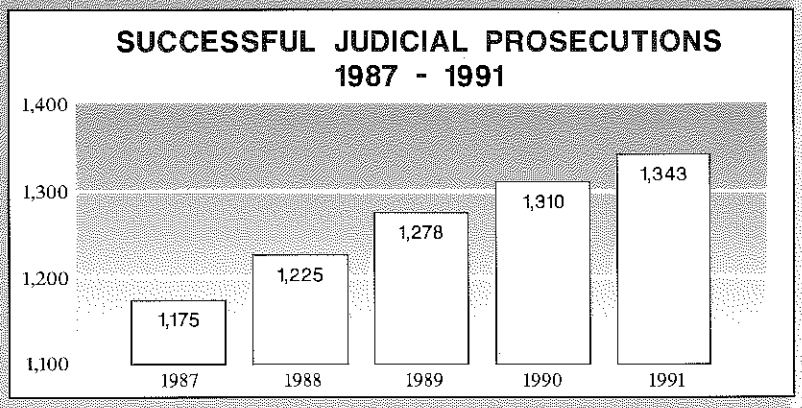
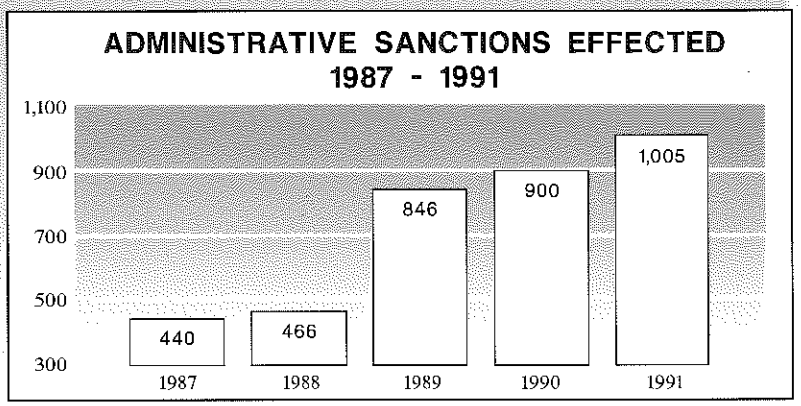
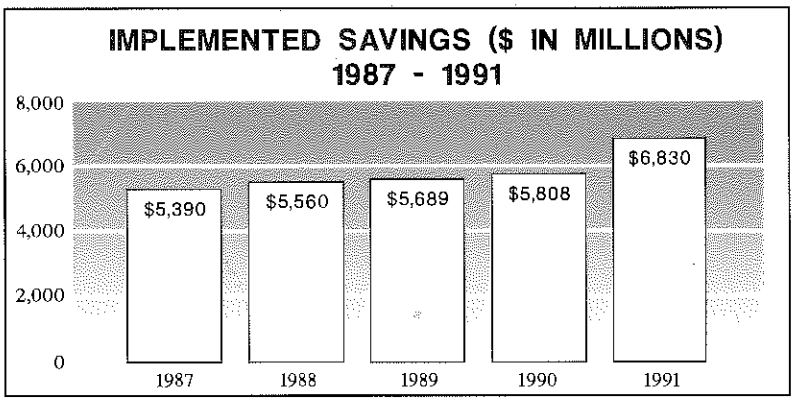
Shaw







Semiannual Report

April 1, 1991 - September 30, 1991

Office of Inspector General

Richard P. Kusserow
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

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-120	Advisory and Assistance Services
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 1320 a-7, 1320 c-5, 1395l, 1395m, 1395u, 1395dd and 1396b, the Social Security Act

FOREWORD

I am pleased to submit this semiannual report on the activities of the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) for the 6-month period ending September 30, 1991. This report is being issued in accordance with the provisions of the Inspector General Act of 1978 (Public Law 95-452), as amended.

The OIG has a statutory responsibility to protect the integrity of HHS programs and operations as well as the health and welfare of the beneficiaries served by those programs. The OIG is also responsible for conducting reviews of departmental management activities and continues to be actively involved in the Department's program to ensure effective internal controls. In addition, OIG participates in coordinating Governmentwide activities to reduce fraud, waste and abuse, and to improve management processes.

The OIG's work covers all operating divisions of the Department. Its activities in each of these areas are covered in separate chapters in this report:

- *The Health Care Financing Administration administers the Medicare and Medicaid programs.*

- *The Social Security Administration manages the Nation's Retirement, Survivors and Disability Insurance programs, the Supplemental Security Income program and Part B of the Special Benefits to Disabled Coal Miners (Black Lung) program.*

- *The Public Health Service promotes biomedical research, disease cure and prevention, and the safety and efficacy of marketed food, drugs and medical devices, measures the impact of toxic waste sites on health, and conducts other activities designed to ensure the general health and safety of American citizens.*

- *The newly created Administration for Children and Families combines the programs of the former Family Support Administration and the Office of Human Development Services, except for the Administration on Aging. This division provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families, and includes a variety of programs that provide social services to American children and families, Native Americans and the Nation's developmentally disabled.*

The OIG is comprised of three components - the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. A complete listing of OIG audit and inspection reports is being furnished to the Congress under separate cover. Copies are available upon request.

