments received on behalf of the 25 beneficiaries since December 1993; and identify and refund overpayments received for all other beneficiaries inappropriately classified as ESRD since OIG's sample period of September 1992. Humana concurred with the recommendations and presented a plan of action to implement them. (CIN: A-04-94-01096)

Ambulatory Surgical Services in Hospital Outpatient Departments: Procedure Coding Differences

When a beneficiary undergoes ambulatory surgery, one would expect both the hospital outpatient department (OPD) and the physician to bill for the same procedure. Yet, in Region I, OIG identified a 23 percent rate of inconsistency between the OPD procedure code and the physician procedure code for the same ambulatory surgery. Additional analysis showed a similar rate of inconsistency nationwide.

The procedure coding differences have an immediate and future effect on the Medicare program: a significant number of incorrect payments are made to both OPDs and/or physicians; beneficiaries are making incorrect payment of their 20 percent coinsurance; and data which HCFA may utilize in developing future reimbursement rates are inaccurate.

The OIG recommended that HCFA consider three measures to address procedure coding differences: until the Medicare Transaction System (MTS) is phased in, foster coordination and communication between providers so that procedure coding differences are identified prior to submission of claims; require the peer review organizations (PROs) to review the entire episode of care for pattern analyses; and design an edit for the MTS to identify procedure coding differences between OPD and physician claims, and to generate a notice to OPDs and physicians informing them that procedure coding differences have been identified. In response to the draft report, HCFA agreed with the first and third recommendations. However, HCFA nonconcurred with the second, suggesting that screening of unified claims files with intermediary or carrier medical review should be substituted for PRO review. (CIN: A-01-94-00507)

Costs Claimed by St. Johns Home Health Agency

The OIG determined that more than 75 percent of St. Johns' reimbursement claims for providing home health services for the fiscal year ending June 30, 1993 were inappropriate because: 21.5 percent were for home health visits not made; 29 percent were for visits made to individuals who were not homebound; 23.5 percent were for visits which physicians

denied authorizing; and 1.5 percent were for visits which the beneficiary did not want or were not adequately documented.

Of the $45.4 million claimed by St. Johns for FY 1993, OIG estimated that $25.9 million was for improper claims. While recognizing that St. Johns is currently in bankruptcy proceedings, OIG recommended that HCFA, to the extent possible, recover overpayments as part of those proceedings. The HCFA concurred with the recommendation. (CIN: A-04-94-02078)

Controls over Electronic Billing at Selected Medicare Contractors

The OIG reviewed the operations of three intermediaries and two carriers in Region V to identify strengths and weaknesses in internal controls over provider billings made via electronic media claims (EMCs) and Medicare payments made via electronic fund transfers (EFTs). The purpose of this analysis was to better understand what control practices and procedures may be needed for MTS, the new Medicare claims processing system currently in the design phase.

Generally, OIG found that the contractors' internal controls over EMC and EFT transactions were adequate. Many of the existing controls were noteworthy and should be considered for inclusion in MTS. However, OIG recommended that HCFA establish requirements that would provide for uniform and consistent internal controls applicable to EMC and EFT processing. Further, OIG proposed that HCFA consider actions to strengthen other control and safeguard measures, and to increase the use of EFT. The OIG plans a follow-up review to address concerns raised by HCFA regarding areas particularly vulnerable to fraud and abuse. In response to the draft report, HCFA agreed with all recommendations. (CIN: A-05-93-00056)

Use of Bid Proposal Audits of Peer Review Organizations

In a prior report on 12 audits of PRO bid proposals (CIN: A-14-91-00343), OIG noted that $43.7 million of the $196 million in proposed costs were unsupported. The OIG also found that HCFA had no systematic method of informing PROs of OIG findings nor a follow-up mechanism to ensure that PROs corrected the procedural deficiencies which OIG identified.

In a follow-up audit, OIG found that HCFA had inserted the appropriate language in the requests for proposal (RFPs) alerting PROs to OIG's findings, but that it did not take steps required to monitor PROs' corrective action. Further, the results of 49 bid proposal audits completed subsequent to the earlier audit showed that PROs continued to include unsupported costs in their bid proposals, and at an even higher rate than previously reported.

The OIG developed a "Proposal Guidance Book" to clarify the documentation needed to support proposed costs. Because of its success in using the book during nine recent bid

proposal audits, OIG is offering it to all PROs. The OIG believes that it could be most useful as an up-front control over the quality of PRO bid proposals, and has recommended that HCFA incorporate its use in the RFP process. Also, OIG recommended that HCFA develop a systematic approach for monitoring PROs' corrective actions on internal control deficiencies. The HCFA agreed with OIG's recommendations, and will include the Proposal Guidance Book in future RFPs. Of note is that the benefit of OIG's proposal guidance approach was recognized with the Secretary's Continuous Improvement Program Award. (CIN: A-03-93-03001)

Criminal Fraud

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

- As the result of a joint undercover investigation by OIG and the Federal Bureau of Investigation, five persons involved in a Medicare and Medicaid fraud scheme were given jail sentences. Four, including the owner of two vascular testing clinics and a DME company as well as three of her employees, were ordered to make restitution totaling more than $2 million to Medicare and $243,500 to Medicaid. They also received jail sentences ranging from 21 to 51 months. The four had paid individuals to submit to an extensive battery of diagnostic tests which were placed in Medicare and Medicaid patient files and for which they filed for more than $4 million in claims. They also paid a carrier contract employee to pass on to them carrier records. The contract employee was sentenced to 12 months in jail.

- A State-owned hospital in Iowa agreed to repay Medicare $521,170 for overbilling for services. During a separate anesthesiology investigation, an allegation was made that the hospital was billing for ventilation management although this service should have been included in the global fee. Investigation showed that the hospital was billing for ventilation management for all intensive care patients, regardless of whether they received this service. The hospital claimed to have understood from the carrier's medical director that it could bill for Medicare and private insurers in the same fashion.

- In California, a superior court judge turned down a proposal that a convicted ophthalmologist be permitted to spend a year performing eye surgery in an impoverished country, and ordered him to begin serving his 16-month prison sentence. In December 1991, the ophthalmologist was convicted in State court on 36 counts of grand theft for billing Medicare for services he did not perform. His scheme involved intentionally causing astigmatism by

sewing a stitch too tightly in patients undergoing cataract surgery. When the patients returned complaining of vision problems, he cut the stitch and normal vision returned. The stitch-cutting was billed to Medicare as a $2,000 corneal transplant. During a 4-year period, he billed Medicare more than $1.3 million for over 680 eye operations. Free on bond during an appeal, he lost his appeal earlier this year. In a rare prison sentencing of a physician in State court for Medicare fraud, he also was fined $350,000, assessed a penalty of $280,000 and ordered to pay $56,000 in restitution.

- The former owner of an Oklahoma ambulance company was sentenced to a year and a day in Federal prison and 2 years supervised probation for Medicare and Medicaid fraud. Over a 2-year period, the woman and her husband defrauded the programs of $370,000 in false billings. They submitted bills for ambulance trips for dialysis patients that they claimed were not ambulatory, but surveillance cameras caught several of the patients walking to and from the ambulances with little or no assistance. Because of the couple's financial condition, the woman was ordered to pay restitution of only $926 and a special assessment of $250. Her husband pled guilty earlier and was sentenced to 3 years probation and ordered to pay $113 in court costs. The ambulance company has gone out of business.

- In Texas, a laboratory owner was sentenced to 3 months in prison, followed by 90 days in home confinement and 3 years supervised probation for fraudulent Medicare billing. The man operated a mobile clinic which offered free screenings for senior citizens. He or one of his employees would obtain their Medicare numbers and bill the program for unnecessary tests or tests not performed. He was ordered to pay restitution of $265,110 and a special assessment of $50.

- An Ohio dentist was sentenced to 1 1/2 years confinement, to be served consecutively, on 15 counts of selling controlled drugs to patients. He was fined $2,500 on each count, for a total fine of $37,500. The confinement period was suspended to time served and he was put on indefinite probation not to exceed 5 years. This case was developed from Project Pharm-Div, a joint OIG and Cincinnati police department undercover operation. The project is aimed at identifying and prosecuting individuals involved in the abuse of pharmaceutical drugs, fraud against Medicare and Medicaid, and various frauds involving the misuse of Social Security numbers. To date 16 individuals and entities have been prosecuted in Federal or State courts as a result of the project.

- In Ohio, a physician was sentenced on the basis of a negotiated plea whereby he had agreed to cooperate with the Government in exchange for dismissal of charges under pretrial diversions for his sister/employee, and for his corporation. During a 4-year period, he billed Medicare more than $1.5 million and was paid $560,000, over 60 percent of which was for laboratory services supposedly performed in-house. A carrier utilization review showed he billed as much as 600 percent more than his peers in some areas. He was accused of billing Medicare, the Civilian Health Medical Program of the Uniformed Services, and private insurers for laboratory services not performed or not medically necessary, double billing and money laundering. His sister had been charged with offering a witness a bribe for refusing to cooperate with an OIG agent. He was sentenced to 1 year of confinement, 3 months to be served in prison, 3 months in a halfway house and 6 months in monitored home confinement, after which he will serve 3 years probation. He was ordered to make restitution of $37,000. The sentence was reduced because of his substantial assistance to the Government. Negotiations are continuing toward a settlement of pending civil damages.

- In Michigan, a pharmacy and its former office manager were sentenced for Medicare and Medicaid fraud. The pharmacy was ordered to make restitution of $22,700, while the office manager had to pay $25,000 plus $500 in court costs. He was also sentenced to 1 year in prison. They had billed for urinary incontinence and decubitus ulcer kits which were neither related to the patients' conditions nor medically necessary. They also billed for greater quantities than delivered. The office manager was suspended from program participation in 1988 for 5 years because of a racketeering charge involving illegal drugs, and he was office manager of the pharmacy while under suspension. He has since set up several new businesses in Florida.

- The owner/operator of a retail optical store in New York was sentenced for submitting false Medicare claims. From January 1989 until June 1993 Medicare paid him $237,000, of which $180,000 was overpayment. He billed for eyeglasses not provided or misrepresented services to receive payment when none would have been allowed. He also discussed kickback arrangements with another optical dealer. When confronted by agents, he made a complete written statement admitting his fraudulent activities. He was sentenced to 6 months probation and ordered to repay $24,000. A civil prosecution is underway for the remainder of the fraudulent amount.

- In Virginia, the twelfth and final person was sentenced in a scheme in which Traveler's Insurance employees issued Medicare checks to friends who forged and cashed them. The woman was sentenced to 4 months home confinement and 3 years probation. She was ordered to pay a $2,000 fine, a $150 special assessment and restitution of $11,101 for the two Medicare checks she cashed. Those previously sentenced in the case included two Traveler's employees, a top manager of an international beverage company, a former deputy sheriff and the chief buyer for a drugstore chain. The embezzlement involved 56 Medicare checks totaling $250,000.

- A Wyoming woman was sentenced after pleading guilty to making false statements to Medicaid. As office manager for an optical store, the woman altered patient records and physicians' prescriptions to charge Medicaid for tinted, ultraviolet and scratch-resistant lenses that were not medically necessary. She also failed to honor the company's warranty policy, charging Medicaid for replacement glasses when something went wrong with a pair of eyeglasses. She was sentenced to 18 months probation and 180 hours of community service, with a fine of $50. The optical company repaid $27,900 to Medicaid rather than risk civil action.

- In Indiana, a registered nurse was sentenced to 10 months home detention, 4 years probation and 192 hours of community service, and ordered to pay $10,000 in restitution for submitting false reports of skilled nursing visits to the home health agency for which she worked. The result was that the agency submitted the reports to Medicare, which then overreimbursed about $100,000. Noting that the nurse had been convicted in 1975 of mail fraud and in 1993 of theft from patients' homes, the judge ordered her not to be involved in any home-bound nursing care.

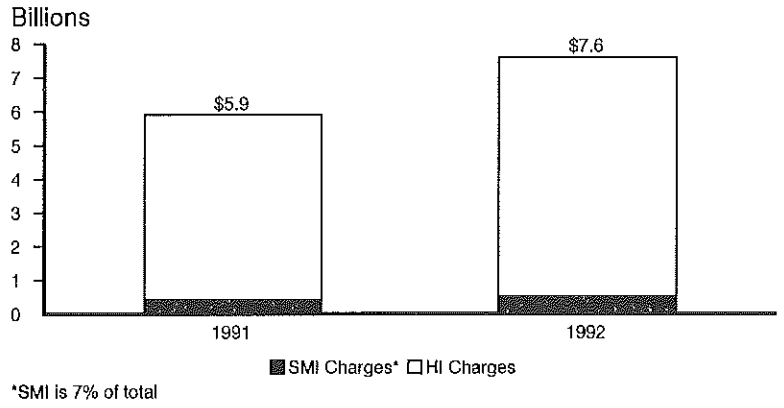
- A New York physician was sentenced to a total of 84 months imprisonment and fined $25,000, to be paid immediately along with a $50 assessment for each of 5 counts of mail fraud, 1 count of arson and 2 counts of witness tampering. The OIG was originally requested by the Bureau of Alcohol, Tobacco and Firearms to disprove the physician's alibi for his whereabouts during a burglary several days before his office was burned, as well as find out where he had fled. During the investigation, OIG found the physician in West Virginia, disproved his alibi, and found evidence of 48 instances in which he submitted duplicate bills to two Medicare carriers as well. Although he was not indicted on Medicare charges, the judge used the information in determining his sentence.

Medicare Services Provided to Residents of Skilled Nursing Facilities

Performance Measure

While Medicare does not cover expenditures for traditional long-term nursing home care, it does provide extended care to qualified beneficiaries in participating skilled nursing facilities (SNFs) under the HI program. In addition, residents may receive services covered under the SMI program, such as physician care and outpatient services. In a study of SMI services provided to Medicare beneficiaries receiving extended care benefits in SNFs, OIG found that charges in excess of $413 million and $517 million were made for these services in 1991 and 1992, respectively. As illustrated in the following chart, SMI represents a small but important part of the total cost of care for SNF residents.

SMI PORTION OF THE COST OF CARE FOR SNF RESIDENTS



Given Medicare's potential exposure to abusive practices, monitoring services provided under these benefits and addressing program vulnerabilities are important. The OIG concluded that further work is needed in at least the following areas: the State to State variation in extended care bed day costs for particular SMI services; the appropriateness of the millions of dollars in SMI payments made each year for services normally included in the extended care benefit and the resulting inequities in resident cost liability; the adequacy of residents' knowledge about the cost and frequency of services billed outside the nursing facilities' bills; the policies and practices of various State Medicaid programs as they contribute to program vulnerabilities in the Medicare extended care benefit; the monitoring of extended care utilization over time and review of services experiencing rapid growth without any known reason; and the lack of physician involvement in some SNF stays.

The HCFA agreed with OIG's conclusions and suggested that a statutory "rebundling" provision for SNFs (similar to that for hospitals) is needed. The OIG agreed that this is the direction to take. To assess the impact of rebundling, OIG is conducting a more exhaustive analysis of services included in the extended care benefit and also covered by the SMI program. (OEI-06-92-00863)

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 801 sanctions, in the form of exclusions or monetary penalties, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. About half of the exclusions were based on conviction of program-related crimes, conviction of controlled substance manufacture or distribution, conviction related to patient abuse or loss of license to practice health care. Monetary penalties can be assessed under several civil monetary penalty (CMP) authorities which have been delegated to OIG.

A. Program Exclusions

Title XI of the Social Security Act provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, controlled substance abuse, revocation or surrender of a health care license, or failure to repay health education assistance loans (HEALs). Exclusion is mandatory for those convicted of program-related crimes or crimes relating to patient abuse. A significant number of OIG exclusions involve failure to repay HEALs, as discussed in more detail in the chapter on the Public Health Service. During this reporting period, OIG imposed exclusions on 773 individuals and entities in all.

The OIG reviews all factors involved in a case to determine whether an exclusion is appropriate and, if so, the proper length of the exclusion. Factors reviewed include information solicited directly from the provider and information obtained from outside sources such as courts, licensing agencies, or other Federal or State programs. The following exclusions are examples of some imposed during this reporting period:

- A Utah physician and clinic owner was excluded from participation in the Medicare and all State health care programs for 25 years because of a 1993 conviction for filing false claims. He was convicted and excluded in 1987 for similar crime; nevertheless, he continued to submit claims under the names and provider numbers of physicians who worked at his clinic. In addition to his lengthy program exclusion, the State revoked his medical license indefinitely.

- After pleading guilty to two counts of sexual assault involving seven separate incidents of patient abuse committed over a 4-year period, an Alaska physician, who specialized in obstetrics/gynecology, was excluded for 15 years. The sexual assaults occurred while the patients were undergoing physical examinations. According to the court psychiatrist, the doctor then used his position as a church elder and respected community member to shift the blame from himself to his victims.

- A California gynecologist was excluded for an indefinite period because his license to practice medicine in the State of California had been revoked. The revocation was based on a finding that the physician committed acts of gross negligence; gross incompetence; gross immorality involving acts of dishonesty, moral turpitude and corruption; repeated negligent acts; unprofessional conduct involving sexual abuse, misconduct and relations with patients. These acts included surgical procedures performed without anesthesia in an office setting; unnecessary laser surgery; unnecessary hysterectomies; needless invasive tests; purposeful misdiagnoses; and the intentional infliction of mental anguish and physical pain.

- A Maryland ambulance company owner was excluded for 10 years. This action was taken after his conviction for submitting claims to the Medicaid program which misrepresented transportation services. The services were either not provided or provided to persons not eligible for medical assistance.

- A plea agreement entered into by a California prosthetist caused him to be excluded for 25 years. The prosthetist, who owned an orthopedic center, billed Medicare for bilateral contractures that were not supplied. The Medicare contractor developed information that the prosthetist had submitted almost $850,000 in claims to Medicare and Medi-Cal that were based on false representations. Of that amount, he was paid over $489,000. In addition to agreeing to repay the Government $400,000, paying $250,000 in restitution, and serving 27 months in prison, the 25-year exclusion will ensure that the prosthetist will be eligible for Medicare himself before he can participate as a health care provider in the Federal program again.

- A Michigan DME supplier was excluded for 20 years consecutive to completion of a 10-year exclusion imposed as a condition of a CMP agreement entered into in 1989. After he was excluded, he violated the terms of this exclusion by being involved in billing the Medicaid program. In addition to violating the terms of his exclusion, he was convicted of taking kickbacks involving the Medicaid program.

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

- In February 1992, a California oncologist was excluded for a period of 10 years based on a determination that he had rendered over 3,900 excessive, unnecessary and potentially risky services to seven Medicare beneficiaries over a relatively short time period. For more than 28 months, the DAB conducted an extensive review in this matter. The DAB's ALJ concluded that the doctor had shown an extreme disregard of his medical responsibilities and a "shockingly callous indifference to the well-being of the seven patients." The ALJ further found that the doctor had jeopardized the patients' health while depriving them of the opportunity to receive treatment that could have abated or cured their cancers. Further, the doctor had caused the patients unnecessary suffering by having them endure numerous, prolonged infusions of subtherapeutic dosages of chemotherapy with repeated blood tests and vitamin injections of marginal efficacy. In addition to the quality of care issues, the ALJ found that the doctor's record of unnecessary and excessive treatment, when combined with his refusal and inability to follow standard Medicare billing practices, demonstrated the doctor's eagerness to generate the maximum amount of Medicare billings and raised questions about whether services had been provided as claimed in the patient records. This decision marks the first time an ALJ has determined that a health care provider should be permanently excluded from participation in the Medicare and State health care programs.

B. Civil Penalties for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law allows recoupment of some of the monies lost through illegitimate claims, and it also protects health care providers by affording them due process rights similar to those available in the program exclusion process. Many providers elect to settle their cases prior to litigation. The Government, with the assistance of OIG, recouped approximately $101 million through both CMP and False Claims Act civil settlements and hearing decisions related to health care during this reporting period.

- A Michigan carrier agreed to pay $27.6 million to settle a qui tam suit initiated by a former employee. The carrier was responsible for auditing participating hospitals' cost reports to ensure accuracy. An investigation showed that the carrier performed inadequate, cursory audits in which it disregarded hundreds of dollars in overpayments. The carrier later gave HCFA fraudulent work papers in an attempt to show that complete and accurate audits had been performed. The precise amount of loss to the Government could not be determined because it would have required auditing more than 200 hospitals. As part of the settlement, the carrier agreed to repay the entire amount HCFA had paid to perform audits over the last 4 years (approximately $13 million).

  This same Michigan carrier also agreed to pay $24 million to settle charges of violating MSP laws. Under these laws, private insurers are required to act as primary benefits payer under certain circumstances when an individual has medical insurance under both Medicare and an employer health plan. An OIG audit determined that the carrier failed to pay claims of Medicare beneficiaries who had overlapping coverage with the carrier (see page 3). In its capacity as the Medicare contractor in Michigan, the carrier paid thousands of dual coverage claims from Medicare trust funds rather than from its own funds. The HCFA terminated the carrier's contract on September 30, 1994.

- A New York pharmaceutical corporation and three of its subsidiaries agreed to pay $3.4 million to settle Government allegations that they filed false Medicare claims. Acting on information acquired during another investigation, OIG found that the corporation's employees were forging doctors' signatures on certificates of medical necessity and beneficiaries' signatures on assignment forms for surgical dressings. Expansion of investigation to the three subsidiaries, all of which were operated by the same corporate officer, showed the same activities for incontinence, ostomy and urostomy supplies. The companies also violated point-of-sale regulations and billed for supplies never sent. Over a period of a year and a half they caused Medicare to lose more than $2 million. They have agreed to continue a recently implemented compliance program, and to cooperate in investigation of other participants. Criminal charges are pending against the corporate officer responsible for the companies' fraudulent activities.

- A Massachusetts carrier paid $2.75 million to settle a qui tam suit initiated by a former employee. The settlement was based upon submission of false Medicare reports for Massachusetts, Maine, New Hampshire and Vermont. The carrier misrepresented and inflated the number of claims and reviews it

processed in periodic reports submitted to HCFA. The carrier also received larger reimbursements from Medicare as a result of the false data submitted to HCFA. As part of the settlement agreement, the carrier agreed to hire more workers to detect and investigate allegations of fraud and abuse by Medicare providers. The carrier also agreed to cap the reimbursement it will seek from the Medicare program for the coming year.

- A Texas ophthalmologist signed an agreement to pay the Government $849,000 to resolve allegations of submitting false claims for reimbursement for physician and related medical services to the Medicare program. Many of the fraudulent claims submitted to Medicare were for services not actually provided, were for services not provided as claimed or were billed at an inflated rate. This was a global settlement which also involved a criminal plea based upon kickback allegations as well as the submission of false claims.

