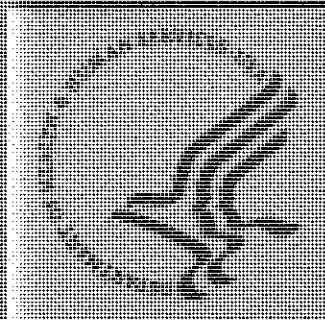


Semiannual Report



Office of Inspector General

October 1, 1993 - March 31, 1994

June Gibbs Brown
Inspector General

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

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 over 75 civil monetary penalty and exclusion authorities such as those at:

- Title 31, United States Code, section 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



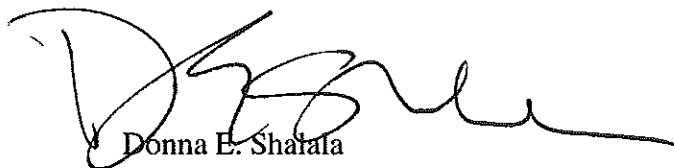
THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

A MESSAGE FROM THE SECRETARY

I would like to take this opportunity to acknowledge the vital role played by the Office of Inspector General (OIG) in protecting the integrity of the programs administered by the Department of Health and Human Services. The OIG's statutory mission is to identify program and management problems and propose recommendations to correct them. This activity is vital to maximizing the effectiveness and efficiency of our programs and operations.

As an independent fact-finder, OIG helps the Department assure that appropriate fraud and abuse safeguards are built into new Administration proposals and maintained in existing programs. The Department and the people we serve can ill afford losses caused by fraud, waste and abuse. We must be diligent in our efforts to utilize resources in the most cost-effective manner, and continue to improve our responsiveness and accountability to our customers.

By working together, we will help achieve our common goal of ensuring better service to the American people.



Donna E. Shalala

FOREWORD

I am pleased to present my first semiannual report as Inspector General at the Department of Health and Human Services (HHS). In my first months at HHS, I have come to appreciate first-hand both the expanse of the Department's programs and the Office of Inspector General's (OIG) deserved reputation for excellence in fulfilling its mission.

The OIG has a responsibility to protect the integrity of HHS programs and the health and welfare of the beneficiaries of those programs. Given the Department's size and scope, this is a broad mandate. Outlays for the more than 300 HHS programs are expected to exceed \$632 billion in Fiscal Year 1994, accounting for over one-third of the budget of the United States. Moreover, the Department's programs impact the well-being and quality of life of virtually every U.S. citizen.

The OIG's impact in dollars alone has been impressive. Between 1981 and 1993, \$57 billion in savings, fines, settlements, restitutions and receivables resulted from OIG activities and implementation of our recommendations. This represents an increase from \$4 saved for every OIG dollar spent in 1981 to \$61 saved for every OIG dollar appropriated in 1993. Despite dwindling resources, I am committed to continuing this solid return to the American taxpayers.

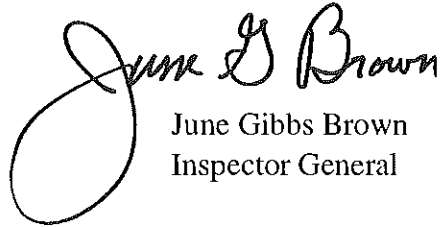
Two of this Administration's top policy initiatives (health care and welfare reform) will, if enacted, have a profound impact on the way health care and welfare are financed and delivered, as well as create new challenges for OIG. We are working with agency managers to build in sufficient safeguards and controls to prevent and detect fraud, waste and abuse and to assure a high quality of service delivery to the programs' beneficiaries.

In a joint effort with the Department of Justice, we have established the Executive Level Health Care Fraud Policy Group to identify important health care fraud initiatives. Moreover, HHS OIG is forming partnerships with State auditors and program evaluators to analyze issues that affect both the Medicare and Medicaid programs. We are also working to optimize coordination with other OIGs, particularly those with responsibilities in the health care area.

As in Government as a whole, we have begun to streamline our own operations and management structure to minimize costs and ensure that the greatest proportion of our resources is concentrated on the investigations, audits and inspections through which we carry out our mandate. We are implementing new review and investigative methodologies to perform our work. Along with strategic priority setting and staff deployment, these

measures will assist us in directing our limited resources to oversee the most critical HHS issues.

I am proud of the accomplishments of our office, and committed to meeting ambitious goals for HHS OIG and obtaining meaningful results. The resources invested in our office will continue to be used to the benefit of taxpayers and program beneficiaries. With the continued cooperation and support of the Congress, departmental managers and the Secretary, I look forward to meeting the challenges ahead.

A handwritten signature in black ink, reading "June Gibbs Brown". The signature is stylized, with a large, looping "J" and "B".

June Gibbs Brown
Inspector General

HIGHLIGHTS

In this first half of Fiscal Year 1994, 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.

Reducing Unnecessary Spending:

- The OIG's work resulted in a \$27 million settlement with Provident Life and Accident Insurance Company stemming from the company's failure to comply with Medicare secondary payer requirements. (See page 5)
- The OIG recommended that California refund \$7.6 million and establish procedures to ensure that the Federal Government is given full credit for Medicaid third party liability settlements. (See page 20)
- The OIG found that the Social Security Administration (SSA) did not stop payments timely for 4,700 disabled beneficiaries who completed their post trial work periods. This resulted in SSA overpaying them \$13.7 million, of which it has recovered \$4 million. (See page 31)
- The OIG reviewed the training and administrative costs that New York allocated to Federal programs from April 1, 1988 to March 31, 1991 and identified more equitable allocation methods and an estimated overcharge of \$12.2 million. (See page 64)

Preventing and Detecting Fraud and Abuse:

- A hospital in Washington, D.C. agreed to pay \$2.5 million to settle charges that it improperly billed Medicare for bills eventually paid by other sources. (See page 13)
- In New York, a physical therapist was sentenced to 27 months incarceration for billing public and private insurers \$1 million for services he did not render. (See page 7)
- A hospital in Kansas agreed to a civil monetary settlement and publication of advertisements acknowledging its responsibilities to provide emergency medical treatment to patients regardless of ability to pay. The hospital had

turned away a woman without assessing her condition, claiming no physician was available. (See page 13)

- A New York physician who ran one of the Nation's largest "Medicaid mills," largely serving substance abusers, was excluded from the Medicare and all State health care programs for 25 years after being convicted of submitting false claims costing Medicaid \$1 million. (See page 10)
- A California woman was sentenced to life in prison without possibility of parole for murdering tenants of her boarding house for their Supplemental Security Income benefits. (See page 33)
- A Washington, D.C. woman must pay \$196,800 under the Program Fraud Civil Remedies Act for converting to her own use \$13,400 in benefits mistakenly sent to her deceased mother. (See page 28)

Identifying Systemic Management Problems:

- An OIG study, requested by the Chairman of the Senate Special Committee on Aging, identified several challenges faced by the National Institutes of Health (NIH) to the effective management of NIH's Cooperative Research and Development Agreements program and made recommendations to ensure its future success. (See page 41)
- The OIG recommended controls that SSA needs to ensure that self-employment income transactions are correctly posted to earnings records. (See page 24)
- The OIG recommended several actions to ensure that universities consistently apply Office of Management and Budget (OMB) requirements regarding recharge centers. Included were proposals that the Department work with OMB to ensure that criteria related to the financial operation of recharge centers are clear, and that universities conduct self-reviews to strengthen their financial management of these services. (See page 56)
- The systems States use to allocate an estimated \$20 billion each year in administrative and indirect costs to Federal programs are a continuing concern. The OIG provided input to OMB on this issue for its revision of Circular A-87, Cost Principles for State and Local Governments. (See page 56)

Promoting Improved Service Delivery:

- The OIG concluded that SSA needs to develop a strategy for improving 800 number performance on peak days and improving the precision of its 800 number access measure. (See page 29)
- The Public Health Service (PHS) is in the process of implementing the OIG's recommendations to improve preschool immunizations by having the Maternal and Child Health (MCH) Bureau capitalize on its potential to guide and direct State MCH program efforts. (See page 40)
- An OIG study recommended that PHS and the Health Care Financing Administration work together to improve coordination between school-based health centers and managed care providers to promote better access to quality health care. (See page 40)
- As part of its national review of health and safety standards at child care facilities that receive Federal funds, OIG, accompanied by State inspectors, performed unannounced inspections of facilities in South Carolina. The OIG found deficiencies similar to those identified in North Carolina, Wisconsin and Nevada, including fire code violations, unsanitary conditions, playground hazards and toxic chemical accessibility. (See page 46)

Developing and Assessing Performance Measures:

- The OIG issued its opinion on SSA's financial statements for the seventh year and again reported that SSA has been improperly using Internal Revenue Service records as the basis for transferring employment tax revenues to the Social Security trust funds. (See page 24)
- The OIG found that, despite some problems and complaints that merited attention from program managers, a majority of participants in the Job Opportunities and Basic Skills program gave high ratings overall to the program, its activities and support services. (See page 49)

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.

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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 insurance for persons age 65 or older and for certain disabled persons. Financed by the Federal Hospital Insurance (HI) Trust Fund, Fiscal Year (FY) 1994 expenditures for Medicare Part A are expected to exceed \$101 billion. Medicare Part B (supplementary medical insurance) is an optional program which covers most of the costs of medically necessary physician and other services. Financed by participants and general revenues, FY 1994 expenditures for Medicare Part B are estimated at \$57 billion.

The Medicaid program provides grants to States for medical care for approximately 35 million low-income people. Medicaid outlays have risen at a dramatic pace, causing Medicaid spending to become the fastest rising portion of both the Federal and State budgets. Federal Medicaid spending rose in FY 1993 to nearly \$76 billion. Federal expenditures are expected to reach \$87 billion in 1994. Eligibility for the Medicaid program is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children or Supplemental Security Income. The Federal grant is open-ended, paying from 50 to 83 percent of the State's Medicaid expenditures, based on a calculation of the State's relative wealth.

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

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 724 successful actions against wrongdoers in these programs.

Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1992

Performance Measure

The OIG reviewed HCFA's design and implementation of internal controls used to report the Medicare accounts receivable balances, including Medicare secondary payer claims, of Medicare contractors. The OIG found that internal control policies and procedures at selected Medicare contractors were not effective because controls for the authorization of transactions and separation of duties were not adequately designed. The HCFA needs to improve financial reporting guidance and establish clearer internal control objectives relating to the accounts receivable function.

The OIG recommended that HCFA continue to evaluate and improve its financial management system; strengthen its financial reporting directives to Medicare contractors and ensure that contractors receive the requisite training to properly record and report accounts receivable; and comply with the appropriate guidelines to estimate the allowance for uncollectible receivables. In response to the draft report, HCFA generally concurred that improvements are necessary in its accounting for Medicare receivables. The OIG commends HCFA's efforts to implement corrective action to produce timely and reliable financial statement information. (CIN: A-01-92-00516)

Implementation of the Federal Managers' Financial Integrity Act for Fiscal Year 1992

The OIG reviewed HCFA's implementation of the Federal Managers' Financial Integrity Act (FMFIA) for FY 1992 by evaluating: the segmentation process HCFA used to develop its current management control plan; coverage of Medicare contractors under the program; and financial management systems inventory and reviews. The HCFA had reported that its management controls and financial management systems provided reasonable assurance that the objectives of FMFIA were met. While OIG found that HCFA had improved its FMFIA program, it continued to have concerns regarding HCFA's reasonable assurance because adequate reviews had not been performed to test the management control systems at the Medicare contractors and all financial management systems.

The OIG recommended that HCFA develop a review methodology that would actually test management controls at the contractors, and expand financial management systems reviews to meet the requirements of the Office of Management and Budget Circular A-127. The OIG determined that, without such testing, HCFA's reasonable assurance of compliance with FMFIA should be questioned. The OIG had raised similar concerns in its report on HCFA's FY 1991 FMFIA program, and throughout FY 1993 it continued to discuss the issue of HCFA's reasonable assurance with the Department, the Office of the Assistant Secretary for Management and Budget, HCFA and the management oversight council.

In response to the draft report, HCFA agreed that strong management controls at Medicare contractors were mandatory, but stated that it had an adequate system in place to test the management controls at all Medicare contractors. The OIG continues to recommend that HCFA modify its review methodology to ensure that the Medicare contractor's management controls are adequate and to expand its financial management systems reviews. (CIN: A-14-92-03009)

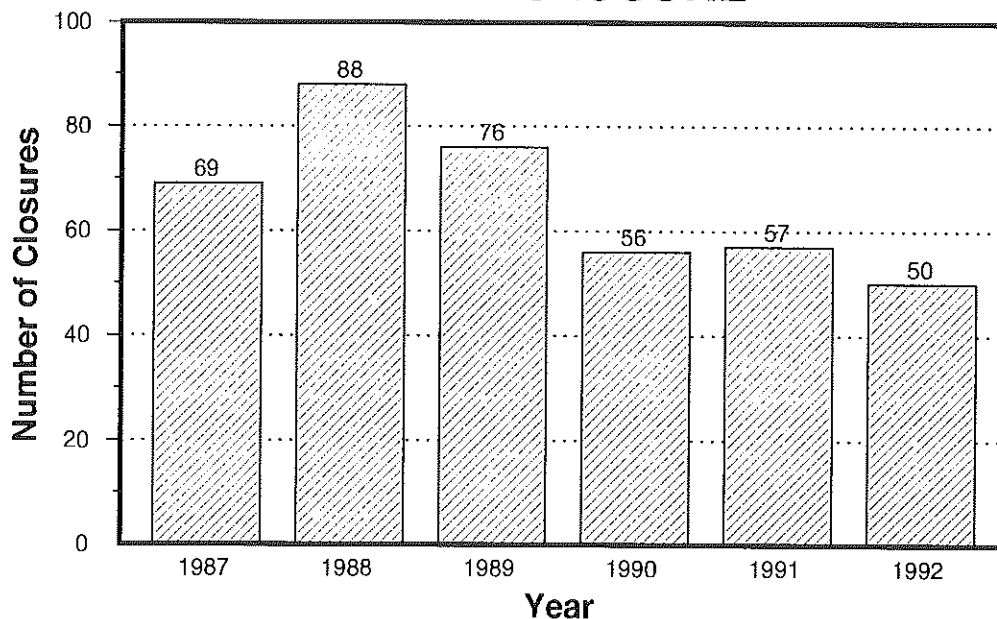
Hospital Closure: 1992

Performance Measure

The closure of general, acute care hospitals in recent years has generated public and congressional concern. The OIG previously issued five reports describing the nationwide phenomenon of hospital closure in years 1987 to 1991. The current report continues OIG's analysis of hospital closure to determine the effects of this phenomenon.

The OIG determined that the extent, characteristics, and impact of hospital closure in 1992 were similar to those identified for hospital closures in the previous 5 years. As illustrated in the following chart, fifty hospitals closed in 1992, continuing a downward trend in the annual number of closures.

HOSPITAL CLOSURE



Most of the hospitals that closed in 1992 were small and had low occupancy. When a hospital closed, few patients were affected; most had emergency and inpatient medical care available within 20 miles. (OEI-04-93-00500)

Medicare Administrative Costs

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

A. Associated Insurance Companies

The OIG contracted for an audit of Medicare administrative costs claimed by Medicare contractor Associated Insurance Companies, Inc., for FYs 1987 through 1989. Amounts audited were approximately \$22 million for Part A and \$45 million for Part B. The OIG recommended that the contractor adjust its final administrative cost proposal for this period by approximately \$3.8 million for Parts A and B to eliminate unallowable and unallocable costs charged to the Medicare programs. The contractor concurred on some findings and disagreed on others. (CIN: A-05-93-00054)

B. Pennsylvania Blue Shield

In a review of Pennsylvania Blue Shield (PBS), OIG found that during the period October 1, 1987 through September 30, 1991, PBS claimed \$328 million for administering the Medicare Part B program. The OIG recommended that PBS make procedural improvements and refund \$1 million in unallowable costs to the Medicare program. The PBS stated that procedural improvements were made and that \$1 million would be refunded to the Medicare

program. However, PBS did not agree with all of the findings, and reserved the right to challenge some of them in its negotiations with HCFA. The HCFA generally agreed with OIG's findings and recommendations. (CIN: A-03-92-00035)

Medicare Secondary Payer

The OIG has estimated that the Medicare program may be paying out as much as \$1 billion a year unnecessarily because Medicare fiscal intermediaries 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. Additionally, the Omnibus Budget Reconciliation Act (OBRA) of 1993 establishes a new health insurance reporting system for all employers who are required to file a Form W-2.

While HCFA reported that it had completed most of the milestones in its 1993 corrective action plan, 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 6-month period, OIG issued a report on the Provident Life and Accident Insurance Company involving Medicare secondary payer (MSP) issues. In April 1988, the Department of Justice (DOJ) filed a lawsuit against Provident Life and Accident Insurance Company seeking to recover overpayments due the Federal Government as a result of Provident's failure to comply with MSP requirements. The OIG provided audit services as a member of a task force to determine the amount of Provident's MSP liability. In May 1993, DOJ settled its lawsuit against Provident for \$27 million. The agreement contained provisions which, if implemented, should help preclude extensive MSP overpayments in the future. The OIG will monitor implementation of the settlement agreement provisions. The OIG recommended that HCFA continue its efforts to resolve similar MSP situations. (CIN: A-04-92-02049)

Funding of Contractor's Pension Costs

The OIG determined that two Medicare contractors, in an attempt to protect the allowability of pension costs for future Medicare reimbursement, used paper transfers of pension assets from other lines of business to fund the Medicare pension segment. Such transfers do not constitute funding and are unacceptable in meeting Federal funding requirements. The two contractors concurred with OIG's proposed removal of the paper transfers from the Medicare segments. The OIG recommended that HCFA require similar action for other

contractors that executed paper transfers in an attempt to fund pension costs. The HCFA concurred with OIG's recommendation. (CIN: A-07-93-00684)

Contractors' Segmented Pension Costs

To ensure that a no-profit, no-loss principle is followed regarding pension plans and costs, Medicare contractors are required to treat Medicare as a segment for calculating and charging pension costs.

A. Aetna Life Insurance Company

In an audit of Aetna Life Insurance Company's implementation of its Medicare contract clause on pension plan segmentation, OIG found that the company had, as of January 1, 1991, understated Medicare pension assets by \$3 million. The OIG recommended that Aetna increase the assets of the Medicare segment as of January 1, 1991 by \$3 million. The company agreed that the Medicare segment's assets were understated, but disagreed with the amount of the understatement. The HCFA concurred with OIG's recommendations. (CIN: A-07-93-00633)

B. Blue Cross and Blue Shield of Maryland

The OIG's review of Blue Cross and Blue Shield of Maryland's (BCBSM's) implementation of the pension portion of its Medicare contract found that the contractor had, as of January 1, 1991, understated Medicare pension assets by \$1.9 million. The OIG recommended that BCBSM appropriately increase the Medicare portion of the pension assets. The BCBSM agreed with the recommendations. (CIN: A-07-93-00692)

C. Blue Shield of California

An OIG audit found that California Blue Shield overstated Medicare pension assets by \$1.8 million and accumulated \$424,403 in unfunded pension costs that were unallowable for Medicare reimbursement. The OIG recommended financial adjustments and procedural corrections. Although the contractor did not agree, HCFA concurred with the findings and recommendations. (CIN: A-07-92-00585)

Unfunded Pension Costs

The OIG determined that, as of January 1, 1991, Travelers Insurance Company had accumulated \$1.2 million in pension costs that were unallowable for Medicare reimbursement. For Medicare reimbursement, pension costs must be measured, assigned and allocated in accordance with cost accounting standards (CAS), and funded as specified by the Federal Acquisition Regulations.