The Office of Audit Services (OAS) is responsible for conducting audit services for HHS, and for overseeing audit work done by others. Audits are conducted to fulfill OIG's responsibilities under the Inspector General Act, and to address high priority areas of interest to the Secretary, the Congress and program administrators. Audits assess the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent reviews of HHS programs and operations in order to reduce waste, abuse and mismanagement, and to promote economy and efficiency throughout the Department. They focus on HHS's role in administering the Nation's critical health and human services programs, and are designed to provide sustained and balanced coverage in these areas. The OIG's auditors conduct their work in accordance with the Government Auditing Standards (Yellow Book) published by the U.S. General Accounting Office and the American Institute of Certified Public Accountants standards.

The Office of Investigations (OI) protects the integrity of HHS programs and the well-being of legitimate HHS beneficiaries by investigating allegations of fraud and abuse by providers of services and seekers of illegal benefits. Investigation of grant and contract fraud and employee violations of ethical conduct standards are also its responsibilities. Its investigations result in criminal prosecutions, administrative sanctions and civil actions against wrongdoers, including monetary penalties and exclusion from HHS programs. The OI proposes systemic changes to remedy program flaws discerned during investigations, to prevent future fraudulent activities. Special fraud alerts are issued to warn agencies and organizations of illegal schemes which drain the trust funds or victimize beneficiaries. Exclusion of unscrupulous and incompetent medical care providers from program participation prevents their further enrichment or harm to patients. The OI also oversees State Medicaid fraud control units which investigate and prosecute provider fraud and abuse in the Medicaid program.

The Office of Evaluation and Inspections (OEI) conducts short term management and program evaluations that focus on issues of concern to the Department, the Congress and the public. Over one-third of the inspections are requested by the Secretary, the operating divisions or the Congress. Program inspections offer the Department's managers a fast, unbiased, highly reliable way of gathering information about their programs. Inspections are usually completed within 6 to 9 months to ensure that pertinent information is available before decisions are made. Inspections contain findings and recommendations which assist program managers in improving quality of care for the Department's clients, improving

program efficiency, identifying and correcting program vulnerabilities and identifying areas for cost savings.

In recognition of the Department's responsibility to meet the important social goals and pressing health needs of the American public, the Secretary has set specific objectives and established program directions for the operating divisions designed to achieve those objectives. The Secretary's goals for HHS are to:

- *ensure the necessary support for biomedical research,*
- *prevent disease and social pathology,*
- *improve access to health care for all Americans,*
- *maximize the cost-effectiveness of health care services,*
- *strengthen the American family,*
- *promote personal responsibility for health and social fitness, and*
- *maintain the integrity of the Social Security and Medicare programs.*

The OIG's activities support those goals by promoting high quality, cost-effective health care and human services, improved access to health care for all Americans, and the integrity of the Social Security and Medicare trust funds. In addition, OIG is focusing particular attention on the Department's efforts to improve its financial systems.

Reporting on program performance is an area of growing interest at the Federal, State and local levels of government. There is an increasing focus on reporting service efforts and accomplishments, or performance measurement, as an integral part of accountability reporting. Under the Chief Financial Officers Act of 1990, there is a requirement to report on program performance or, more explicitly, to include with the financial statements of reporting entities a discussion of performance indicators and measures. A performance indicator is an index or pointer used to evaluate the progress in achieving program goals or objectives. Performance indicators may differ for each level of program goal or objective and for each corresponding organizational level. Performance measures are quantitative expressions of the ratio of two performance indicators used to evaluate a program goal or objective, such as the efficiency of an immunization program being measured by the number of inoculations provided per dollar of cost.

Financial results pertaining to a particular accounting period are more meaningful when related to information on program or agency outputs. Therefore, we are identifying performance measures which result from our work and which may be usable for reporting. Throughout the body of this semiannual report, we have tagged some items as "performance indicators" by marking them with the symbol 

. These audits, inspections

and investigations offer a quantifiable assessment as to whether the programs or activities reviewed are achieving their desired goals. We consider this an important first step in the development and evolution of performance measurement. As we and others expand our work in programmatic performance measurement, the array of indicators and measures will also be enhanced.