- In Pennsylvania, an ophthalmologist and his corporation agreed to a $652,125 settlement of charges that he had submitted false Medicare claims. The ophthalmologist billed for procedures not performed or not medically necessary, and for upgrading routine services that Medicare would not have compensated. He did not even have the equipment to perform one procedure for which he billed. As one of the terms of settlement, he agreed not to bill Medicare or any State health care program for 2 years.

- In Hawaii, an internist and her husband agreed to pay $150,000 in settlement of civil claims for defrauding the Medicare and Medicaid programs. Formerly the personal physician of ex-President Marcos of the Philippines, the internist pled guilty to mail fraud and to billing Medicare and Medicaid for hundreds of services that were not performed. The same series of services and ailments were reported with regularity for patients, including office examinations, blood tests, urinalysis, electrocardiograms and surgical hip injections. Her husband, who served as employee, officer, director and owner of her corporations, also participated in the schemes. The couple defrauded Medicare and Medicaid of at least $450,000.

- A Minnesota dentist signed an agreement to pay the Government $16,000 in cash, plus another $15,000 in community service (500 hours) at a clinic to settle charges of false Medicaid claims. In 1989, the dentist was indicted for diverting more than $18,000 in Medicaid and private insurance payments for her personal use while serving as tribal dentist for the Mille Lacs Band of Chippewa Indians. Although she was convicted by a jury in 1990, the judge entered a judgment of acquittal and dismissed the case. In March

1993, the Assistant United States Attorney filed a civil suit under the False Claims Act, which has finally been settled.

Kickbacks

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

Over the years, more than 700 convictions, judgments and settlements have been obtained as a result of OIG investigations of violations of the anti-kickback statute. The following cases are examples of some of those concluded during this reporting period:

- A home infusion company agreed to pay $500,000 to reimburse the Government for damages to Medicare and for the cost of investigation, to avoid action against it for certain business practices it used with physicians. At the same time, the Government filed suit and obtained a consent decree that permanently enjoins the company from engaging in improper financial arrangements with referring physicians. The company used several business arrangements to induce physician referrals, including offering restricted stock for physicians in infusion centers the company managed and otherwise tying their profits to referrals to the company.

- In Texas, the president of a DME company, one of his partners, the former company manager and the owner of a nursing home became the last of seven persons sentenced for Medicare fraud involving false billings and kickbacks. The president was sentenced to 33 months in prison and 3 years probation, while his partner was sentenced to 150 days home detention and 5 years probation. The manager was sentenced to 5 years probation and 180 days home detention. They had participated in a scheme in which the company billed Medicare for body jackets when it really provided seat pads. The seat pads were manufactured in Mexico for $50 each, but Medicare was billed $800. Over a 2-year period, the company billed Medicare more than $1.6 million, which the company officials were ordered by the court to repay. The nursing home owner accepted bribes from the owner of the DME company for permitting his company to supply ostomy and feeder supplies to a nursing home he and his wife owned. The DME company owner purchased $500,000 in life insurance policies for the couple in exchange for being allowed to supply the nursing home. The nursing home

owner was sentenced to 5 years probation and 120 days home confinement, fined $10,000 and ordered to pay a $50 assessment.

- A pharmaceutical company agreed to pay $450,000 in settlement of civil and administrative claims that it defrauded the Medicare program. The company created a "grant-in-aid" research program which offered physicians kickbacks in the form of grants in exchange for performing small-scale studies of its antibiotic. From 1986 to 1991, the physicians were paid fees of $500 to $2,500 to treat patients with the company's antibiotic. Investigation showed that in most cases the research performed by the physicians was not of scientific value. In addition, some physicians never completed the research but received full payment from the pharmaceutical company. The company instituted a corporate integrity program to ensure adherence to high ethical standards of business conduct.

- The administrator and the marketing representative of a Kansas psychiatric hospital were convicted and sentenced for paying an employee counselor with the Postal Service for patient referrals. The administrator was sentenced to 34 months in a Federal penitentiary, assessed $1,550 and fined $6,430. The marketing representative was imprisoned for 30 months, assessed $1,550 and fined $53,430. Over an 18-month period, they paid the employee counselor approximately $50,000 for referring Texas postal workers or their family members to the hospital. The hospital received more than $650,000 in Federal employee benefits payments while these patients were in treatment. The counselor was sentenced to 2 years probation because of his cooperation in the case. He was fined $2,500 and terminated from his 14-year employment with the Postal Service. The case was a spin-off of a nationwide investigation of the hospital's parent company, which earlier resulted in a $379 million CMP settlement.

- A West Virginia physician agreed to pay $1.25 million in penalties, restitution and investigative costs to resolve allegations of violations of the Federal anti-kickback statute and fraudulent billing of Medicare, Medicaid, the Railroad Retirement Board, and the Civilian Health and Medical Program of the Uniformed Services. The physician also paid half of a $230,000 settlement on behalf of another physician involved, agreed to a 10-year exclusion from all federally funded health care programs and promised to sell his medical practice within 90 days to a nonaffiliated third party. The physician had submitted a large number of false Medicare claims for unnecessary surgery, and had treated patients for glaucoma and cataracts when they did not have these conditions. The hospital with which he had a kickback arrangement signed a civil settlement earlier.

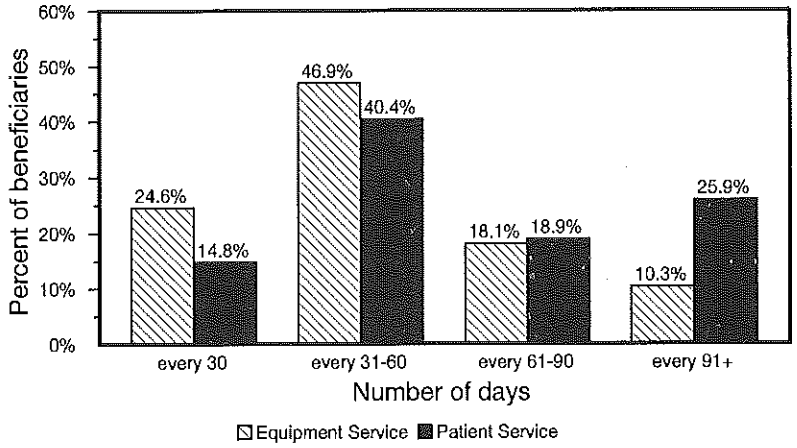
Oxygen Concentrator Services

Performance Measure

Designed primarily for home use, oxygen concentrators provide long-term, life-sustaining supplemental therapy for patients with inhibited pulmonary function. These patients typically require periodic services from oxygen suppliers, such as equipment monitoring and maintenance, emergency service, and patient instruction and assessment.

The OIG found that some beneficiaries receive extensive services, while others receive few services. Eight percent of the sampled beneficiaries did not receive any equipment services and nearly half received no patient services. Of the beneficiaries who received one or more services, the frequency of service varied widely, as illustrated in the following chart.

FREQUENCY OF SERVICE



The OIG determined that Medicare policies contribute to the variation in support services because they fail to delineate specific service requirements for suppliers. Moreover, beneficiaries may not be knowledgeable enough to select suppliers who provide appropriate ongoing services.

The OIG recommended that HCFA develop a strategy to ensure that Medicare beneficiaries receive necessary care and support in connection with their oxygen therapy. Included in the options OIG proposed were: educating providers and beneficiaries about the kinds of services available and recommended by national organizations; promoting industry standards to ensure better and more consistent supplier practices; and setting minimum service standards by requiring suppliers to meet accreditation, certification or licensing requirements. (OEI-03-91-01710)

Incontinence Supplies

In two related inspections, OIG examined the issue of payment for incontinence supplies. In one report, OIG noted that Medicare allowances for incontinence supplies more than

doubled in 3 years, despite a drop in the number of beneficiaries using these supplies. The OIG found that questionable billing practices may account for almost half of incontinence allowances in 1993. A policy change proposed by HCFA will probably address these practices by clarifying covered services and providing a mechanism to link incontinence accessory supplies to prosthetic devices.

In the second inspection, information obtained from nursing homes and beneficiaries led OIG to conclude that some suppliers engage in questionable marketing practices; beneficiaries may be receiving unnecessary or noncovered supplies; and some suppliers present nursing homes with false or misleading information about Medicare coverage for these items.

As a result of these studies, OIG plans to initiate an audit to determine if any overpayments are involved. Additionally, OIG will undertake a national investigation of questionable practices engaged in by specific suppliers of incontinence supplies. (OEI-03-94-00772; OEI-03-94-00770)

Durable Medical Equipment Billed during Nursing Facility Stays

Performance Measure

Federal law provides that DME may be billed to Part B of the Medicare program only if the equipment is provided in the beneficiary's residence. The law specifies that a SNF cannot be considered a residence. Claims for DME and other items covered under Medicare Part B are now processed by four regional carriers.

The OIG determined that approximately $8.9 million in 1991 and $10.8 million in 1992 were incorrectly allowed for DME billed during SNF stays. Ninety-nine percent of DME bills submitted by suppliers for patients in Part A SNF stays showed the location as "home" or "other". Most of the incorrect equipment billings during a SNF stay represented items prescribed for use prior to, or after, a skilled stay. Further, OIG found that approximately half the patients in its sample were not discharged to their homes, meaning that incorrect payments for equipment might have continued.

To minimize the opportunity for incorrect DME payments, OIG recommended that HCFA: improve the "place of service" coding system used by suppliers; ensure that the carriers instruct suppliers of their responsibility for determining the beneficiary location before billing for Part B equipment; and assess the effectiveness of the DME regional carriers' processes. (OEI-06-92-00860)

Fraud Involving Durable Medical Equipment Suppliers

The DME industry has consistently suffered from waves of fraudulent schemes in which Medicare or Medicaid is billed for equipment never delivered, higher-cost equipment than

that actually delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State from that billed in order to obtain higher reimbursement. Two years ago, HCFA published new regulations addressing reimbursement problems that have recurred over the years, especially those created by telemarketing and carrier shopping. It is hoped that consolidation of claims processing into four regional jurisdictions, as specified in the regulations, will resolve many of these problems. In the meantime, OIG continues to obtain settlements and convictions of unscrupulous suppliers for schemes perpetrated before the regulations were published, as shown in the following examples:

- An Illinois DME company and its president agreed to a $68,000 settlement of allegations of billing Medicare for supplies not provided, falsifying physicians' signatures on medical necessity forms, adding and whiting out information on the forms, and substituting equipment of a lesser type than that billed. A former employee had filed a qui tam action against the company. During the investigation, the company vice president who actually ran its operations fled to Iraq. The settlement included proceeds from the sale of the vice president's home and other assets, and an additional amount from the president, the DME company and a related company of which he was also president, for a total payment of $122,000.

- In New York, two of the three owners of a DME company were sentenced for Medicare fraud. One was sentenced to 3 years in prison with 30 months suspended on the condition that he serve 6 months consisting of 60 consecutive weekends. He was also ordered to comply with an agreement to repay $900,000 for false billings for transcutaneous electrical nerve stimulator units and kits. The second owner, who cooperated with the Government, was sentenced to 24 months probation and ordered to pay a $100 special assessment. He has already paid $500,000 to Medicare and $600,000 to the Internal Revenue Service. The third owner was sentenced to prison earlier. All three owners pled guilty to Medicare fraud and income tax evasion.

- In Georgia, the owner of a DME company was sentenced to 200 hours of community service and 5 years probation. The owner also was ordered to pay $5,444 in restitution for causing Medicaid to be billed for more expensive ostomy supplies than were provided, and for rebilling denied claims — using changed dates of service — until they were paid. A CMP agreement is pending.

- A California woman who was part owner and manager of two separate medical supply companies was excluded from the Medicare and Medicaid programs for 10 years after her conviction for participation in a scheme

wherein she billed the Medi-Cal program for incontinence products that were never ordered or delivered. She solicited business from Medi-Cal patients and then accepted payment for the delivery of their Medi-Cal stickers. Medical supplies that were returned to the companies or not accepted by the Medi-Cal beneficiaries were billed to the program as if delivered. Other products which were not delivered or were returned or placed in warehouses were delivered or sold to other customers, resulting in double billing the program for the same products. The woman also employed sales people to pay Medi-Cal patients for their stickers which were then used by program providers to bill the Medi-Cal program.

Health Care Antifraud Project

The Secretary of the Department of Health and Human Services is authorized to engage in demonstration projects to test improved methods of investigating fraud in the Medicare and Medicaid programs. Using this authority, OIG and HCFA have joined in a project to develop an innovative approach to preventing and detecting fraud and abuse in two rapidly growing sectors of the health care industry: home health agencies and nursing homes, and ancillary services and supplies for each. The Secretary has included this project as part of the Department's Reinvention of Government initiative.

The project is designed to bring together the talents and expertise of a wide range of Federal and State officials, and concentrate their combined energies on fraud and abuse in home health agencies and nursing homes. A multidisciplinary team of auditors, program managers, evaluators, utilization review experts, investigators and advocates are focusing on fraud in five States which represent a major share of Medicare and Medicaid expenditures and beneficiaries: California, Florida, Illinois, New York and Texas. The project is targeting several specific schemes and activities, including: false billing schemes and kickbacks involving providers, including durable medical supply companies; patient abuse and substandard medical services to long-term care patients; claims for items, services and visits not provided, not provided as claimed, not medically necessary or not authorized by a physician; and claims submitted to Medicare and Medicaid for the same items or service.

The project is the first in which health care providers are offered the opportunity to voluntarily disclose to the Government evidence of fraud in their home health agencies and nursing homes. Through self-disclosure they may minimize the cost and disruption of an investigation, negotiate a monetary settlement in lieu of prosecution, and possibly avoid exclusion from Medicare and Medicaid program participation when appropriate. The project is to take 2 years for completion and evaluation. If it proves to be both effective and efficient, other areas may be singled out for similar treatment.

Social Security Administration

Chapter II

SOCIAL SECURITY ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

Approximately 60 years ago, the Social Security Act established a national insurance system that would be financed through payroll taxes collected from workers and employers and would pay benefits to workers in their old age. The Old Age and Survivors Insurance (OASI) program, and the Disability Insurance (DI) program (collectively OASDI), added in 1956, are popularly called Social Security.

In Fiscal Year (FY) 1995, the Social Security Administration (SSA) expects to pay over $330 billion in cash benefits to more than 43 million beneficiaries. The program is financed almost entirely through payroll taxes paid by employees, their employers and the self-employed. Benefits are distributed to retirees and disabled persons, their spouses and dependent children, and certain surviving family members of deceased insured workers.

The Supplemental Security Income (SSI) program is a federally administered, means-tested assistance program that provides a nationally uniform, federally funded floor of income for the aged, blind and disabled. Beginning January 1974, SSI replaced State and county run assistance programs for the aged, blind and disabled that were funded by a mix of Federal and State money. Federalization of assistance for these categories permitted the establishment of uniform eligibility criteria. In FY 1995, SSA expects to pay SSI benefits of about $25 billion to over 6 million recipients.

The Office of Inspector General (OIG) has reviewed all aspects of SSA's programs and operations, including: DI benefits, information resources management, program integrity and efficiency, quality of service, representative payee and SSI benefits, including benefits to children with mental impairments. The OIG has also provided oversight to SSA's financial management by auditing SSA's financial statements, examining internal controls and reporting on the status of debt management activities. Fraud and abuse in Social Security programs have historically been based on two types of deception: concealment of a recipient's status and/or the use of false Social Security numbers (SSNs) to obtain benefits.

Effective March 31, 1995, SSA became an independent agency. The independent SSA will have its own presidentially-appointed Inspector General (IG). In the interim, until the new SSA IG is appointed and confirmed, the Department of Health and Human Services (HHS)

IG will manage both the HHS OIG and the new SSA OIG organizations. The new SSA organization was initially created from HHS resources. The HHS OIG transferred 259 positions to SSA, including 3 senior executive positions. The transfer included furniture, equipment and applicable funding.

Internal Controls and Compliance with Laws and Regulations: Fiscal Year 1994

The OIG audited SSA's internal accounting controls and compliance with laws and regulations for FY 1994 as part of the overall Chief Financial Officers Act review. In summary, OIG found that: SSA's overpayment systems could not generate reliable accounts receivable data without additional manual analysis; SSA was not in compliance with the Social Security Act's requirement regarding transfers of employment tax revenues to the trust funds; and SSA was not performing continuing disability reviews (CDRs) as required by the Act. The OIG also noted other weaknesses in SSA's internal control structure which resulted in underpayment of approximately $479 million to SSA beneficiaries over a period of 15 years. In its response to the draft report, SSA generally agreed with the recommendations and cited actions it is taking to implement them. The SSA is in the process of reviewing and commenting on the final report. (CIN: A-17-94-00520)

Progress in Implementing Debt Management System

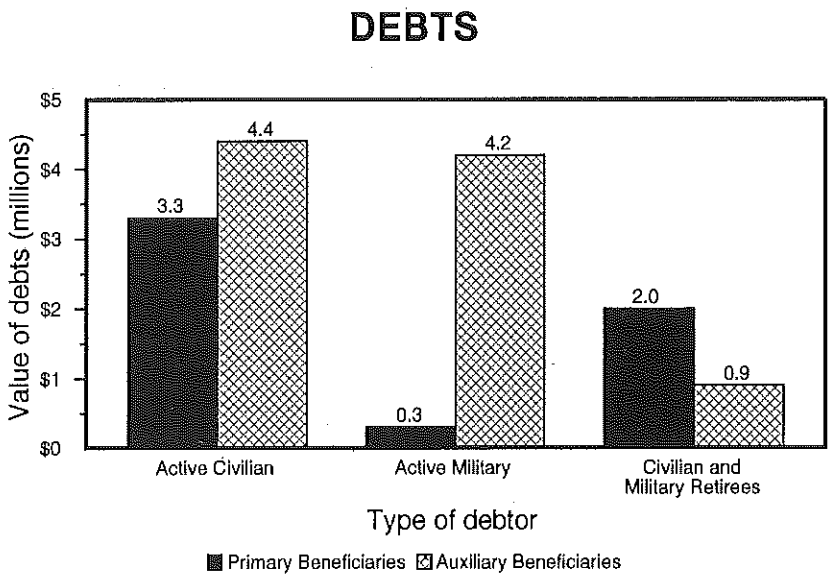
The SSA debt management system (DMS) is being designed to control, account for and facilitate timely recovery of all programmatic debts due SSA. The DMS has been under development since 1988. Implementation of DMS is occurring in a series of incremental software releases which will continue for the next several years.

In its current audit, OIG determined that all scheduled initiatives were successfully implemented for the period reviewed (October 1993 through March 1994). However, OIG found that SSA has not acted on previously reported recommendations to develop a strategy for redesigning the software used to process OASDI postentitlement transactions (i.e., those transactions that take place after an individual becomes entitled to benefits) and integrate that strategy with the DMS transition plan. Although SSA agreed to take action, it is now a year later and this strategy has not been developed. The OIG again recommended that SSA develop a comprehensive plan for the modernization of OASDI postentitlement, and that this plan be cross-referenced to the DMS transition plan. The SSA is in the process of reviewing and commenting on the final report. (CIN: A-13-94-00507)

Federal Salary Offset and Debt Collection

The OIG assessed the potential impact of salary offset as a means of recovering overpayments to former Social Security beneficiaries who are now Federal employees or retirees. In its inspection, OIG found that Federal employees and retirees owe SSA $15.2

million in OASDI benefits. As illustrated in the following chart, nearly two-thirds of this debt was incurred by auxiliary beneficiaries, such as spouses or children.



There were 13,000 OASDI debtors identified as Federal employees or retirees; most are currently employed. Debtors, on average, owed $1,155; almost half were earning more than $20,000 annually.

The OIG recommended that SSA submit a legislative proposal to implement Federal salary offset for debts incurred through overpayments under the Social Security Act. The SSA agreed that the use of Federal salary offset would enhance its debt collection efforts and is actively pursuing the required statutory authority. (OEI-03-92-00700)

Processing Repayment Checks

Beneficiaries often send personal checks to SSA to repay overpayments. The program service centers (PSCs) are required to credit beneficiaries' overpayment accounts on its record systems before depositing the checks with the Federal Reserve Bank (FRB). However, when FRB cannot negotiate checks, it returns them to SSA. The PSCs are then required to adjust the entries previously made to these record systems in order to correct the overpayment balances due the Government.

The OIG conducted a review to determine whether internal controls ensured that OASDI beneficiaries' records were adjusted by the PSCs for nonnegotiable checks. The OIG visited 2 of the 6 PSCs and found that 27 of 60 returned checks were not properly processed. In

addition, 7 of these 27 checks could not be traced through the accounting system and, therefore, were susceptible to loss.

The SSA issued revised procedures in August 1993 which should help SSA ensure recovery of overpayments related to returned checks and provision of correct information to beneficiaries and the Internal Revenue Service for income tax purposes. However, OIG believes that further improvements are possible and recommended that SSA establish a system for monitoring the returned check process. The SSA concurred and is in the process of implementing the recommendation. (CIN: A-09-93-00173)

Manual Payments

The SSA makes certain payments through a one-check-only action (OCOA) payment process. In a review of this process, OIG found that SSA had issued duplicate payments; made payments without proper authorization or without evidence showing that proper authorization was obtained; and issued payments that were incorrectly posted to records. The OIG estimated that 353 payments totaling nearly $687,000 contained errors or resulted in incorrect payment records; this included almost $260,000 in duplicate payments. These errors were caused by: benefit authorizer failure to review payment history information before authorizing payments; benefit authorizer failure to follow established policy regarding authorization of payments; and lack of system controls to detect SSN errors or balance payment data before updating payment records. The OIG recommended that SSA enhance internal control procedures over the recording and paying of OCOA payments. In its response to the draft report, SSA generally concurred with the recommendations. (CIN: A-03-93-02602)

Processing of Financial Institutions' Notifications of Change

A notification is an electronic message that a financial institution sends to FRB to advise SSA of changes to beneficiaries' direct deposit information. In an evaluation of SSA's controls over processing and recording such changes, OIG found that beneficiaries' records were updated accurately and in a timely manner to reflect changes in direct deposit data except when the SSN was not on the notification. The SSA's computer system rejected and reported only the first 10 notifications that did not have SSNs. These notifications were recorded on a reject list, but SSA did not advise the financial institutions that the notifications could not be processed. Approximately 12 percent of the notifications transmitted did not contain SSNs. Consequently, financial institutions received inaccurate beneficiary direct deposit information from SSA and had to manually post payments to the appropriate accounts. Also, these changes were not updated on SSA's records and management lacked information needed for monitoring the notification process.

The OIG recommended that SSA remove the limit of 10 for purposes of counting notifications that do not have SSNs; and identify notifications without SSNs and return them

electronically to financial institutions for correction. In response to the draft report, SSA concurred with OIG's recommendations and began implementation. (CIN: A-06-93-00002)

Field Office and 800 Number Coordination

In October 1988, SSA established a national 800 number service and converted its local teleservice centers (TSCs) to the national system. The advent of the national 800 service precipitated the creation of a new public contact component within SSA; however, the evolution of 800 service has not been without its problems.