The OIG recommended that Travelers: separately identify \$1.2 million as an unallowable component of pension costs as of 1991; continue a yearly update of unallowable pension

cost components related to the unfunded costs for 1986 through 1990; and identify unallowable components of pension costs for any subsequent years for which CAS costs of the pension plan are not funded. While Travelers disagreed with the calculations, HCFA concurred with the findings and recommendations. (CIN: A-07-93-00665)

Home Office Costs at End Stage Renal Disease Facilities

At HCFA's request, OIG conducted a review to determine the reasonableness, allowability and allocability of the home office costs reported by National Medical Care, Inc. (NMC) at 22 selected facilities for Calendar Year 1991 in accordance with prescribed Medicare principles of reimbursement. The request was in connection with a study mandated under the OBRA 1990 to determine the costs, services and profits associated with various dialysis treatments provided to end stage renal disease (ESRD) patients.

The OIG found that NMC charged Medicare approximately \$1.5 million in unallowable home office costs. The OIG recommended that NMC establish procedures to exclude from future cost reports the unallowable charges identified in the review. Where such costs are under appeal, they should be identified in accordance with HCFA guidelines. In addition, OIG recommended that HCFA instruct the fiscal intermediaries to make the appropriate adjustments to the selected facilities' cost reports for 1991. The NMC officials disagreed with the majority of OIG's findings. The HCFA concurred with the OIG recommendations and has begun to implement them. (CIN: A-01-93-00509)

Ambulance Services for Medicare End Stage Renal Disease Beneficiaries: Payment Practices

Performance Measure

This report describes the growth in Medicare expenditures for Part B ambulance services for persons with ESRD. It also discusses problems with the coding of payment systems. The OIG recommended that HCFA establish a code for scheduled transports and require the uniform use of codes. Also, OIG offered optional strategies to take advantage of the lower costs associated with high-volume scheduled transports. Implementation of one or more strategy could result in savings of \$11.4 to \$34.1 million annually. The HCFA agreed to make coding changes and to explore ways to improve the payment system. (OEI-03-90-02131)

Criminal Fraud

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

- A New York man and his wife were sentenced for conspiracy to defraud Medicare, workers' compensation, and numerous private insurance

companies of more than \$1 million. The man, a registered physical therapist, was sentenced to 27 months incarceration and 3 years probation, and ordered to make restitution of \$125,000 and to pay a \$50 fine. His wife was sentenced to 2 years probation and a \$50 fine. The couple submitted bills for no-show appointments, cancelled appointments and services not rendered.

- The owner of an Indiana ambulance company was sentenced to 41 months in prison and 3 years probation for defrauding the Medicare, Medicaid and Social Security programs as well as private insurers. He filed claims amounting to more than \$200,000 for transporting stretcher cases, when most of the patients his company transported were ambulatory or in wheel chairs. Many of his company's records, obtained by search warrant, contained "post-it" notes from him to a clerk to "bill this to Medicare because I need the money." Also discovered during the investigation was the fact that he had been fraudulently receiving Social Security disability benefits for 10 years while employed and operating a business.
- In Florida, five persons were sentenced in a scheme in which multiple companies were set up to charge Medicare for liquid nutritional supplements and feeding kits. All but one were sentenced to several months in prison, and they were ordered to pay restitution totalling more than \$5 million. Included were two company owner/operators and a billing clerk, as well as two physicians who signed blank certifications for patients regardless of medical necessity or eligibility. Some 20 persons were involved in the scheme, and more than a dozen companies. Medicare was defrauded of an estimated \$20 million.
- The husband and wife owners of two home health agencies in Texas were ordered to repay \$180,770 for defrauding Medicare by switching patients between the two agencies to increase reimbursement. The agencies operated out of the same location, employed the same nurses, and served the same patients. They frequently switched patients about every 60 days to obtain the higher number of visits permissible in billing for "new" patients. Agency employees also altered dates and misrepresented patient medical conditions in nurses' notes. The owners were charged with mail fraud regarding the billings for 19 patients, for which they illegally obtained more than \$90,000. The husband was sentenced to serve 4 months in a halfway house and his wife 4 months home detention.
- A Pennsylvania osteopath was sentenced to 15 months imprisonment for defrauding Medicare and Blue Shield of close to \$90,000 over a 4-year

period. He was ordered to pay full restitution and a \$400 special assessment. The osteopath submitted claims for removing foreign bodies from patients' ears when he actually performed ear irrigations and upgraded procedural codes to reflect costly hepatitis panels. He then submitted altered patient medical records to cover up the false claims. Earlier, he had been excluded from participating in Medicare and State programs for possession of cocaine.

- A pharmacist was sentenced in Ohio to 2 years in prison, fined \$5,000, and ordered to pay court costs and to forfeit \$26,000 seized earlier from his bank accounts for charges related to Medicaid fraud. The pharmacist pled guilty to writing fraudulent certificates, drug abuse and trafficking in drugs.
- A Utah physician and clinic owner was convicted on 32 Federal counts of mail fraud, submitting false claims, and aiding and abetting. Although he was excluded from participating in the Medicare and State health care programs in 1987 for similar crimes, he continued to submit claims under the names and provider numbers of physicians who performed services at his clinic. He also upcoded claims and billed for services not rendered. He was sentenced to 56 months in prison and 3 years probation upon release, fined \$50,000, and assessed a special victim's assessment fee of \$1,600. Restitution will be decided by the probation office.
- A speech therapist was sentenced in Minnesota to 16 months incarceration for causing the submission of false Medicare claims. He contracted with a therapy company to bill Medicare and Medicaid for his work in several nursing homes. The company reported that he overstated time spent with patients, claiming up to 20 hours a day. He claimed to provide speech therapy to a patient several days after the patient's death, and to nursing home residents he never met. He also was observed using flash cards with a blind resident. The therapist was ordered to pay restitution of \$40,000 and a fine of \$25,000.
- A Virginia psychiatrist was ordered to pay \$48,000 in fines and restitution for illegally billing seven insurance programs, including Medicare, Medicaid and the Civilian Health and Medical Program of the Uniformed Services. He billed for counselling sessions that never occurred or inflated time. He was ordered to serve 6 months home confinement and 750 hours community service.

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 625 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. The majority 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 either the False Claims Act or civil monetary penalty authorities which require less stringent evidence of intent to defraud.

A. Patient and Program Protection Exclusions

The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health 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 and controlled substance abuse, as well as for revocation or surrender of a health care license while a disciplinary proceeding is pending before a State licensure board. 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 health education assistance loans (HEALs), as discussed in more detail in the chapter on the Public Health Service. During this reporting period, OIG imposed exclusions on 599 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 New York physician who ran one of the largest Medicaid mills in the Nation was excluded from the Medicare and State health programs for 25 years. The physician had been sentenced to 2 to 6 years in prison for repeatedly defrauding the Medicaid program. For more than 3 years he operated an assembly-line medical practice, catering largely to substance abusers and billing Medicaid more than \$1 million. He submitted false claims stating that he had provided program recipients with various medical services, such as comprehensive exams and a range of motion tests, when he had simply given the patients the prescriptions they requested without any examination at all. He also falsified patient records to conceal the fraud.

- A New York dentist was excluded for 10 years for illegally diagnosing and testing thousands of patients--including cleanings, drillings, extractions and root canals--after his license had been revoked.
- A New Jersey anesthesiologist was excluded for 15 years after being sentenced to an 8-year term in an adult diagnostic and treatment center for aggravated sexual abuse of a patient. He performed abusive acts while the patient was undergoing podiatry surgery.
- Two workers in developmental centers were excluded for 10 years because they were convicted of injuring patients. A supervisor in an Alabama center struck and kicked mentally retarded patients. An employee of a Florida center burned a patient with coffee.
- The owner of a medical supply company in California was excluded for 10 years for defrauding the Government of approximately \$1.1 million. The owner was part of an elaborate scheme run by family members wherein the Medicaid program was billed for supplies that the company allegedly provided to residents of group homes they owned. They collected medical supply orders and Medi-Cal stickers regardless of patients' needs or entitlement status. The owner was sentenced to 1 year in jail and ordered to make restitution of \$10,000. Most of the remainder of the family fled to the Philippines after the scheme was uncovered.
- In Illinois, a laboratory owner and his laboratory were excluded from the Medicare and all State health programs for 10 years. They were convicted of defrauding the Medicaid program of \$480,000.
- In 1991, a Kentucky ambulance company was excluded from program participation for 10 years because of its owner's conviction of a Medicaid-related crime. Subsequently, documentation was submitted to show that the owner had formally disassociated himself from the company, which was then reinstated retroactively to the date of the exclusion. Later information showed that the convicted owner's sale of the company was a sham, and that he had continued to own and operate the company from the date of his conviction to the present. The OIG has now excluded the company retroactively to the date of the original 10 years.

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. 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. The following rulings on OIG decisions during this period were particularly significant:

- An Indiana district court ruled that the decision to reinstate a provider to participate in the health care programs belongs solely to the Secretary and is not reviewable by the court. The case involved an osteopath who had been excluded for 1 year. His exclusion had been upheld by an ALJ and the Departmental Appeals Board, so he appealed to the district court. Prior to the district court rendering its decision, the doctor filed for reinstatement. However, information had been received which showed there might be a basis not to reinstate him. Notified that no decision could be made on his request for reinstatement until this information could be reviewed, he then amended his appeal to include a motion to show why he should not be reinstated. In its ruling stating that reinstatement is not reviewable by the court, the osteopath's exclusion from the programs was also upheld.
- A court of appeals affirmed a district court's denial of the motion by a Pennsylvania rehabilitation center owner to enforce his plea agreement and enjoin the Secretary from excluding him from the Medicare program. The man had been excluded from program participation for the minimum-required 5-year period as a result of his conviction of a Medicare program-related crime. He asked the trial court to enjoin the exclusion because he claimed it violated his plea agreement, arguing that the exclusion was a "claim" that was covered in the agreement. The court ruled that there was no merit to his claim that the exclusion amounted to an additional criminal sanction or penalty.
- An ALJ upheld the 10-year exclusion of a Maryland woman who owned and operated a licensed day care center which provided group and individual psychiatric therapy to Medicaid recipients. She had submitted bills for psychiatric services not rendered totaling approximately \$1.6 million. She argued that the time of exclusion length was extreme, but the ALJ upheld the OIG decision.

B. Civil Penalties for False Claims

Under the civil monetary penalty (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 \$75 million through both CMP and False Claims Act civil settlements and hearing decisions related to health care during this period.

- A hospital in Washington, D.C., signed a \$2.5 million agreement to settle charges under the False Claims Act that it had counted as income and failed to return excess Medicare payments amounting to more than \$1.6 million. The excesses occurred when Medicare paid for items or services that eventually were paid for by other sources, such as worker's compensation or private insurance. The hospital's billing policy was to write off, and deposit in interest-bearing accounts, Medicare credit balances after 90 days. The settlement is the first negotiated as a result of an OIG joint audit and investigative review of hospital credit balances. The hospital agreed to implement a corrective action plan to ensure that Medicare is not billed as the primary payer. It also abandoned writing off Medicare credit balances. The case resulted not only in the elimination of unacceptable practices, but also in a new system of reviews and internal controls to prevent these and similar problems from occurring in the future. (CIN: A-03-91-00030)
- A Kansas hospital signed an agreement in settlement of a violation of the patient "anti-dumping" statute, which forbids the turning away of patients who are pregnant or have an emergency condition. When a patient came to the hospital emergency room she was told that her doctor was not there. When she asked to see another doctor she was told that none were in town, so she went to another town for treatment. The peer review organization found that, although she had no emergency condition, the hospital did not screen to ascertain her condition and did not have an adequate physician call system. The hospital agreed to pay a \$2,500 civil monetary penalty and publish two community outreach advertisements in a local newspaper, acknowledging the hospital's responsibilities to provide emergency medical treatment to patients regardless of ability to pay and without delay to determine insurance status.
- A Pennsylvania laboratory agreed to pay \$2.4 million in settlement of claims that it defrauded Medicare by manipulating doctors into ordering medically unnecessary tests. In mid-1987, the laboratory informed its doctor-clients that they would automatically receive the results of a ferritin test, which estimates iron storage, with every basic blood test series they ordered. The doctors were billed a nominal fee for the series, but the ferritin tests were billed separately to Medicare at the maximum rate allowable. Since Medicare covers only tests which doctors have said are medically

necessary, the laboratory was causing false claims to be submitted when it substituted its judgment for the doctors' judgment.

- A California orthopedic surgeon agreed to pay a total of \$581,500 to settle charges of submitting false claims for Medicare reimbursement. The surgeon billed for services performed while he was out of the country, and billed for x-ray and physical therapy services that were performed by unlicensed, untrained personnel. The surgeon was convicted of theft from the Medi-Cal program in 1987 for filing similar false claims and was excluded from the Medicare and State health care programs for 25 years.
- In Washington State, a large trust agreed to pay \$575,000 in civil monetary penalties in settlement of possible claims resulting from the misdeeds of two of its trustees. The trustees had been given prison sentences for abusing their trusteeship, and had to pay hundreds of thousands of dollars in restitution and fines. They falsely claimed they owned a nursing home which was part of the trust, operated the home as trustees, and claimed the owners and trustees were not related. They raised the rent (to themselves), then gifted their interest in the home to a charitable foundation for which they were also trustees and took income tax deductions.
- A county hospital in Maryland agreed to pay \$275,000 to settle Government claims related to fraudulent Medicare billings. The hospital billed for physical therapy services for which physician certifications or orders were altered or nonexistent. A review of 392 Medicare claims showed that 236 were improper.
- A private non-profit corporation in Michigan and its president paid a total of \$150,000 for submitting false claims to Medicare. The corporation charged for physical therapy services for community mental health clients when they actually provided exercise therapy and counseling to improve motivation, endurance, general health and socialization--which are not covered by Medicare. The corporate president duped two local doctors into permitting use of their provider numbers for billing purposes. The doctors turned over to him the payments received. As part of a global resolution, the corporate president paid \$75,000 to settle a civil suit in the case. In a subsequent criminal sentencing, the judge fined the corporation \$75,000, even though he was aware of the civil settlement.

Acquisition Costs of Prosthetic Intraocular Lenses

Performance Measure

The OIG conducted an inspection to evaluate whether Medicare's current reimbursement policy for intraocular lens (IOL) implants is prudent. The OIG found that: IOLs can be purchased for less than \$200; the ability of a purchaser to secure a low price did not depend on the type of lens technology purchased, volume of lenses purchased or size of the institution purchasing the lenses; arrangements between IOL purchasers and vendors make Medicare's ability to obtain a fair price for IOLs problematic; and out-of-pocket expenses for Medicare patients are 2.5 to 3 times greater in hospital outpatient departments than in ambulatory surgical centers.

This report resulted in OBRA 1993 legislation reducing Medicare's \$200 fixed IOL payment to \$150. The OIG projects that Medicare will save more than \$18 million annually and more than \$90 million over 5 years. (OEI-05-92-01030)

Home Infusion Therapy

Home infusion therapy has made it possible for increasingly sophisticated treatments to be given in the home, including enteral and parenteral nutrition, intravenous antibiotics and chemotherapy. In a review of the Medicare home infusion industry, OIG found that Medicare payments for home infusion therapy are rising rapidly, as illustrated in the following table.

GROWTH OF INFUSION SERVICES UNDER MEDICARE PART B

Infusion Services in the Home:	Calendar Year 1990	Calendar Year 1991	Increase
Estimated number of beneficiaries	14,500	27,700	91%
Estimated total dollars allowed	\$61 million	\$191 million	213%
Estimated average dollars allowed	\$4,243	\$6,923	63%

Based on data from a 1992 Office of Technology Assessment study, an analysis of carrier payments and the comments of respondents in its own study, OIG determined that there is great variability in coverage policy among Medicare carriers. While 17 carriers have policies to cover only the drugs and conditions specified by HCFA in its Coverage Issues Manual, other carriers cover not only these, but a wide variety of other drugs as well.

Further, OIG found that physician ownership and other financial arrangements are common in the industry.

The OIG recommended that HCFA monitor spending to better identify trends; provide more specific coverage guidelines; and collect ownership and compensation information, use this information to monitor referral and utilization patterns, and refer suspected cases of abuse to OIG. The HCFA concurred with OIG's recommendations. (OEI-02-92-00420)

Marketing of Orthotic Body Jackets

Performance Measure

This inspection examined the marketing practices of orthotic body jacket suppliers. The OIG found that DME suppliers initiated orders for devices that did not meet the construction and medical purpose requirements of legitimate orthotic body jackets. Physicians did not provide controls to prevent the sale of such nonlegitimate devices. Many physicians were not aware of what they had authorized because they had signed certificates of medical necessity (CMNs) that had been completed by suppliers. The CMNs provided no controls to assure medical need. Patient diagnoses and conditions listed on CMNs were not those that would normally require orthotic body jackets.

The OIG suggested that HCFA continue to alert its regional fraud and abuse coordinators and contractors to potential abuse in this area, and advise contractors to exercise diligence in reviewing claims for orthotic body jackets. The OIG has inspections planned to study this issue in greater detail. The inspections will look at: the usefulness of CMNs; the appropriateness of payments for equipment, supplies and professional services provided to beneficiaries in nursing homes; and the role of physicians in controlling patients' medical care. (OEI-04-92-01081)

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/Medicaid costs.

Over the years, more than 500 convictions, judgments and settlements have been obtained as a result of OIG investigations of violations of the anti-kickback statute. Examples follow:

- The former billing clerk and 14 former patients of a Georgia chiropractor were sentenced in a kickback scheme costing Medicare and more than 30 insurance companies millions of dollars. All were incarcerated and ordered

to pay fines and restitution. The chiropractor and his office manager wife had paid employees 10 percent of each week's revenues, and had paid patients 33 percent of whatever the carriers paid on their claims. Claims were submitted for patients and their families regardless of whether they were treated. In one instance, bills were submitted for 169 persons supposedly treated in one day. The current actions bring to more than 40 the number of persons sentenced thus far, including the chiropractor and his wife, who earlier received lengthy jail sentences and were ordered to pay \$2.2 million in restitution.