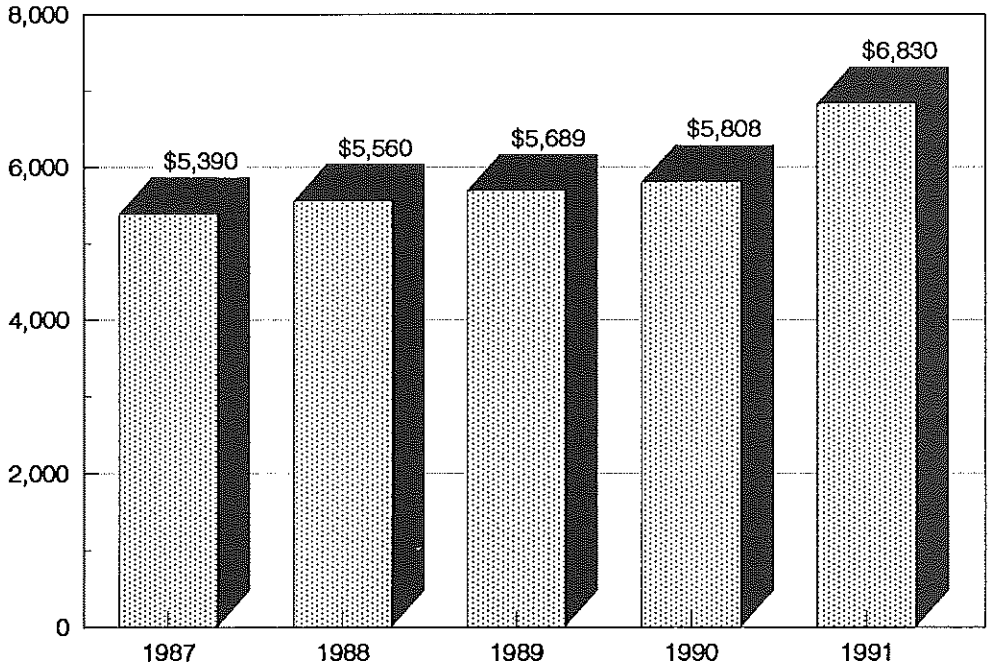
We recognize that the accomplishments described in this report would not have been possible without the cooperation and assistance of departmental managers and Members of the Congress. We greatly appreciate their continued support.

Richard P. Kusserow
Inspector General

HIGHLIGHTS

Monetary Benefits - Over the last 5-year budget cycle, $29.3 billion in savings, settlements, fines, restitutions and receivables have resulted from Office of Inspector General (OIG) activities and implementation of OIG recommendations.

IMPLEMENTED SAVINGS ($ IN MILLIONS)
1987 - 1991



The following items highlight monetary benefits resulting from OIG activities and implementation of OIG recommendations made during the second half of the fiscal year:

- Medicare will save over $1 billion in the first year as a result of reductions in capital-related payments for inpatient and outpatient hospital services. (See pages A-1 and A-2)

- Requiring mandatory Social Security coverage for all noncovered State and local government employees who are not participating in a public employees' retirement system will generate $500 million in trust fund revenues in Fiscal Year (FY) 1991. (See page A-1)

- By identifying and correcting overpayments and underpayments made in processing combined family maximum records, the Social Security Administration (SSA) will save $4 million. (See page A-3)

- By identifying and recovering unreported investment income from institutions participating in the Health Professions Student Loan and Nursing Student Loan programs, the Public Health Service (PHS) will collect $3.2 million. (See page A-3)

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

- The OIG identified provisions in the formula used to establish the Federal share of States' costs for four federally assisted programs, that appear to depart from the intent of the Congress. That intent appears to have been to distribute Federal assistance according to a State's ability to share in program costs as measured by State per capita income relationships. If the formula remains unchanged, the net costs of these provisions over the next 5-year budget cycle will be approximately $57.2 billion for Medicaid, $12.8 billion for the Aid to Families with Dependent Children program, and $2.3 billion for the Foster Care and Adoption Assistance programs combined. (See page 92)

- The OIG recommended that the Health Care Financing Administration (HCFA) take action to control provider tax and donation programs used by States to increase the nonfederal share of States' Medicaid expenditures. Unless restricted or capped through congressional action, these programs could cost the Federal Government almost $3.8 billion in FY 1991 and about $12.1 billion by the end of FY 1993. (See page 51)

- In assessing the financial impact of including the payment for laboratory services in Medicare's recognized charges for physician office visits (laboratory roll-in), OIG estimated that Medicare could save over $1 billion per year. The OIG also found that laboratory roll-ins would provide sufficient funds for most physicians to cover the costs they would incur in securing laboratory work. (See page 47)

- The OIG estimated that SSA could save approximately $900 million if it could successfully pursue legislation establishing a consistent definition of month of eligibility for age-based retirement and survivor payments. (See page 59)