In a study of the factors affecting coordination between SSA field offices and TSCs, and the resulting impact on the public, OIG concluded that most field office and 800 number employees were dedicated to their jobs and to improving public service. However, OIG found that the relationship between field offices and TSCs was adversely affected by the lack of clearly integrated processes for serving the public through the 800 number. Moreover, some SSA policies, processes and procedures generated multiple public contacts that increased workloads to the detriment of good public service. In addition, many employees expressed the belief that a more user-friendly computer system would improve coordination, reduce errors and improve efficiency.

The OIG recommended that SSA integrate 800 number and field office processes; reexamine its training strategy and develop a line of responsibility that cuts across all components to ensure that agencywide training needs are met; better control and reduce workloads by eliminating unnecessary administrative messages and holding 800 number employees accountable for completing certain calls within their scope of duties; and more effectively obtain and consider employee feedback in its systems modernization initiative. The SSA agreed with all of the findings and recommendations. (OEI-05-92-00040)

Social Security Fraud

Eighty-six persons were convicted and sentenced during this reporting period for defrauding the OASI program or the DI program. The OASI convictions frequently involved relatives or representative payees converting to their own use Social Security benefits intended for others, including those mistakenly sent to deceased beneficiaries, as shown in the following examples:

- In Texas, a man and his wife were ordered to make restitution of $974,300 after being convicted of conspiracy to defraud SSA, mail fraud and use of a false SSN. The man faked his own death in a fiery automobile accident as part of an insurance fraud scheme, and the woman applied for and received Social Security survivors benefits. The man was caught when he tried to find work under a false SSN. He was sentenced to 48 months in prison, and she to 30 months.

- In Louisiana, a woman was sentenced to 5 years probation for filing falsely for spouse's insurance benefits. She was ordered to serve home confinement for the first 6 months, submit copies of any Government assistance filings and attend mental health treatment at the discretion of the probation office. In 1991, she and her husband filed for DI benefits for themselves and their children on the basis of the husband's entitlement. According to their applications they were separated but not divorced, and the children were the husband's stepchildren. Investigation showed that they were divorced in February 1986, that the woman remarried in March 1986, that she was again divorced in June 1987, and that she remarried again in 1990. After her divorce from her first husband, she also told the Air Force that she was still married to him in order to get dependent identification cards for herself and her children. The husband, who is retired from the Air Force, is still under investigation. About $28,000 in unmerited benefits was paid. No restitution was ordered from the woman because of her lack of assets.

- Two persons were sentenced in Massachusetts for their part in the theft and negotiation of Social Security benefits checks. The checks were stolen in a series of postal vehicle break-ins. Although many of the 20 checks stolen were destroyed before negotiation, most of the remainder were negotiated through a beauty shop owned by the pair. One person was sentenced to 5 months in prison and 36 months supervision, with special conditions including prohibition against owning a dangerous weapon, provision of financial information and drug testing when required. The second person received the same sentence, without the jail term but with alcohol testing and participation in drug and mental health programs added. Each was fined $1,000. The two individuals who committed the break-ins were sentenced earlier, and a pretrial diversion is being negotiated with the wife of one of them.

- In Pennsylvania, a woman was sentenced for misusing Social Security survivor benefits intended for her two nieces, from 1979 until 1986. The woman did not report to SSA that the children had not been in her care since 1979, and she fraudulently received benefits totaling $38,840. Before her sentencing, one of the nieces advised the judge in a prepared statement that the children were mentally and physically abused by their aunt, and that the State put them in foster care in 1979. The woman denied the abuse allegations, stating that she loved and took care of her nieces although they did things that made her "crazy." She was sentenced to 5 years probation and ordered to pay restitution to be determined by the probation department

and to serve 200 hours of community service. She was also ordered to undergo psychological counseling and to pay $184 in court costs.

- In Illinois, a woman who was representative payee for disability benefits for her husband and their children was sentenced for making false statements to SSA. In 1985, the woman applied for disability benefits on behalf of her husband, stating that he was mentally ill, trying to burn down the house, hiding under the crawl space, refusing to sign forms and failing to recognize her. She became representative payee on the basis of her statements and telephone confirmation by a neighbor, whom investigators subsequently were unable to locate. In December 1988, the husband, who had been working as an independent contractor for a trucking company, applied for disability benefits after becoming unable to work because of diabetically related kidney failure. He discovered for the first time that his wife, from whom he had separated several years before, was receiving benefits on his behalf. The total overpayment was approximately $42,000. The woman was sentenced to 6 months home confinement, 3 years supervised release and 300 hours of community service. Restitution was not ordered because of indigence.

The type of fraud most commonly committed against the DI program is concealing work activities while collecting benefits, as indicated in the following examples:

- In Michigan, the vice president of a music company was sentenced to 21 months in prison for telling Government agencies he was not working while he collected benefits. Investigation showed he had received more than $100,000 while working at the music company. He was ordered to repay $19,000 to SSA, $43,566 to the Railroad Retirement Board and $81,400 to the Department of Labor.

- A California man operated a sports merchandise and memorabilia mail order company from his residence while collecting both DI and SSI benefits. He advertised his business in newspapers where customers placed orders and sent checks, but he never sent the orders or the money back. He was sentenced to 5 months in a halfway house, 5 months home detention, 3 years probation and 300 hours of community service. He also had to make restitution of $35,000 and pay a $200 assessment fee.

- Another California man was found to have two different employers and worked full time under his wife's SSN since 1988 while receiving DI benefits. He was allowed to enter a pretrial diversion program for 18 months on condition that he pay restitution of $24,700 to SSA.

- In Iowa, a man was sentenced to prison and ordered to repay $40,300 he obtained by working as a truck driver and back hoe operator collecting DI benefits. The man worked under a false SSN he obtained in the name of his deceased brother. The man's prison sentence was reduced from 14 to 6 months because he cooperated with the Federal Bureau of Investigation in numerous drug cases. Moreover, although his benefits were terminated because of his conviction, he was able to convince a judge that he suffered from a low intelligence quotient and claustrophobia. The judge overturned SSA's termination and the man's benefits will resume after he serves his prison term for defrauding the very same program.

Identifying Disabled Beneficiaries Working under Other Social Security Numbers

The SSA records wages of workers by using SSNs reported by employers. Current controls used by SSA to detect work activity for disabled beneficiaries include the earnings enforcement processes, which compare wages reported by employers to wages reported by beneficiaries. When the SSNs used by employers differ from those issued and recorded by SSA, these processes do not detect work activity by individuals receiving DI or SSI payments. The use of different SSNs may occur intentionally as a result of beneficiaries' trying to hide income, or unintentionally as a result of reporting errors by beneficiaries or employers.

The OIG used a computer program which matched names and mailing addresses of 10 percent of 7.5 million disabled individuals receiving DI or SSI payments to all earnings processed by SSA in 1991 that had not been posted to individuals' earnings records. Through this means, OIG identified eight cases where the names and addresses of the disabled beneficiaries on SSA's benefits records matched the names and addresses of the wage earners. Seven of the eight cases resulted in investigations for potential fraud and/or correction of the earnings records. One employer reporting error affected the earnings records of 188 individuals with wages totaling $1.8 million.

The OIG recommended that SSA implement a computer matching system similar to the one used for this review. The SSA agreed that a computer matching program would enhance its existing controls and is examining the feasibility of performing this program. (CIN: A-13-92-00235)

Disability Research Demonstration Program

Performance Measure

Since 1980, the Congress and SSA have initiated several efforts to improve the disability programs and reduce the drain on disability program funds. One of the efforts was the research demonstration program (RDP), SSA's largest continuous research demonstration effort.

In a sample study of RDP grants, OIG found that the program did not thoroughly test alternatives for improving employment of disabled beneficiaries as the Congress intended. The SSA's decision to use grants rather than contracts or cooperative agreements may have limited potential for successful accomplishment of the objective. In its 1992 interim report to Congress, SSA pointed out that most of the RDP projects had not been carried out in a manner consistent with statistically significant research. The OIG concluded that RDP grants produced some useful benefits, but no lasting improvements in disability programs.

The OIG recommended that SSA use contracts or cooperative agreements rather than grants for the RDP. Grants may be an effective way to collect information and ideas, but contracts and cooperative agreements are typically better methods for definitively testing specific program changes where substantial involvement by an executive agency is needed. Also, SSA should complete its final evaluation of RDP and report the results to the Congress. The SSA concurred with the recommendations. (OEI-04-91-01660)

Initial Disability Claims

Performance Measure

The SSA recently mounted a major initiative to reengineer the disability claims process. In connection with that effort, SSA requested that OIG conduct a survey to determine applicant perspectives on, and experiences with, the Social Security disability claims process.

As indicated by the following table, many applicants found the disability claims process to be difficult and confusing.

GOING THROUGH THE DISABILITY CLAIMS PROCESS				
THE PROCESS WAS:	Overall	DI	SSI	Concurrent
Very or somewhat easy	32%	34% (83)	37% (75)	26% (64)
Neither easy nor hard	22%	22% (52)	24% (49)	21% (50)
Somewhat or very hard	46%	44% (105)	39% (80)	53% (129)

Applicants would like: more direct, personal and understandable explanations of the disability programs, the claims process and the forms; more assistance in reading and filling out the disability claims forms; specific persons to contact concerning the status of their disability claims; and more timely decisions on their disability claims.

The OIG determined that two items need immediate corrective action. The SSA should invest more time in providing quality explanations to applicants on how to apply for disability benefits, and should improve the clarity of the questions and instructions on its disability claims forms so they are easier for applicants to understand. In its response to the final report, SSA generally concurred with the recommendations and outlined the initiatives now being considered which will improve and simplify the disability claims process. (OEI-06-91-01730)

Use of Competitive Contracts or Negotiated Agreements for Consultative Examinations

Consultative examinations (CEs) are medical examinations purchased by States to assist in determining whether claimants are eligible for Social Security disability benefits. The OIG determined that opportunities exist for State disability determination services (DDSs) in Region VII to achieve savings by using competitive contracts or negotiated agreements to purchase CEs. Moreover, use of these contracts or agreements could expedite the disability determination process by improving the timeliness and quality of CEs. The OIG recommended that SSA work with State DDSs to develop and utilize competitive contracts or negotiated agreements to purchase CEs to the maximum extent possible. The SSA concurred and is in the process of implementing the recommendation. (CIN: A-07-93-00731)

Supplemental Security Income Payments to Children With Mental Impairments

The OIG issued three audit reports on SSI disability payments provided to children with mental impairments. The audits were in response to congressional requests and numerous allegations of improper payments to children. About $4.5 billion in SSI payments were paid to children with disabilities in 1993.

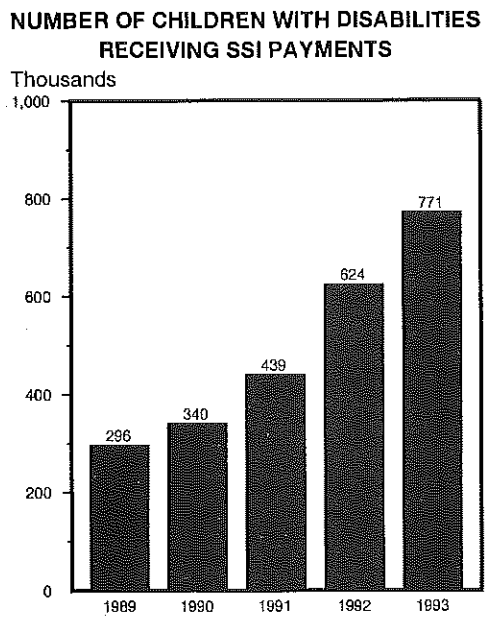
The initial report assessed various concerns relative to the intent of the SSI program for children with mental impairments. The second report evaluated States' compliance with SSA's guidelines for adjudicating claims for SSI benefits to children with mental impairments. The third report described the types of medical services provided under the Medicaid program to children with mental impairments who were receiving SSI benefits.

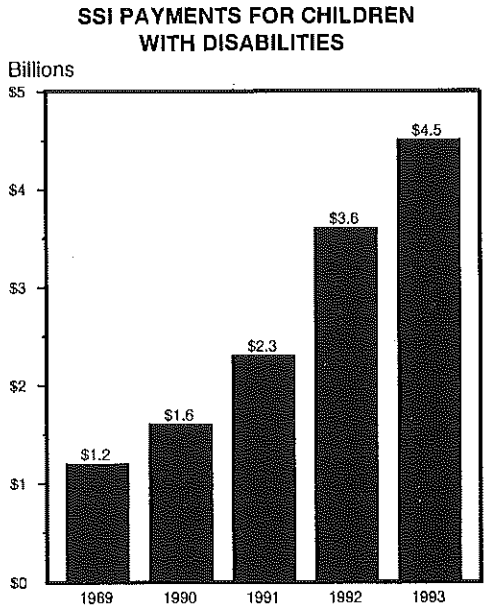
A. Participation of Children with Mental Disabilities in the Supplemental Security Income Program

Performance Measure

This report addresses the concerns of teachers, school administrators, psychologists and others brought to OIG's attention by Members of the Congress. These concerns focused primarily on the congressional intent of SSI payments made on behalf of children with disabilities and the manner in which some children are determined eligible for the SSI program.

The 1990 Supreme Court decision in Sullivan v. Zebley mandated that SSA revise its method of determining SSI eligibility for children with disabilities by requiring individualized functional assessments of children who would have previously been denied SSI benefits. The Zebley decision and SSA's response to it have had a major impact on the growth of child participation in the SSI program, though some of this growth was due to other factors. As illustrated below, the number of disabled children receiving SSI benefits and the amount of SSI payments to disabled children have grown substantially over the 5-year period from 1989 to 1993.





In addressing the concerns raised, OIG found that there was considerable confusion about the intent of the SSI disability program for children. The OIG recommended that SSA work with the Commission on Evaluation of Disability in Children, established pursuant to the Social Security Independence and Program Improvements Act of 1994, to revisit the purpose of SSI payments made on behalf of children with disabilities and the method of determining their eligibility for the program. Further, OIG recommended that SSA develop a CDR profile of SSI beneficiaries, including children, whose disabling impairments are most likely to improve, and conduct CDRs on the basis of these profiles. The SSA agreed with OIG's recommendations. (CIN: A-03-94-02602)

B. Disability Determinations for Children with Mental Impairments

In this review, OIG found that State DDS agencies did not always comply with SSA guidelines when making disability determinations for children with mental impairments applying for SSI benefits. The OIG estimated that for over 37,000 of the nearly 125,000 children in the audit universe, the disability determinations were incorrect for more than 12,000 children (10 percent), or the decisions were not supported by sufficient evidence in

the case files for almost 25,000 children (20 percent). A much lesser problem was found in the denied cases reviewed.

The State DDSs indicated that they had problems with the lack of clarity and objectivity of SSA's guidelines. Among other things, OIG recommended that SSA improve guidelines and criteria for making disability determination decisions on children applying for SSI benefits. The SSA agreed with the recommendations. (CIN: A-03-94-02603)

C. Medicaid Services Provided to Children with Mental Impairments

This report provides information on Medicaid services received by children with certain mental impairments who were determined eligible for the SSI program during Calendar Year 1992. The OIG found that almost 95,000 of the nearly 125,000 children with mental impairments received Medicaid services within 1 year after SSI eligibility, but most of the services were not directly related to their mental impairments. Seventy-four percent of the children with mental impairments did not, for example, receive psychiatric or psychological services under Medicaid, including 61 percent of the children diagnosed as having a conduct disorder.

The OIG recommended that SSA provide the report to the Commission on the Evaluation of Disability in Children which is to review several issues involving child participation in the SSI program. In its comments to the draft report, SSA concurred with the OIG recommendation to present the report to the Commission. In addition, SSA made several suggestions aimed at improving the usefulness of the report. (CIN: A-03-94-02604)

Supplemental Security Income Payments to Drug Addicts and Alcoholics

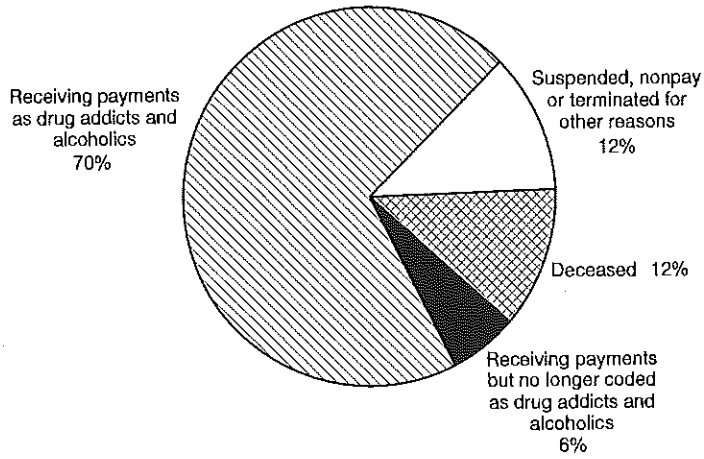
A. Continued Dependence

Performance Measure

In early 1994, OIG conducted a study that determined the payment status as of April 1993 for a 1 percent sample of drug addict and alcoholic recipients who had been receiving SSI payments in June 1990. The OIG found that after 3 years, almost 80 percent of drug addicts and alcoholics continued to receive SSI payments and that payments rarely ceased due to successful treatment.

In the current study, OIG compared the records of all drug addicts and alcoholics who were receiving SSI in June 1990 and those receiving SSI in February 1994. Despite congressional treatment mandates and SSA's efforts, OIG found that most drug addicts and alcoholics awarded SSI prior to June 1990 continued to receive SSI payments based on drug addiction or alcoholism, and that current intervention and treatment requirements rarely resulted in removing recipients from the SSI rolls.

JUNE 1990 DRUG ADDICTS AND ALCOHOLICS: PAYMENT STATUS AS OF FEBRUARY 1994



The OIG recommended that SSA: collect accurate treatment status information for all drug addicts and alcoholics; correct the Supplemental Security record (SSR) using this information; and regularly update the treatment status on the SSR. The SSA is reportedly expanding and intensifying its referral and monitoring of drug addicts and alcoholics treatment by contracting with referral and monitoring agencies in all States. Improving the linkage between these agencies and its own databases should enable SSA to determine the effectiveness of the treatment requirement and continued eligibility for SSI payments. Further, OIG proposed that SSA increase the number of acceptable treatment codes to more accurately reflect the current status of drug addicts and alcoholics. These codes could indicate if appropriate treatment is available, if the recipient is on a waiting list and what type of treatment the recipient is receiving. In response to the draft report, SSA agreed with OIG's recommendations and described steps it is taking to improve treatment status information for drug addicts and alcoholics. (OEI-09-94-00071)

B. Statutory Requirements

Performance Measure

The SSI legislation requires recipients who are disabled as a result of drug addiction or alcoholism to have representative payees help them manage their benefits and to participate in treatment programs to facilitate their rehabilitation. In a survey of recipients, payees, monitoring agencies and State Medicaid agencies, OIG found that only about one-third of drug addict and alcoholic recipients are in treatment; there are few significant differences in how organizational and individual payees deal with recipients; and there are significant weaknesses in SSA's implementation of the SSI requirements for drug addicts and alcoholics.

The OIG recommended that SSA provide referral and monitoring agencies with updated listings of all drug addict and alcoholic recipients in their States; take appropriate steps to see that field offices act promptly on referral and monitoring agency reports on recipients' treatment status; send a special notice to all drug addicts' and alcoholics' payees reminding them of the treatment requirement for their recipients and clarifying their reporting responsibilities regarding that treatment; clarifying the role of Alcoholics Anonymous and Narcotics Anonymous in the drug addicts and alcoholics program; and establishing procedures to assure that new payees are properly informed about the unique requirements which apply to drug addicts and alcoholics. The SSA agreed with OIG's recommendations. (OEI-02-94-00110)

Supplemental Security Income Fraud

Similar to "regular" Social Security fraud, SSI fraud also often entails illegal conversion of deceased or other beneficiary checks. On occasion it involves concealment of resources to obtain or retain eligibility for benefits.

- In Ohio, a woman signed an agreement to pay $40,000 in settlement of charges that she had failed to report her marriage and family income and property while receiving SSI benefits. She was not prosecuted criminally because of her health and family situation, but she had to pay $7,000 at once and $100 a month thereafter.

- A California man who concealed his spouse's income while receiving SSI and retirement benefits, as well as a veteran's non-service-connected pension, was ordered to make restitution of $46,600. He also was sentenced to 2 years probation. He had fraudulently filed for spousal retirement benefits under a duplicate SSN. The judge granted a motion to allow SSA to garnish his own retirement benefits to recover the SSI loss.

- A woman in Ohio who had been a representative payee for an SSI beneficiary failed to report her death and fraudulently received $4,100. After she failed to respond to SSA's attempts to resolve the matter, a default judgment of $12,300 was found against her, and the United States Attorney's office proceeded with collection.

- In Indiana, a woman applied for and received SSI benefits for her seriously ill infant. Within a month after application, she began working full time but failed to notify SSA. As a result, she was overpaid $9,670 over 3 years. She was sentenced to 3 years probation and ordered to make restitution of $1,800.

On the West Coast, the results of two projects involving SSI fraud in Asian immigrant communities were turned over to SSA for in-depth review of eligibility.

- During this reporting period, a Vietnamese interpreter who assisted ineligible refugees to obtain SSI was sentenced in Washington State to 5 years in prison and ordered to make restitution of $795,000 to SSI and the State welfare program. He helped refugees fake depression, suicidal tendencies, headaches supposedly resulting from beatings and imprisonment by the Communists, and delayed stress syndrome. He usually charged a refugee half of the first SSI check issued, which averaged about $3,200. One other interpreter, two State welfare employees and two beneficiaries were successfully prosecuted. Over 150 names were turned over to SSA for case review.

- A similar project in California resulted in the referral of 75 Southeast Asian SSI beneficiaries to SSA for review. By the end of this reporting period, 50 reviews had been completed and 26 persons had been removed from the benefit rolls.

Time and Attendance Reporting Practices at Hearing Offices

In a review of time and attendance recording and reporting practices in six regions, OIG determined that the Office of Hearings and Appeals (OHA) needs to strengthen procedures to improve the effectiveness of internal controls. The OIG recommended that internal controls be reinforced in the following areas: supervisory oversight; timekeepers' completion and processing of records; and employees' recording and certification of records. Each regional chief administrative law judge (RCALJ) concurred with recommendations made in the regional reports and initiated or agreed to initiate corrective actions.