- In Florida, five persons were sentenced as the result of a continuing investigation into a conspiracy in which Medicare was fraudulently billed about \$5.2 million for oxygen concentrators, nebulizers, medications and tests. Three men were ordered to pay \$2.3 million in restitution, and were sentenced to 41, 46 and 51 months in jail, for paying physicians for prescriptions which they sold to two medical supply companies and a laboratory to use in billing Medicare. One of the company owners and one of the physicians--who had also billed for house calls he did not make--were convicted and given prison terms as well.
- A second Florida investigation involving kickbacks to physicians for prescriptions for unnecessary medical supplies also resulted in five sentencings during this period. More than a dozen companies, set up supposedly to supply Medicare patients with liquid nutritional supplements and feeding kits, defrauded Medicare of an estimated \$20 million. A man and woman who operated some of the companies and paid recruiters to sign up senior citizens for "free milk" (for which they billed Medicare) were sentenced to 51 and 24 months in prison, respectively. They are to make restitution of more than \$4.6 million. Another woman who did the billing for several of the companies was sentenced to 5 months in prison and ordered to pay restitution and fines of over \$251,000. Two physicians who were paid for signing blank certifications for patients, regardless of the medical necessity or their eligibility, were sentenced to 30 and 12 months in prison and ordered to pay a total of almost \$865,000. Others await sentencing. The "kingpin" of the scheme fled the country but was found in Venezuela and extradited. He awaits trial.
- A New York radiologist was excluded from Medicare and State health care programs for 10 years after being sentenced to 1 to 3 years in prison for participating in a massive kickback scheme. He had systematically billed Medicaid for thousands of medically unnecessary, duplicative, forged and unreadable sonogram tests. His Medicaid billings went from \$8,200 to

more than \$2.2 million in 2 years and involved huge kickbacks to more than 50 so-called "salesmen."

- A Georgia hospital entered into a settlement whereby it agreed to pay \$75,000, and undertake corrective action in the future, in lieu of legal proceedings for violations of the Medicare/Medicaid anti-kickback statute. The OIG had determined that the hospital had offered illegal remuneration to physicians, such as below-market leases for office space, to induce the referral of patients to the hospital. The settlement was the result of one of the first investigations undertaken by OIG that focused on illegal kickbacks to physicians. *(4-93-30011-9, Kennestone Hospital)*
- In California, five persons, including three physicians, were sentenced and another five pled guilty in a DME kickback scheme. A DME company was set up to pay physicians, independent contractors and sales agents for referral of patients for prescriptions for transcutaneous electrical nerve stimulators (TENS). The company billed Medicare \$2 million for the TENS units, and was paid \$475,000.

Embezzlement of Medicare Funds

Convictions and sentences were obtained in several cases involving embezzlement by former employees of Medicare carriers.

- The first person was sentenced for participating in an embezzlement scheme perpetrated by former employees of the Virginia carrier that netted an estimated \$100,000. The employees, including the supervisor of a special carrier project in which Medicare beneficiaries were paid by manually drawn checks, wrote checks which friends forged, cashed and gave back 50 percent of the proceeds. A woman who admitted cashing 17 checks was sentenced to 12 months incarceration and ordered to repay more than \$70,150. Further convictions and sentencings are expected.
- A former employee of the Rhode Island Medicare carrier was sentenced for embezzling more than \$30,000 from the program. Her duties included microfilming undeliverable reimbursement checks. After beneficiaries complained about not receiving checks, investigation showed that she had embezzled 44 checks over a 5-month period and cashed them at local banks for her own use. She was sentenced to 6 months home confinement and 250 hours community service, and ordered to make full restitution.

- Three former employees of the Florida carrier were given probationary terms and ordered to pay \$5,500 in restitution for Medicare money they embezzled. The three manipulated data to cause the carrier's system to issue fraudulent checks to them.
- A former hospital official in Pennsylvania and several others were convicted of embezzling Medicare and Department block grant funds paid to the hospital. After his release from prison, the former official received \$128,000 from a life insurance policy but made no payment on a fine of \$23,350 and restitution of \$159,570, as he had been ordered. Instead, he distributed the money to friends and relatives, and attempted to keep the money a secret from the probation department. He was told by the court to pay the fine immediately and submit a plan for restitution, or he would have to return to prison for 6 to 9 months.

Cooperative Work with the Health Care Financing Administration and State Auditors

In an effort to help curb runaway Medicaid costs, OIG has formed partnerships with State auditors and evaluators, as well as HCFA staff, to undertake joint projects for improvement of the program. These projects are intended to produce mutually beneficial results and savings at both the Federal and State levels. The OIG is sharing the methods and results of its earlier Medicare and Medicaid projects to provide State auditors with leads for cost savers. In turn, OIG will use States' experiences to estimate the national impact of successful recommendations implemented at the State level, which could result in Federal support for these recommendations. Suggested areas for joint reviews include: Medicaid credit balances; Medicaid drug rebates; third party liability; home health agencies; payments for nonphysician services; and prospective payment system transfers.

Currently, North Carolina is conducting a joint review with OIG staff involving Medicaid drug issues. The National Association of State Auditors, Comptrollers and Treasurers is conducting a nationwide joint review with OIG of Medicaid drug issues that could include as many as 11 additional States. Louisiana recently completed an audit of its Medicaid rebate program and issued a report in October 1993. At the Federal level, OIG is working with HCFA to assist the agency in expanding on OIG findings for nationwide coverage and in the conduct of joint reviews. One recent example is HCFA's expanded work on Medicaid drug rebate issues developed by OIG. These partnership arrangements help OIG, HCFA and the States achieve their common missions with maximum efficiency.

Medicaid Drug Rebate: Weighted Average Manufacturer Price

In an analysis of the weighted average manufacturer price (WAMP) provisions of OBRA 1990, OIG determined that utilization data needed to make WAMP calculations would not

be available on a timely basis, and WAMP calculations would be unpredictable and could have a negative impact on Medicaid drug rebate collections. The HCFA agreed with the findings. The WAMP provisions of OBRA 1990 were recently repealed by OBRA 1993. (CIN: A-06-93-00070)

Improper State Claims for Federal Medicaid Funds

The costs of the Medicaid program are shared by the Federal and State governments. However, the law and regulations stipulate that the Federal Government will share in the costs of care and treatment only when certain criteria are met.

A. Third Party Liability Payments: California

The objective of this audit was to determine if California gave the Federal Government full financial credit for casualty third party liability (TPL) settlements and awards for the period July 1, 1988 through June 30, 1992. The OIG found that the State did not comply with Federal laws on TPL credits, allowing recipients to keep an estimated \$7.6 million in funds that rightfully belonged to Medicaid.

The OIG recommended that California refund the \$7.6 million to the Federal Government and establish procedures to ensure that the Federal Government is given full credit for TPL settlements and awards in accordance with Federal laws. The State did not concur, arguing that OIG misinterpreted applicable Federal laws. However, after consideration of the State's comments and consultation with the Office of General Counsel, OIG continues to believe that its findings and recommendations are correct. (CIN: A-09-92-00095)

B. Third Party Liability: Florida

The OIG audited third party liability (TPL) identification and collection from insurance companies by the State of Florida under the Medicaid program. The OIG found that Florida had not sought reimbursement from Blue Cross and Blue Shield of Florida, Inc. (BCBSF) since January 1989 for 305,230 claims with potential TPL. The 305,230 claims totaled \$8.5 million (Federal share of \$4.7 million). These claims were not billed because Florida had suspended its submission of paper claims to BCBSF until an electronic billing medium could be designed and implemented by the fiscal agent.

The OIG recommended that the State consistently bill each insurance carrier on a timely basis to avoid a backlog; design and implement policies and procedures to identify, account for, bill, collect and report TPL resources; and conduct the exchanges with the frequency specified in its TPL action plan. The State generally agreed with OIG's recommendations. It has billed BCBSF for \$1.7 million and is continuing to pursue funds owed the Medicaid program. (CIN: A-04-92-01020)

C. Intermediate Care Facilities for the Mentally Retarded: Minnesota

The objectives of this review were to quantify the Medicaid overpayments identified in the provider audits of intermediate care facilities for the mentally retarded (ICFs/MR) by the State of Minnesota, and determine if these overpayments were recovered and refunded to the Federal Government in accordance with Federal regulations.

The OIG found that Minnesota unnecessarily delayed refunding over \$2.9 million (Federal share) of Medicaid overpayments made to 75 ICFs/MR providers between October 1, 1985 and August 31, 1991. The OIG recommended that the State make an appropriate adjustment to HCFA for that amount, and establish policies to ensure compliance with the Federal regulations regarding the discovery and refunding of the Federal portion of provider overpayments. The State agreed to the first recommendation and did not comment on the second. The HCFA has not made a final management decision on the report's recommendations. (CIN: A-05-92-00062)

D. Institutions for Mental Diseases: New York

In this follow-up audit, OIG reviewed HCFA's resolution of recommendations in an earlier audit. In that audit, OIG found that New York State had improperly claimed Medicaid reimbursement for beneficiaries between the ages of 21 and 64 at two psychiatric hospitals in Westchester County during the period October 1, 1986 to September 30, 1989. The OIG determined that since these two hospitals were distinct, free-standing psychiatric hospitals that were institutions for mental diseases, the State should not have claimed Federal financial participation for beneficiaries in the 21 to 64 age group. In its follow-up review, OIG concluded that HCFA has an adequate and reliable system of controls and procedures in place for resolving audit findings. (CIN: A-02-93-01021)

State Medicaid Fraud Control Units

In FY 1993, Medicaid health care provider payments exceeded \$130 billion. Medicaid fraud control units (MFCUs) are currently responsible for investigating fraud in more than 94 percent of all Medicaid health care provider payments. Forty-two States now have units and are receiving funds and technical assistance from OIG. Following the mandate of the Congress, the MFCUs bring to prosecution persons charged with defrauding the Medicaid program, and those charged with patient abuse and neglect. They also work with local survey and utilization review units to draft proposed regulations governing providers to ensure that these regulations will stand up in court.

During the first half of FY 1994, OIG administered a little over \$34 million in appropriated grants to the MFCUs. The MFCUs reported 328 convictions and \$18 million in fines, restitutions and overpayments collected for the period July 1, 1993 through December 31, 1993.

Social Security Administration

Chapter II

SOCIAL SECURITY ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

Nearly 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, added in 1956, are popularly called Social Security. In Fiscal Year (FY) 1994, the Social Security Administration (SSA) expects to pay over \$314 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 1994, SSA expects to pay SSI benefits in excess of \$29 billion to over 6 million recipients.

The Office of Inspector General (OIG) reviews all aspects of SSA's programs and operations, including: disability insurance benefits, information resource management, program integrity and efficiency, quality of service, representative payees and SSI benefits. The OIG is also providing 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. Over the past few years, the misuse of SSNs has grown far beyond mere benefits fraud to include a wide range of "con" games and violent crime. Moreover, during this reporting period successful prosecutive actions were taken against several persons involved in the sale of confidential information available by using SSNs to gain access to employment earnings records. The extraordinary increase in Social Security

fraud, particularly SSN fraud, comes at a difficult time for OIG because of diminishing investigative resources.

Social Security Administration's Financial Statements: Fiscal Year 1993

The OIG issued its opinion on SSA's financial statements for the fiscal year ended September 30, 1993. This was the seventh year that OIG has expressed an opinion on SSA's financial statements. The OIG reported that SSA has been improperly using Internal Revenue Service records as the basis for transferring employment tax revenues to the Social Security trust funds. This has resulted in an overstatement of SSA's "total net position." The SSA is seeking legislation to resolve this matter.

During FY 1993, SSA improved its accounting for receivables from overpaid beneficiaries. These improvements enabled OIG to satisfy itself as to the collectibility and fair presentation of the "accounts receivable, net" and the related "bad debts and writeoffs" expense. The FY 1992 opinion is still qualified as to this issue. (CIN: A-13-94-00518)

Social Security's Internal Accounting Controls and Compliance with Laws and Regulations: Fiscal Year 1993

This report was part of the overall Chief Financial Officers Act review. The OIG determined that, while SSA's debt management system has been improved, it still remains a material nonconformance which does not comply with the Federal internal accounting control standards. The SSA agreed to continue to address debt management system deficiencies.

The OIG also found that SSA is still using Internal Revenue Service data as a basis for determining the amount of monies to be credited to the Social Security trust funds. This practice is not in compliance with the Social Security Act, which provides that employment taxes are to be transferred to the trust funds based on a certification of wages through records maintained by the Secretary of Health and Human Services. The SSA agreed to continue to seek legislation to amend the Act, but did not agree to report this issue as a material weakness in its FY 1994 Federal Managers' Financial Integrity Act report.

Finally, OIG noted that SSA has not performed continuing disability reviews (CDRs) that are required by the Act. A subsequent OIG report will address the CDR issue in more detail. (CIN: A-13-93-00408)

Posting of Self-Employment Income to the Master Earnings Record

The OIG determined that SSA needs to implement better controls to ensure that self-employment income (SEI) transactions are adequately checked before being posted to

an individual's earnings record. The OIG estimates that in Calendar Year 1991, SSA posted about 6,800 SEI transactions totaling \$18.5 million to the wrong earnings record, and that as of January 1993, for Tax Years 1978 through 1990, SSA incorrectly posted over 30,000 SEI adjustment transactions totaling \$95.5 million to the earnings records of the SEI earners' spouses. As a result of OIG's review, SSA initiated software changes to prevent erroneous postings from its suspense file. The OIG recommended that SSA: complete the software changes; modify software procedures to check adjustment transactions from the Internal Revenue Service for accuracy before posting; and correct the SEI transactions posted to the wrong earnings record.

Further, OIG determined that SSA needs controls to ensure that SEI exception reports, which may contain erroneous SEI adjustments, are secured and examined promptly. As of February 1993, SSA had a 5-year backlog of exception reports for about 13,000 transactions, and 5 exception reports totaling about 11,000 transactions were missing. The OIG recommended that SSA continue examination of the SEI exception reports and monitor the workload, and develop control procedures to prevent missing exception reports. The SSA agreed with the recommendations. The missing exception reports, which were found subsequent to OIG's review, were added to SSA's pending backlog. (CIN: A-13-93-00428)

Processing of Delayed Claims

In this OIG follow-up review, OIG found that SSA field offices and program service centers were not following procedures for processing claims in delayed status or adequately utilizing SSA's claims control system to control the disposition of delayed claims. Either SSA did not take corrective action or the actions taken were ineffective.

The OIG recommended that SSA reemphasize policies and procedures to ensure that field personnel understand their responsibilities and the importance of strict compliance in processing delayed claims; identify and take appropriate actions to properly adjudicate claims which have been in delayed status for 6 months or more; and provide for automated follow-up and reporting controls for delayed claims of 6 months or more. The SSA generally concurred with the findings and recommendations, and reported that implementation activities are underway. (CIN: A-06-92-00096)

Processing Death Termination Actions

The OIG conducted a review of OASI and DI termination action cases at the Northeastern Program Service Center (NEPSC) in which individuals, entitled to benefits at a future date (advance filing cases), died before or during their date of entitlement (DOE) month. In such cases, benefits are not payable because entitlement ends with the month preceding a beneficiary's death.

During October through December 1990, NEPSC processed death notices for 317 advance filing cases. The OIG found that a computer system limitation adversely affected 101 advance filing cases where deaths occurred before the DOE month. This system limitation and untimely manual termination actions caused incorrect payments in 53 of the 101 cases.

Because the system for processing death termination actions is centrally designed and SSA-wide, OIG believes that the number of cases adversely affected could be sizeable. The OIG recommended that SSA correct the system limitation that prevents automated processing of advanced filing death cases. The SSA concurred and is in the process of implementing this recommendation. (CIN: A-02-91-00002)

Diversion of Social Security Payments from Nursing Home Residents

Performance Measure

The OIG conducted this study in response to the concerns of nursing home administrators, long term care ombudsmen and other advocates for the elderly that an increasing number of residents are unable to pay their nursing home bills because their Social Security payments have been diverted by family members or other individuals.

The OIG found that the problem is not as extensive as feared. Nevertheless, each diversion represents a real or potential problem for both the SSA beneficiary and the nursing home. Between January 1991 and June 1992, approximately 5,700 residents (fewer than 1 percent of all residents who received Social Security) were unable to pay their nursing home bills because of diversion. The OIG estimates that nursing homes are unable to collect \$5 million per year because of diverted Social Security payments. This is less than 1/100 of 1 percent of the industry's annual revenue. Although nursing homes try to collect the unpaid bills, they rarely discharge residents for nonpayment. Also, nursing homes do not routinely involve public agencies in diversion cases.

The SSA agreed to OIG's recommendation to educate nursing homes about when and how to request a representative payee for a resident and report payment diversion to SSA and/or another agency. (OEI-09-91-01320)

Social Security Fraud

Over 100 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 Hawaii, an employee of the Department of Defense was sentenced to a year in prison after pleading guilty to converting his daughter's Social Security benefits to his own use. As representative payee for his daughter, he received her survivor's benefits from 1974 until May 1991 and used them to pay his own rent and bills. In the meantime, the daughter was living with a neighbor and knew nothing of the benefits, none of which were spent on her. He was ordered to pay \$37,000 in restitution.
- A 75-year-old New Jersey man was sentenced to 4 months incarceration, 4 months home confinement and 3 years probation, ordered to make restitution of \$3,600 and assessed a \$50 special fee for Social Security benefit fraud. Himself a recipient of Social Security benefits, the man cashed his deceased mother's Social Security checks from October 1963 through September 1989 and used the money for his personal needs. He received approximately \$81,000 illegally by converting his mother's checks.
- An Indiana woman was sentenced to 5 1/2 years incarceration, suspended, ordered to make restitution of \$40,800, and fined \$10,000 for concealing her mother's death and forging and cashing her Social Security benefits checks. An out-of-State relative had told police it was difficult to believe that her mother, who was in her seventies, was always indisposed when they called. Police found the mother's decaying remains in a padlocked mobile home next to the woman's house. She had been dead more than 3 years.
- An investigator with the Indiana Medicaid Fraud Control Unit (MFCU) was sentenced to 36 months imprisonment, 30 months suspended and 6 months stayed, pending repayment of full benefits intended for her father. The investigator and her father shared an account into which his SSA checks were directly deposited. After his death, she continued spending the benefits. She had to repay \$10,400 and pay a \$525 probation fee plus a \$114 fine. Her position as criminal investigator with the State MFCU was terminated.

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

- A New Hampshire man was sentenced to 21 months incarceration for defrauding SSA of more than \$34,300. In 1988, the man successfully appealed an SSA denial of disability benefits, claiming he had been unable to work since 1986. During that time, and subsequently, he worked as a hotel desk clerk and a part-time teacher of accounting at two colleges. While supposedly medically unable to operate a motor vehicle, he bought

and operated a motorcycle under a false identity. He was ordered to pay full restitution plus a \$150 special assessment.

- A Wyoming man was sentenced to 2 years in jail and 5 years probation for Social Security and bank fraud. He was ordered to make restitution to a bank of over \$17,000. While receiving Social Security disability benefits, the man owned and managed a construction company and operated heavy equipment. He received approximately \$35,000 to \$50,000 in overpayments from SSA. No restitution was ordered because the judge believed the money could be recouped through administrative procedures.
- A Michigan man was sentenced to 5 months in prison, 5 months of house arrest and 2 years supervised probation for disability fraud. He was also fined \$20,000 and ordered to make restitution of more than \$39,300 to SSA. A building contractor, he began receiving disability benefits from SSA in 1979. After bragging to friends and family about ripping off the system, he came under investigation which led to his conviction.
- A Wisconsin man was sentenced to 6 months imprisonment and 3 years probation, and ordered to pay \$5,900 in restitution for fraudulent receipt of Social Security disability benefits. Investigation showed that he worked as a self-employed bank courier while collecting disability benefits. He had previously been convicted of fraud in connection with receipt of unemployment compensation benefits.
- A Vietnam veteran, who lost a leg in the war, was sentenced in Missouri for abusing Social Security disability and Medicare benefits in fraudulently obtaining drugs. From 1984 through 1992 he saw doctors in three different States on first-time visits, complaining of pain from the leg. He saw, on an average, three physicians a week, receiving prescriptions for Percoset and Valium and obtaining 40 pills per prescription per day. He took some of the pills himself and sold the rest. He was sentenced to 3 years probation and ordered to seek treatment for his addiction.
- In the first case to go to a hearing under the Program Fraud Civil Remedies Act (PFCRA), the Departmental Appeals Board affirmed an administrative law judge (ALJ) decision imposing the maximum amount of penalties and assessments for Social Security fraud. Modeled after the civil monetary penalty law for Medicare and Medicaid, PFCRA makes it a liability to make, present, submit or cause to be made, presented or submitted any claims which a person knew or had reason to know were false.

Between October 1986 and August 1989, a Washington, D.C. woman wrongfully converted 34 Social Security widow's benefit checks made payable to her deceased mother, thereby improperly receiving \$13,400 from SSA. Aggravating circumstances were found in that she wrongfully converted an additional 190 Social Security checks from January 1971 to October 1986, and that she had attempted to conceal her misconduct by lying to the SSA field representative regarding the whereabouts of her deceased mother. The ALJ had found, and the Departmental Appeals Board agreed, that the woman was liable under PFCRA for having submitted claims she knew were false, and that all but one of the aggravating circumstances asserted by the Department existed. She therefore had to pay the maximum amount of penalties and assessments, which totaled \$196,800.

Access to Social Security's 800 Number

Performance Measure

Nearly from its inception, SSA's 800 number has been a source of public complaints regarding high busy signal rates and long hold times. Believing that focusing primarily on the busy signal rate is misleading, SSA began looking at the percentage of clients gaining access on the same day of their initial call as a clearer measure of service.

The OIG found that same-day access is not a commonly used industry measure for 800 number operations. Other organizations using 800 numbers frequently tracked their performance by monitoring such indicators as busy signal rates, abandoned call rates, length of calls and speed to answer. Also, the same-day measure does not fully reflect ease of access since most callers who get through to SSA do so within one hour, as illustrated in the following table.

ACCESS FOR PEAK AND NON-PEAK DAYS, FEBRUARY 1992

Access Measures	Peak Days (9 days) N=5,094,325	Non-Peak Days (10 days) N=2,244,336
Busy signal rate	52%	9%
Same-day access rate	86%	98%
Within 1 hour access rate	83%	98%
Within 15 minutes access rate	80%	98%

N=attempted calls

Moreover, in most organizations reviewed by OIG, the 800 number systems were developed from scratch to have sufficient staff to meet expected demand. Built upon an existing teleservice system, SSA's 800 number system was not designed to meet the current huge demand on peak-call days.

The OIG concluded that SSA needs to develop a strategy for improving 800 number performance on peak days by such means as: balancing demand-causing events (such as cycling checks and notices); developing staffing options; expanding its use of advanced technological options; and encouraging the public to call at non-peak times. Further, SSA should improve the precision of its 800 number access measure by examining the percent of callers getting through within either 15 minutes or 1 hour of their initial attempt. The SSA agreed with the first recommendation and cited a number of initiatives undertaken towards this end. It is continuing to study the second recommendation. (OEI-02-91-00223)

Courtesy Telephones in Selected Field Offices

In reviewing the feasibility of installing courtesy telephones connected to the 800 number nationwide telephone system in selected SSA field offices, OIG found that clients who choose to visit SSA field offices are usually provided service within 30 minutes. There are occasions, however, especially in large urban offices, where clients encounter longer waiting lines. Based on waiting time surveys and telephone calls to the 800 number, OIG concluded that some clients would voluntarily choose to conduct their business over the telephone to avoid waiting in long lines at field offices. The cost to install and maintain courtesy telephones would be minimal.

The OIG recommended that SSA evaluate the workload, staffing, physical layout and specific needs for each field office. In those offices that demonstrate a need based on fluctuating workloads and potential client usage, OIG recommended that SSA install courtesy telephones. In response to the draft report, SSA agreed that installing courtesy telephones in certain field offices might be worthwhile, but expressed several concerns that need to be addressed before acting on the recommendation. The SSA is developing plans to conduct further tests and will implement the recommendations if warranted and if funds are available. (CIN: A-09-92-00072)

Obtaining Medical Evidence

The OIG examined whether delays in obtaining medical evidence of record (MER) have affected the timeliness of claims decisions, thereby contributing to the growing backlog of disability claims. Traditionally, disability examiners in State agencies, known as disability determination services, are responsible for developing and acquiring MER. However, the

pressures of current workloads make it difficult for them to manage the task along with their decision-making duties.

The OIG determined that SSA needs to find new approaches for acquiring MER. While there are a number of methods being tested that show merit, SSA has no evaluation plan for measuring and comparing the efficiency, quality and timeliness of the various approaches. The OIG recommended that SSA develop indicators to uniformly measure the performance alternatives, and expand the method showing the greatest potential for improving claim processing time and cost-effective operations. In response to the draft report, SSA generally agreed with the recommendations. (CIN: A-13-92-00106)

Work-Related Payment Cessations for Disabled Beneficiaries

Disability payments are supposed to stop when beneficiaries are earning over \$500 per month after completing a 9-month trial work period (TWP). Delays result in beneficiaries' receiving payments that are not due them. The OIG found that SSA was not effective in stopping disability benefits timely due to delays in contacting beneficiaries at the end of a TWP, notifying beneficiaries that their payments will stop and stopping the payments. During FYs 1990 and 1991, SSA stopped payments to 7,051 disabled beneficiaries for post-TWP earnings of over \$500 per month. It did not stop payments timely for 4,724 of those beneficiaries, consequently overpaying them \$13.7 million. Of that amount, SSA has recovered approximately \$4 million, has not recovered \$7.6 million, and has waived or suspended efforts to collect \$2.1 million.

The OIG recommended that SSA: develop a workload management system to permit managers to identify and review cases where TWP-completion diary dates should be established; require field offices to input start-work dates for Office of Disability Operations or program service center review; eliminate unproductive work notices; separately control and work TWP-completion diary alerts before other nonpriority workloads; and shorten from 60 days to 30 days diaries for receipt of statements describing work. In response to the draft report, SSA generally agreed with the recommendations and stated that it will address the issues cited in the report. (CIN: A-13-92-00231)

Overpayments to Disability Insurance Beneficiaries Who Return to Work

Performance Measure

The OIG examined the process that SSA uses to limit payment of benefits to disabled worker beneficiaries after they have returned to continuing work at substantial gainful activity. The OIG found that, while very few disability beneficiaries ever return to work after entitlement, those who do return and continue to work at substantial gainful activity are likely to receive disability insurance overpayments.

The OIG recommended that SSA focus development efforts on cases most likely to lead to overpayments and that it complete development sooner. Implementing this change could result in an annual savings of an estimated \$8 million. The SSA, in its response to the draft report, generally agreed with OIG's recommendations. (OEI-01-92-00020)

Work Experiences of Blind and Nonblind Disabled Beneficiaries

When Social Security disability beneficiaries return to work, the disability insurance program uses an earnings threshold called substantial gainful activity (SGA) to determine whether to pay disability insurance benefits. There is a significantly higher SGA amount for the blind than for the nonblind, which allows them to earn more before their cash payments are suspended or terminated. Over the years, the Congress and advocacy groups have debated the appropriateness of the different SGA amounts. In studying the effect of the different SGA levels on the work experiences of the disabled, OIG found that less than 2 percent of disabled beneficiaries have earnings that exceed the annual SGA amounts. While blind beneficiaries are more likely than all the nonblind disabled combined to have earnings, the same is true for several other diagnostic categories. The costs of the higher SGA amount for the blind are relatively small, because few disabled beneficiaries are blind and few blind beneficiaries earn incomes above the nonblind SGA amount. If the nonblind disabled SGA amount were raised to the blind SGA amount, it would cost approximately \$1.2 billion in additional disability insurance payments in the first 5 years, not including increased Medicare, Medicaid and SSI payments. The OIG concluded that SSA's computerized data are inadequate to determine the effects of the different SGA amounts on work performance or work incentives in general.

The OIG recommended that SSA routinely collect and publish data concerning disabled beneficiaries who work. This would provide baseline and longitudinal data that could be used to determine whether beneficiaries are returning to work because of disability insurance work incentives. The SSA agreed with the thrust of OIG's recommendation and intends to improve management information concerning disabled beneficiaries who work. (OEI-09-90-00050)

Drug Addicts' and Alcoholics' Continued Dependence on Supplemental Security Income

Performance Measure

The OIG determined that almost 80 percent of drug addict and alcoholic recipients continued to receive SSI payments after 3 years and that payments rarely cease due to successful treatment. Additional inspections are planned to provide more information concerning the treatment status and outcomes of drug addicts and alcoholics receiving SSI. (OEI-09-94-00070)

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. During this period, one case even involved serial murder:

- A California woman was convicted in a jury trial for murdering three of seven SSI beneficiaries found buried in the yard of her boarding house. She had been charged with murdering all seven former boarders, plus two found elsewhere, for their benefits. The OIG investigators who assisted in identifying the victims and the theft of their benefits checks also proved that the woman had impersonated one of the victims in attempting to obtain Dalmane, a drug found in seven bodies. She was sentenced to life imprisonment without possibility of parole. A mistrial was declared on the other six murder charges because the jury deadlocked on a decision on them.
- In New York, a disability recipient was sentenced to 70 months in prison for Social Security benefits fraud and making false statements, and 70 more months for mail fraud and illegal distribution of a controlled substance. He was also ordered to make restitution of nearly \$300,000. Posing at various times as a psychiatrist, neurologist, attorney and real estate agent, the man filed false medical reports to SSA which resulted in fraudulent SSI and disability benefits for his "patients." He also used a fictitious registration number of the Drug Enforcement Administration to write prescriptions for codeine, and failed to report to SSA that he was no longer disabled. Had his schemes continued, the loss to SSA would have exceeded \$2.5 million.
- A woman was sentenced in Pennsylvania to 4 months home detention and 5 years probation, and ordered to pay restitution of \$15,200 for converting her mother's SSI benefits checks to her own use. Her mother died in February 1989, but she did not report the death and admitted to receiving and negotiating the checks, which continued to be mailed.
- Two women were sentenced in New York for SSI benefits fraud. The two conspired with a former claims representative to issue and cash SSI checks, with the first woman as representative payee, and retroactive benefits for the second woman's disabled children which were not due them. The first woman was sentenced to 18 months in prison and ordered to make restitution of \$10,950, the amount that was defrauded. The second woman was sentenced to 1 year of supervised probation and restitution of \$6,900 to

SSA. The former claims representative was previously found guilty and imprisoned.

- Two women were sentenced in South Dakota for theft and forgery of a retroactive SSI benefit check. The check, in the amount of \$2,653, was intended for a 3-year-old girl. It was cashed at a local grocery store and used to pay bills, buy a car and purchase groceries. The car was registered in the girl's name. The women both pled guilty to forgery. One was sentenced to 3 years probation, ordered to make restitution of \$200, fined \$500 and ordered to pay a special assessment of \$50. The other was sentenced to 2 years probation, ordered to make restitution of \$2,450 and told to pay a special assessment of \$50.
- A woman who reported that she found a syringe in a soft drink can in Colorado, was shown tampering with the soft drink in a supermarket video. Subsequent media attention suggested that she might be terrorizing an elderly woman under her care. The OIG investigated to determine whether she might be the elderly woman's representative payee. Instead, they discovered that she received SSI benefits and had unreported income. She was sentenced to 51 months in jail and ordered to pay restitution and fines of more than \$6,600 for the SSI fraud. Although the mistreatment could not be proven, she was also convicted of product tampering.

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:

- A meatpacking company in Nebraska pled guilty to SSN misuse, Social Security benefits fraud, harboring aliens and filing false employment documents. The company was fined \$103,000. The settlement came nearly 2 years after Federal agents raided the plant, arresting more than 300 people. Of those arrested, 250 agreed to deportation without hearings. The company admitted to harboring aliens, but it claimed that illegal workers were never hired knowingly.
- A California man was sentenced for falsely endorsing a fraudulent check for \$27,000 with the name and SSN of a Salvation Army employee. The man found a piece of paper on the street with the employee's name and SSN and passed it on to a friend. The friend gave it to his former wife, at the time an SSA benefits authorizer, who accessed the SSA computer system, created a

false benefits record in the name and SSN of the employee, and entered a disability date, to generate the fraudulent checks for the man. He was sentenced to only 6 months imprisonment and 3 years supervised release because he implicated the friend and the former wife, who have been indicted in the case.

- A man was sentenced in Massachusetts to 30 months in prison for false use of an SSN. He attempted to bribe an SSA employee to give him a new SSN card, and on the same day applied for and received a State identification card and learner's permit under an SSN not assigned to him. He will serve 3 years supervised probation upon release.

Even more prevalent is the use of fraudulent SSNs in the commission of a wide variety of scams and other crimes. The OIG is constantly approached by other Federal, State and local authorities for assistance in identifying and locating suspects and developing cases on everything from insurance and income tax fraud to money laundering and murder. Some of these cases completed during this reporting period included the following examples:

- A former banker was sentenced in Texas to 78 months in Federal prison, followed by 3 years probation, and fined \$750 for misuse of Social Security numbers as part of a bank fraud scheme. The man attempted to buy a savings and loan association with the association's own money. In 1990, he arranged for an accomplice at the savings and loan to wire him \$1.51 million in thrift money to be used to buy the savings and loan. He intended to hide the theft from the association by issuing \$1.51 million in fictitious loans.
- In Colorado, an insurance agent was sentenced to 3 years in prison for wire fraud and SSN misuse, and ordered to pay restitution of \$40,000 and a fine of \$100. The agent obtained employment applications for companies he claimed to be setting up, and had prospective employees complete life insurance forms. He submitted the forms and paid 1 month's premium, and the insurance companies paid him a year's worth of commissions. Later he used phony employees and SSNs. Total losses to companies where Colorado has venue were \$85,000. Nationwide, the losses amounted to several hundred thousand dollars. The agent is now under investigation by other States.
- Nine individuals, six of them members of the same family, were sentenced to prison in Illinois for terms ranging from 2 1/2 to nearly 5 years for a series of schemes through which they defrauded several insurance companies. They obtained approximately \$500,000 by submitting false

claims under fraudulent SSNs in 27 incidents in several cities throughout the United States. The claims were based on automobile and slip-and-fall accidents that were either staged or never occurred. In addition, three of the defendants, two of whom were insurance company employees, stole blank checks from an insurance company and cashed them on forged endorsements for \$68,000. The group moved from city to city, using false names and SSNs which made them difficult to find or identify.

- A Massachusetts man was sentenced to 57 months incarceration for using aliases and false SSNs as the preparer of numerous income tax returns for persons claiming low levels of income that was not earned. Many of these people, who shared the resulting refunds with the man, were collecting SSI, disability and Aid to Families with Dependent Children benefits on the basis of their lack of income. The man also filed for nonexistent people. He is to serve 3 years supervised release following his prison term, and was ordered to refrain from having anything to do with preparing income tax returns for anyone other than himself and his immediate family. He had filed over 500 false income tax returns claiming refunds totaling more than \$492,800, of which only \$63,500 was actually paid because of the OIG investigation. The remaining returns were intercepted before payment could be made.
- A New York man was sentenced to 5 years probation and 10 months home confinement, and ordered to make restitution of \$128,200 for misuse of SSNs and mail fraud. He was also ordered to perform 300 hours of community service, continue psychiatric counseling and pay a special assessment of \$100. The man secured medical coverage for several fictitious corporations using fraudulent SSNs and addresses. He acquired subscribers for his scheme by advertising medical insurance at low rates in local newspapers. He obtained payment by submitting fake claims without the subscriber's knowledge and having the checks sent to post office boxes. After obtaining medical benefit payments for people listed as employees, he notified the insurance companies that the subscribers were no longer in his employ.
- After pleading guilty to mail fraud and misuse of SSNs, a Connecticut woman was sentenced to 4 months incarceration, 5 months home detention wearing an electronic bracelet and 3 years supervised probation. She was also ordered to make restitution of \$31,770 to her employer and pay \$1,260 to the State of Connecticut unemployment compensation fund, plus a \$50 assessment. The woman used false names and SSNs to submit workers' compensation claims to her employer.

- The female accomplice of a man known as the "Love Bandit" was sentenced in Texas to 9 months incarceration and 3 years supervised release. She was ordered to make restitution of \$34,658 to the Department of Housing and Urban Development (HUD) and to pay a mandatory special assessment of \$100 for misuse of SSNs. She had used multiple identities and SSNs to open bank accounts in Texas and Arizona, and had defaulted on a HUD-insured mortgage which had been obtained through the fraudulent use of a SSN. The woman, whose case was the subject of national attention, had assisted the "Love Bandit" in relieving over a dozen women of their life savings. The "Love Bandit" was also sentenced on other charges.

Although SSN fraud presents a major problem to true number holders and the general public, the decline in OIG investigative resources has necessitated that fewer SSN cases be investigated. The OIG has developed criteria for limiting SSN fraud investigations to cases adversely affecting issuance of SSNs, maintenance of wage records, or departmental programs or trust funds.

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 food, drugs, cosmetics 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), previously the Alcohol, Drug Abuse and Mental Health Administration, to assist States in refining and expanding treatment and prevention services. The PHS will spend more than \$19.9 billion in Fiscal Year (FY) 1994.

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 property management, travel approval, preaward and recipient capability audits, and evaluation of PHS's information resource management activities. This oversight work has

provided valuable recommendations to program managers for strengthening the integrity of PHS policies and procedures.

Preschool Immunizations: Role of the Federal Maternal and Child Health Bureau

Performance Measure

As a result of recent data showing large percentages of two-year-olds are not appropriately immunized, the Federal Interagency Committee on Immunizations has developed an action plan to coordinate Government agency immunization efforts and improve immunization rates. While CDC receives approximately 99 percent of the Department's funds for immunization-related activities, the Maternal and Child Health (MCH) Bureau also has specific legislative and departmental immunization responsibilities.