The OIG further recommended that the Associate Commissioner, OHA, reemphasize to supervisors the importance of their role in authorizing, reviewing and certifying time and attendance documents for their employees; to timekeepers their responsibilities in handling, completing and processing time and attendance records; and to employees their responsibilities in complying with time and attendance policies and procedures. The OIG also proposed that the Associate Commissioner, OHA, schedule training for all timekeepers who have not attended formal training on their time and attendance responsibilities and follow up on corrective actions that the six RCALJs agreed to take. The SSA concurred with each of the findings and recommendations. (CIN: A-01-93-02008)

Travel Performed by Administrative Law Judges

At the request of the Senate Committee on Governmental Affairs, OIG evaluated the procedures used by OHA to authorize and assign travel of ALJs hearing Social Security

disability cases. The OIG found that OHA's established travel procedures were intended to ensure that travel performed in conjunction with hearing disability cases was conducted in a cost-effective manner and assigned equitably among ALJs. Although it appeared that OHA had generally established adequate procedures to authorize and assign travel in connection with hearing disability cases, OIG identified improvements that could be made in the implementation of these procedures.

The OIG recommended that the chief ALJ reemphasize to RCALJs and hearing office ALJs the importance of: taking advantage of opportunities to maximize the cost-effectiveness of travel to balance disability caseloads by encouraging ALJs to take trips of 2 weeks or more; and rotating travel among ALJs to more equitably distribute the responsibility of hearing travel dockets and the opportunity to travel. The SSA concurred with OIG's findings and recommendations. (CIN: A-01-93-02004)

Fraudulent Social Security Numbers

One of OIG's most important responsibilities is protection of the SSN enumeration system. In addition to misuse of SSNs to obtain undeserved program benefits, attempts to compromise the application process are relatively common, as shown in the following examples:

- In Texas, a man was sentenced to 43 months in prison and fined $110,000 after being allowed to plead guilty to conspiracy, SSN misuse, mail fraud and passport fraud in exchange for testimony in the murder-for-hire trial of a female acquaintance. He helped the woman flee prosecution by using the SSN of his deceased cousin. At the request of the State Department, OIG traced the SSN to the south of France, where the woman was arrested and deported. The man was arrested later while trying to enter the country from Mexico. Although the woman was convicted of the murder-for-hire, she was not given the death penalty because of the terms of her extradition.

- A widely known organized crime figure in New York was sentenced to 168 months in prison and 2 years supervised release after conviction on charges related to Social Security fraud. The man engineered a "no-show" job scheme for his son, whereby the son padded his Social Security account and later received unemployment benefits from a job he never actually held. The father was later convicted of bookmaking and racketeering as well. His son was sentenced earlier to 30 months in prison, and ordered to repay $3,620 and a special assessment of $50.

- Four persons were sentenced in Ohio for their part in a scheme involving inmates of a correctional institution, SSN fraud and illegal income tax refunds. The inmates went through prison files for names and SSNs and

used the skills taught in the prison print shop to manufacture false income tax forms. They filled out the forms with the false names and SSNs, and had tax refunds sent to friends, relatives and business acquaintances. Federal and State refunds totaled more than $200,000. One individual was sentenced to 90 months in jail, a second to 12 months (3 suspended), a third to 41 months (11 suspended) and a fourth to 2 years probation. Total fines, assessments and restitution ordered amounted to $3,750.

- In Texas, a woman was sentenced to prison once more for credit card and SSN fraud after receiving early release from convictions for similar offenses. The woman was convicted of credit card fraud in 1986 and 1989. The condition for her early release from prison was that she was not, in any manner, to obtain credit or credit cards or accounts. A few months after her release, she proceeded to use her younger daughter's SSN to obtain credit cards and to establish credit so she could purchase assets such as automobiles. After indictment and a psychiatric evaluation in which she was found competent, she pled guilty and was sentenced to 2 years in jail, followed by 3 years supervised probation.

- In 1992, a man who posed as a psychologist and was hired by an Indian Health Service clinic, was sentenced to 21 months in prison for assuming a fraudulent identity. The investigation disclosed that earlier he had been commissioned by the Public Health Service to work in a Federal prison in Georgia, but he had been terminated because of questionable credentials. In both instances he used the identity of an individual who died in 1984. After being released from jail, the man went to live with his twin brother in St. Louis. There he misused SSNs to gain credit and perpetrate bank fraud, but claimed his brother had done it. He pled guilty after handwriting analysis showed he was the one who had filed a false application. His probation was revoked and he was ordered to serve an additional 10 months in prison, to be followed by 2 years probation.

Public Health Service

Chapter III

PUBLIC HEALTH SERVICE

Overview of Program Area and Office of Inspector General Activities

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

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

Staffing and Management of the Office of Research Integrity

At the request of the Assistant Secretary for Health, OIG assessed whether the Office of Research Integrity (ORI) is properly staffed, organized and managed to fulfill its responsibilities regarding scientific misconduct in research programs, and if a recent request by ORI for additional staff is justified. The OIG found that ORI has produced some noteworthy results since its establishment. It has conducted workshops, published newsletters, developed policies and procedures, prevailed in 22 findings of scientific misconduct, and successfully litigated 4 cases and several major legal and policy issues before the Departmental Appeals Board.

Based on its study, OIG concluded that ORI does not need an increase in its staff of scientists or attorneys at this time. The OIG also identified opportunities for ORI to improve its operations, some of which will allow it to make better use of existing staff. Among its recommendations, OIG proposed that ORI establish a strategic plan to provide balance between its roles in stewardship (misconduct investigations and compliance reviews) and in educational outreach and technical assistance. Such a plan should also provide ORI with the tools to better handle fluctuations in its workload. Further, OIG suggested that ORI set performance measures to assess the quality, quantity and timeliness of work conducted; develop a training plan to enhance the professional skills of ORI staff; and hire trained, professional investigators to team with scientists for investigations of scientific misconduct.

The PHS concurred with the recommendations and stated that ORI had begun to implement them. The ORI will keep the Office of the Secretary apprised of its progress on a quarterly basis. (CIN: A-15-94-00029)

Scientific Fraud

In what some have labeled a first case of its kind, a former research scientist at two universities and the two universities themselves agreed to pay total restitution of nearly $1.6 million in settlement of charges that the scientist falsified data to obtain $1.3 million in grants from NIH. The case arose from a qui tam complaint that the scientist, who conducted research on the cause of immune system suppression after burn injuries, made false statements on progress reports and applications for grant renewals. Responsible officials at both universities had certified that the statements he made were true.

Preapproval Promotion Activities

In May 1991, OIG looked at possible preapproval promotion by Monsanto Agricultural Company of bovine somatotropin (bST), an animal drug developed to increase milk production in cows, which at the time, was still under review by FDA. Monsanto's bST was approved by FDA in November 1993.

In a follow-up review performed as a result of a congressional request, OIG found that FDA had taken appropriate corrective action in anticipation of recommendations made in the May 1991 report, and had properly concluded that, overall, Monsanto-sponsored focus groups and a video produced beginning in December 1992 did not violate the intent of Federal regulations. However, OIG also found that FDA failed to issue a required warning letter stating that regulatory action would be taken if violative activities occurring at a January 1993 seminar continued. Further, OIG determined that Federal regulations should be revised to directly describe what constitutes allowable promotional activities.

The OIG recommended that FDA ensure that Federal regulations governing preapproval promotion are revised to address activities that sponsors can undertake while being in compliance with the regulations; and develop criteria, formal staff guidelines and policies to be used for review of potential preapproval promotion activities. The PHS generally agreed with OIG's findings and recommendations, and indicated that FDA is currently revising the regulations, and developing internal guidelines on promotion and advertising. (CIN: A-15-93-00018)

Hospital Reporting to the National Practitioner Data Bank

Performance Measure

The OIG conducted this inspection in response to a PHS request to determine how hospitals are responding to their legal obligation to report adverse actions to the National Practitioner Data Bank. The report noted that about 75 percent of all hospitals in the United States have never reported an adverse action taken against practitioners to the data bank, and that there has been considerable State-by-State variation in reporting rates.

The OIG recommended that PHS support further inquiry to foster a better understanding of the factors influencing hospital reporting to the data bank and sponsor a conference to focus attention on issues influencing such reporting. Further, OIG proposed that PHS work with the Health Care Financing Administration (HCFA) to ensure that the Joint Commission on Accreditation of Healthcare Organizations assesses more fully hospitals' compliance with the law. The PHS and HCFA agreed to prepare a joint letter that will be sent to the Joint Commission urging it to devote greater attention to hospital compliance with the data bank law. (OEI-01-94-00050)

Nonfederal Audit Reports Related to the Indian Health Service

This report summarizes IHS findings in nonfederal audit reports (i.e., audits of Federal awards conducted by independent public accountants or other nonfederal auditors pursuant to Office of Management and Budget Circulars A-128 or A-133) issued during Calendar Year 1992 where IHS or an agency of the Department of Health and Human Services (HHS) was responsible for audit resolution. The OIG reviewed 133 nonfederal audit reports of tribes, nonprofit organizations and other governmental organizations. The HHS funding to

these auditees totaled approximately $234 million, including IHS funding of approximately $137 million. The 133 reports contained 511 findings with questioned costs of over $1.2 million. The OIG categorized and summarized the 511 findings into the following seven deficiency categories: internal controls; cash management; financial reporting; cash disbursement; policy and procedures; accounting system; and program and administrative requirements.

The OIG recommended that IHS use the nonfederal reports to identify and address recurring deficiency areas where improvements are needed in order to effectively and efficiently administer IHS-funded programs. The IHS should focus its attention in these areas by issuing guidelines and instructions to the administrators of tribal programs; holding training workshops; and closely monitoring corrective actions. The PHS concurred with the OIG recommendations and reported that their implementation was underway. (CIN: A-05-93-00079)

Exclusions for Health Education Assistance Loan Defaults

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

The Social Security Act permits and, in some instances, mandates exclusion from Medicare and State health care programs for nonpayment of these loans. Since mid-1992, over 1,000 people have been excluded for defaulting on their HEAL debts. During this 6-month semiannual period, 287 were excluded as a result of PHS referral of their cases to OIG.

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

At the conclusion of this reporting period, 267 individuals had taken advantage of the opportunity and entered into settlement agreements or completely repaid their HEALs. The amount of money being repaid through settlement agreements or through complete repayment totals almost $20 million.

PHS Systems for Assuring that Programs Are Necessary, Productive and Nonduplicative

Through passage of the Government Performance and Results Act (GPRA) of 1993 and formation of the National Performance Review, the Administration and the Congress

underscored the need for managers and decision-makers to know how well Government is working. The PHS, as early as 1990, issued guidance through the Assistant Secretary for Health requiring that its agencies perform program evaluations which identify program outcomes.

The OIG found that the numerous evaluations of its programs and activities performed by PHS each year provide useful information but do not necessarily measure program results. The OIG believes that current PHS systems, with some reorganization and redirection, could better produce information needed to measure performance.

The OIG recommended that PHS create annual performance plans and reports which include program goals and the measurement of program performance against these goals to meet the mandate of GPRA; increase the number of evaluations which meet the Assistant Secretary for Health's guidance by establishing objective, measurable criteria for evaluating program necessity, productivity and duplication in accordance with program objectives; and develop procedures and training to ensure that program performance evaluations are integrated into the program planning, legislative planning and budgets systems in accordance with the Assistant Secretary for Health's 1990 guidance. In its comments to the draft report, PHS agreed with these recommendations and reported that it has initiated corrective action to implement them. (CIN: A-01-93-01514)

Fraud and Abuse of Grant Funds

The embezzlement of money is particularly egregious when the funds were intended to help people in extremely difficult circumstances. The following cases concluded during this period were in this category:

- In Oklahoma, the former chairperson of the Ponca Tribe was sentenced to 12 months in prison and ordered to make restitution of $19,000 to the tribe. After IHS made a $140,670 electronic overpayment in grant funds for alcohol rehabilitation, the woman had the money transferred to the general account. She then had the tribal secretary-treasurer write checks to her for nonrelated expenses and to other individuals who would cash them and give her the money. The secretary-treasurer was sentenced earlier to 6 months home detention and 2 years probation, and ordered to pay restitution of $250.

- The former director of an alcohol rehabilitation program funded by IHS in South Dakota was sentenced for embezzling money from the program. She was fined $250, ordered to pay $4,512 in restitution, and sentenced to 3 years probation.

Administration for Children and Families, and Administration on Aging

Chapter IV

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. Expenditures for the ACF programs are expected to exceed $32 billion for Fiscal Year 1995. The major programs include: Aid to Families with Dependent Children (AFDC), Emergency Assistance, Child Support Enforcement (CSE), Foster Care, Job Opportunities and Basic Skills (JOBS) training, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant program.

The Family Support Act of 1988 provides a comprehensive restructuring of the welfare system to reduce long term dependency on welfare programs. The last phase of the Act is slated for implementation in 1995. The Office of Inspector General (OIG) identifies opportunities to improve Federal and State management of delivery of program services and monitors the implementation of the Act. The OIG also reviews the cost-effectiveness of the various social services and assistance programs, including determining whether authorized services are rendered to eligible recipients at the lowest cost.

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

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

The OIG has reported opportunities for program improvements to target the neediest for services; expand available financial resources; upgrade data collection and reporting; and enhance program oversight. Current work includes a discussion of benefits offered by intergenerational activities.

Nationwide Review of Health and Safety Standards at Child Care Facilities

Performance Measure

One of the identified goals of welfare reform is to assure that children are cared for in healthy and safe environments. In addition to actions required at the State level, OIG determined that greater Federal oversight is needed to improve health and safety of children in the Nation's federally-funded child care programs.

The OIG's audits in five States identified numerous instances in which child care facilities did not comply with State health and safety standards. The OIG recommended that ACF provide to State agencies identified best practices, which could include: parental involvement; provider self-appraisals; and private/public partnerships (e.g., accreditation boards or commercial inspectors). The OIG also proposed that ACF assign child-care health and safety responsibilities to a single unit within ACF, and share the results of this report with the State agencies responsible for the administration and oversight of child-care facilities. The ACF is in the process of initiating actions to enhance the health and safety of children. (CIN: A-04-94-00071)

Foster Care Placement in Relatives' Homes

Reviews by OIG in Ohio and Indiana assessed the extent to which State licensing requirements were met in cases where foster children were placed in the homes of relatives. Under the Foster Care program (title IV-E of the Social Security Act), if an eligible child is placed in a foster home, the home must be licensed or approved by the State agency. The licensing standards must provide equal protection for all children in foster care. The OIG found that in Ohio and Indiana less stringent standards were being used to approve relatives' foster homes.

The OIG recommended that the State ensure that all relatives' foster homes meet the same standards used by the State in licensing foster homes. Indiana concurred with the findings and recommendation and presented a corrective action plan. Ohio agreed that there was a discrepancy between State policy and county practice, and also presented a corrective action plan. (CIN: A-05-94-00005; CIN: A-05-94-00031)

Foster Care Contract Services

Foster care facilities are reimbursed through per diem rates, consisting of maintenance and service components. The maintenance portion of the rate covers food, shelter, clothing,

daily supervision and costs associated with providing these items. The service portion of the rate reflects costs for activities such as counseling, therapy, medical diagnoses, educational and psychological testing.

The OIG conducted an audit to determine whether the costs used by Iowa facilities to establish per diem rates were eligible for title IV-E reimbursement. In its review of job descriptions, the level of care provided and the duties of staff at the facilities, OIG found that a significant portion of the time and effort classified as maintenance should have been classified as service. Federal reimbursements for service costs are limited because the funding for social services is capped, whereas maintenance payments are reimbursed under the title IV-E open-ended funding. For the 3 facilities reviewed over a 20-month period, OIG estimated that Iowa claimed ineligible maintenance payments, totaling a potential $1.2 million (Federal share).

The OIG recommended that the State prorate the per diem rates of the facilities between maintenance and service components based on actual costs for those components, and design and implement a time study for facilities that produce equitable allocations of costs to title IV-E. In general, State officials and regional ACF officials disagreed with the findings and recommendations. (CIN: A-07-93-00703)

Independent Living Programs for Foster Care Youths

Performance Measure

Through the title IV-E Independent Living Program (ILP), ACF supports State efforts to assist adolescents in foster care to prepare for independent adult life. The program received permanent reauthorization in August 1993, at $70 million per year. The ACF took this occasion to reexamine its approach to the program and asked OIG to provide information and ideas on improving long term management and program reporting strategies.

The OIG recommended that ACF undertake two broad strategies to better ensure accountability, promote quality State services and enhance understanding in the field of independent living. The ACF's decisions regarding its overall approach to independent living will help direct its choice of specific options in each area. The OIG proposed that ACF restructure its independent living program application and program reporting procedures by requiring and supporting better State planning; strengthening independent living reporting mechanisms; improving the content of independent living reporting; and focusing on program performance and outcomes. Also, OIG recommended that ACF focus its management and program reporting efforts on information sharing by providing written information to the States and facilitating information sharing through ACF staff. In its response to OIG's draft report, ACF agreed with the two recommendations. (OEI-01-93-00090)

Independent Living Program: District of Columbia and West Virginia

The OIG audited ILPs administered by the District of Columbia and the State of West Virginia to determine whether recommendations made in prior audits were satisfactorily resolved. Such follow-up audits are required by Office of Management and Budget Circular A-50. The OIG found that, on the whole, satisfactory corrective action was taken by the District and West Virginia on the previous recommendations. However, some problems existed in the recovery of funds recommended for disallowance. The ACF had attempted to recover the recommended disallowances of nearly $250,000 from the District and $590,000 from West Virginia through offset of prior years' awards, but no funds were available. West Virginia issued a check to the Federal Government when recovery through offset was unsuccessful.

The OIG recommended that ACF act to recover funds from the District. Because of changes made subsequent to its audit, a separate OIG review will evaluate the effectiveness of current ACF audit resolution policies and procedures. (CIN: A-03-94-00600; CIN: A-03-94-00601)

Exemptions from Participation in the Job Opportunities and Basic Skills Program: California

The OIG evaluated a California county's application of the JOBS program provisions that exempt certain AFDC recipients from participating in education, training and employment activities. The OIG found that 48 percent of randomly sampled cases were either improperly granted exemptions or exemptions were not supported by required documentation. For example, individuals exempted on the basis of working 30 or more hours per week were often working less, and in some cases were unemployed. In addition, 12 percent of sampled cases were classified under the wrong exemption category.

Improvement in procedures would allow more AFDC recipients to be considered for education and training opportunities, thus providing more people the opportunity to leave the welfare rolls. Accordingly, OIG recommended that the State require the county to implement corrective actions; inform other counties of conditions identified; and emphasize the need to comply with applicable Federal and State criteria for granting exemptions under the program. The State concurred. In addition, OIG advised ACF to upgrade its efforts in monitoring the JOBS program, and providing guidance and technical assistance to the States in their exemption granting process. (CIN: A-09-94-00048)

Welfare Administrative Costs

This report presents five alternative options for reimbursing administrative costs in the Medicaid, AFDC and Food Stamp programs. The OIG found that the current cost

reimbursement system for welfare administrative costs creates unnecessary documentation and accounting burdens; results in unexplained disparities among States; and allows for unpredictable Federal expenditures. The OIG believes that it should be replaced by a system that provides adequate funding for States; incentives for efficient operations; decreased Federal monitoring and oversight; and predictable Federal expenditures. The options presented in this report are meant to serve as a starting point in developing a new welfare administrative cost system. In costing out four of the options, OIG identified savings that ranged from $727 million to $7.6 billion over 5 years. The fifth option showed increased costs of approximately $3.4 billion over 5 years. Results of this study were presented before a congressional subcommittee in the spring of 1994. (OEI-05-91-01080)

Aid to Families with Dependent Children Payments after Death

As a result of a congressional request, in 1988 the General Accounting Office (GAO) conducted a study to determine if federally funded public assistance benefits were improperly continued after a recipient's death. Based on a review of 229 cases in 2 States and the District of Columbia, GAO concluded that AFDC and other public assistance may have continued for up to 2 years or more after the death of some recipients.

To determine if States were still issuing AFDC benefits after death, OIG analyzed a three State probe sample of 54 cases with dates of death in 1992. The OIG found that none of the deceased persons in its sample was receiving AFDC benefits at death and that, therefore, no improper AFDC payments were made. Although the computer match of State and Social Security Administration records from which the sample was drawn included both young and old people who received public assistance, the vast majority of the recipients in the sample were of advanced age, not children or young parents who would typically receive AFDC.

State and local officials interviewed stated that the incidence of mortality among AFDC recipients is quite low, and that AFDC staff are usually notified in a timely manner when deaths occur. While unable to conclusively determine whether or not public assistance payments were being made on behalf of deceased AFDC recipients based on its limited sample, OIG believes that the universe of AFDC recipient deaths is too small to warrant further review. (OEI-04-91-00040)

State Income and Eligibility Verification Systems

The State Income and Eligibility Verification System (IEVS) was established by the Congress in the 1984 Deficit Reduction Act to reduce errors in determining eligibility and benefit levels in the Food Stamp, AFDC and Medicaid programs. The implementing regulations require State agencies to compare income reported by program applicants and recipients from several data sources, including those of the Internal Revenue Service, the Social Security Administration and the States themselves.

In previous studies, OIG found that State IEVS practices and levels of matching success and efficiency varied considerably. Nevertheless, the most promising approach to improving the cost-effectiveness of matching systems seemed to be through the initiative and experimentation of individual States. For this reason, OIG decided to compile the information gathered from its reviews of State practices in an easy to read reference document and share it among the States and Federal agencies. The OIG hopes thereby to stimulate discussions within and among State and Federal agencies as they exchange views and attempt to improve computerized eligibility verification. (OEI-06-92-00081; OEI-06-92-00082)

Welfare Fraud

Welfare assistance provided under the AFDC, Medicaid, Food Stamp and general assistance programs is based on State determinations of eligibility. As a result, welfare fraud is usually perpetrated by providing false information about one's circumstances, such as claiming a nonexistent dependent child or concealing income which would render the applicant ineligible. Suspected fraud is discovered through a variety of mechanisms, ranging from disclosure by a disgruntled acquaintance or relative to computer matches of welfare lists against worker's compensation rolls or income tax returns.

The following cases are examples of some of OIG's activities in the area of welfare fraud:

- In New York, a woman who used fake baptismal certificates and other false documents to create 15 fictitious families was sentenced to 3 years in jail, to be followed by 3 years parole. The woman illegally received $450,000 in benefits from the AFDC, food stamp and Medicaid programs under at least 15 different aliases and for 73 children (including 11 sets of twins). At the peak of her activity in late 1990 and early 1991, she was simultaneously collecting benefits under 8 aliases and for 46 children. She was barred from applying to the welfare program for at least 6 months after her release, and ordered to repay $50,000.

- A Texas woman receiving AFDC benefits failed to inform the State agency that she was also receiving Social Security child's benefits. The woman was placed on a deferred adjudication and ordered to pay $3,740 in restitution and fines.

- In Massachusetts, a woman was overpaid $59,370 in AFDC, Medicaid and Food Stamp benefits because she failed to disclose earned and unearned income to the State welfare department. She was sentenced to 6 months probation and ordered to make full restitution.