An OIG study concluded that the MCH Bureau has not fully capitalized on its potential to guide and direct State MCH program efforts to improve preschool immunizations. Further, requirements related to the collection and reporting of State immunization rates have been difficult to implement. The OIG believes that the MCH Bureau should play an important, if limited, role in improving preschool immunization. The OIG recommended that PHS ensure that the MCH Bureau: strengthen its guidance and direction to State MCH programs to increase preschool immunization rates in addition to other comprehensive care services; and closely collaborate with CDC to assure a coordinated effort to improve the immunization surveillance, reporting and delivery system. The PHS concurred with OIG's recommendations and is in the process of implementing them. (OEI-06-91-01180)

School-Based Health Centers and Managed Care

An OIG study indicated the need for greater coordination between school-based health centers and managed care providers. The Department of Health and Human Services (HHS) funds both these health care delivery systems to promote better access to quality health care.

The OIG found that onsite school-based health centers increase access to health care for adolescents. However, little coordination exists between these centers and managed care providers, so that neither is able to coordinate or manage all the care given to their patients. In communities where such coordination does exist, all parties appear to benefit. Although both types of care are expanding rapidly, HHS has no focal point to coordinate departmental programs and activities in these areas.

The OIG recommended that PHS and the Health Care Financing Administration (HCFA) each designate a contact to coordinate school-based health center issues in their agencies and to assist parties outside HHS who need information about these centers. The PHS, HCFA and the States should encourage cooperation between school-based health centers and managed care providers. Also, PHS and HCFA should work with HHS agencies to fund appropriate studies and grants to add to the Department's knowledge about school-based

health centers and managed care providers. Both PHS and HCFA supported OIG's recommendations. (OEI-05-92-00680; OEI-05-92-00681)

Cooperative Research and Development Agreements at the National Institutes of Health

Performance Measure

At the request of the Chairman of the Senate's Special Committee on Aging, OIG conducted a study to assess the extent to which NIH protects the public interest in its establishment and oversight of cooperative research and development agreements (CRADAs). The Federal Technology Transfer Act (FTTA) of 1986 established the CRADA as a means to foster the private commercialization of Federal technology.

Both Government and industry participants in NIH CRADAs reported that the CRADA was a useful mechanism for collaboration. However, OIG identified several challenges to the effective management of the NIH CRADA program which could jeopardize its future success. The OIG recommended that NIH: implement guidelines that clearly indicate the types of research projects that are appropriate for the CRADA mechanism; build upon its current efforts to clarify and streamline the CRADA review and approval process; further develop the fair access guidelines to reflect the full range of issues involved; develop and maintain a central database system to track all ongoing CRADA work; and, along with the Office of the Secretary and the Office of the Assistant Secretary for Health, seek a consensus on how to resolve the reasonable pricing controversy. The PHS concurred with all recommendations but the first in its comments to the draft report, believing that current guidelines are adequate in that regard. The OIG continues to believe that further guidance as to appropriate projects is needed to fulfill the intent of the FTTA. The OIG is particularly concerned that basic science research projects and NIH routine testing of industry-patented inventions may not be well-suited for the CRADA mechanism. (OEI-01-92-01100)

National Institutes of Health Consensus Development Program

The OIG found that 52 percent of the medical school departments it surveyed for this study had addressed NIH consensus findings in recent continuing medical education (CME) activities. The OIG identified several factors that limit greater dissemination and acceptance of NIH consensus findings and their incorporation into continuing education activities. These included limited familiarity with the program, the format of the statements, and basic concerns about the effectiveness and usefulness of the program.

The OIG recommended that NIH attempt to maximize the potential of medical school continuing education as a dissemination vehicle by: taking steps to increase awareness of the program among those responsible for CME; identifying more effective ways of encouraging the incorporation of consensus findings into CME activities; and strengthening its efforts to understand and address basic concerns about the Consensus Development Program. The Public Health Service agreed to do so. (OEI-01-91-01760)

National Institutes of Health Research Funds at Universities

The OIG reported that universities did not always spend Federal funds awarded by NIH as budgeted. In many cases, awarded funds were not used during the budget period and were carried forward to the next award period. While both practices are permissible under current Government regulations, they affect NIH's ability to monitor the cost of its research.

The OIG recommended that PHS require grantees to submit a revised budget covering unspent grant funds when there is a substantial carryover of funds from one budget year to another. Further, OIG proposed that the Department expedite an ongoing pilot project at selected universities, approved by the Office of Management and Budget (OMB) in 1992, to obtain the electronic transfer of detailed expenditure data. The PHS and the Assistant Secretary for Management and Budget concurred with the recommendations. (CIN: A-06-91-00073)

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. Once they have graduated and begun earning money, students are expected to repay the loans according to a repayment schedule. Some, however, continue to ignore their indebtedness despite repeated reminders by PHS, which serves as loan manager. In the past, PHS's only recourse was to refer the cases to the Department of Justice (DOJ) for collection. However, with DOJ's caseload, even civil judgments were not always collected. As a result, the Government failed to recoup millions of dollars from medical professionals who were in a position to afford repayment.

To enhance enforcement of repayments, the Social Security Act also authorizes, and in some cases requires, exclusions from Medicare and State health care programs. Since mid-1992, more than 500 people have been excluded for defaulting on their HEAL debts. During this 6-month semiannual period, 322 were excluded as a result of PHS referral of their cases to OIG.

Defaulting individuals may enter into settlement agreements with PHS and OIG whereby the exclusion is stayed while they repay their debt. If an individual defaults on the settlement agreement, the exclusion takes effect and remains in effect until the entire debt is repaid, and he/she has no appeal.

By the end of this reporting period, 76 individuals had taken advantage of this opportunity and entered into settlement agreements. The amount of the money being repaid through this arrangement totals more than \$5.6 million. Seven of the 76 have completely repaid their debts.

Centers for Disease Control and Prevention: Data Processing Costs

The OIG found that CDC has not complied with requirements to implement a charging system for its data processing costs. Although CDC established a "fee-for-service" policy that data processing costs would be charged to all users, the policy was never implemented. The OIG recommended that PHS direct CDC to implement the policy. While PHS's comments to the draft report expressed disagreement with OIG's findings and conclusions, it stated that CDC would analyze its charges to all users and take action to correct any major inequities. The OIG is encouraged by CDC's plan to perform an analysis of its charges and to take any appropriate corrective action. (CIN: A-04-92-03503)

Indian Health Service

As a result of program weaknesses stemming from insufficient financial controls and inattention to management, OMB designated IHS a high risk area in 1990. The development of effective management became a major agency priority. A more responsive and efficient management had to be developed to assure quality health care in a time of growing demand and constrained resources.

In September 1991, recognizing some of IHS' management improvement efforts, OMB reduced the agency's high risk designation to level one, "significant progress." However, several issues were unresolved as of the FY 1992 Federal Managers' Financial Integrity Act report: IHS was not paying the lowest possible price for contract health services; not all IHS health facilities had achieved quality assurance through accreditation; IHS needed to improve collections where beneficiaries had other insurance; and IHS needed to develop action plans to address material weaknesses identified in FY 1992 in the areas of procurement, alcoholism/substance abuse and the advance payment system.

In FY 1993, IHS successfully petitioned OMB for removal from the high risk list. The IHS demonstrated to OMB that it had completed action on contract health services, one of the material weaknesses originally part of the high risk area, and that it had developed a corrective action plan for material weaknesses identified in FY 1992. In addition, IHS demonstrated that progress had been made on two nonmaterial weaknesses considered part of the high risk area: all IHS hospitals and health centers had been accredited; and FY 1993 third party collections reached a record of \$159 million, up from \$66 million in FY 1988. The OIG plans to review IHS' corrective actions in the areas where material weaknesses were previously declared.

Contract Preaward Audits: Fiscal Year 1992

This report provides a summary of the results of 89 contract preaward audit reports completed for PHS in FY 1992. In that period, PHS awarded over 12,000 contracts totaling more than \$2.1 billion. Based on requests by PHS agencies, OIG issued 89 preaward audit

reports in FY 1992, covering proposed costs for awards totaling approximately \$238 million. The OIG determined that a majority of the proposals reviewed contained overstated projected costs. (CIN: A-02-93-02517)

**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 total \$32 billion for Fiscal Year (FY) 1994. The major programs include: Aid to Families with Dependent Children (AFDC), Child Support Enforcement (CSE), Child Care, Job Opportunities and Basic Skills (JOBS) training, Head Start, Foster Care, Adoption Assistance and Refugee Resettlement.

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. Overall, OIG has found that there are significant barriers to effective coordination and service delivery among these programs, including Head Start, Foster Care and Adoption Assistance, and the CSE programs. Although the Department has made changes and appears to be on the right course, improvements are needed to better target these services to the needs of children. The OIG reports have focused on ways to increase the efficient use of the program dollar, 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. Also, OIG is monitoring the effectiveness of actions being taken to identify and correct material weaknesses under the Federal Managers' Financial Integrity Act.

Health and Safety Standards at Child Care Facilities: South Carolina

As part of its national review of health and safety standards at child care facilities that receive Federal funds, OIG conducted a review in South Carolina. The facilities visited receive Federal funding from the Social Services Block Grant for Day Care and the Foster Care programs.

Accompanied by State inspectors, OIG performed unannounced inspections of the facilities, noting deficiencies which included fire code violations, unsanitary conditions, playground hazards and toxic chemical accessibility. The OIG recommended that the State improve monitoring by conducting more site visits to facilities; perform unannounced inspections; use sanctions against facilities that do not meet standards or fail to correct violations; improve coordination of the various child care licensing agencies and inspection groups; and obtain background checks of criminal history for all individuals before employment. The State fully concurred with the recommendations and has initiated corrective action. (CIN: A-04-92-00044)

Financial Management Systems and Control Structures at Head Start Grantees

At ACF's request, OIG summarized the types of concerns being reported by nonfederal auditors engaged by Head Start grantees for required audits. The OIG report was based on a review of 674 audit reports on 569 different grantees, and included a summary of over 1,700 audit findings identified between September 1, 1990 and December 31, 1991.

The OIG found that a significant number of grantees continue to have problems in the following areas: about 41 percent had internal control problems and 39 percent had accounting records and procedures problems; 44 percent did not fully comply with applicable Federal laws and regulations, filed inaccurate and untimely Federal financial reports or submitted independent audits that did not fully meet Federal standards; and 24 percent had deficiencies in cash management practices.

The OIG recommended that ACF evaluate the types of findings being reported by the nonfederal auditors and focus more of its technical assistance efforts toward improving the financial management capability of its Head Start grantees. Further, OIG proposed that those grantees repeatedly reported as having financial management problems be reviewed and that corrective action plans and milestone dates for corrective action be established and incorporated into the terms and conditions of the grant agreements. The ACF generally agreed with the recommendations. (CIN: A-17-93-00001)

Foster Care Eligibility: California

The OIG identified several areas where the State could make improvements to ensure that Federal eligibility requirements are met for foster care cases claimed for Federal financial participation (FFP). The OIG recommended that: the State improve the flow of information to eligibility workers to ensure that decisions reflect requirements of Federal and State laws and regulations; procedures involving the licensing of foster homes be modified and quality control procedures strengthened to help ensure that foster care cases claimed for FFP are properly supported and meet Federal eligibility requirements; and differing Federal and State interpretations of program requirements be resolved to improve the operation of the program.

Based on the sample results, OIG estimated that the State claimed at least \$51.7 million in Federal funds for cases without adequate documentation over the 3-year period covered by the audit. However, in light of provisions contained in the Omnibus Budget Reconciliation Act of 1993, no recommendation for a monetary recovery was made. The State generally concurred with the procedural recommendations. (CIN: A-09-92-00086)

Retroactive Foster Care Claims: Missouri

At ACF's request, OIG reviewed retroactive foster care claims paid to the State of Missouri. The State had filed five revised claims with ACF for costs of the foster care program. Total claims for Federal reimbursements were \$17.9 million for the period January 1, 1989 through December 31, 1991.

The OIG found that the State's records did not support amounts claimed. Irrespective of the lack of documentation, OIG determined that \$4.6 million may be unallowable because the claims were not based on the approved cost allocation plan, and another \$5.7 million may be unallowable because they were filed after the regulatory deadline. The OIG recommended that Missouri withdraw unsupported claims of \$17.9 million. The State agreed that its claims included significant errors and will submit a revised claim. The ACF agreed with OIG's findings. (CIN: A-07-92-00601)

The At-Risk Child Care Program

Performance Measure

The OIG examined State participation in the At-Risk Child Care program, which provides child care services for children of low-income working families not receiving AFDC, who need child care to accept or maintain employment, and would otherwise be at risk of requiring AFDC. Federal regulations give States considerable latitude in implementation of the program and their participation is optional. The program is one of several overseen by ACF, which has encouraged States to coordinate all the funding sources for child care so as to provide seamless service to families.

The OIG found that, despite a slow start, most of the 13 sampled States now expect to make full use of available at-risk child care funds. The States report targeting families most at risk of going on welfare, and they are coordinating the at-risk child care program with other subsidized child care programs. Many respondents reported that States are accomplishing this coordination despite funding and statutory variations among Federal funding sources which make them difficult to administer. The OIG concluded that States are clearly attempting to provide seamless services to families, and proposed that the Congress and ACF explore ways to make it easier for States to coordinate and manage these programs. (OEI-02-92-00140)

Undistributed Child Support Collections

The OIG reviewed undistributed child support payments collected from absent parents at six California counties. The review found that the counties: were not required to monitor or report on the status of undistributed collections to the State; had accumulated child support payments of over \$8 million, of which at least \$2.7 million was over 1 year old; and were not reporting collections over 3 years old which had reverted to the State under the State's unclaimed money law or transferred to general funds as CSE program income. In addition, one county did not report interest of \$256,000 earned on child support collections and give credit to the Federal Government.

The OIG recommended that the State agency take appropriate corrective action, including requiring counties to monitor and report the amount and status of all undistributed child support collections; credit the Federal Government with its share of reverted or transferred funds; and provide instructions to all counties regarding undistributable collections. The State agreed with the recommendations. (CIN: A-09-93-00030)

Exceptions to Wage Withholding for Child Support

The OIG found that State CSE agencies are essentially complying with the provision for immediate wage withholding in child support orders. Most child support orders include a provision for immediate wage withholding; few exceptions to immediate wage withholding are granted; in cases where there is no income to withhold, the orders include a stipulation for wage withholding in the future without further order of the court; and only in a small

number of support orders do CSE agencies not include an immediate wage withholding provision or explicitly grant an exception. Because of the extremely high level of compliance, OIG made no formal recommendation for action by ACF. (OEI-07-91-01220)

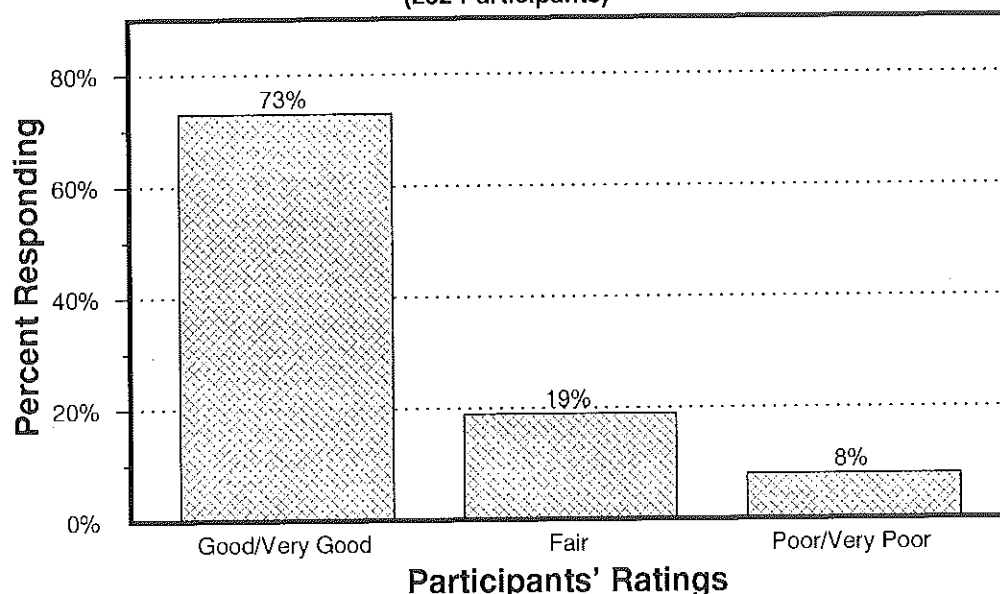
Participants Rate the Job Opportunities and Basic Skills Program

Performance Measure

This report reflects early experiences with the JOBS program as seen from the unique perspective of the participants themselves. The OIG found that a majority of the 232 participants surveyed gave high ratings to the overall JOBS program, its activities and support services, as illustrated in the following chart.

PARTICIPANTS' OVERALL RATINGS OF JOBS PROGRAM

(232 Participants)



Eighty-four percent of respondents said that they would recommend the program, and eighty-three percent believed that it would help them get off welfare. Nevertheless, a significant number of respondents experienced problems and/or voiced concerns in the following areas: insufficient information as to the availability of specific program activities or services; lack of sufficient support services; deficient case manager services and attitudes; and understanding noncompliance penalties and benefit reductions.

Eighty-six percent of respondents shared specific suggestions for improving the program, including: emphasizing education and training in order to achieve self-sufficiency; improving support services such as child care and transportation; strengthening case managers' performance of the orientation, service explanation and assessment processes; and having case managers provide empathetic support to program participants. (OEI-06-90-00150)

Job Opportunities and Basic Skills Work Supplementation Program

The OIG conducted audits in Illinois and Ohio to determine the adequacy of the States' monitoring to ensure that the work supplementation program (WSP) of the JOBS program was being operated effectively. The OIG found that the monitoring procedures designed and implemented by Illinois were adequate to ensure that the WSP is administered effectively and in accordance with Federal requirements.

In Ohio, where the JOBS program is county administered, there was no mechanism in place to obtain and summarize the statewide statistics needed to evaluate the results of the program. Additionally, Ohio claimed \$65,000 (\$39,000 Federal share) in program expenditures for 84 ineligible participants and overstated the financial report for the December 1992 quarter by \$258,000 (\$156,000 Federal share). The OIG recommended improvements in State oversight and financial adjustments to the JOBS program. The State concurred. (CIN: A-05-93-00096; CIN: A-05-93-00050)

Job Opportunities and Basic Skills Federal Financial Participation Rate

The OIG reviewed JOBS Federal financial participation (FFP) claims by the State of Texas to determine whether correct matching rates were used and costs claimed were allowable. Although the controls were adequate, OIG found one instance where the State claimed expenditures exceeding the authorized ceiling by \$473,000 (\$189,000 Federal share). The State made the appropriate financial adjustment. The review also identified \$500,000 (\$250,000 Federal share) in unallowable transportation payments.

The OIG recommended that the State: monitor FFP rates for claims; reimburse the Federal Government for unallowable expenses; ensure that case workers and supervisors are trained; and implement cost-effective use of bus passes and tokens. The State concurred with the recommendations. (CIN: A-06-92-00102)

Emergency Assistance

The OIG audited the Ohio and Maryland emergency assistance (EA) programs to determine whether program funds were used properly. The Ohio program was generally adequate. In Maryland, OIG found a weakness in controls over application forms and case files which potentially threatened the integrity of payments made under the EA program.

The OIG estimated that \$1.2 million (\$619,000 Federal share) in assistance payments made during FYs 1991 and 1992 were not adequately supported. Without case files and client application data, there was insufficient assurance that clients requested EA payments,

payments were based on legitimate needs of clients and payments were eligible for Federal financial participation.

The OIG recommended that Maryland perform a review of internal controls over case files and client application forms and either provide ACF with additional information to support the questioned payments or refund \$619,000 to the Federal Government. (CIN: A-05-93-00051; CIN: A-03-93-00562)

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:

- A woman was sentenced in Ohio to 4 months home detention and 3 years probation, and ordered to pay \$1,000 in restitution for misusing Social Security numbers (SSNs) to commit welfare fraud. While employed as a computer operator under one SSN, the woman applied for and received three others. She used these SSNs to collect AFDC benefits and food stamps. She came to OIG's attention as a referral from a drug investigation in which she and her son were charged with trafficking in cocaine. The son, who was subsequently sentenced to 20 years incarceration, was considered one of northern Ohio's biggest drug dealers.
- In Maryland, a woman who worked under several different names and SSNs while collecting welfare benefits was sentenced to 64 years in prison, with 58 suspended and three 2-year terms to run concurrently. The State attorney had requested OIG assistance in establishing the true identity of the woman, the true wages earned and the amount of welfare overpayment. The woman had also embezzled \$16,000 from one of her employers which, along with her earnings, made her ineligible for State assistance.

One region in particular has been highly successful in pursuing welfare fraud through Federal, State and local cooperative investigative projects and by grouping cases for mass indictments to achieve maximum public awareness. During this period, the following actions were reported:

- Some 115 persons were charged with welfare fraud in two Ohio counties as the result of joint OIG and State investigative work. Total fraud amounted to more than \$500,000. A great many of the charges were the result of tips by relatives or acquaintances of the perpetrators.
- In Indiana, 20 persons were charged as a result of a Federal and State multi-agency task force investigating welfare fraud and fraud against the Government. Those charged had caused a cumulative loss of \$367,200 in Social Security, rent assistance, AFDC, food stamps and Medicaid benefits. Some collected welfare benefits for children who did not live with them. One 77-year-old woman fraudulently received more than \$67,600 in benefit payments which continued to be sent to her deceased mother and her deceased husband.

Community Services Grants

A. Haitian Task Force

In response to an ACF request based on allegations by a former Haitian Task Force (HTF) employee of HTF's fraudulent use of Federal funds, OIG reviewed a \$472,500 discretionary grant awarded to HTF in 1990. The OIG was unable to substantiate fraud through its audit, but has referred the case to its investigative staff for additional review. The OIG determined that HTF did not achieve the ultimate objective of creating viable enterprises that could have employed 106 low-income individuals. Moreover, the grantee used over \$200,000 for unaccountable and unallowable purposes.

More importantly, however, OIG concluded that the HTF grant is an example of a continuing weakness in ACF's discretionary grants process. In OIG's opinion, ACF program and financial management staff did not effectively manage the grant, monitor grantee actions and provide adequate oversight. The OIG recommended that ACF: track the receipt and filing of grantee reports and monitor grantees through these reports; where cash requirements can be predicted, ensure that cash draw downs are in accordance with schedules approved in grant applications; incorporate stronger controls over grantees with respect to terms and conditions of the grant by monitoring the achievement of those terms and conditions; conduct coordinated site visits that assess both program and financial issues; and test the correction of the reversionary interest material weakness. In response to the draft report, ACF agreed with the recommendations and indicated that some improvements have been initiated. The ACF agreed to implement the remainder of the recommendations within the limitations of current resources. (CIN: A-12-93-00017)

B. District of Columbia

In a review of the District of Columbia's (DC) use of Community Services Block Grant (CSBG) funds in FY 1992, OIG found problems in management controls over the allocation of administrative expenditures. The District did not exceed the statutory limit on administrative expenses. However, it did not ensure that only applicable administrative expenses were charged to the block grant. As a result, many cases were found where requisitions, contracts and other expenses could not be validated. The OIG questioned \$99,819 of the \$100,339 audited CSBG administrative expenses.

The OIG recommended that DC: develop and submit a corrective action plan to address the systemic weakness in controls; provide documentation validating that the \$99,819 questioned was actually used for CSBG administrative expenses, or provide justified, substitute FY 1992 CSBG administrative expenses. (CIN: A-12-93-00042)

Project Officers' Management of Five Contracts

In a review of five randomly selected FY 1992 contracts, OIG found that only three of the five project officers had completed the required basic project officer course. The OIG also determined that the documentation of project planning was adequate for two of the contracts, with the requirement for assessing related projects and avoiding duplication of effort being the weakest planning area. Management of contract projects by the project officers was inadequate on two contracts. On one project, the project officer did not have and was unaware of the deliverables due the Government. In another instance, a contract was 3 years late in fulfilling a congressional reporting requirement.

The OIG recommended that ACF: implement controls to ensure that project officers complete the required training; enforce the requirements to document all phases of the planning process; and require project officers to monitor contract deliverables by employing a schedule of deliverable due dates. The OIG further recommended that overdue congressional reports be reviewed and reassessed as to whether they are still necessary. The ACF concurred with the findings and initiated action to implement the recommendations. (CIN: A-12-93-00011)

General Oversight

CHAPTER V

GENERAL OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities other than financial management (which is discussed in Chapter 1). The Office of the Secretary (OS) will spend \$137 million in Fiscal Year (FY) 1994 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. Another 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 1994 work in departmental management and Governmentwide oversight focuses principally on financial management and managers' accountability for resources entrusted (discussed in Chapter 1), standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance.

Summary of Calendar Year 1992 Activity at Colleges and Universities

During Calendar Year 1992, the Federal Government allocated an estimated \$10.5 billion to research universities, of which the Department of Health and Human Services contributed \$5.5 billion. In this same period, OIG and nonfederal auditors performed 679 audits in the

college and university area, resulting in Governmentwide findings of over \$361.5 million. Through its audits and special initiatives, OIG recommended actions which resulted in recovery of misspent funds, significant savings relative to future expenditures, and meaningful reforms to the methods and regulations governing the reimbursement of research costs.

In addition, OIG has numerous other audits and reviews underway with reports in progress. The OIG believes that its current and planned audit work will continue to address significant concerns in the area of federally sponsored research during the 1990s. (CIN: A-01-93-04004)

Determining State and Local Government Administrative and Indirect Costs

The cumbersome systems used to annually allocate an estimated \$20 billion in administrative and indirect costs to Federal programs are a continuing concern to Federal and State communities. The OMB requested OIG input on this issue for its revision of Circular A-87, Cost Principles for State and Local Governments. Expanding its attention beyond specific cost principles, OIG focused on the processes used to identify, collect and charge Federal programs with an increasing share of the cost burden.

The OIG noted that: resources are limited to perform Federal negotiation and audit oversight activities necessary to ensure the propriety of claims; Federal cognizance assignments are splintered, limiting interaction among Federal agencies; cost allocation systems are not sufficiently sophisticated to show total Federal dollars expended nationally for administrative and indirect costs at State and local entities; the States use highly diversified systems, making cost comparisons difficult; current technology used by consultants is changing the way costs are allocated to Federal programs; and little is done at any level to ensure that only allowable costs are allocated for reimbursement under Federal grants and contracts.

The OIG believes that reforms are needed to establish less burdensome and costly ways to reimburse costs to each level of government. The report offers, for consideration and further study, a range of options to facilitate the allocation process. (CIN: A-12-92-00014)

Recharge Centers

This report summarizes the results of OIG's review of specialized service funds known as recharge centers at 12 universities. Recharge centers at universities operate as in-house enterprises and are used to finance, account for and report on the provision of goods and services to other university operating units. The OIG review identified a total of \$3.2 million in overcharges to the Federal Government because universities did not establish or

adhere to policies and procedures for recharge centers, and maintain adequate accounting systems and records.

The OIG recommended that universities develop and implement policies consistent with Office of Management and Budget (OMB) requirements regarding recharge centers, and that the Department's Division of Cost Policy and Oversight work with OMB to revise guidance to ensure that criteria related to the financial operation of recharge centers is clear. The OIG plans to work with the Division of Cost Allocation (DCA) to enlist universities to participate in self-reviews to strengthen financial management of recharge centers. The Assistant Secretary for Management and Budget generally concurred with OIG's recommendations. (CIN: A-09-92-04020)

Preaward Pilot Project

The OIG has found a positive return on investment in preaward audits of contractor bid proposals. To improve efficiency without sacrificing quality, a new approach is being piloted for certain contract proposals submitted to the Health Care Financing Administration (HCFA). As an example, four peer review organizations located in the Philadelphia region recently agreed to participate in the pilot when bidding on their noncompetitive renewal contracts. The pilot is also available for bids submitted by organizations that do not currently have the contract for which they are bidding. The initiative is voluntary on the part of the bidders. For the most part, the proposal audits are conducted at the audit office; however, some onsite work is still required.

Bidders are provided with a proposal guidance book which they complete and return to the OIG regional office. The book includes a section on the most common cost categories, direct and indirect, included in most bid proposals. Each section provides a description of the type of cost documentation required for that specific cost category, supplemented in most cases by specific examples. The bidder submits a copy of its proposed budget together with a copy of the checklist for each category included in the proposal, along with supporting documentation. The information requested is the type that would have been requested by OIG auditors had it conducted the audit onsite and which should already have been developed by the bidder during the preparation of the bid proposal.

The OIG has found that use of this method results in fewer unsupported costs. Bidders know specifically the documentation needed to support their proposed costs and provide the documentation as requested. In this manner, OIG meets its responsibility to ensure that proposals are adequately documented and that costs are reasonable. Significant audit resources are saved in time and travel funds. Advantages to bidders include having less interruption of their normal business operations due to the presence of onsite auditors. Completion of the proposal guidance book becomes easier once it becomes familiar.

This pilot does not change the fact that OIG will continue to conduct preaward audits in the future. The audit objectives remain the same and OIG continues to issue reports on the results of the audits.

Advisory and Assistance Service Contracts

The OIG is required to submit to the Congress an annual evaluation of the Department's progress in improving the accuracy and completeness of the information on contracts for advisory and assistance services (AAS) provided to the Federal procurement data system. In evaluating efforts by the Administration for Children and Families (ACF) in this area, OIG determined that ACF had designed significant management controls over AAS and had taken the initiative to train personnel in the administration of AAS contracts. However, OIG noted that coding problems remain.

The subject of AAS contracts is complex, made all the more so by the rescission of OMB Circular A-120, the definitive guidance on consultant contracts. The OIG was encouraged by the ongoing effort by ACF to implement an off-the-shelf procurement system used successfully at other agencies. The new system should help ACF to reduce the number of coding errors. (CIN: A-12-94-00018)

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 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 1993, OIG's National External Audit Review Center (located in Kansas City) reviewed over 3,600 reports that covered over \$785 billion in audited costs. Federal dollars covered by these audits totaled \$156 billion, about \$70 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.
- 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, over 800 individuals were provided with technical assistance through OIG's toll free number. In addition, formal training was provided to certified public accountant societies, State auditor staff, Public Health Service (PHS) program staff, and Administration for Children and Families grantees on issues related to Circulars A-128 and A-133.
- The OIG also has been heavily involved with 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 2,660 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	2,015
Reports issued with major changes	17
Reports with significant inadequacies	<u>628</u>
Total audit reports processed	2,660

The 2,660 audit reports discussed above included recommendations for HHS cost recoveries totaling \$10.6 million as well as over 5,300 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

	<u>Number</u>	<u>Dollar Value</u> (in thousands)	
		<u>Questioned</u>	<u>Unsupported</u>
A. For which no management decision had been made by the commencement of the reporting period ¹	412	\$647,505	\$24,603
B. Which were issued during the reporting period ²	255	\$99,586	\$6,917
Subtotals (A + B)	667	\$747,091	\$31,520
Less:			
C. For which a management decision was made during the reporting period ³ :	277	\$216,054	\$14,260
(i) dollar value of disallowed costs		\$77,573	\$11,493
(ii) dollar value of costs not disallowed		\$138,481	\$2,767
D. For which no management decision had been made by the end of the reporting period	390	\$531,037	\$17,260
E. Reports for which no management decision was made within 6 months of issuance ⁴	116	\$440,301	\$31,850

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

	<u>Number</u>	<u>Dollar Value</u> (in thousands)
A. For which no management decision had been made by the commencement of the reporting period ¹	134	\$2,163,177
B. Which were issued during the reporting period	<u>30</u>	<u>\$24,263</u>
Subtotals (A + B)	164	\$2,187,440
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management		
(a) based on proposed management action	88	\$185,990
(b) based on proposed legislative action ²	<u>3</u>	<u>\$900,000</u>
Subtotals (a+b)	91	\$1,085,990
(ii) dollar value of recommendations that were not agreed to by management	<u>21</u>	<u>\$154,845</u>
Subtotals (i + ii)	112	\$1,240,835
D. For which no management decision had been made by the end of the reporting period ³	52	\$946,605

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 91 of the Department's regulations under development and 90 departmental legislative proposals.

In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigative and legislative experience and recommendations 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 money penalty (CMP) and program exclusion authorities which the Inspector General administers. During this reporting period, OIG submitted for consideration six separate legislative proposals developed as a result of its experience with administering existing statutory authorities and the need to develop alternative sanctioning approaches.

During this same reporting period, OIG prepared and published two proposed rules addressing civil money penalties for physician ownership of and referral to certain health care facilities, and additional safe harbors under the anti-kickback statute.

The OIG continues its development of several other regulations 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 sanctions authorities.

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 four hearings. 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. For example, at a hearing before the Energy and Commerce Committee of the House of Representatives, OIG testified on HCFA's efforts to reclaim funds overpaid to hospitals.

The OIG continues to track all relevant congressional hearings and pending legislation related to a wide range of HHS issues.

Governmental Accounting

A. Training Costs: New York

As requested by DCA, OIG reviewed training and administrative costs allocated to Federal programs by New York State from April 1, 1988 to March 31, 1991. Federal charges for the period totaled \$61.1 million and \$7.3 million, respectively. The review identified more equitable allocation methods and an estimated overcharge of \$12.2 million.

In addition to refund of overcharges, OIG recommended that New York allocate training costs based on actual number of participants and discontinue use of third party contributions to meet State share of costs. Also recommended were a number of specific corrections to the State's cost allocation system. The DCA generally agreed with OIG's recommendations. (CIN: A-02-92-02007)

B. Internal Service Funds: Oregon

In a follow-up audit of the accumulated surplus at Oregon's internal service funds (ISFs), OIG found that the State had not implemented the recommendations of two previous OIG audits. Consequently, Oregon's ISFs had an accumulated surplus at June 30, 1991 of \$64.4 million (\$12.1 million Federal share), an increase of \$14.5 million (29 percent) since the first audit. The surplus represented the excess of revenues generated from services and products provided over expenses incurred by ISFs.

The ISFs are used to account for the financing of goods and services provided on a cost reimbursable basis by service centers to other agencies within the governmental entity. Federal cost principles require that such centers operate on a break-even basis by charging users for the allowable cost of goods and services provided. The Federal Government shares in ISF billings when the clients claim reimbursement for these billings as costs under Federal programs.

The OIG recommended that Oregon refund the \$12.1 million Federal share of the accumulated surplus and adjust billing rates at least annually to eliminate any surplus or deficit. The State did not agree with the recommendations. (CIN: A-10-93-00011)

C. Cost Allocation Plans: Florida

The OIG reviewed Florida's cost allocation plans (CAPs) to determine the reasonableness of the administrative cost structure used to charge indirect costs to the Federal Government for State Fiscal Years 1990 and 1991. The OMB Circular A-87 requires that indirect costs be distributed to activities on a basis relative to benefits received. The OIG found significant

weaknesses in the internal control procedures utilized by the State to prepare the CAPs. The deficiencies related to misclassified, erroneous or duplicative cost data could have resulted in a \$34 million overcharge to benefitting activities, of which the Federal Government share is approximately 20 percent. In addition, salaries and other expenditures were not properly allocated to the benefitting activities.

In its internal report, OIG recommended that DCA work more closely with the State to improve the submission of CAPs to assure that they provide adequate, reliable data for identifying, measuring and allocating costs to Federal programs. (CIN: A-04-92-00046)

Department's Implementation of the Lobbying Act

In its forth annual evaluation of the Department's implementation of the Lobbying Act, OIG determined that the Department has implemented the necessary procedures to carry out the Act's requirements. While OIG found no indications that the Department was not in compliance with the Act, it did voice strong reservations concerning the adequacy of the reported disclosures. Further, although departmental officials were aware of the Act's requirements, OIG again found uncertainty about the application of the law to specific lobbying activity. (CIN: A-17-92-00016)

Review of Department Detailees

The OIG reported in its annual report to the Congress on Department employees detailed to congressional committees and offices in FY 1993. The report to the House and Senate Appropriations Committees indicated the grade, position and office of each person detailed from the Department. (CIN: A-17-94-00002)

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 New York, a former Social Security Administration (SSA) field representative was sentenced to 13 months in prison and ordered to pay restitution of \$52,600 and a \$100 special assessment for retirement benefits and bank fraud. He used fraudulent identification documents to apply for benefits and credit cards, and opened bank accounts into which the SSA benefits were directly deposited. He then withdrew the monies from automated teller machines. His scheme was uncovered when the wife of a deceased beneficiary inquired at an Ohio SSA office about benefits due her on her deceased husband's earnings and found that retirement benefits had

been paid him since 1991. The former employee was charged with stealing \$15,600 from SSA and \$37,000 from seven banks.

- A former New Jersey SSA claims representative and her husband, a contract security guard with the General Services Administration, were sentenced to 7 and 3 months in prison, respectively, for soliciting and accepting bribes to process Social Security number (SSN) applications for illegal aliens. Upon release, both will serve 3 years probation. Fines were not imposed because of their inability to pay.
- The former executive director of a New Mexico health center and a PHS commissioned officer pled guilty to misuse of Federal funds and was ordered to make restitution of \$6,450. While detailed to the health center, which received PHS funds for medical care of low-income families, he used a Government credit card to make cash withdrawals for personal use.

Criminal Prosecutions

During this semiannual reporting period, OIG investigations resulted in 590 successful criminal actions. Also during this period, 738 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 543 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 \$8.1 million for other public or private entities.

Appendices

APPENDIX A

Implemented Office of Inspector General Recommendations to Put Funds to Better Use October 1993 through March 1994

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 of bonds.

Legislative savings are annualized amounts based on Congressional Budget Office estimates for a 5-year budget cycle. Programmatic savings are calculated by OIG using departmental figures for the year in which the change is effected. Total savings for this period amount to \$2,592.9 million.