- Welfare fraud projects conducted in two counties in Ohio, where OIG works with State and local officials to identify individuals defrauding these programs, yielded 17 convictions during this period. One project has resulted in a total of 33 convictions to date, and the other 19.

The Department makes grants available to community action groups to assist low income individuals with weatherization and other energy-efficiency improvements designed to reduce their heating bills. Successful actions were completed in two cases of fraud in this Low Income Home Energy Assistance Program (LIHEAP).

- The former manager of a community council that served several rural counties in Minnesota was sentenced to 15 months confinement and 3 years supervisory release for preparing fictitious invoices for home improvement work by companies created by five other defendants, who submitted the invoices for work only partially or never done. The manager then approved checks for the invoices, and the other defendants paid him kickbacks of close to 60 percent. Two of the five other defendants were sentenced to 4 months confinement, and the remainder to home detention or probation. Among the six, the restitution ordered totaled $157,450.

- In New Jersey, two more persons were placed on a pretrial diversion program in a scheme in which county employees paid LIHEAP funds to themselves and others under fictitious names and Social Security numbers, concealing their incomes. Thus far, 17 persons have pled guilty or entered a pretrial diversion program, and a total of $79,000 has been ordered in restitution. Another defendant died during the course of the investigation.

Refugee Employability Services

The OIG found that California's procedures for contracting with counties for refugee employability services should be improved to ensure that funds made available for specific time periods match the need for services during those periods. The audit concentrated on Los Angeles County, where it was found that $2.3 million of the $7.8 million provided for the audit period remained unused at the end of the period.

Further, significant and widespread problems were found in case file documentation supporting eligibility, training participation, job placement and delivery of services. Deficiencies noted included unexplained and questionable alteration of records; incomplete records; documents with inconsistent information which differed from information elsewhere in case files; and forms attesting to attendance, services and other activities that were frequently signed and dated in advance. The conditions occurred to such an extent that

the case file records could not be relied on in assessing the providers' performance or verifying that services were provided.

The OIG made several specific recommendations for strengthening contracting procedures between the State and participating counties; for improving county oversight over the program; and for ensuring compliance with contract requirements. The State concurred and stated that corrective action was being taken. (CIN: A-09-93-00106)

Colocated Intergenerational Activities in Departmental Programs

Performance Measure

An OIG review identified benefits that colocated, intergenerational facilities would provide to children, seniors and the community, as well as common concerns in the implementation of such programs. The AoA and ACF could take advantage of benefits offered through intergenerational activities by encouraging the colocation of programs, such as Head Start and senior centers, on a voluntary basis.

The OIG recommended that AoA and ACF examine whether the demonstrated successes in colocating programs and facilities in the private and public sector can be more broadly applied on a voluntary basis. The AoA and ACF generally agreed with OIG's conclusions and recommendations. (CIN: A-05-94-00009)

General Oversight

CHAPTER V

GENERAL OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities. The Office of the Secretary (OS) will spend $121 million in Fiscal Year (FY) 1995 to provide overall direction for departmental activities as well as common services such as personnel, accounting and payroll to the individual operating divisions. Central to these activities is the development of the Department of Health and Human Services' (HHS') budget and its execution, as well as the related activities of establishing and monitoring departmental policy for debt collection, cash management, payment of HHS grants, and contracts and procurements. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

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

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

Nonfederal Audits

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

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In FY 1994, OIG's National External Audit Review Center (located in Kansas City) reviewed over 5,100 reports that covered over $1.1 trillion in audited costs. Federal dollars covered by these audits totaled $349 billion, about $177 billion of which was HHS money.

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

A. Office of Inspector General's Proactive Role

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

- Through evaluation of reported data, OIG is able to provide basic audit coverage and analyze reports to identify entities for high-risk monitoring and trends that could indicate problems within HHS' programs. These problems are brought to the attention of departmental management to improve program administration. In addition, OIG profiles nonfederal audit findings of a particular program or activity over a period of time to identify systemic problems. Such a profile of Indian Health Service findings is shown on page 47.

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

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number and through training. During the past 6 months, nearly 600 individuals were provided with technical assistance through OIG's toll free number. In addition, formal training was provided to certified public accountant societies and State auditor staff on issues related to Circulars A-128 and A-133.

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

B. Quality Control

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

Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 2,360 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,988
Reports issued with major changes	8
Reports with significant inadequacies	364
Total audit reports processed	2,360

The 2,360 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling $4.8 million as well as 3,340 recommendations for improving management operations. In addition, areas were identified for follow-up by OIG auditors.

Resolving Office of Inspector General Recommendations

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

A. Questioned Costs

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

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

	Number	Dollar Value (in thousands)	
		Questioned	Unsupported
A. For which no management decision had been made by the commencement of the reporting period[1]	443	$447,806	$14,499
B. Which were issued during the reporting period[2]	145	$280,764	$ 320
Subtotals (A + B)	588	$728,570	$14,819
Less:			
C. For which a management decision was made during the reporting period[3]:	302	$573,621	$ 2,939
(i) dollar value of disallowed costs[4]		$557,895	$ 1,228
(ii) dollar value of costs not disallowed		$ 15,726	$ 1,711
D. For which no management decision had been made by the end of the reporting period	286	$154,949	$11,880
E. Reports for which no management decision was made within 6 months of issuance[5]	132	$118,009	$11,633

See Appendix D for footnotes.

B. Funds Put to Better Use

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

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

	Number	Dollar Value (in thousands)
A. For which no management decision had been made by the commencement of the reporting period[1]	72	$1,874,709
B. Which were issued during the reporting period	21	$1,101,393
Subtotals (A + B)	93	$2,976,102
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management[2]		
(a) based on proposed management action[3]	57	$1,183,952
(b) based on proposed legislative action	1	$ 15,200
Subtotals (a+b)	58	$1,199,152
(ii) dollar value of recommendations that were not agreed to by management	5	$ 470,445
Subtotals (i + ii)	63	$1,669,597
D. For which no management decision had been made by the end of the reporting period[4]	30	$1,306,505

See Appendix D for footnotes.

Legislative and Regulatory Review and Regulatory Development

A. Review Functions

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. During this reporting period, OIG reviewed 61 of the Department's regulations under development and 130 departmental legislative proposals.

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

B. Legislative and Regulatory Development Functions

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

During this reporting period, OIG continued its development of several regulatory initiatives related to the safe harbor provisions under the Medicare and State health care programs' anti-kickback statute, and various rulemaking efforts related to expanding and revising its CMP and peer review organization sanction authorities. These efforts included development of OIG final rules addressing CMPs for prohibited referral arrangements and revised safe harbors for managed health plans, and the Federal Register publication of a proposed rule addressing CMPs for hospital physician incentive plans.

C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process and the preparation and provision of congressional testimony. During this 6-month period, OIG testified at several hearings. For example, in the 103rd Congress, OIG testified on issues such as Medicare reimbursement for ambulance services and oxygen concentrators. Thus far in the 104th Congress, OIG has presented testimony on Medicare cost savers and an overview of the Department's programs. The hearing process offers OIG the opportunity to meet its statutory obligation of keeping the Congress informed of its work with regard to the effective and efficient operation of Department programs. The OIG continues to track all relevant congressional hearings and pending legislation related to a wide range of HHS issues.

Graduate Student Compensation at Selected Universities

The objectives of this audit were to determine whether graduate student compensation charged to federally sponsored research was reasonable and whether OMB Circular A-21, Cost Principles for Educational Institutions, should be modified. Graduate students play a central role in research, working on sponsored research projects under the direction of a faculty member. Their compensation can include salary, health benefits and tuition remission.

For the most recent fiscal year for which data was available, three of the four universities audited charged federally sponsored research about $5.7 million for what OIG found to be unreasonable compensation. In the absence of clear guidance on reasonable compensation to graduate students, OIG utilized the starting salary of an entry-level research professional at each university as a measure of reasonableness for that university. The OIG determined that the three universities used a liberal interpretation of reasonableness which did not meet the "prudent person" requirement for such charges.

The OIG believes that it would be helpful if OMB Circular A-21 provided specific guidance on graduate student compensation. Accordingly, OIG recommended that the Assistant Secretary for Management and Budget (ASMB) work with OMB to provide guidance on the standard of reasonableness for graduate student compensation. The ASMB agreed with OIG's recommendation that graduate student compensation be based on assigned responsibilities and not exceed compensation of other individuals of similar experience performing similar work at the university. It forwarded the final OIG report to OMB with its endorsement that the subject be addressed in the next revision to Circular A-21. (CIN: A-01-94-04002)

Civil Penalties for False Claims: Training Cost Settlement

The OIG's audit and investigative work resulted in a $27 million recovery from the State of New York. The $27 million was a settlement by the State, several State colleges and 5 State employees based on allegations by the Federal Government that they knowingly submitted false or improper claims. Under the Social Security Act, the Federal Government disburses funds to States for training social service workers who implement such Federal programs as Medicaid, adoption and foster care, child support enforcement and Aid to Families with Dependent Children.

Almost half the settlement relates to New York's requiring its private training contractors to provide in-kind "contributions" for the State's share of matching funds. The OIG worked closely with the Department of Justice in developing civil fraud issues that arose from audit work and a later qui tam suit filed by a former State employee.

Employee Fraud and Misconduct

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

- In California, a former administrative officer with the Public Health Service (PHS) was sentenced for illegally converting frequent flyer mileage credits, earned on Government business, for personal use or for friends and family members. The man was sentenced to 36 months probation and fined $1,000. As a condition of his guilty plea, before the sentencing he reimbursed PHS $30,413 that he had converted to personal use. In addition, he voluntarily turned over to PHS 28 frequent flyer award cheques, the equivalent of seven round-trip tickets for PHS employees from San Francisco to Washington, D.C..

- A former service representative in a New York Social Security Administration (SSA) office was sentenced after pleading guilty to fraud. She admitted obtaining mothers' maiden names of various Social Security number (SSN) holders and selling them to a Nigerian credit card ring. The ring tricked banks into sending replacement credit cards to mail drops and then elicited the password on the accounts by knowing the depositors' mothers' maiden names. The OIG developed a program enabling it to establish that she was the only person who had accessed those SSNs on specific dates and times. She was sentenced to 2 years probation and ordered to pay a $50 assessment.

- In California, a former Social Security benefits authorizer was sentenced to 3 years probation and ordered to pay restitution of $1,298, perform 200 hours of community service, and pay a special assessment of $50. The woman also lost her retirement and other benefits. She used her position to create a false record that generated checks to a forger. The forger was convicted earlier and sent to prison.

- A development clerk in a New Jersey SSA office applied for and cashed replacement salary checks after she had received and cashed her original checks. She was placed on a pretrial diversion program and ordered to pay restitution of $970.

Criminal Prosecutions

During this semiannual reporting period, OIG investigations resulted in 433 successful criminal actions. Also during this period, 572 cases were presented for prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors in 378 cases.

The number of convictions in this period has declined from previous reporting periods. Resource constraints in OIG have resulted in fewer criminal investigators and a growing backlog of cases. In keeping with its commitment to the highest priorities, OIG has reduced investigative coverage in some geographic and program areas. Existing staff are being concentrated in States with the most HHS program dollars and being deployed to work on the most serious program violations.

Cooperation with Other Law Enforcement Agencies

Many Federal, State, and local law enforcement and regulatory agencies depend on OIG expertise for assistance in identifying, locating, investigating and prosecuting individuals who have improperly used SSNs in a broad range of illegal activities, including bank and credit card fraud, licensing and income tax fraud, welfare fraud, drug trafficking and racketeering, as well as fraud in programs such as student loans, food stamps and unemployment compensation. Other agencies also benefit from OIG investigations, such as private health insurers, State Medicaid programs and drug regulatory entities. Many of these cases in which OIG participates result in monetary fines, recoveries, restitution or savings for the other agencies. During this period, the monies accruing from these cases amounted to approximately $8.4 million for other public or private entities.

Appendices

APPENDIX A

Implemented Office of Inspector General Recommendations to Put Funds to Better Use October 1994 through March 1995

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

Legislative savings are annualized amounts based on Congressional Budget Office estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures for the year in which the change is effected. Total savings for this period amount to $4,278.8 million.

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Raise and Index the Medicare Part B Deductible: The Medicare Part B deductible should be raised to $100 and indexed. (ACN: 09-52043)	Section 4302 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 increased the Part B deductible to $100 beginning in 1991. However, OBRA 1990 did not subject the deductible to indexing.	$585
Reimbursement for Outpatient Facility Services: The Health Care Financing Administration (HCFA) should limit outpatient department (OPD) facility fees and beneficiary charges to the applicable ambulatory surgical center (ASC) rate or reduce payments for OPD services to bring them in line with ASC payments. (OAI-85-IX-00046; CIN: A-14-89-00221)	Section 4151(b) of OBRA 1990 reduced payments for hospital outpatient services paid on a reasonable cost basis, and section 4151(c)(1)(a) modified the blending formula for payments for ambulatory surgical procedures performed in OPDs. Section 13522 of OBRA 1993 extended the 5.8 percent reduction in payment for OPDs through 1998.	460
Payment Rates for the Drug Epogen: Reimbursement for Epogen should be based on units administered rather than a flat rate. The HCFA should reduce the reimbursement rate not to exceed $10.10 per 1,000 units administered. (CIN: A-01-90-00512; CIN: A-01-92-00506)	Section 4201(c) of OBRA 1990 based the payment rate for Epogen on 1,000 units rounded to the nearest 100 units. Section 13566 of OBRA 1993 reduced the reimbursement rate for Epogen to $10 per thousand units.	92
Preaward Audits: The OIG reviewed peer review organizations' (PROs') contract proposals and contract extensions, and provided contracting officials at HCFA with reports documenting questioned costs and unsupported costs. (Various CINs)	Contracting officials used OIG recommendations to negotiate contracts at significantly lower rates than originally proposed.	62

OIG Recommendation	Status	Savings in Millions
Medicare Payments for Unnecessary and Poor Quality Endoscopies: The HCFA should reduce the incidence of payments for unnecessary and poor quality gastrointestinal endoscopies. (OEI-09-88-01006)	The OIG accepted the PROs' Fourth Scope of Work as an acceptable corrective action plan for HCFA to address OIG's recommendation and reduce payments for unnecessary and poor quality endoscopies.	$54.8
Modifications to Medicaid Drug Rebate Program: Establish State-specific cost reduction targets based on the comparison of individual State drug prices with national and international drug price data; set specific drug price limits for brand name drugs similar to those in place for multi-source drugs; or negotiate directly with manufacturers for prescription drug discounts and rebates. The HCFA should support legislation to retain the current procedures for computing additional rebates. (CIN: A-06-93-00070; OEI-12-90-00800)	Section 13602 of OBRA 1993 permitted States to operate prescription drug formularies meeting certain requirements; removed current law prohibition on the imposition of prior authorization controls with respect to new drugs during the first 6 months following Food and Drug Administration approval; and repealed the weighted average manufacturer price inflation formula for calculating the additional rebate under current law.	54
Intraocular Lenses in Ambulatory Surgical Centers and Hospitals: In a 1988 report, OIG recommended that HCFA establish a national Part B reimbursement cap of $200, with a handling fee not to exceed 10 percent, for any intraocular lens (IOL) billed to Medicare. After later studies found that IOLs were available for lesser amounts, OIG issued a report in June 1990 recommending that Medicare pay a flat $150 for all IOLs. In a March 1994 report, OIG recommended that payments for IOLs be reduced to current acquisition rates. (OEI-07-89-01664; OAI-07-89-01662; OAI-07-89-01661; OAI-07-89-01660; OAI-09-88-00490; OAI-85-IX-046; OEI-05-92-01030)	Section 4151(c)(3) of OBRA 1990 maintained the $200 IOL allowance provided for in the regulations as part of the ASC payment amount, through December 31, 1992. Section 13533 of OBRA 1993 reduced payments for IOLs in ASCs to $150.	38
Medicaid Estate Recoveries: The HCFA should make stronger programmatic initiatives on estate recoveries and encourage statutory changes to enhance asset control and recovery activities, such as making liens (or some other form of encumbrance) a condition of eligibility. States should be required to recover Medicaid personal needs allowance funds from a deceased individual's estate to offset the cost of care. (OAI-09-86-00078; CIN: A-01-93-00002)	Section 13612 of OBRA 1993 required States to recover the costs of nursing facility and other long-term care services furnished to Medicaid beneficiaries from the estates of such beneficiaries, and establish hardship procedures for waiver of recovery in cases where undue hardship would result.	37
Short/Doyle Medicaid Payment Rates: The State of California should ensure that Short/Doyle payments are limited in accordance with the State's Medicaid plan and Federal requirements. (CIN: A-09-91-00076; CIN: A-09-92-00094)	The HCFA approved a California State plan amendment that modified and clarified the States's reimbursement policy for Short/Doyle Medicaid mental health services.	7.1

OIG Recommendation	Status	Savings in Millions
SOCIAL SECURITY ADMINISTRATION		
Social Security Coverage for State and Local Government Employees: Require mandatory Social Security coverage for all noncovered State and local government employees who are not participating in a public employees' retirement system. (CIN: A-02-86-62604)	Section 11332 of OBRA 1990 extends Social Security coverage to most State and local employees not participating in a public employee retirement system. The effective date is July 1, 1991.	$2,700
Enhancements to Social Security Administration's Enumeration Verification System: Modify the enumeration verification system (EVS) process 212 (which is a mechanism for verifying Social Security number information), match EVS unverified records against the master beneficiary record (MBR) and correct EVS date of birth tolerances. (OEI-09-86-00068)	The Social Security Administration (SSA) modified their systems; their Social Security number verification procedure now matches EVS unverified records against the MBR and supplemental security record. This procedure was implemented as part of the State verification and exchange system. In addition, SSA modified the EVS tolerances to conform to published specifications.	5.6
Presumptive Disability Payments to Supplemental Security Income Recipients: The SSA should highlight presumptive disability (PD) reversal rates in management information reports on State disability determination services (DDS) agencies' performance. It also should issue a reminder to field offices and State DDS agencies that SSI PD payments are to begin no earlier than the month in which the PD decision is made. (OEI-07-89-01650)	In June 1992, SSA began including PD and presumptive blindness (PB) reversal rates for each State in monthly management information reports on DDS performance. The reports also include usage rates. This information will focus attention on State DDS agencies with high reversal rates and thereby assure that PD decisions are appropriate. Also, in November 1992, SSA issued a program circular to SSA field offices and States that included a reminder that PD/PB payments can be made no earlier than the month in which the decision is made.	4.3
GENERAL OVERSIGHT		
Indirect Cost Rate Reviews: The OIG provides audit assistance to the Division of Cost Allocation (DCA) to support negotiations of indirect cost rates with universities and nonprofit organizations. (Various CINs)	Based on results of completed negotiations, DCA credited OIG with the Federal share of actual savings for Fiscal Years 1992 and 1993 as shown.	179

APPENDIX B

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

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

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Modify Formula for Costs Charged to the Medicaid Program: The Health Care Financing Administration (HCFA) should consult with the Congress on modification of the Federal Medical Assistance Percentage formula used to determine the Federal share of costs for the Medicaid and other programs which would result in distributions of Federal funds that more closely reflect per-capita income relationships. (CIN: A-06-89-00041)	No legislative proposal was included in the President's Fiscal Year (FY) 1996 budget.	$4,100
Indirect Medical Education: Reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether any adjustment factor is warranted for all teaching hospitals. (CIN: A-07-88-00111)	Although the President's FY 1995 budget contained a proposal to reduce the IME factor to 3 percent, no legislative proposal was included in the President's FY 1996 budget.	2,130
Medicare Coverage of State and Local Government Employees: Require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1988. If this proposal is not enacted, seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (CIN: A-09-88-00072)	Although the President's FY 1995 budget contained a proposal to include under Medicare all State and local government employees hired before April 1, 1988, no legislative proposal was included in the President's FY 1996 budget.	1,559
Clinical Laboratory Tests: Require laboratories to identify and bill profiles (groups of related tests) at reduced rates whenever they are ordered, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (CIN: A-09-89-00031)	Although the President's FY 1995 budget included a proposal to reinstitute coinsurance for clinical laboratory services, no legislative proposal was included in the President's FY 1996 budget.	1,130

OIG Recommendation	Status	Savings in Millions
Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)	The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.	$1,100
Medicare Secondary Payer - Retroactive Recoveries: The HCFA should ensure that contractors' resources are sufficient and instruct contractors to recover improper primary payments; ensure that contractors take sufficient action to preclude the loss of backlogged Medicare secondary payer (MSP) cases (claims where contractors are more than one quarter behind in sending a demand letter) because the recovery period lapsed; implement financial management systems to ensure all overpayments are accurately recorded; and pursue alternative strategies such as contingency contracts, demonstration and incentive programs, or fund collection activities from recovery proceeds. (CIN: A-01-90-00509; CIN: A-01-91-00525; CIN: A-04-91-02004; CIN: A-04-92-02037; CIN: A-04-92-02057; CIN: A-02-93-01006; CIN: A-04-92-02049; CIN: A-14-94-00392; OEI-07-89-01683)	Adequate, consistent funding levels of payment safeguards, including MSP, have not been established. However, HCFA believes that it has sufficient funding to process the existing MSP backlog. The HCFA has also developed an MSP overpayment tracking system. However, this system has not been fully implemented at all contractors and it is not considered a financial management system. Efforts to stabilize funding of payment safeguards by establishing a mechanism that secures funding from the trust funds are being pursued by HCFA. The HCFA will consider demonstration projects.	961.6
Medicare Secondary Payer - Avoid Future Overpayments: The HCFA should revise the justification for an FY 1990 legislative proposal, which would require insurance companies, underwriters and third-party administrators to periodically submit employer group health policy (EGHP) coverage data directly to HCFA, and resubmit it. The HCFA should administratively: revise all Medicare claims forms to require a positive or negative response pertaining to other health insurance coverage; request that the Social Security Administration (SSA) maintain beneficiary spousal information in its master beneficiary record system for use by HCFA; assure compliance with all initial enrollment procedures and collect health insurance information for disabled beneficiaries during the required disability waiting period. (CIN: A-09-89-00100; CIN: A-09-91-00103; CIN: A-14-94-00392; CIN: A-14-94-00391; OEI-07-90-00760; OEI-07-90-00763)	The legislative proposal was not included in the President's FY 1996 budget. The HCFA is considering OIG's administrative recommendations.	900