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Capital-Related Costs of Inpatient Hospital Services:		
Discontinue inappropriate Medicare prospective payment system (PPS) payments for hospital costs. (ACN: 14-52083; ACN: 09-52020)	Section 4001 of the Omnibus Budget Reconciliation Act (OBRA) 1990 provides for a 10 percent reduction for capital-related payments attributable to portions of cost reporting periods or discharges occurring from October 1, 1991 and ending September 30, 1995.	\$840
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 OBRA 1990 increased the Part B deductible to \$100 beginning in 1991. However, OBRA 1990 did not subject the deductible to indexing.	570
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. However, the disparity between OPD and ASC payments still exists.	395
Capital-Related Costs of Outpatient Hospital Services:		
Discontinue inappropriate Medicare PPS payments for hospital costs. (ACN: 14-52083; ACN: 09-52020)	Section 4151(a) of OBRA 1990 reduces payments for outpatient capital by 15 percent for portions of cost reporting periods in Fiscal Year (FY) 1991 and by 10 percent in FYs 1992 through 1995.	345

OIG Recommendation	Status	Savings in Millions
Coronary Artery Bypass Graft Surgery and Cataract Surgery: The HCFA should place special limitations on reasonable charges for the primary surgeon's fee for coronary artery bypass graft (CABG) surgery, and should consider consolidating payments for primary surgeons, assistant surgeons and anesthesiologists. The HCFA should periodically assess the changes in surgical procedures and technology, and mandate adjustments to Medicare reimbursement. (OAI-09-86-00076; OAI-85-IX-00046)	Section 6104 of OBRA 1989 required a further reduction from those imposed in OBRA 1987 in the Medicare reimbursement rates for CABG surgery and for cataract implant surgery effective April 1, 1990.	\$205.3
Continuous Ambulatory Peritoneal Dialysis Supplies: The HCFA should limit payment allowances to suppliers who deal directly with end stage renal disease (ESRD) patients to amounts allowable under a single composite rate to an ESRD facility. (CIN: A-09-87-00108)	Section 6230 of OBRA 1989 reduced payments for supplies to no more than the amounts paid under a single composite rate to an ESRD facility, beginning February 1, 1990.	165
Recovery of Medicaid Credit Balances in Skilled Nursing Facilities: The HCFA should take action to adjust Medicaid credit balances in skilled nursing facilities. (OEI-07-90-00911)	On February 18, 1992, HCFA sent a memorandum to all regional administrators describing actions to be taken with the State Medicaid agencies to assure that credit balances were promptly reflected on the States' claims for Federal reimbursement. Credit balances were recovered.	18
Recovery of Medicare Credit Balances in Skilled Nursing Facilities: The HCFA should take action to adjust Medicare credit balances in skilled nursing facilities. (OEI-07-90-00911)	On February 20, 1992, HCFA instructed the appropriate Medicare fiscal intermediaries to recover funds through the remittance procedure. Credit balances were recovered.	12.7
SOCIAL SECURITY ADMINISTRATION		
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

OIG Recommendation	Status	Savings in Millions
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

ADMINISTRATION FOR CHILDREN AND FAMILIES

Coordinate Third Party Liability Information: The Office of Child Support Enforcement (OCSE) should enforce current regulations regarding medical support by amending its Program Results Audit Guide and applying penalties to States found negligent in applying those regulations. (OAI-07-88-00860)	The OCSE amended its Program Results Audit Guide to reflect the medical support regulations and has penalized negligent States.	32
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APPENDIX B

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

This schedule represents potential annual savings or one-time recoveries which could be realized if Office of Inspector General (OIG) recommendations were enacted by the Congress and the Administration through legislative or regulatory action, or policy determinations by management. 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		
Medicare Secondary Payer: Definition Expansion Savings		
Extend the Medicare secondary payer (MSP) provision to include end stage renal disease (ESRD) beneficiaries without limitation. Also, seek legislation making Medicare the secondary payer for all retirees of exempt State and local government agencies, if legislation requiring Medicare coverage and hospital insurance contributions for all State and local government employees, including those hired prior to April 1, 1986, is not enacted. (CIN: A-09-88-00072; CIN: A-10-86-62016)	In the 102nd Congress, H.R. 11 (as passed by the Senate) contained a provision to extend the MSP ESRD provision from 18 to 24 months. However, this provision was not enacted. The proposal to include under Medicare all State and local government employees hired before April 1, 1986 has been included in previous Presidential budgets. Although this proposal was not enacted, OIG continues to advocate this legislation. As an alternative, the Health Care Financing Administration (HCFA) could seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies.	\$2,070
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
Indirect Medical Education:		
As an interim measure, 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)	While the past administration sponsored several legislative proposals to reduce the adjustment factor, none were enacted. The OIG continues to recommend that HCFA reduce the IME adjustment factor to the level supported by empirical data.	1,045

OIG Recommendation	Status	Savings in Millions
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 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; OEI-07-89-01683)	During Fiscal Year (FY) 1992, HCFA provided the contractors an additional \$20 million in administrative funding to reduce the MSP backlog, but the backlog continues. The HCFA has also developed an MSP overpayment tracking system. However, it is not considered a financial management system. In addition, the Department submitted an FY 1994 legislative proposal to establish a payment safeguards revolving fund to provide smoother and more certain funding levels which could result in more consistent and efficient contractor MSP operations. The HCFA submitted a legislative proposal that would establish a cost recovery fund for carriers.	\$961.6
Medicare Secondary Payer: Prospective Savings 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 for FY 1994; require that employers report EGHP coverage on the Wage and Tax Statement (W-2); 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; establish a national data bank system containing primary insurance information; assure compliance with all carrier first claim development 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; OEI-07-90-00760; OEI-07-90-00763)	The HCFA is considering these recommendations and supports the establishment of a national clearinghouse of health insurance information as an alternative. It has taken some measures to prevent mistaken Medicare payments, such as: the initial enrollment questionnaire, the common working file and the implementation of the Internal Revenue Service (IRS)/HCFA/SSA data match project. Corrective action plans have not been implemented on some of OIG's recommendations. Even though the Omnibus Budget Reconciliation Act (OBRA) 1993 includes many MSP provisions, including extending the data match through 1998 and establishing a health claims clearinghouse for all employers who are required to file a Form W-2, OIG continues to recommend that HCFA resubmit the legislative proposal that would require employers and insurance companies to report MSP information directly to HCFA on a quarterly basis. The OIG also continues to recommend that HCFA identify and maintain spousal information.	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)	The HCFA did not agree that there were inappropriate cost elements in payment rates, but agreed that there is some validity to OIG's position on excess capacity. The OBRA 1993 reduces the Federal rate for capital payments by 7.4 percent and extends the 10 percent reduction for capital costs for outpatient hospital services through 1998. The OIG continues to recommend that HCFA determine the extent of the capital reductions to fully account for hospitals' excess bed capacity and report that percentage to the Congress.	\$800
Clinical Laboratory Tests: Seek legislation to set the fee schedules at amounts comparable to what physicians are paying laboratories for the same tests; develop policies and procedures to ensure that profiles are more appropriately reimbursed; and work with contractors to simplify the processing of bills from laboratories. (CIN: A-09-89-00031)	The OBRA 1993 reduced the fee schedules. However, OIG continues to recommend that HCFA seek legislative reform in FY 1994.	426
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 hospitals which are profitable, and the inclusion of a bad debt factor in the diagnosis-related group (DRG) rates. (CIN: A-14-90-00339)	While HCFA has not submitted a legislative proposal, OIG continues to believe that legislation is needed.	400
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.	210

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 efforts to expand tip reporting requirements, it believes that any proposal to change the requirements would be within the jurisdiction of 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 and public disability benefit payments in all States. (OEI-06-89-00902)	The SSA will defer evaluation of the recommendation pending further study to determine the impact on affected States and on the beneficiaries residing in those States. Moreover, SSA is calculating the program savings that might result, indicating that OIG projected savings seem high.	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
Overpayments to Supplemental Security Income Recipients: Nursing homes should be required to report to SSA admissions of Supplemental Security Income (SSI) recipients within 1 day after they are admitted. (CIN: A-07-91-00376)	The SSA concurred that improved reporting by nursing homes to SSA of admissions of SSI beneficiaries could prevent overpayments and that nursing homes should report this information directly to SSA. However, SSA believed that appropriate regulations should be pursued through HCFA. The HCFA did not concur since it did not believe the recommendation should be pursued via a Medicaid regulation. The OIG, SSA and HCFA are attempting to reach a consensus as to how to implement the recommendation.	22

OIG Recommendation	Status	Savings in Millions
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 until the issue is addressed in the health care reform bill.	\$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 workers' compensation (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
Revise Criteria for Waiving Overpayments: The SSA should seek a regulatory or combined regulatory and statutory change to the current waiver policy so that waivers are not granted to individuals under 59 years of age. These individuals would still be entitled to consideration of their financial condition using the current criteria for financial hardship. However, if SSA determines that the individual's current financial condition does not permit repayment, the collection effort would be suspended or terminated rather than waived. This would allow SSA to seek recovery if and when a debtor is financially able to repay the debt. (CIN: A-05-90-00034)	The SSA did not concur. It questioned the cost-effectiveness and equity of the proposal.	9
Collect Nonresident Alien Taxes: Use SSA's automated systems to identify retroactive nonresident alien taxes due and develop procedures to facilitate collection by the automated system. (CIN: A-13-90-00041)	The SSA replied that it agreed with OIG's recommendation. The SSA is designing the needed automated systems. Changes and implementation are scheduled for FY 1994. The SSA indicated that these cases would not be worked until the process is automated.	7.7

OIG Recommendation	Status	Savings in Millions
GENERAL OVERSIGHT		
Disallow Interest Charges on Unfunded Liabilities of Government Pension Plans: The Office of Management and Budget (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
Accelerate Federal Grantees' Deposits of Payroll Taxes: Require recipients of Federal funds to deposit payroll taxes on the same day Federal funds are drawn down to meet payroll needs. (CIN: A-12-88-00110)	The recommendations are being considered by OMB in its initiative to develop cost containment proposals. Corrective action is pending implementation of the Cash Management Reform Act.	103.4
Recover Federal Share of Excess Reserves in Self-Insurance Funds: The OMB should revise Circular A-87 to tighten standards for charging of self-insurance funds to Federal programs and improve reporting by the States on fund operations, condition and funds flow. (CIN: A-04-90-00018; CIN: A-05-88-00082; CIN: A-02-88-02010; CIN: A-04-88-00061; CIN: A-03-91-01450; CIN: A-04-90-00019; CIN: A-04-91-00023; CIN: A-04-88-00060; CIN: A-04-90-00020; CIN: A-10-86-86-60450; CIN: A-03-91-14562; CIN: A-03-92-00603; CIN: A-04-91-00024)	The OMB has developed changes to its cost principles that will tighten the standards and improve reporting on self-insurance funds. The OMB will seek and consider public comments before finalizing revisions to Circular A-87. The OIG continues to recommend that OMB clarify all rules on self-insurance funds by finalizing revisions to Circular A-87 cost principles.	76
Disallow State Sales Tax Charged to Federal Programs: The OMB should review Circular A-87 to disallow payment of self-assessed State sales tax as charged to Federal programs. (CIN: A-04-87-00040)	The OMB has developed a change to Circular A-87 cost principles that will disallow payment of self-assessed sales and similar taxes as an allowable cost to Federal programs. The OMB will seek public comments and make changes as appropriate. The OIG continues to recommend that OMB clarify the rules relating to charging of State sales taxes by finalizing revisions to Circular A-87.	54

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. Further, it will require carriers to: stay abreast of changes in relevant laws and regulations concerning medical practice requirements; make every reasonable effort to receive, on an ongoing basis, information from State licensing authorities and other appropriate bodies about the currency of licenses; and maintain provider number applications for at least 6 years after deactivation of the number.
Review of Medicare Bill and Claim Processing - Opportunities for Long Term Improvement: The HCFA should initiate a strategic planning effort to determine the feasibility of further streamlining Medicare operations through standardization, consolidation and system integration. Further, HCFA should include the initiative in its information resources management (IRM) strategic plan submission to the Department. (CIN: A-14-91-02532)	The HCFA was largely in agreement with the recommendations and believes that in several instances it has already taken corrective actions.

OIG Recommendation**Status**

Review of HCFA's Implementation of the Project to Redesign Information Systems Management:

The HCFA should include in its IRM plan a discussion of how it intends to assign duties of sufficient scope to, and maintain the independence of, its principal IRM official (PIO). Also, the Assistant Secretary for Management and Budget (ASMB) should review HCFA's implementation of recently issued departmental IRM policy, particularly with respect to assignment of PIO duties. (CIN: A-14-91-02533)

The HCFA disagrees because it believes that the duties of the senior IRM official in HCFA are properly assigned within HCFA's organizational structure. The ASMB has issued several IRM policies to improve the planning and management controls of departmental operating division IRM programs.

Improve HCFA's Federal Managers' Financial Integrity Program:

The HCFA should enhance the testing used to evaluate the contractors' claims processing internal controls. Also, HCFA should consider reclassifying risk assessments of internal control areas that are pending material weakness and high risk areas to a high risk rating. (CIN: A-14-91-03413)

The HCFA agreed and has established a contractor claims processing internal control task force. The HCFA believes a moderate risk rating is appropriate for some high risk areas.

Implement Proper Accountability over Billing and Collection of Medicare 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 by January 1994.

SOCIAL SECURITY ADMINISTRATION**Social Security Payments for Vocational Rehabilitation:**

The Social Security Administration (SSA) should require the States to establish a formal mechanism to screen and enroll those SSA clients who show the greatest potential for successful rehabilitation. (OAI-07-89-00950)

The SSA is reviewing the entire area of vocational rehabilitation referral, and has established a task force with the Rehabilitation Services Administration to jointly develop a framework for better screening mechanisms and a more effective referral process.

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.

Modernized Claims System Needs Controls to Compensate for Lack of Separation of Duties:

The SSA needs to implement controls in the modernized claims system since employees are authorized to take, develop, adjudicate and effect payment on a claim without any independent review or compensating controls. (CIN: A-13-89-00025)

The SSA generally agreed and has proposed corrective action.

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 the Public Health Service, developed a uniform referral and monitoring process for treatment of drug addicts and alcoholics. To date, 44 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 (SSI) 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.
Better Controls Would Help Post More Earnings to Wage-Earners' Accounts: The OIG made 29 recommendations which, if implemented, should substantially improve SSA's capability for correcting name and SSN errors for reported earnings. (CIN: A-13-89-00040)	The SSA agreed with most of the recommendations and has implemented several of them. In addition, SSA has implemented recommendations made by its own work group convened to explore wage reporting problems.
Work Incentives for Disabled SSI 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-13-91-00206)	A proposal for legislation to remedy the wage certification issue is now under review in both the Departments of Health and Human Services (HHS) and Treasury.
Supplemental Security Income Accounts Payable: The SSA needs to identify the problems in the SSI accounts payable system, document the causes and integrate the solution into a systemic plan. (CIN: A-13-91-00206)	The SSA agreed to initiate the recommended actions.

OIG Recommendation	Status
Security of Manually Issued Social Security Number Cards: The SSA should reconcile (daily) blank SSN cards dispensed to cards typed and voided, and involve supervisors with the reconciliation and the flow of blank SSN cards. It should also establish tighter controls over the mutilated card process. (CIN: A-13-91-00204)	The SSA agreed with the recommendations and indicated that it has taken corrective action to strengthen the internal controls over the processing and issuance of manually prepared SSN cards.
Telecommunications Management: The SSA should test new telecommunications technology after first identifying those functions where it can have the most impact on reducing costs and improving service. It also needs to monitor procurement and perform a needs assessment regarding video services. (CIN: A-09-91-00105)	The SSA concurred and is continuing to work on a sound network strategy and an evaluation of emerging technology. It will focus on optimum utilization in a cost-effective manner.
Central Computing Strategy: The SSA's data systems are highly centralized and need to be protected against down-time or catastrophic failure. (CIN: A-13-89-00041)	The SSA is continuing to evaluate and proceed with distributed data processing alternatives. The back-up and recovery plan, however, was addressed and completed in June 1993 when a contract was awarded. The contract will provide resources to support online and batch systems in the event of a major outage at SSA's National Computer Center.
Death Match Operation: The SSA should: build an appropriate management information system into future death match enhancements to help monitor performance and detect errors; correct and continue to process certain rejected death records; and generate death verification alerts for all suspended beneficiaries so their payments can be terminated. (CIN: A-13-90-00046)	The SSA is addressing the recommendations in planned systems modification projects.
Accelerate Efforts to Improve the Systems Providing Overpayment Accounting Data in the Debt Management System: The SSA should accelerate efforts to develop a comprehensive plan for replacing Retirement, Survivors and Disability Insurance and Supplemental Security Income (SSI) "back-end" processes (programmatic systems providing overpayment accounting data). (CIN: A-13-92-00216)	The SSA has issued a debt management transition plan which documents "back-end" processing with the debt management system.
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**

Improve the Printing and Mailing of Social Security Cards:

The SSA should improve security of Social Security Number (SSN) cards in the loading dock area, better account for each SSN card printed or spoiled, and reduce the number of undeliverable SSN cards. Security and control should be improved in the mailing operation, and improvements should be required of the mailing contractor. (CIN: A-13-90-00047)

The SSA agreed and is taking corrective action.

PUBLIC HEALTH SERVICE**Fully Implement Internal Controls in the Food and Drug Administration's Medical Device 510(k) Review Process:**

The OIG recommended that the Food and Drug Administration (FDA) 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)

In a September 2, 1993 status report to OIG, PHS 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.

Improve Public Health Service Controls over Technology Transfers and Royalty Income:

The National Institutes of Health (NIH) should improve procedures to properly record patents, account for foreign patent rights and work with the Department of Commerce to monitor licensing and royalty areas. The NIH should also disclose a material internal control weakness in technology transfer and royalty income areas in the next Federal Managers' Financial Integrity Act (FMFIA) report. (CIN: A-01-90-01502)

The NIH reviewed the area and the material weakness, and developed a corrective action plan to remove the weakness. The NIH is now proceeding with the implementation of the corrective actions.

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 (APS) 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 a January 27, 1993 status report to OIG, PHS reported that corrective actions have been taken or planned to implement recommendations in the subject report. Among the key actions taken were: the declaration of a material internal control weakness in APS and the decision to transfer the advance payment function from APS to the departmental payment management system (PMS). In addition, IHS has begun the orderly transfer of area office tribal contracts to PMS and expects to complete this process by the end of Calendar Year 1994.

Properly Justify the Acquisition of Computer Equipment and Services at the Centers for Disease Control and Prevention:

The ASMB should suspend the delegation of procurement authority for the Centers for Disease Control and Prevention's (CDC) planned acquisition until CDC demonstrates the need for and cost benefit of the acquisition; direct PHS to require that CDC document its requirements analysis and the costs and benefits of the planned acquisition of microcomputers; and review the role of PHS in reviewing proposed computer acquisitions. The Assistant Secretary for Health should require CDC to document its requirement analysis and the costs and benefits, and review the role of PHS in reviewing the proposed acquisition. (CIN: A-15-92-00016)

Delegation of procurement authority was reinstated September 18, 1992 to the Assistant Secretary for Health, who subsequently reinstated this delegation to CDC.

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.