OIG Recommendation	Status	Savings in Millions
Reduce Hospital Capital Costs: Seek legislative authority to continue mandated reductions in capital payments beyond FY 1995. The HCFA should determine the extent of the capital reductions that are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070; CIN: A-14-93-00380)	Although the President's FY 1995 budget contained a proposal to reduce inpatient capital payments beyond FY 1995, no legislative proposal was included in the President's FY 1996 budget.	$820
Medicaid Payments to Institutions for Mentally Retarded: The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010)	The HCFA nonconcurred with OIG's recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA and OIG negotiated an agreement for HCFA to send the report to all State Medicaid directors. This action has been taken.	683
Expand Medicare Secondary Payer Provisions: Extend the MSP provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016)	The President's FY 1996 budget contains a proposal to extend the MSP provision for individuals with ESRD to 24 months. Notwithstanding this proposal, OIG continues to advocate that Medicare should always be a secondary payer for ESRD beneficiaries.	503
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt policy. The OIG presented an analysis of four options for HCFA to consider including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system (PPS) hospitals which are profitable, and the inclusion of a bad debt factor in the diagnosis related group (DRG) rates. (CIN: A-14-90-00339)	This proposal was not included in the President's FY 1996 budget.	487.7

OIG Recommendation	Status	Savings in Millions
Terminate Medicare Disproportionate Share Adjustments: Terminate disproportionate share adjustment payments without redistribution of the funds to PPS hospitals. Payments under PPS adequately compensate hospitals for services provided to Medicare patients, including low-income patients. (CIN: A-04-87-00111)	Although the President's FY 1995 budget contained a proposal to phase down Medicare disproportionate share payments, no legislative proposal was included in the President's FY 1996 budget.	$430
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality. (CIN: A-05-89-00055; CIN: A-05-92-00006)	The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. As a final measure, HCFA may submit a legislative proposal to remove these stays from the usual DRG payment methodology. No proposal was included in the President's FY 1996 budget.	210
Graduate Medical Education: Revise the regulations to remove from a hospital's allowable graduate medical education (GME) base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020)	The HCFA is studying various options for legislative changes and believes a total restructuring of the GME payment system may be necessary. No legislative proposal was included in the President's FY 1996 budget.	157.3
Eliminate Inappropriate Payments for Total Parenteral Nutrition: The HCFA should: instruct carriers to adhere to a strict interpretation of the coverage guidelines for concentrated, purified nutrients; require the carriers to intensify review of certificates of medical necessity, discuss therapeutic options with physicians and monitor the use of nutrients over time; and review research into the clinical appropriateness of and payment methodologies for intradialytic parenteral nutrition (IPN). (OEI-12-92-00460; CIN: A-04-93-02073)	While HCFA generally agreed with OIG's recommendations, a subsequent review revealed that new claims were being paid for IPN contrary to Medicare coverage guidelines and the carriers' own guidelines which do not provide coverage for supplemental nutrition.	96.8
Recover Overpayments and Expand the Diagnosis Related Group Payment Window: The fiscal intermediaries should recover improper payments made to hospitals for nonphysician outpatient services (such as diagnostic tests and laboratory tests) rendered within 72 hours of the day of an inpatient admission, and refund the beneficiaries' coinsurance and deductible related to these payments. The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (CIN: A-01-92-00521)	The HCFA agreed to recover the improper billings and to refund the beneficiaries' coinsurance and deductible. It did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's FY 1996 budget.	92.1 [1]

OIG Recommendation	Status	Savings in Millions
Reduce Medicare Payments for Hospital Outpatient Department Services: Establish a legislative initiative to reduce the current payments for services in outpatient departments to bring them more in line with ambulatory service center (ASC) approval payments. Pay outpatient departments the ASC-approved rate or adjust hospital payments by a uniform percentage. (CIN: A-14-89-00221; OEI-09-88-01003)	The HCFA is currently preparing a report to the Congress on developing a PPS for outpatient departments. In addition, although the President's FY 1995 budget coutained a proposal to eliminate a formula-driven overpayment in hospital outpatient departments, no legislative proposal was included in the President's FY 1996 budget.	$90
Generic Drugs: The HCFA should identify and alert States to methods which would encourage the use of lower priced generic drug products in the Medicaid program. The HCFA should also take a more active role to encourage States to use generic drugs; provide stronger incentives for States to adopt policies that encourage use of generic drugs; monitor the States' efforts to encourage the use of lower priced drugs; and formally assess those activities. (CIN: A-06-93-00008)	The HCFA generally concurred with the recommendations.	49
Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)	The HCFA considered a proposal recommending that the 190-day lifetime limit for psychiatric hospitals be extended to general hospitals; however, such a proposal was not included as part of the President's FY 1996 budget.	47.6
Nonemergency Advanced Life Support Ambulance Services: The HCFA should modify its Medicare policy to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513)	Although HCFA concurred with the recommendations, it has yet to make the regulatory change planned. The OIG's findings were discussed on December 16, 1994, before the Senate Appropriations Committee, Subcommittee on Labor, Health and Human Services, Education and Related Agencies.	47
Medicaid Payments for Employer Group Health Insurance: The HCFA should continue to strongly support States implementing Section 1906 of the Social Security Act, and should propose legislation that allows States to pay EGHP deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules. (OEI-04-91-01050)	The HCFA concurred with the first recommendation and has been working in partnership with regional offices and States to promote full implementation. The HCFA deferred comment on the second recommendation.	32

OIG Recommendation	Status	Savings in Millions
Recover Medicaid Credit Balances: The HCFA should perform a formal evaluation of the State agencies' oversight of hospitals' procedures regarding Medicaid credit balances and the timely refunding of overpayments. Further, it should increase its monitoring of State agencies' activities to reduce overpayments in the areas of third party liability and duplicate payments. (CIN: A-04-92-01023)	The HCFA agreed to recover estimated outstanding credit balances and to perform an evaluation of State agencies' oversight activities. However, HCFA disagreed with the recommendation to increase its monitoring of State agencies' activities to reduce overpayments in the areas of third party liability and duplicate payments, but agreed to send the report to the State Medicaid directors.	$25
Further Reduce Medicare's End Stage Renal Disease Rates: Reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)	The HCFA agreed that ESRD facilities have become more efficient in their operations and that the composite payment rate should reflect the costs of outpatient maintenance dialysis treatment in an efficiently operated renal facility. While the Omnibus Budget Reconciliation Act (OBRA) of 1990 prohibited HCFA from changing the ESRD composite rates, it mandated a study to determine the costs and services and profits associated with various modalities of dialysis treatments.	22 [2]
Medicaid Cost Sharing: The HCFA should promote the development of effective cost sharing programs by: allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services; and allowing for higher beneficiary cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800)	The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. It plans to solicit information from States implementing cost sharing and distribute it to States that do not impose it.	19.8
Monitored Anesthesia: The HCFA should study the appropriateness of paying the same amount for monitored anesthesia care and general anesthesia in view of the fact that other insurers are more restrictive than Medicare. (OEI-02-89-00050)	The HCFA does not concur with this recommendation.	18

OIG Recommendation	Status	Savings in Millions
Establish Mandatory Prepayment Edit Screens for Medicare and Medicaid: The HCFA should move swiftly with the process of establishing mandatory prepayment edit screens for the Medicare and Medicaid programs. (CIN: A-03-91-00019)	The HCFA believes that the OIG approach does not consider the carriers' responsibility to establish Medicare coverage and payment policy when there is no national HCFA policy. The OIG disagrees. Good internal control procedures would require basic edit checks to ensure that the procedure codes are not manipulated. The HCFA, however, is addressing the rebundling issue in the development of its Medicare Transaction System, a single integrated claims processing system for both Part A and Part B claims that will replace the 14 different systems now used by Medicare contractors.	$12.9
Limit Reimbursement for Hospital Beds: The HCFA should develop a new approach for reimbursing suppliers for hospital beds used by Medicare beneficiaries at home. A new reimbursement methodology should reflect a hospital bed's useful life and the number of times a bed can customarily be rented over that period. (CIN: A-06-91-00080)	Although the President's FY 1995 budget contained a proposal that would authorize competitive bidding for durable medical equipment, no legislative proposal was included in the President's FY 1996 budget.	9.8
Medicare Claims for Railroad Retirement Beneficiaries: Discontinue use of a separate carrier to process Medicare claims for Railroad Retirement beneficiaries. (CIN: A-14-90-02528)	As introduced in the House, H.R. 3400, the Government Reform and Savings Act of 1993 (which addressed many of the National Performance Review recommendations) called for the repeal of the authority for a separate carrier chosen by the Railroad Retirement Board.	9.1
Medicare Payments for Orthotic Body Jackets: The OIG should require the durable medical equipment regional carriers (DMERCs) to closely monitor claims for body jackets, including: analysis of payment trends, provision of an early warning of abusive practices and monitoring of suppliers who have engaged in abusive practices. (OEI-04-92-01080)	The HCFA concurred and has instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices. The Statistical Analysis DMERCs produce quarterly reports and monthly ad hoc reports which assist the DMERCs in identifying potential abusive practices, and monitor those suppliers that appear to engage in abusive practices.	7
Medicare's Reimbursement for Hospital Emergency Room X-Rays: The HCFA should pay for reinterpretations of x-rays only when attending physicians specifically request a second physician's interpretation in order to render appropriate medical care before the patient is discharged. (OEI-02-89-01490)	The HCFA will revise the hospital emergency room x-ray interpretation policy guidelines in the Medicare Carriers Manual 2020G. The manual revision is currently under development.	4

OIG Recommendation	Status	Savings in Millions
Third Party Liability Settlements and Awards: The HCFA should develop legislative proposals to close the loopholes in OBRA 1993 that allow Medicaid beneficiaries who receive settlements and awards from third parties as a result of accidents to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. The HCFA should also develop guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties. (CIN: A-09-93-00033)	The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to the Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g. health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements.	$3
Hospital General and Administrative and Fringe Benefit Costs: Revise the Provider Reimbursement Manual (PRM) to provide explicit guidelines on the allowability of certain general administrative and fringe benefit costs. (CIN: A-03-92-00017)	The HCFA will conduct an in-depth analysis of the issues identified by OIG and will revise the PRM as appropriate to address specific categories of general and administrative and fringe benefit costs in order to provide better guidance to hospitals, other providers and intermediaries concerning the allowability of these costs.	2.1 [3]
SOCIAL SECURITY ADMINISTRATION		
Close Loopholes Affecting the Federal Insurance Contributions Act Wage Base: Require that salary reduction agreements established under Internal Revenue Code cafeteria plans be included in the definition of wages for Federal Insurance Contributions Act (FICA) purposes. (CIN: A-05-86-62602)	This proposal was not included in the President's FY 1996 budget.	1,533 [4]
Lodging Compensation: Include permanent lodging compensation for FICA coverage. (CIN: A-09-90-00050)	The SSA did not support this recommendation. Among other things, SSA believed that it might be difficult to administer if the value of employer-provided lodging were treated differently for FICA and income tax purposes, since this could be confusing and lead to reporting errors. The OIG pointed out that this recommendation does not appear to be more difficult to implement than the clergy provisions. This proposal was not included in the President's FY 1996 budget.	221

OIG Recommendation	Status	Savings in Millions
Expand Mandatory Tip Reporting Requirements: Expand the requirements for mandatory reporting of tip income to include other types of businesses where tipping is a common practice. (CIN: A-09-89-00072)	Although SSA supports OIG's recommendations, it believes that any proposal to change the requirements would be within the jurisdiction of the Internal Revenue Service (IRS). The IRS has not supported this proposal.	$134
Recover Value Lost to the Trust Funds from Past Due Debts: Institute a policy change to allow recovery for each delinquent overpayment at the higher of the interest income lost to the trust funds or the value lost to the trust funds due to inflation. (OAI-03-88-00680)	The SSA disagrees with the proposed method of recovery in the absence of a clear legislative mandate. The OIG remains convinced that the recommendation is appropriate.	112
State Reverse Offset Laws for Disability Benefits: The SSA should seek legislation rescinding reverse offset laws, and requiring a reduction of the Social Security disability payment because of workers' compensation (WC) and public disability benefit payments in all States. (OEI-06-89-00902)	This proposal was not included in the President's FY 1996 budget.	40.5
First Month of Eligibility: The SSA should submit a legislative proposal establishing a consistent definition of eligibility for age-based retirement and survivor payments. (OEI-12-89-01260)	The SSA did not agree with the recommendation and thought that it should be supported with a stronger rationale.	40
Develop Cost Standards for Disability Determination Services: The SSA should adopt the reimbursement method for laboratory fees used by Medicare for use by the disability determination services (DDSs). (OAI-06-88-00820)	The SSA had been considering a proposed rulemaking which would apply the Medicare laboratory fee schedule for use by DDSs, but deferred action until more experience was gained using a new consultative examination regulation. However, recent feedback on the regulation indicates that there is not enough information to implement the Medicare fee schedule. Moreover, due to budget and resource limitations, SSA plans to defer action on this recommendation.	15.3
Unreported Workers' Compensation: The SSA should expedite current negotiations and consider expansion of information exchange agreements with several States. A pilot exchange should be conducted to determine the most efficient method of obtaining WC information. If the pilot proves to be cost-effective, SSA should seek legislation to require States to identify WC recipients. (OEI-06-89-00900)	The SSA is negotiating with a State for a pilot WC information exchange agreement to determine the efficacy of legislation to require States to provide SSA with WC information.	11.7

OIG Recommendation	Status	Savings in Millions
Recover Supplemental Security Income Benefits through Income Tax Refund Offset: Take administrative action to recover certain SSI overpayments through income tax refunds. (OAI-12-86-00065)	The SSA has implemented tax refund offset to recover Old Age, Survivors and Disability Insurance overpayments. In consideration of the potential for a relatively small collection of delinquent debt and other priority demands for available resources, SSA has postponed implementation of tax refund offset for SSI debt until 1995.	$6
Revoking Penalties Under Good Cause Policy: The SSA should provide for independent and/or supervisory review of penalty revocation decisions before final authorization of such transactions and entry of the results into the automated system. (CIN: A-13-91-00208)	The SSA selected a sample of 1,151 earnings enforcement actions to use in its continuing review of the earnings enforcement operations and to evaluate actions related to the establishment and subsequent disposition of penalties. The information for the 1993 enforcement operations will be compared to study results from earlier enforcement operations to test effectiveness of operational initiatives concerning penalties and reviews. The SSA's Office of Program and Integrity Reviews expects the results of the analysis and its preparation of its summary report in early 1995.	5.6
New Cards for New Brides: The SSA should actively pursue the acquisition of computerized marriage records from States having this capability. (OEI-06-90-00820)	The SSA agreed with this concept, but is studying quantitative and cost issues before agreeing to implement.	5.5
Child Dependents' Dates of Birth: The SSA should review the universe of child dependents with incorrect dates of birth; identify and collect overpayments; create mandatory edits to preclude processing a claim when dates differ on the payment record and Social Security number (SSN) record; and modify alert verification processes to better identify date of birth discrepancies. (CIN: A-01-92-02001)	The SSA agreed with this concept, but is studying quantitative and cost issues before agreeing to implement.	5.3 [5]
Make Work Incentives Sufficient for Low-Earning Beneficiaries: Defer any benefit increases based on the trial work earnings of a disabled beneficiary until he or she reaches age 62 and can receive retirement benefits, or until his or her disability benefits period is up and he or she refiles for disability. (CIN: A-13-92-00223)	This proposal was not included in the President's FY 1996 budget.	3.7

OIG Recommendation	Status	Savings in Millions
PUBLIC HEALTH SERVICE		
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to various functions performed by the Food and Drug Administration (FDA), possibly including premarket review and approval for drugs and devices, inspections of additional manufacturing facilities, and inspections of food processors and establishments. (OEI-12-90-02020; OEI-05-90-01070)	The President's FY 1996 budget includes proposals to expand user fees into the medical devices field and import inspections, which would result in $39 million in fees. There is no provision for food safety inspections, but OIG estimates that an additional $233 million could be collected if its proposal were enacted.	$272
Limit Graduate Student Compensation: The Assistant Secretary for Management and Budget (ASMB) should work with the Office of Management and Budget (OMB) to revise Circular A-21 to stipulate a reasonableness standard for graduate student compensation charged to federally sponsored research based on assigned responsibilities and not to exceed compensation paid to other individuals of similar experience for similar work. (CIN: A-01-94-04002)	The ASMB endorsed the OIG recommendation, concluding that a prudent person would not provide greater compensation to individuals who are less qualified by education and practical experienee than others performing similar work.	5.7
Recharge Center Costs: Universities should: improve their oversight of recharge centers; develop and implement policies and procedures for the operation of recharge centers that are consistent with OMB Circular A-21; establish and maintain adequate accounting and recordkeeping procedures for recharge centers; and analyze and adjust billing rates to eliminate deficit and surplus funds. (CIN: A-09-92-04020)	The ASMB concurred with the recommendations and has recommended to OMB that Circular A-21 be revised to provide more definitive guidance on the financial operations of recharge eenters.	3.2
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Reducing Federal Financial Participation: The Administration for Children and Families should consult with the Congress on modifications to the Federal medical assistance percentages formula which would result in distributions of Federal funds that would more closely reflect per-capita income relationships. (CIN: A-06-90-00056)	This proposal was not included in the President's FY 1996 budget.	1,100

OIG Recommendation	Status	Savings in Millions
Reduce Incentive Payments and Base Them on States' Performance: Base incentive payments on the States' demonstrated ability to meet Federal child support enforcement (CSE) requirements and performance objectives. Also, consider OIG recommended options to reduce financial incentives realized by States that would result in a more equitable cost sharing with the Federal Government. These options are: limiting incentives to a break-even point where a State's share of Aid to Families with Dependent Children collections, plus incentive, equal the State's share of CSE costs; eliminating incentives to poor performing States; and reducing the Federal share of administrative costs. (CIN: A-09-91-00147; CIN: A-09-91-00034)	This proposal was not included in the President's FY 1996 budget.	$277
Limit Federal Participation in States' Costs for Administering the Foster Care Program: Limit Federal participation in Foster Care administrative costs through one of the following actions: limit future increases in administrative costs to no more than 10 percent per year; fund administrative activities via a single block grant with future increases based on the consumer price index; limit administrative costs to a percentage of maintenance payments; or restrict, through legislation, the filing period for retroactive claims, namely require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. (CIN: A-07-90-00274; OEI-05-91-01080)	This proposal was not included in the President's FY 1996 budget.	247
GENERAL OVERSIGHT		
Disallow Interest Charges on Unfunded Liabilities of Government Pension Plans: The OMB should revise Circular A-87 limiting Federal sharing of actuarially determined pension costs, including amortization of unfunded liabilities, to situations where the State and local governmental unit are funding such costs through an actuarially sound plan. Interest costs caused by late funding should not be allowed. (CIN: A-09-87-00031)	Because of the sensitivity and financial impact of the proposed changes on the State and local governmental entities, OMB has expended considerable effort working with State and local interest groups prior to issuance as a draft proposed rule change. The OIG continues to recommend that OMB clarify the rule relating to pensions by finalizing revisions to Circular A-87.	1,300

OIG Recommendation	Status
On-the-Job-Training Provided Under the Job Opportunities and Basic Skills Program: The ACF should encourage States to establish and implement procedures for determining the success of Job Opportunities and Basic Skills (JOBS) participants and the On-the Job Training program. The ACF should also ensure that the On-the-Job-Training and other components of JOBS are being effectively monitored in all States. (CIN: A-05-93-00019)	The ACF agreed with OIG's recommendations and is taking corrective action.
Strengthen Head Start Grantees' Financial Management Systems: The ACF should intensify efforts to assure that Head Start grantees have adequate systems of internal controls; maintain proper accounting records; have systems for assuring program requirements are met; and obtain acceptable independent audits and submit reports in accordance with Federal requirements. The ACF should also take appropriate action when grantees do not meet these requirements. (CIN: A-17-93-00001)	The ACF generally agreed with OIG's recommendations.
Measure Head Start Grantees' Performance: The ACF should establish and implement performance measures and procedures for determining Head Start grantees' compliance with program requirements, and as a basis for establishing uniform ratings and identifying management practices that create high-risk conditions. (CIN: A-04-90-00009)	The ACF agreed with the importance of strengthening performance measurement criteria but disagreed with OIG's conclusions relative to high-risk conditions.
Ensure that Head Start Program Attendance Goals and Matching Reqnirements are Met: The ACF should establish and implement procedures to ensure that center-based Head Start grantees attain the expected attendance goal of 85 percent of funded enrollment. The ACF should also seek a legislative change to require that funding levels be based on current conditions (not historic funding levels) and require current information to support requests for waivers of nonfederal matching requirements. (CIN: A-04-90-00010)	The ACF noted that it is obtaining information from its grantees to improve internal reporting procedures. As far as average daily attendance, ACF states that an average daily attendance of 85 percent is a service goal, not a program requirement of Head Start grantees. The ACF is also reviewing Head Start procedures to grant waivers.
Health and Safety Standards at Child Care Facilities: The ACF should work with States to improve the health and safety practices of child care facilities. In addition to actions ACF is already taking, OIG recommended that ACF provide State agencies with identified best practices including: parental involvement, provider self-appraisals and private/public partnerships. (CIN: A-04-94-00071; CIN: A-07-93-00718; CIN: A-12-92-00044)	The ACF generally concurred with OIG's findings and recommendations, and is taking actions to enhance the health and safety standards of child care facilities.

OIG Recommendation	Status
ADMINISTRATION FOR CHILDREN AND FAMILIES	
Summarization of Head Start Grantee Audit Findings: The Administration for Children and Families (ACF) should increase training and technical assistance to grantees; strengthen procedures regarding grantee monitoring and use of interest bearing accounts, and refunding interest income; implement the new audit requirement for nonprofit organizations administering Federal programs; develop procedures to detect grantees with interfund transfers; reevaluate procedures to ensure that excess cash is not drawn; and obtain evidence that excess balances are collaterally secured when awarding grants. The ACF should also reemphasize that the nonfederal match is properly documented and met; require evidence of current licensing or compliance with all of the facility standards; and emphasize use of sales tax exemptions and timely deposits of tax refunds. (CIN: A-07-91-00425)	The ACF is in general agreement with the recommendations.
Fees for Child Support Services Provided to Non-Aid to Families with Dependent Children Applicants: The ACF should continue to pursue legislative proposals to: ensure that States charge a reasonable fee when providing child support services to non-Aid to Families with Dependent Children (AFDC) applicants; reduce the large disparity in application fees charged by States; and charge an annual user fee for non-AFDC clients. In lieu of a legislative proposal, ACF could study the feasibility of alternative means for States to recoup from non-AFDC clients the cost of providing services. (CIN: A-06-91-00048)	The ACF submitted legislative proposals in 1991 and 1992 to address this issue. No legislative proposal was included in the President's FY 1996 budget.
Undistributed Child Support Payments: The ACF should remind States to: monitor and expedite the distribution of collected child support payments; place undistributed payments in interest bearing accounts; and report escheated payments and interest as State income. (CIN: A-09-93-00030)	The ACF agreed to participate in a joint effort with OIG to determine the extent of these problems, but disagreed with the need to remind States of ACF's policies and procedures for undistributed collections. The ACF expected considerable alleviation of the undistributed collections as States complete their automated systems.
Wage Withholding of Child Support Payments: The ACF should work with State Child Support Enforcement agencies to ensure standardized court order forms; issue detailed guidance to employers about the legal process for garnishment of wages for child support; and establish an electronics funds transfer system for expediting the payment process. (CIN: A-12-91-00016)	The ACF is working with State agencies regarding standardized court order forms and has implemented the remaining recommendations.
Overpayments of Aid to Families with Dependent Children: The ACF should take steps to improve controls by State agencies in detecting and recovering AFDC overpayments, and obtain information needed to effectively manage State overpayment collection activities. (CIN: A-01-92-02506)	The ACF agreed with OIG's recommendations and is taking corrective action.

OIG Recommendation	Status
Improve Controls Over Advisory Committee Conflict of Interest: The NIH should: review advisory committee members' financial disclosure forms to identify perceived or actual conflicts of interest; require ongoing reviews to identify changes in financial interest that could result in conflicts of interest; revise required financial disclosures to include involvement in nonfederal grants and contracts; and provide guidance to determine when a waiver should be sought to obtain essential services of a committee member. (CIN: A-15-93-00020)	The NIH concurred with OIG's recommendations and has taken actions which, when fully implemented, will significantly strengthen internal controls.
Implement a Charging System for Centers for Disease Control and Prevention Data Processing Costs: The PHS should require the Centers for Disease Control (CDC) to implement a system for charging data processing costs to its component centers consistent with the provisions of the Federal Information Processing Standards Publication 96. (CIN: A-04-92-03503)	The PHS did not concur with OIG's recommendations. However, it agreed to analyze its charging systems and correct any major inequities. The CDC reported that it analyzed its computer charges and found them not to be based on actual utilization. However, it stated that the charges included other costs incurred and that it will analyze these costs to ascertain whether there are any actual inequities.
Improve Monitoring of Community Health Center Grantee Financial Controls: The PHS should strengthen its monitoring procedures to improve community health centers' accountability over grant funds. (CIN: A-07-92-00518)	The PHS concurred with OIG's recommendations and indicated that onsite peer reviews began in FY 1994 to strengthen monitoring of community health centers.
Costs Incurred under Acquired Immune Deficiency Syndrome Grants: The PHS should develop a performance measure for acquired immune deficiency syndrome (AIDS) grants based on the extent to which grant funds are used for grant administration versus provision of direct services. (CIN: A-03-93-00351)	The PHS concurred with the intent of the OIG recommendation to develop a performance measure for AIDS grants. The PHS did not agree to modify its current grants award process, but plans to stress the need to closely monitor amounts proposed for administrative costs, particularly in those cases where the amounts proposed are higher than average experience.

OIG Recommendation	Status
Tighten Controls of the Advance Payment System Used by the Indian Health Service to Advance Cash to Contractors and Grantees: The PHS should: consider reporting the problems identified in the advance payment system used by the Indian Health Service (IHS) to advance funds to its contractors and grantees as a material internal control weakness or a material nonconformance under FMFIA; assess the propriety of funds advanced to 16 contractors who commingled IHS funds with their other funds; and evaluate alternatives for improving the current system of advancing funds to IHS contractors and grantees. (CIN: A-06-90-00001)	In its July 21, 1994 report on the status of corrective actions taken on OIG reports, PHS noted that IHS has corrected certain problems disclosed by the OIG report. Correction of all the problems will reportedly be completed when all area office tribal contracts are transferred to the departmental payment management system, expected by December 31, 1995.
Federal Involvement in Patents: The National Institutes of Health (NIH) should develop procedures to obtain information on patents issued to NIH grantees and determine if these patents were developed with Federal funds. (CIN: A-15-93-00029)	The PHS generally concurred with OIG's recommendations. The NIH has completed its review of patents issued to one grantee and found additional patents that were made with NIH support. The NIH has implemented a pilot project to assess the accuracy of reporting compliance for selected research institutions and has contacted the U.S. Patent Office to develop procedures which will lead to better monitoring of all federally supported patents.
Ensnre that All Superfund Grantees Are Audited: The PHS should direct its Superfund agencies to establish procedures to ensure that all Superfund grantees submit audit reports and that grantees that are unwilling to have a proper audit conducted are sanctioned. (CIN: A-04-93-04506; CIN: A-04-93-04518)	The PHS directed the Superfund grant offices to take steps to ensure that all Superfund grantees provide the required audit reports.
Improve Financial Reporting and Monitoring of Research Funds at Universities: The Department should require grantees to submit a revised budget for the use of unspent grant funds when a substantial carryover of funds occurs from one budget period to another. Additionally, the Department should expedite the pilot project for obtaining detailed expenditure data from universities. (CIN: A-06-91-00073)	The Assistant Secretary for Management and Budget and PHS concurred with OIG's recommendations. In April 1992, the Office of Management and Budget (OMB) gave the Department approval to conduct a pilot project with selected universities to obtain detailed expenditure data by electronic transfer. This project is still under development. In addition, PHS added language to its grant policy statement that defines "significant rebudgeting."
Improve Accountability Over National Institutes of Health's Management and Services and Supply Funds' Activities: The NIH should improve accountability over personal property and inventory by performing monthly reconciliations and perform adequate follow-up procedures on discrepancies noted by physical counts. The NIH should also develop policies and procedures for retaining supporting accounting documentation. (CIN: A-15-93-00008)	A Board of Survey was initiated and presented a series of recommendations to improve property management.

OIG Recommendation	Status
New Approaches for Obtaining Medical Evidence: The SSA should develop indicators to uniformly measure the performance of alternatives for processing medical evidence of record. (CIN: A-13-92-00106)	The SSA concurred and is taking corrective action.
Improve Controls Over Duplicate Postings of Self-Employment Income to the Master Earnings Records: The SSA needs better controls to provide reasonable assurance that self-employment income transactions are not duplicated when posted to the master earnings file. (CIN: A-13-92-00228)	The SSA agreed with OIG's recommendations and is taking corrective action.
Disability Work Incentives: The OIG recommended that SSA provide a subsequent trial work period to low-earning beneficiaries as an incentive to remain employed. (CIN: A-13-92-00223)	The SSA agreed that improvements are needed in motivating beneficiaries to return to work, and is pursuing development of legislative enhancements in the trial work provision to give greater security to beneficiaries trying to work.
Identify Disabled Beneficiaries Working under Another Social Security Number: The SSA should implement a computer match to identify cases where disabled beneficiaries may be working under different SSNs. (CIN: A-13-92-00235)	The SSA agreed that a computer match would enhance existing controls and is examining the feasibility.
Peripheral Vision Disability Assessment: The OIG recommended that SSA allow the use of currently available and widely used, automated peripheral vision testing devices for disability assessments. (CIN: A-13-93-00429)	The SSA agreed with the intent of OIG's recommendation and will move forward to expand the use of automated testing.
Install Courtesy Telephones: The SSA should determine where the installation of courtesy telephones in field offices could improve service delivery. (CIN: A-09-92-00072)	The SSA agreed to pursue the recommendation on a pilot test basis.
PUBLIC HEALTH SERVICE	
Fully Implement Internal Coutrols in the Food and Drug Administration's Medical Device 510(k) Review Process: The FDA should modify its exception report for use on a quarterly basis to detect possible manipulation of the 510(k) process; periodically sample reviewer workload to ensure compliance with the "first-in, first-reviewed" policy; require reviewers to document responses to all items on the review checklist; conduct bioresearch monitoring inspections on devices likely to result in 510(k) submissions; complete postmarket testing of the four devices it selected for review and increase the number sampled for future tests; include in its quality control reviews an independent scientific evaluation of reviewers' 510(k) decisions; and periodically monitor employee compliance with procedures for employee/industry contacts. (CIN: A-03-92-00605)	The PHS has reported that FDA has made significant progress in rectifying deficiencies in this program area, and that it will continue to monitor FDA's efforts until all corrective actions are implemented.

OIG Recommendation	Status
Integrated Debt Management System: The SSA should develop a plan detailing how the debt management system software modernization effort will be integrated with SSA modernization initiatives for Retirement, Survivors and Disability Insurance post-entitlement. (CIN: A-13-93-00403)	The SSA agreed with OIG's recommendations and stated that a plan is being developed.
Ensure that Earnings are Properly Posted to Wage Earners' Accounts: The SSA should implement 29 OIG recommendations that would substantially improve SSA's capability for correcting name and SSN errors for reported earnings. (CIN: A-13-89-00040)	The SSA has implemented several of the recommendations. The remaining recommendations will be resolved by full implementation of the earnings modernization system.
Strengthen Modernized Enumeration System Controls: The SSA needs to improve controls for taking and entering SSN application information. Among other things, OIG recommended that the Immigration and Naturalization Service (INS) enumerate aliens applying for original SSNs. (CIN: A-13-90-00045)	The SSA generally agreed with OIG's recommendations. However, SSA recommended that OIG revisit the issue of INS enumeration at a later date because INS cannot currently accept additional workloads.
Act Timely on Work Related Payment Cessations: The SSA needs to take steps to stop disability payments in a timely manner and prevent overpayments when disabled beneficiaries complete a trial work period. (CIN: A-13-92-00231)	The SSA generally agreed with the recommendations, but did not agree to shorten from 60 days to 30 days diaries for receipt of statements describing work.
Improve the Printing and Mailing of Social Security Cards: The SSA should improve security over unissued Social Security cards, better account for cards printed or spoiled, and reduce the number of undeliverable cards. (CIN: A-13-90-00047)	The SSA is implementing the recommendations.
Improve the Social Security Number Records Correction Process: The SSA needs to: improve the automated SSN records correction system controls; improve security over sensitive documents; ensure that SSN records correction workloads are processed in a timely manner; and better monitor the processing of emergency SSN requests. (CIN: A-13-92-00237)	The SSA is in the process of implementing the recommendations.
Death Termination Actions: The SSA should eliminate the system limitation that requires the manual processing of death termination actions in advance filing cases when the beneficiary dies prior to the date of entitlement month. (CIN: A-02-91-00002)	Implementation of this recommendation will be accomplished under the Title II Redesign Automatic Data Processing Plan.
Protect Social Security Administration Data Systems: The SSA should continue efforts to pilot and evaluate distributed data processing alternatives to its centralized computer center. (CIN: A-13-93-00041)	The SSA agreed and is moving toward an environment that takes advantage of both centralized and distributed processing systems.

OIG Recommendation	Status
Further Improvements Necessary to 800 Number Telephone System: The SSA should decrease the number and increase the size of telephone centers, make better use of technology and back-up agents to increase handling capacity and accuracy, and initiate a pilot to determine whether the telephone centers could become full service centers. (CIN: A-09-90-00071)	The SSA has referred the issue of the number and size of the telephone centers to a work group for evaluation. It has included evaluation of technological improvements in its service delivery plans and has expanded use of back-up units in its program service centers. The SSA did not support the concept of full service centers for the 800 number system.
Project Clean Data: The SSA should develop, maintain and widely disseminate a software package for detecting invalid Social Security numbers (SSNs) patterned after Project Clean Data. (OEI-12-90-02360)	The SSA agrees with the objective but believes greater use of the enumeration verification system would be more effective. The SSA is conducting a pilot test to assess employer interest and use.
Drug Addicts and Alcoholics: The SSA should work with PHS and HCFA to develop clearer definitions for drug addiction and alcoholism status, treatment and successful rehabilitation. (OEI-02-90-00950)	The SSA, working in conjunction with HCFA and PHS, developed a uniform referral and monitoring process for treatment of drug addicts and alcoholics. To date, 45 States have contracted to administer this process, and the remaining States are expected to be under contract in the near future.
Delayed Notices of Planned Action: Because of the potential cost implications of field office failure to maximize opportunities for overpayment avoidance by using manual notices of planned action in the Supplemental Security Income program, OIG recommended that SSA initiate a review to determine the extent of the problem. (OEI-04-90-02160)	The SSA is conducting a comprehensive review of the subject. The OIG will defer its actions until after the results of SSA's studies are compiled.
Work Incentives for Disabled Supplemental Security Income Recipients: The Commissioner of SSA should take the lead in organizing efforts to identify and study ways to encourage employers to hire severely disabled workers. (OEI-09-90-00020)	The SSA believes that coordination of agency efforts is a good idea, but that it should not assume the lead for such a Governmentwide effort. However, SSA has initiated several pilots to test different approaches to encourage the disabled workers to return to work.
Wage Certification: The SSA should expeditiously seek congressional guidance on the proper method for certifying wages so that proper revenue amounts are credited to the trust funds. (CIN: A-13-93-00408)	The SSA has drafted a legislative proposal to address this issue.
Establish Better Controls to Help Prevent or Detect Duplicate Payments to Attorneys: The SSA should: document a procedure instructing employees to look up attorney fee payments that may have been previously recorded before making any payment; modify the automated system with a control to detect duplicate payments to attorneys; review all potential duplicates identified by OIG for Calendar Year 1991 and begin recovery procedures; and periodically identify and review cases that contain two or more identical attorney fee payments to determine if a duplicate payment was made. (CIN: A-13-92-00219)	The SSA has implemented several of the recommendations and is proceeding with actions to implement the remaining recommendations.

OIG Recommendation	Status
Sanction Referral Authority of Peer Review Organizations: The HCFA should adopt one or more of the following options for changing the peer review organization (PRO) authority: repeal or modify the "unwilling or unable" requirement; substantially increase the monetary penalty; maintain the authority as it now exists, but mandate referrals to State medical boards when PROs confirm serious quality of care problems. (OEI-01-92-00250)	The HCFA opposed the first option, supported the second and concurred with the third. It plans to develop a Memorandum of Agreement which will provide the necessary mechanism for PROs to exchange information about those physicians found to have serious quality of care problems with the States.
Limits of Beneficiary Financial Liability: The HCFA should support legislation requiring physicians to make refunds to beneficiaries for amounts collected in excess of charge limits. (OEI-02-92-00130)	The HCFA supports legislation requiring physicians to make refunds to beneficiaries for amounts collected in excess of charge limits.
Inappropriate Payments for Total Parenteral Nutrition: The HCFA should review research concerning the use of intradialytic parenteral nutrition (IDPN). If IDPN is considered reasonable and necessary for the treatment of a subset of end stage renal disease patients, it should be paid on a per-capita basis, with discounts negotiated by each facility or the networks, or by using some other method that takes into account the efficiencies associated with facility administration of the nutrients. (OEI-12-92-00460)	The HCFA agreed that there has been inappropriate coverage of IDPN in the past and has proposed changes in the policy to ensure appropriate coverage.
Physician Office Surgery: The PROs should extend their review to surgery performed in physicians' offices. (OEI-07-91-00680)	The HCFA continues to work with the PROs to refine a methodology for review of quality of care for ambulatory services. The implementation plan is to expand the review of ambulatory services to additional States, first on a pilot basis, then on an implementation basis in other States.
Patient Advance Directives - Early Implementation Experience: The HCFA should develop and issue specific regulatory guidelines clarifying acceptable documentation methods to assist providers in meeting the requirements of the Federal statute. The statute requires providers to inform individuals of any rights they have under State law regarding self-determination. (OEI-06-91-01130)	The HCFA did not concur with the recommendation, but is willing to provide assistance to States by issuing a program memorandum containing examples of what would constitute acceptable documentation of whether a patient has an advance directive.
SOCIAL SECURITY ADMINISTRATION	
Suspended Payments Need to be Resolved Timely: The SSA should, in direct deposit cases where the beneficiary is placed in suspense status, institute stronger controls to ensure that timely action is taken to resolve these suspensions so that SSA can either terminate or reinstate payments. (CIN: A-13-89-00027)	The SSA agreed to proceed with policy and procedural changes. The SSA plans to develop a system to identify cases and generate control alerts.

OIG Recommendation	Status
Consider Recommended Safeguards over Medicaid Managed Care Programs: The HCFA should consider safeguards available to reduce the risk of insolvency, and to ensure consistent and uniform State oversight. (CIN: A-03-93-00200)	The HCFA generally concurred with OIG's recommendations, but felt that a broader analysis of managed care plans was needed to support broad program recommendations. The OIG notes that the same concerns raised in its report have been expressed by the Congress and the General Accounting Office. The OIG is continuing reviews of Medicaid managed care plans.
Provide Additional Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program: The HCFA should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The HCFA should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (CIN: A-06-91-00092)	The HCFA did not concur stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP but did not provide specific written methodology for computing AMP.
Use of Emergency Rooms by Medicaid Beneficiaries: The HCFA should encourage States to develop initiatives to review and reduce nonemergency use of emergency rooms by Medicaid beneficiaries, and assist them through data analysis instructions, expedited review of waiver applications for managed care and dissemination of effective emergency room control practices. (OEI-06-90-00180)	The HCFA indicated that it was concerned that it may not have sufficient resources to encourage States to develop initiatives to review and reduce nonemergency use of emergency rooms or disseminate annual reports on effective practices, but it will assist States by expediting the review of State applications for waivers to implement their efforts to control emergency rooms.
Avoid Future Medicare Secondary Payer Overpayments: To identify Medicare secondary payer (MSP) situations, HCFA should continue to implement its corrective action plan to eliminate the designation of MSP as a high risk area, and seek legislation which would require employers to report other health insurance coverage on the W-2 and tax statement. (CIN: A-09-89-00100; OEI-07-90-00760; OEI-07-90-00763)	The HCFA is continuing implementation of the corrective action plan. The HCFA did not agree with the recommendation on use of the W-2, indicating that it preferred to evaluate the outcome of recent legislation which mandated a data exchange between the Internal Revenue Service, SSA and HCFA.
Recover Past Medicare Secondary Payer Overpayments: The HCFA should ensure that there is adequate funding available to contractors to pursue collection of MSP overpayments, and instruct contractors to recover the MSP overpayment backlog and notify insurance companies of improper payments within recovery regulation time frames. (CIN: A-09-91-00103; CIN: A-04-92-02037)	The HCFA is in the process of establishing funding needs for recoveries and agreed to make recovery of backlog cases a top priority.
Review Social Security Administration Procedures that Impact Medicare Trust Funds: The HCFA should review SSA's wage certification procedures to ensure that the transfer of Medicare Hospital Insurance trust funds is consistent and performed in accordance with the Social Security Act. (CIN: A-14-92-03013)	The SSA is pursuing a legislative solution to this problem.

OIG Recommendation	Status
Medicare Trust Funds' Accounts Receivable Balances: The HCFA needs to improve its internal controls and the controls of its fiscal intermediaries and carriers related to the recording and reporting of accounts receivables. Additionally, HCFA needs to properly estimate the allowance for uncollectible receivables and determine the amounts to be written off as uncollectible. In a review conducted in accordance with the Chief Financial Officers Act, OIG continued to find weaknesses in contractors' controls. (CIN: A-01-92-00516; CIN: A-14-93-03027)	The HCFA concurred with OIG's recommendations, except that HCFA believes it has used reasonable estimates to report on the allowance for uncollectible receivables.
Postretirement Benefits: Because of a change in the method for accounting for postretirement benefits (other than pensions), HCFA should alert the fiscal intermediaries' auditors to give special attention to accrued retiree health care costs on Medicare cost reports. (CIN: A-01-92-00520)	The HCFA did not concur with the recommendation believing that the current guidelines address Medicare's reimbursement policy. The HCFA has decided not to issue additional guidelines to the fiscal intermediaries since it believes that final Medicare cost reporting regulations, yet to be published, will properly accomplish this task.
Medicare Trust Funds' Accounts Payable Balances: The HCFA should improve its internal controls and the controls of its fiscal intermediaries and carriers related to the recording and reporting of accounts payable. The HCFA should also perform Federal Managers' Financial Integrity Act (FMFIA) sections 2 and 4 reviews on all carrier accounts payable internal controls and financial management systems. (CIN: A-04-92-02054; CIN: A-05-92-00106)	The HCFA concurred with the recommendations. Regarding recommendations to perform FMFIA section 2 and 4 reviews at contractors, a work group established by HCFA has contracted with a Medicare contractor and a certified public accounting firm to evaluate internal controls at Medicare contractors.
Improve Financial Management Systems to Enhance Financial Reporting: The HCFA should develop and implement financial management systems and related accounting and administrative internal controls to ensure that all Medicare liabilities are reported to the HCFA general ledger at fiscal year end. (CIN: A-14-92-03015)	The HCFA agreed that reasonable data should be included in the reporting of Medicare liabilities. However, HCFA asserts that the process for developing a reasonable estimate of a liability for provider reports would be too cumbersome. The HCFA is currently developing the Medicare Transaction System that will include an integrated accounting subsystem to estimate the amount of appealed cost reports.
Clarify the Allowability of General and Administrative Costs at Medicare Hospitals: The HCFA should revise the Provider Review Manual (PRM) to further clarify the allowability of specific types of general and administrative and fringe benefit costs. (CIN: A-03-92-00017)	Based on its analysis of OIG's finding and similar findings in a General Accounting Office report, HCFA will consider revising the PRM to address specific categories of general and administrative and fringe benefit costs to provide better guidance to hospitals concerning the allowability of these costs.

OIG Recommendation	Status
Implement Proper Accountability over Billing and Collection of Medicaid Drug Rebates: The HCFA should ensure that States implement accounting and internal control systems in accordance with applicable Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current and complete disclosure of drug rebate transactions and provide HCFA with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (CIN: A-06-92-00029)	The HCFA concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The HCFA expects to have regulations in place in Fiscal Year (FY) 1995.
Physical Therapy in Physicians' Offices: The HCFA should take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. Some options are: conduct focused medical review; provide physician education activities; apply existing physical therapy coverage guidelines for other settings to physicians' offices. (OEI-02-90-00590)	The HCFA concurred with options one and two, and have distributed copies of the report to the carriers to determine if the issues identified are problems in their service areas. The HCFA is also forming a work group that represents physicians who provide physical therapy services in their offices to focus on the clinical appropriateness of services provided, including monitoring of these services.
Lessons From Inspections of Mammography Facilities: The HCFA should reach an agreement on the role of HCFA's screening mammography certification program in the interim period before full implementation of the Mammography Quality Standards Act (MQSA). (OEI-05-92-00300)	The HCFA and the Food and Drug Administration (FDA) have agreed on an approach to surveying screening mammography facilities between now and the time MQSA becomes effective (after September 30), when FDA will assume responsibility for all certification activity. The HCFA will also issue a regulation to accept FDA's quality standards for Medicare facilities that provide mammography services.
Use of Nursing Homes and Medigap Guides: The HCFA should work with the Social Security Administration (SSA) and the Assistant Secretary for Public Affairs to develop a more effective strategy to make the booklets available to all beneficiaries. (OEI-04-92-00481)	The HCFA concurred with OIG's recommendation. It is also considering other OIG suggestions, such as distributing information through physicians' offices, hospital personnel and post offices to continue to improve its communication with beneficiaries.
Coding of Physician Services: The HCFA should produce and promulgate to the American Medical Association and medical specialty societies clear coding objectives and criteria for Medicare's resource-based payment system, and encourage them to apply the objectives in the development of new or revised codes. Also, HCFA should apply coding objectives and criteria when evaluating new or revised codes to assure compliance with the needs of the Medicare Fee Schedule. (OEI-03-91-00920)	The HCFA concurred with both recommendations. Improvements were made to the evaluation and managements codes, and steps have been taken to guard against coding changes leading to the circumvention of the relative value units for new and revised codes.