Child Support Enforcement Payments - Financial and Program Implications:

Incentives should be based on the States' demonstrated capability to meet Federal child support enforcement (CSE) requirements and performance objectives. In addition, the Office of Child Support Enforcement should continue its efforts to revise the CSE incentive formula to be more equitable for both the States and the Federal Government. The OIG also has recommended various options for legislative changes to increase the effectiveness and efficiency of the CSE program. (CIN: A-09-91-00147)

The ACF agreed with the thrust of the OIG recommendations, indicating it will continue to pursue the adoption of its legislative proposal on performance-based incentives. It was submitted to Congress in February 1992. The ACF submitted a budget proposal to revise the method of calculating incentives. The ACF agreed that the restructuring of incentives would facilitate improvements.

OIG Recommendation	Status
Protect Federal Interest in Real Property Acquired by Grantees: The ACF should establish a management information system to identify, track and monitor real property purchased with grant funds. The management information system should include the date, type, location and cost of property purchased. (CIN: A-12-90-00020)	The ACF implemented the Office of Community Services grants tracking and monitoring computer system in 1990 to identify, track and monitor real property that was purchased with Federal grant funds. According to ACF's corrective action plan, this material weakness' targeted correction date is Fiscal Year 1993. A corrective action review will be performed within 1 year from completion date.
Improve Management of Community Services Discretionary Grants: The ACF should: develop grant policies and procedures that implement the Department's grants administration manual; provide adequate oversight of external grant application reviewers and resolve grant application reviewer comments before funding grants; prepare guidelines for selecting grantees for site visits, following up on site visit problems and documenting the visit; process expenditure reports timely to prevent draw down of unobligated balances and expedite recovery of misused grant funds; and obtain and use available audit reports to expedite the review and close-out process to eliminate the backlog of expired and terminated grants. (CIN: A-12-90-00022)	The ACF advised that corrective actions have been or are being taken. However, ACF did not agree with OIG's recommendation to resolve reviewers' comments, stating that there is no requirement to resolve the comments before funding. The ACF is moving to close out the backlog of expired grants and protect the Government's interest.
Improve Cash Management of Child Support Collections: The ACF should require the State and local agencies to: specify that collection and recording procedures be in writing; maintain accurate records and proper segregation of the collection and recording processes; restrict access to the computer systems; increase controls over the receipt forms, blank checks and signature devices; perform follow-up reviews to ensure that all child support agencies are offsetting interest earned on child support collections; negotiate with investment institutions to maximize earnings on deposited child support collections; perform follow-up reviews to determine the status of undistributable child support collections; and ensure that all CSE agencies have adequate systems for establishing, recording, maintaining and reviewing account balances. (CIN: A-12-91-00018)	The ACF generally concurred with the findings and recommendations and indicated that increased efforts would be made to promote adequate internal controls and cash management practices at the State level.

OIG Recommendation**Status**

Ensure State Compliance with Health and Safety Regulations at Child Care Facilities:

North Carolina should reevaluate their (federally-required) plan to assure timely, accurate and comprehensive inspections that will assure compliance with State regulations. The plan should assure compliance with fire codes, building codes, sanitation regulations, requirements for background checks on child care providers and day care regulations by accommodating consultant workload. In addition, North Carolina should review regulations and eliminate vagueness, provide technical assistance to providers, provide health and safety information to parents, and ask parents to report conditions that would be harmful to their children. (CIN: A-12-92-00044)

North Carolina generally concurred with the observations noted.

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 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-09-90-01040)

The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department.

Ensure that New York Allocates Training Costs to Federal Programs for Actual Number of Attendees:

The Department should be more aggressive when approving State plans to ensure that the State (among other actions): allocates future training contracts to programs based on the actual number of participants; maintains documentation which clearly details which programs benefit from future training and, where applicable, allocates training costs to all benefitting programs; and discontinues using third party contributions provided by private contractors to meet its share of training costs. (CIN: A-02-91-02002)

The Department's Division of Cost Allocation (charged with approval of State cost allocation plans) expressed agreement with the findings and recommendations.

APPENDIX D

Notes to Tables I and II

Table I

¹ The opening balance was adjusted to reflect a downward revaluation of recommendations in the amount of \$14,819.

² Included in the reports issued during the period are management decisions to disallow \$2,006 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-07-92-00493	Audit of the Cost Allocation Plan Kansas Department of Social and Rehabilitation Services: Follow-up work disclosed that the previously disallowed costs of \$6,132,973 had not been paid to the State.
CIN: A-02-92-20035	Governor's Office of Elderly Affairs, Puerto Rico: The State provided additional documentation to support costs that were previously disallowed of \$2,974,445.
CIN: A-07-90-00353	Medicaid Claims for Case Management in Nebraska: The State provided additional documentation to support costs that were previously disallowed of \$1,552,634.

Not detailed are additional revisions to previously reported decisions totaling \$5,894,130.

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

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

CIN: A-03-92-00010	National Review of Medical Credit Balances, December 1992, \$270,000,000 (Related recommendation of \$157,000,000 outstanding on Table II)
CIN: A-04-92-01023	Audit of Medicaid Credit Balances, March 1993, \$40,931,405 (Related recommendation of \$25,000,000 outstanding on Table II)
CIN: A-01-91-00511	Follow-up Review Nonphysician Hospital Review, December 1992, \$38,511,916
CIN: A-12-91-0018	Cash Management By State Child Support Agencies, August 1991, \$13,200,000 (Related recommendation of \$13,800,000 outstanding on Table II)
CIN: A-03-91-00552	Independent Living Program - National, March 1993, \$6,529,545 (Related recommendation of \$10,161,742 outstanding on Table II)
CIN: A-07-92-00578	BC/BS of Texas Inc. - Unfunded Pension Costs, October 1992, \$6,244,637
CIN: A-03-89-00046	BC/BS Administrative Costs - FY 1985-1988 - Part B, September 1991, \$5,996,278
CIN: A-05-93-00013	MI-BC/BS - Contract Medicare Audit, April 1993, \$3,010,916
CIN: A-07-92-00579	BC/BS of Michigan Inc.- Unfunded Pension Costs, October 1992, \$2,535,698
CIN: A-05-92-00026	Associated Insurance Co. - Medicare Administrative, February 1992, \$2,530,409
CIN: A-02-91-01006	BC/BS of Western NY Medicare ADM CTS Porter, September 1991, \$2,379,239

CIN: A-03-90-02003	BC of Western Pennsylvania Administrative Costs FY 1986-1989, August 1993, \$2,218,528
CIN: A-05-93-19899	Michigan Department of Social Services, November 1992, \$2,104,727
CIN: A-05-90-00090	BC/BS - Administrative Costs Contract Audit, November 1990, \$1,825,677
CIN: A-09-92-00105	ISF - Teal Data Center, July 1993, \$1,800,000
CIN: A-03-91-02000	Independence BC/BS Administrative Cost, June 1993, \$1,763,319
CIN: A-03-92-19733	State of Maryland, August 1992, \$1,505,462
CIN: A-03-90-00053	BC/BS of Virginia Administrative Costs, August 1992, \$1,487,212
CIN: A-01-90-00509	Medicare Secondary Payer Review - AETNA, February 1992, \$1,471,233
CIN: A-03-90-00051	Maryland BC/BS Administrative Costs Contract Audit, November 1990, \$1,438,414
CIN: A-05-93-00057	MI - BC/BS Contract Audit, July 1993, \$1,409,954
CIN: A-05-93-19899	Michigan Department of Social Services, November 1992, \$1,030,218
CIN: A-02-93-19670	State of New York, February 1993, \$893,691
CIN: A-05-92-00060	Contractor Audit - BC/BS Administrative, February 1993, \$879,609
CIN: A-05-91-00136	Community Mutual Insurance Company, August 1992, \$720,668
CIN: A-04-91-04029	Audit of O&M AIDS Campaign Contract, May 1992, \$675,750
CIN: A-02-91-01004	Seguros Servicio De Salud CPA Gedrich, July 1992, \$575,603
CIN: A-04-91-00028	Review of Child Care and Other Supportive Service Costs, April 1993, \$512,718
CIN: A-02-91-03508	Audit of New Jersey Child Care and Supportive Services, June 1993, \$506,710
CIN: A-03-92-16229	State of Pennsylvania, March 1992, \$496,876
CIN: A-06-93-00010	BC/BS Texas, 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-05-93-25697	West Central Wisconsin Community Action Agency, Inc., August 1993, \$324,759
CIN: A-04-93-04178	CDC Contract, July 1993, \$280,673
CIN: A-04-91-04067	Review Appropriateness of HRSA's Noncompetitive Award, May 1992, \$274,697
CIN: A-02-92-02013	Puerto Rico FY 1988 LIHEAP/Weatherization - Eligibility and Implementation, August 1993, \$263,288
CIN: A-07-92-00615	Survey of Denied Medicare O/P Routine Mammograms, August 1993, \$258,186
CIN: A-10-93-00013	BC/BS Oregon Medicare Administrative Costs FYs 1987-1988, August 1993, \$253,901
CIN: A-05-93-00025	Ohio Department of Human Services, July 1993, \$251,013
CIN: A-03-92-20033	State of Delaware, August 1992, \$247,609
CIN: A-02-92-16749	City of San Juan, Puerto Rico, December 1991, \$233,462

CIN: A-05-91-00064	Nationwide Administrative Costs Contract Audit, October 1991, \$211,422
CIN: A-04-93-00051	OCS Grant - Haitian Task Force, Inc., August 1993, \$200,207
CIN: A-05-93-24819	Economic Opportunity Committee of St. Clair Co., August 1993, \$188,691
CIN: A-09-92-06850	Santa Ysabel Band of Mission Indians, September 1992, \$151,081
CIN: A-03-93-21104	State of Pennsylvania, June 1993, \$150,000
CIN: A-09-92-00111	Health Services Advisory Group UCDS Costs, July 1993, \$142,114
CIN: A-05-92-00048	WI Physicians Services, Pension - Medicare versus ERISA, October 1992, \$130,577 (Related recommendation of \$2,068,962 outstanding on Table II)
CIN: A-09-92-00093	BC/BS Arizona Administrative Costs, August 1992, \$129,518
CIN: A-09-93-26171	Tohono O Odham Nation, August 1993, \$125,000
CIN: A-04-93-20785	State of Florida, June 1993, \$103,486
CIN: A-01-92-19975	State of Massachusetts, September 1992, \$96,703
CIN: A-08-93-25718	Ute Indian Tribe, August 1993, \$81,558
CIN: A-09-93-25778	Government of Guam, August 1993, \$23,548
CIN: A-07-93-19985	State of Kansas, January 1993, \$78,511
CIN: A-03-91-02002	Delaware BC/BS Administrative Costs, October 1991, \$66,858
CIN: A-03-91-16232	Unisys Inc., September 1991, \$61,754
CIN: A-04-92-19779	Poarch Band of Creek Indians, August 1992, \$59,904
CIN: A-06-92-19887	Central Tribes of the Shawnee Area, Inc., July 1992, \$57,944
CIN: A-09-93-24018	Pit River Health Services, Inc., August 1993, \$50,693
CIN: A-01-93-24739	State of New Hampshire, August 1993, \$44,955
CIN: A-01-93-20875	State of Maine, May 1993, \$40,540
CIN: A-05-93-25387	Sault Ste. Marie Tribe of the Chippewa Indians, July 1993, \$38,689
CIN: A-10-93-23022	State of Alaska, August 1993, \$34,731
CIN: A-04-93-20784	State of Florida, June 1993, \$33,511
CIN: A-05-93-23653	National Congress of Parents and Teachers, April 1993, \$32,818
CIN: A-03-93-24682	Midatlantic Research Institute, June 1993, \$31,038
CIN: A-09-91-00150	Audit of National Practitioner Data Bank, October 1992, \$24,165
CIN: A-10-93-25001	Western Idaho Community Action Program, Inc., August 1993, \$23,548
CIN: A-01-93-20875	State of Maine, May 1993, \$23,341
CIN: A-10-93-22465	Small Tribes Organization of Western Washington, January 1993, \$23,220
CIN: A-02-93-23974	Joint Council for Economic Opportunity of Plattsburg, August 1993, \$20,644
CIN: A-06-92-20334	Pueblo of Jemez, September 1992, \$20,156

CIN: A-02-93-24129	Council of Jewish Federations Inc., May 1993, \$19,152
CIN: A-05-93-21928	Wright State University, July 1993, \$18,308
CIN: A-03-93-25292	Pennsylvania State University, July 1993, \$17,863
CIN: A-02-93-24742	Puerto Rico Department of Anti-Addiction Services, July 1993, \$17,554
CIN: A-04-93-20961	Commonwealth of Kentucky, January 1993, \$15,000
CIN: A-10-92-20781	Tulalip Tribes of Washington, September 1992, \$14,525
CIN: A-09-93-07000	Yomba Shoshone Tribe, November 1992, \$12,832
CIN: A-09-93-26171	Tohono O Odham Nation, August 1993, \$12,965
CIN: A-01-93-24739	State of New Hampshire, August 1993, \$11,516
CIN: A-03-93-21579	State of West Virginia, April 1993, \$11,380
CIN: A-09-92-06864	San Juan Southern Paiute Tribe, September 1992, \$10,433
CIN: A-05-93-26085	Michigan Family Resources, July 1993, \$9,634
CIN: A-06-92-16588	State of Oklahoma, August 1992, \$9,294
CIN: A-05-93-26238	School District of the City of Muskegon Heights MI, August 1993, \$9,229
CIN: A-09-93-23668	Center for Education and Manpower Resources, Inc., September 1993, \$8,093
CIN: A-03-93-25879	West Penn Hospital Foundation, July 1993, \$8,023
CIN: A-09-93-07000	Yomba Shoshone Tribe, November 1992, \$7,745
CIN: A-10-93-22136	Confederated Tribes of the Grand Ronde Community, December 1992, \$7,384
CIN: A-09-93-26204	Tohono O Odham Nation, August 1993, \$7,332
CIN: A-06-93-24112	Ramah Navajo School Board Inc., July 1993, \$7,319
CIN: A-04-93-24973	Caney Fork Development Corp., June 1993, \$6,768
CIN: A-01-93-25220	Mashantucket Pequot Tribal Council, July 1993, \$6,695
CIN: A-04-92-19467	Trinity Child Development Center Inc., October 1992, \$5701
CIN: A-08-92-16941	Fort Belknap Indian Community, August 1993, \$5,312
CIN: A-06-91-00034	Audit of Collection and Credit Activities at TDHS, January 1992, \$5,081
CIN: A-02-93-22736	Opportunities for Broome, Inc., March 1993, \$5,072
CIN: A-10-92-06777	Coeur D'Alene Tribe of Idaho, September 1992, \$4,868
CIN: A-08-92-16941	Fort Belknap Indian Community, December 1991, \$4,325
CIN: A-08-93-22280	Crow Creek Sioux Tribe, January 1993, \$4,211
CIN: A-02-93-26106	Second Street Youth Center Foundation, Inc., July 1993, \$3,989
CIN: A-03-92-16787	State of West Virginia, June 1992, \$3,547
CIN: A-01-93-26316	Central Maine Indian Association, Inc., August 1993, \$3,484
CIN: A-10-93-00010	BC/BS Oregon - Medicare Administrative for FY 1988, August 1993, \$3,473

CIN: A-03-93-25970	Little Neighborhood Schools, Inc., June 1993, \$2,604
B. Reports in litigation:	
CIN: A-04-92-02056	Administrative Cost Audit of Medicare Part B, May 1993, \$14,722,615
CIN: A-09-91-00155	Blackburn Care Home, November 1991, \$1,772,944, (Related recommendation outstanding of \$662,000 on Table II)
CIN: A-10-91-00011	WPS - Keystone Computer Acquisition, October 1992, \$1,346,681
CIN: A-06-92-00017	IHS Creek Contract Closeout, May 1992, \$468,217
CIN: A-03-91-14988	Maryland Department of Mental Health and Hygiene, March 1991, \$243,703
CIN: A-09-92-20824	Tri-County Migrant Head Start, September 1992, \$7,593
CIN: A-03-91-02004	West VA BC/BS Administrative Cost FY 1985-1990 and Termination Costs, November 1992, \$7,556
C. Reports that have subsequently been resolved:	
CIN: A-05-93-25796	Lorain County Community Action Agency, Inc., June 1993, \$165,000
CIN: A-05-93-26441	Midwest Minnesota Community Development Corp., July 1993, \$25,000

Table II

¹ The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of \$93,320.

² The OIG has reported as "management decisions during the period" those line items in the President's Fiscal Year 1995 budget that relate directly to OIG recommendations contained in issued reports. Management does not report these decisions in its table.

³ Management decisions have not been made within 6 months of issuance on 13 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 Service, July 1992, \$385,000,000
CIN: A-05-92-00006	One Day Admissions Finalization, January 1992, \$233,000,000
CIN: A-02-91-01053	Medicaid - Eliminate Enhanced Fixed Financial Participation - Family Planning, December 1992, \$80,000,000
CIN: A-06-91-00080	Medicare - Review of Part B Reimbursement for Hospital Beds, May 1993, \$6,200,000
CIN: A-06-91-00089	Audit of B Accounts to Detect Status of IHS Cash On Hand, April 1992, \$445,890
CIN: A-02-93-25460	Union Township Community Action Organization, July 1993, \$166,000
CIN: A-06-92-00081	Follow-up Hansen's Disease Center, August 1993, \$164,728
CIN: A-04-93-22872	Montgomery Community Action Committee, Inc., January 1993, \$106,760
CIN: A-03-92-03315	Thomas Jefferson University RFP NCI-CN-25406-41, May 1992, \$50,943
CIN: A-09-90-07111	Yomba Shoshone Tribe, January 1990, \$12,832
CIN: A-06-93-25622	Palo Pinto Community Service Corp., August 1993, \$12,823
CIN: A-04-93-24930	Hinds County Human Resource Agency, June 1993, \$6,596

B. Report in litigation:

CIN: A-09-91-05300

Kass Management Services, Inc., 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	63
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	66
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	61
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	62
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

AAS	advisory and assistance services
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
CME	continuing medical education
CMP	civil monetary penalty
CRADA	cooperative research and development agreement
CSE	child support enforcement
DCA	Division of Cost Allocation
DDS	disability determination service
DI	disability insurance
DME	durable medical equipment
DOJ	Department of Justice
DRG	diagnosis-related group
EA	emergency assistance
EGHP	employer group health policy
ESRD	end stage renal disease
EVS	enumeration verification system
FFP	Federal financial participation
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHS	Department of Health and Human Services
HUD	Department of Housing and Urban Development
ICF/MR	intermediate care facility for the mentally retarded
IHS	Indian Health Service
IME	indirect medical education
IOL	intraocular lens
IRM	information resources management
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance Program
MBR	master beneficiary record
MCH	maternal and child health
MER	medical evidence of record
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
OASH	Office of the Assistant Secretary for Health
OASI	Old Age and Survivors Insurance
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
OPD	outpatient department
PFCRA	Program Fraud Civil Remedies Act
PHS	Public Health Service
PPS	prospective payment system
SEI	self-employment income
SGA	substantial gainful activity
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
TPL	third party liability
TWP	trial work period
WC	workers' compensation

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

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