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

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

OIG Recommendation	Status	Savings in Millions
Pension Reserves: Recover the Federal Government's proportionate share of pension reserve funds used by California to pay current period employer pension costs. (CIN: A-09-92-00116)	The Department's Division of Cost Allocation concurred with OIG's finding; resolution with the State is in progress. The State did not agree that the Federal Government should receive a proportionate share of the reserves saying that the use of the funds was mandated by State law specifically restricting the use to State funding sources only.	$111
Internal Service Funds: California should refund the Federal share of accumulated surpluses in its internal service fund that provides goods and services to State agencies on a cost reimbursable basis, and adjust billing rates to eliminate future surpluses or deficits. (CIN: A-09-93-00039)	The Department's Division of Cost Allocation generally agreed with OIG's findings. However, California did not concur.	12.2
Simplify Administrative/Indirect Cost Allocation Systems: Control the growth of administrative/indirect costs charged to Federal programs through reform of the cost allocation plans. The OIG has identified a range of options, some of which require legislative actions, to reform the cost allocation system. Options for reform include: use of block grant awards; a flat percentage rate for administrative/indirect costs; and negotiation of a nonadjustable rate for a predetermined number of years. (CIN: A-12-92-00014)	The OIG's recommendations are cited in the National Performance Review (NPR) report that call for reform of the cost allocation process. The OMB, in revising Circular A-87, will address the NPR recommendations.	-[6]

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

[2] *This savings estimate represents potential savings to the program of $22 million for each dollar reduction in the composite rate.*

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

[4] *Although OIG is principally concerned with the effects of cafeteria plans on the FICA wage base, it believes that the Treasury could lose revenues in the range of $20.3 billion between 1994 and 1998.*

[5] *Savings depend upon children's dates of birth and, therefore, may extend beyond the 5-year budget cycle.*

[6] *Estimated savings will result from reform of cost allocation plan process. The report of NPR, "Creating a Government that Works Better and Costs Less," estimates a 5-year savings of $3.3 billion by reducing intergovernmental administrative costs.*

OIG Recommendation	Status
Improve the Federal Foster Care Program: The OIG provided options for ACF to consider in its efforts to improve its partnership with State and local governments in administering the Federal Foster Care program. The options included streamlining the process; determining whether legislative change is needed; and determining if certain program requirements could be changed to facilitate compliance. (CIN: A-12-93-00022)	The ACF concurred on the issues raised in OIG's report and is considering a redesign of titles IV-B and IV-E child welfare reviews.
Improve Oversight of Audits of Office of Community Service Grantees: The ACF should track Office of Community Services grantees' implementation of recommendations made as a result of single audits, and follow-up with grantees to ensure actions taken were effective. (CIN: A-12-92-00043)	The ACF agreed and will take steps to implement the recommendations within the limitation of current staffing resources.
Colocating Intergenerational Programs: The Administration on Aging (AoA) and ACF should examine whether demonstrated successes in colocating programs and facilities in the private and public sector can be more broadly applied to departmental programs on a voluntary basis. (CIN: A-05-94-00009)	The AoA and ACF generally agreed with OIG's recommendations.
GENERAL OVERSIGHT	
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify the Department of Health and Human Services' (HHS') disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to PHS, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040)	The OASH has taken the lead in this area and has met with headquarters operating division emergency preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved.
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The OASH should issue guidelines to improve disaster planning. The plans of each operating and staff division should spell out lines of communication with each other, and should specify headquarters and regional lines of communication with the Federal Emergency Management Agency. (OEI-09-90-0I040)	The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department.

OIG Recommendation	Status
Ensure that New York Allocates Training Costs to Federal Programs for Actual Number of Atteudees: The Department should be more aggressive when approving State plans to ensure that the State (among other actions): allocates future training contracts to programs based on the actual number of participants; maintains documentation which clearly details which programs benefit from future training and, where applicable, allocates training costs to all benefitting programs; and discontinues using third party contributions provided by private contractors to meet its share of training costs. (CIN: A-02-91-02002)	The Department's Division of Cost Allocation (charged with approval of State cost allocation plans) expressed agreement with the findings and recommendations.
Reform the Systems for Determining State and Local Government Administrative/Indirect Costs: The OIG identified a number of options, some of which require legislative action, to facilitate the allocation of administrative/indirect costs to Federal grants and contracts These include: establishing a block grant to pay administrative/indirect costs; negotiating nonadjustable rates for a predetermined number of years; and assigning the responsibility for negotiating rates for all entities within a State to one Federal Agency. (CIN: A-12-92-00014)	The National Performance Report included OIG's recommendations. The OMB is working on the development of guidelines to assist States in the charging of administrative/indirect costs to Federal programs.
Revise Hospital Cost Principles for Federally Sponsored Research Activities: The Department should act to modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with OMB Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (CIN: A-01-92-01528)	The Department intends to begin work on revising hospital cost principles when the revisions of the Governmentwide cost principles for universities and State and local governments (OMB Circulars A-21 and A-87 respectively) are finalized by OMB.
Guidelines to Reimburse Educational Institutions and Nonprofit Organizations: The Department should work with OMB to revise applicable cost principles to reflect the change in accounting for post retirement benefit costs arising from implementation of Financial Accounting Standards Board Opinion 106. It should also advise negotiators for the Department's Division of Cost Allocation to pay special attention to such costs when reviewing fringe benefit rates for schools and nonprofit organizations. (CIN: A-01-93-04000)	The OMB has revised Circular A-87 to limit post retirement benefit costs to the amount funded, and agreed that similar provisions should be incorporated in future modifications of circulars applicable to educational institutions and nonprofit organizations (OMB Circulars A-21 and A-122 respectively). In the interim, the Department has issued instructions to negotiators.
Implement Random Moment Sampling Systems and Other Time Studies: The Department, in conjunction with OMB, should issue definitive, authoritative guidelines for States adopting random moment time studies. (CIN: A-07-93-00645)	The Department agreed with OIG's conclusion and is working with OMB in the development of guidelines related to the determination of administrative costs, including standards for the use of random moment time studies.

APPENDIX D

Notes to Tables I and II

Table I

[1] The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of $68.9.

[2] Included in the reports issued during the period are management decisions to disallow $66,770 in costs attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

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

CIN: A-03-92-17195	Virginia Department of Social Services: The grantee provided documentation for previously disallowed costs of $1,244,990
CIN: A-07-92-00526	Nebraska Medicaid Management Information System: The State provided additional documentation for previously disallowed costs of $247,576. Additionally, the Departmental Appeals Board decisions upheld Nebraska for $41,446 in previously disallowed costs.

Not detailed are additional revisions to previously reported decisions totaling $968,069.

[4] Changes from the previous period are accounted for by two large dollar disallowances. The current period decisions are in excess of the overall average.

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

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

CIN: A-02-92-01021	Medicare Credit Balance Roll-up Report, April 1994, $14,900,000
CIN: A-04-92-02056	Administrative Cost Audit Medicare Part B Blue Cross Blue Shield of Florida, May 1993, $14,722,615
CIN: A-03-91-00552	Independent Living Program - National, March 1993, $6,529,545
CIN: A-07-92-00578	Blue Cross of Texas Inc.- Unfunded Pension Costs, October 1992, $6,244,637
CIN: A-03-89-00046	Maryland Blue Cross Blue Shield Administrative Costs - FY 85-88 - Part B, September 1991, $5,996,278
CIN: A-07-93-00713	Pennsylvania Blue Cross Blue Shield Unfunded Pension Cost, May 1994, $5,490,995
CIN: A-05-93-00054	Illinois Associated Insurance Group - Contract Audit, October 1993, $3,355,560
CIN: A-07-93-00633	Pension Segmentation - AETNA Life Insurance Co., October 1993, $3,011,376
CIN: A-05-93-00013	Michigan Blue Cross Blue Shield Contract Medicare Audit, April 1993, $3,010,916
CIN: A-07-92-00585	Pension Segmentation Blue Cross Blue Shield of California, January 1994, $2,973,504
CIN: A-03-93-03308	GSX Services Inc. CACS 263-86-0098, February 1994, $2,806,577

CIN: A-07-92-00579	Blue Cross Blue Shield of Michigan Inc.- Unfunded Pension Costs, October 1992, $2,535,698
CIN: A-05-92-00026	Associated Insurance Co.- Medicare Administrative Audit, February 1992, $2,530,409
CIN: A-03-91-00030	Outpatient Credit Balances - Georgetown University Hospital, July 1994, $2,504,600
CIN: A-02-91-01066	Blue Shield of Western NY Medicare Administrative Costs, September 1991, $2,379,239
CIN: A-03-90-02003	Blue Cross of Western PA Administrative Cost FY 86-89, August 1993, $2,218,528
CIN: A-03-91-02000	Independence Blue Cross Administrative Cost, June 1993, $1,763,319
CIN: A-07-93-00712	Pennsylvania Blue Cross Pension Segmentation, May 1994, $1,646,023
CIN: A-03-92-19733	State of Maryland, August 1992, $1,505,462
CIN: A-03-90-00051	Maryland Blue Cross Blue Shield Administrative Costs - Part A - FY 85-88, August 1991, $1,438,414
CIN: A-05-93-00057	Michigan Blue Cross Contract Audit, July 1993, $1,409,954
CIN: A-07-93-00700	Blue Cross Blue Shield of Massachusetts - Unfunded Pension Cost Audit, May 1994, $1,290,740
CIN: A-07-94-00762	Health Care Service Corp. - Unfunded Pension Costs, July 1994, $1,233,337
CIN: A-07-93-00665	Travelers Insurance Co. - Unfunded Pension Costs, October 1993, $1,218,963
CIN: A-03-92-03316	Human Services Inc., March 1993, $1,182,029
CIN: A-03-93-03313	Biocon Inc. CCS 263-87-0068, February 1994, $1,061,376
CIN: A-07-94-00763	Health Care Services Corp.- Pension Segmentation, August 1994, $1,055,458
CIN: A-05-93-19899	Michigan Dept. Social Services, November 1992, $1,030,218
CIN: A-07-93-00634	Pension Segmentation - Traveler's Insurance Co., October 1993, $1,026,460
CIN: A-09-94-01010	Stratagene Close-out Audit, March 1994, $983,208
CIN: A-02-93-01003	Empire Blue Cross Blue Shield Administrative Cost Medicare Part A, July 1994, $945,696
CIN: A-05-92-00060	Blue Cross Blue Shield Contractor Audit, February 1993, $879,609
CIN: A-07-93-00701	Blue Cross Blue Shield of Massachusetts - Pension Costs Charged Audit, July 1994, $839,740
CIN: A-03-94-03304	Biocon Inc., CACS No1-CP-95644, February 1994, $747,865
CIN: A-05-91-00136	Community Mutual Insurance Co. Administrative Costs, August 1992, $720,668
CIN: A-02-94-27564	State of New Jersey, June 1994, $693,146
CIN: A-04-91-04029	Audit of O&M AIDS Campaign Contract, May 1992, $675,750
CIN: A-07-93-00699	Blue Cross Blue Shield of Massachusetts - Pension Segmentation Audit, April 1994, $658,471

CIN: A-04-93-01069	Monitoring Administrative Cost Audit - Medicare Part A, Blue Cross Blue Shield of South Carolina, July 1994, $590,844
CIN: A-07-93-00679	AETNA Unfunded Pension Cost Audit, May 1994, $590,207
CIN: A-02-91-03508	Audit of NJ Child Care and Supportive Services, June 1993, $506,710
CIN: A-03-92-16229	State of Pennsylvania, February 1992, $496,876
CIN: A-03-93-26413	East Coast Migrant Head Start Project, September 1993, $481,130
CIN: A-06-92-00102	JOBS: Federal Financial Participation, October 1993, $438,996 (Related recommendation of $14,999 outstanding on Table II)
CIN: A-06-93-00042	BCBSTX Administrative Costs - Medicare Parts A&B, January 1993, $434,134
CIN: A-03-91-03310	Beach Advertising (contract close-out), March 1993, $377,424
CIN: A-05-92-00126	Wisconsin Westcap Head Start ACF/RO Request, March 1993, $347,576
CIN: A-10-93-26777	Migrant and Indian Coalition for Coordinated Child, September 1993, $332,689
CIN: A-05-93-25697	West Central Wisconsin Community Action Agency Inc., August 1993, $324,759
CIN: A-09-92-00063	Blue Cross of California - Administrative Costs, September 1992, $310,665
CIN: A-09-94-30178	State of Arizona, June 1994, $267,021
CIN: A-05-93-00025	Ohio - Dept. Human Services, July 1993, $251,013
CIN: A-03-92-20033	State of Delaware, August 1992, $247,609
CIN: A-07-93-00710	Blue Cross Blue Shield of Connecticut - Unfunded Pension Cost Audit, March 1994, $237,392
CIN: A-02-92-16749	City of San Juan Puerto Rico, November 1991, $233,462
CIN: A-05-91-00064	Nationwide Administrative Costs Contract Audit, October 1991, $211,422
CIN: A-05-93-00050	Ohio - ODHS/JOBS/Work Supplementation, October 1993, $194,463
CIN: A-05-93-24819	Economic Opportunity Committee of St. Clair County, August 1993, $188,691
CIN: A-10-92-00005	WPS Administrative Cost Audit, February 1992, $179,891
CIN: A-05-94-28643	Community Action Against Poverty of Greater Indian, January 1994, $176,159
CIN: A-05-94-29825	Licking County Economic Action Development Study, June 1994, $175,420
CIN: A-01-94-31362	Thames Valley Council for Community Action, Inc., July 1994, $169,146
CIN: A-05-94-29229	West Central Wisconsin Community Action Agency Inc., March 1994, $167,977
CIN: A-03-94-26611	State of Delaware, December 1993, $163,100
CIN: A-09-92-06850	Santa Ysabel Band Mission Indians, September 1992, $151,081
CIN: A-03-93-21104	State of Pennsylvania, June 1993, $150,000
CIN: A-09-94-31413	Asian American Health Forum Inc, August 1994, $149,378
CIN: A-05-92-00048	WI Physicians Services Pension - Medicare vs. ERISA, October 1992, $130,577 (Related recommendation of $2,068,964 outstanding on Table II)
CIN: A-09-92-00093	Blue Cross Arizona Administrative Cost, August 1992, $129,518

CIN: A-07-93-00709	Blue Cross Blue Shield of Connecticut - Pension Segmentation Audit, April 1994, $119,472
CIN: A-12-93-00042	Survey of DC Administrative Costs for CSBG FY 1992, February 1994, $99,819
CIN: A-05-94-31408	Tri County Community Action Commission Inc., July 1994, $98,110
CIN: A-01-92-19975	State of Massachusetts, September 1992, $96,703
CIN: A-03-94-27083	Pennsylvania State University, March 1994, $86,479
CIN: A-02-93-02518	Biederman, Kelly and Shafer, February 1994, $72,883
CIN: A-03-91-02002	Delaware Blue Cross Administrative Costs, October 1991, $66,858
CIN: A-03-91-16232	Unisys Inc., September 1991, $61,754
CIN: A-06-94-27816	South Plains Health Provider Organization Inc., March 1994, $60,900
CIN: A-05-94-27548	Hoosier Valley Economic Opportunity Corp., January 1994, $55,811
CIN: A-05-94-31614	Lake Geauga United Head Start, July 1994, $53,354
CIN: A-06-92-19887	Poarch Band of Creek Indians, August 1992, $51,377
CIN: A-03-93-03306	Survey Research Assoc. CACS No1-ES-45067, December 1993, $48,779
CIN: A-02-94-27434	University of Puerto Rico - System, February 1994, $41,454
CIN: A-01-93-20875	State of Maine, May 1993, $40,540
CIN: A-03-92-00351	Frederick Cancer Research and Development Center, April 1993, $35,531
CIN: A-05-94-27622	Lake Geauga Economic Opportunity Corp., January 1994, $36,420 (Related recommendation of $86,988 outstanding on Table II)
CIN: A-04-93-20785	State of Florida, June 1993, $33,511
CIN: A-06-94-28128	Excelth Inc., June 1994, $33,061
CIN: A-01-94-27881	State of Maine, June 1994, $32,460
CIN: A-03-93-24683	Medlantic Research Institute, June 1993, $31,038
CIN: A-02-94-27435	Univ. of Puerto Rico System, February 1994, $29,574
CIN: A-06-94-31602	Tunica Biloxi Indians of Louisiana, August 1994, $24,006
CIN: A-06-92-20334	Pueblo of Jemez, September 1992, $20,156
CIN: A-03-93-22091	Pennsylvania State University, September 1993, $19,878
CIN: A-02-94-31958	Puerto Rico Office of the Governor, June 1994, $19,811
CIN: A-02-93-24129	Council of Jewish Federations Inc. May 1993, $19,152
CIN: A-03-94-27745	American Association of School Administers, April 1994, $19,105
CIN: A-05-93-21928	Wright State Univ., July 1993, $18,308
CIN: A-10-93-26035	State of Washington, September 1993, $15,915
CIN: A-04-93-20961	Commonwealth of Kentucky, January 1993, $15,000
CIN: A-10-92-20781	Tulalip Tribes of Washington, August 1992, $14,525

CIN: A-08-94-31224 Crow Creek Sioux Tribe, June 1994, $13,713

CIN: A-09-93-07000 Yomba Shoshone Tribe, November 1992, $12,832

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

CIN: A-09-94-27562 Tohono O Odham Nation, October 1993, $10,817

CIN: A-01-94-26495 State of Connecticut, June 1994, $10,518

CIN: A-09-92-06864 San Juan Southern Paiute Tribe, September 1992, $10,433

CIN: A-02-94-31816 Union Township Community Action Organization, July 1994, $10,000

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

CIN: A-09-94-27203 University of Hawaii System, March 1994, $9,339

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

CIN: A-03-94-27164 Medical School of Pennsylvania, May 1994, $8,986

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

CIN: A-09-93-23668 Center for Education and Manpower Resources Inc., July 1993, $8,093

CIN: A-03-91-02004 West VA. Blue Cross Blue Shield Administrative Costs FY 85/90 and Termination Costs, November 1992, $7,556

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

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

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

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

CIN: A-01-94-28754 New England Deaconess Hospital Corp., April 1994, $4,447

CIN: A-02-94-31098 University of Rochester, May 1994, $4,043

CIN: A-09-94-31931 Stanford University, August 1994, $3,676

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

CIN: A-05-94-28802 Harcatus Tri County Community Action Organization, January 1994, $2,795

CIN: A-07-94-25955 State of Kansas, December 1995, $2,783

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

CIN: A-03-94-30398 Medlantic Research Institute, June 1994, $2,306

B. Reports in litigation:

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

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

CIN: A-09-93-00091 Walter McDonald Indirect Cost Rates, June 1994, $68,663

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

CIN: A-01-94-30623 State of New Hampshire, June 1994, $3,158

Table II

[1] The opening balance was adjusted to reflect an upward adjustment of $1,234.8 million.

[2] The OIG has reported as "management decisions during the period" those line items in the President's Fiscal Year 1996 budget that directly relate to OIG recommendations contained in issued reports. Management does not report these decisions in its table.

[3] Included are sustained management decisions on funds put to better use of $1,825,672 attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

[4] Management decisions have not been made within 6 months of issuance on 10 reports:

A. Discussions with management are ongoing and it is expected that the following reports will be resolved during the next semiannual reporting period:

CIN: A-06-91-00048	Non-AFDC Application and User Fees for CSE Services, July 1992, $385,000,000
CIN: A-04-94-00075	Miami Office of Refugee Resettlement, July 1994, $570,000
CIN: A-06-91-00089	Audit of Cash on Hand IHS, April 1992, $445,890
CIN: A-05-94-31625	Indiana Health Centers Inc., May 1994, $364,627
CIN: A-05-94-30746	Lorain County Community Action Agency Inc., June 1994, $177,082
CIN: A-06-92-00081	Follow-up Hansen's Disease Center, August 1993, $164,728
CIN: A-06-93-25797	Palo Pinto Community Service Corp., August 1993, $12,823
CIN: A-09-94-27864	Solano County Economic Opportunity Council Inc., March 1994, $12,178
CIN: A-07-94-30827	Community Action Inc.- Topeka Kansas, June 1994, $9,177

B. Report in litigation:

CIN: A-09-91-05300	Kass Management Services, April 1991, $79,829

APPENDIX E

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

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

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	64
Section 5(a)(1)	Significant problems, abuses and deficiencies	throughout
Section 5(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	throughout
Section 5(a)(3)	Prior significant recommendations on which corrective action has not been completed	appendices B and C
Section 5(a)(4)	Matters referred to prosecutive authorities	67
Section 5(a)(5)	Summary of instances where information was refused	none
Section 5(a)(6)	List of audit reports	under separate cover
Section 5(a)(7)	Summary of significant reports	throughout
Section 5(a)(8)	Statistical table I - reports with questioned costs	62
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	63
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none

ACRONYMS

ACF	Administration for Children and Families
AFDC	Aid to Families with Dependent Children
ALJ	administrative law judge
AoA	Administration on Aging
ASC	ambulatory surgical center
ASMB	Assistant Secretary for Management and Budget
CDC	Centers for Disease Control and Prevention
CDR	continuing disability review
CFO	Chief Financial Officer
CMP	civil monetary penalty
CSE	child support enforcement
DCA	Division of Cost Allocation
DDS	disability determination service
DI	Disability Insurance
DME	durable medical equipment
DRG	diagnosis-related group
EGHP	employer group health policy
ESRD	end stage renal disease
FDA	Food and Drug Administration
FFP	Federal financial participation
FI	fiscal intermediary
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GME	graduate medical education
GPRA	Government Performance and Results Act
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHS	Department of Health and Human Services
HI	Hospital Insurance
HMO	health maintenance organization
IEVS	Income and Eligibility Verification System
ILP	Independent Living Program
IME	indirect medical education
IOL	intraocular lens
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance Program
MBR	master beneficiary record
MFCU	Medicaid fraud control unit
MQSA	Mammography Quality Standards Act
MSP	Medicare secondary payer
NIH	National Institutes of Health
NPR	National Performance Review
OASH	Office of the Assistant Secretary for Health
OASI	Old Age and Survivors Insurance
OBRA	Omnibus Budget Reconciliation Act
OHA	Office of Hearings and Appeals
OMB	Office of Management and Budget
OPD	hospital outpatient department
PHS	Public Health Service
PPS	prospective payment system
PRO	peer review organization
RFP	request for proposal
SMI	Supplementary Medical Insurance
SNF	skilled nursing facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
WC	workers' compensation

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Office of Inspector General
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