- In a series of studies on Medicare secondary payer (MSP) issues, OIG found that a significant number of overpayments result from the carriers' failure to identify primary insurance sources. The OIG also found that carriers did not have the resources to collect overpayments on those MSP cases that were identified. Losses to the Medicare program because of those shortcomings were projected to be at least $637 million in FY 1988. (See page 37)

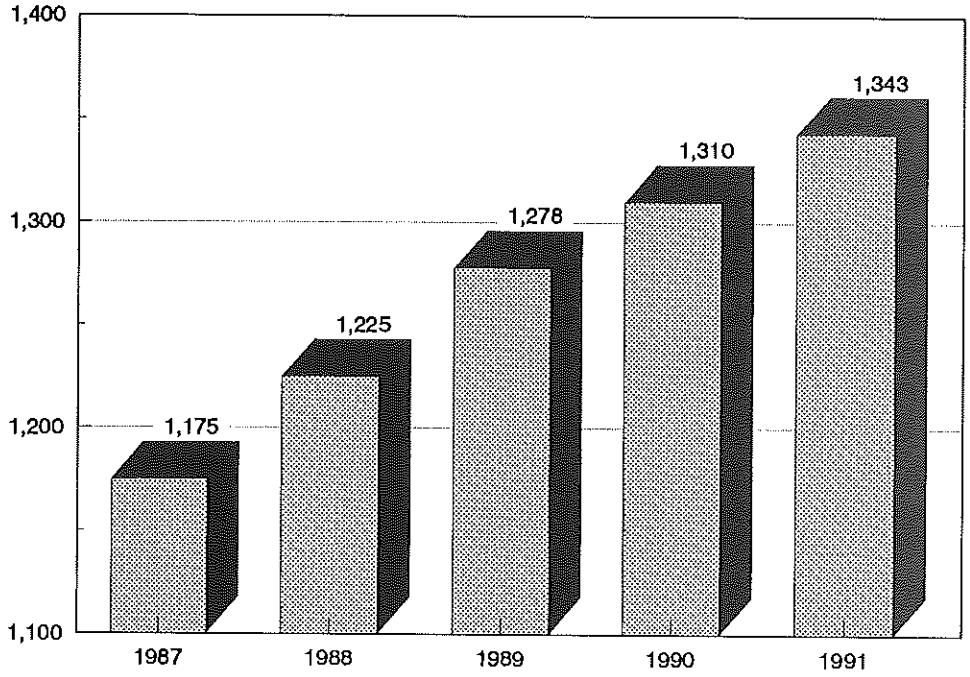
- The OIG recommended a variety of fiscally sound approaches for enhancing Medicare trust fund revenues, establishing more equitable payment policies and enforcing program requirements better. Implementation of these recommendations would help ensure the future solvency of the trust funds. (See page 29)

Internal Control Weaknesses - The Federal Managers' Financial Integrity Act (FMFIA) requires Federal agency heads to establish a continuous process for the evaluation and improvement of the internal administrative, accounting and financial control systems for which they are responsible, and to report annually to the President and the Congress on the status of their internal control and accounting systems.

Chapter I discusses OIG's role in the Department's FMFIA program. In addition, Chapters I through IV discuss material weaknesses in the internal control systems of the Department's operating divisions. The OIG tracks the most significant nonmonetary findings and recommendations and publishes them in a separate report called Program and Management Improvement Recommendations (the Orange Book).

Successful Judicial Prosecutions - As a result of investigations by OIG over the past 5 years, numerous individuals and entities were successfully prosecuted for engaging in crimes against programs of the Department of Health and Human Services (HHS), as illustrated below.

SUCCESSFUL JUDICIAL PROSECUTIONS
1987 - 1991



Appendix E shows the Federal and State jurisdictions in which the FY 1991 prosecutions were accomplished.

During the second half of FY 1991, OIG investigative activities resulted in 614 successful prosecutions. The following items highlight some of the more significant achievements:

- A peer review organization in Florida pled guilty and was penalized for authorizing Medicare payments to hospitals for cases it had not reviewed. (4-88-00956-9
- An official of a New York medical college and two confederates were convicted of embezzling close to $1.6 million in grant money, much of it from the National Institutes of Health. (2-90-00779-4
- A generic drug company and a laboratory which tested the bioequivalency of one of its products were fined $10 million and $200,000, respectively, for obstructing a Food and Drug Administration investigation. (W-89-00084-3
- The president of a Massachusetts health maintenance organization was sentenced to 27 months in prison for accepting kickbacks from a contractor.

- A chiropractor and his wife, who operated several vascular diagnostic centers in Florida, were imprisoned and ordered to make restitution of $637,000 defrauded from Medicare and private insurers. (4-85-01003-9

- The husband and wife owners of a Pennsylvania ambulance company were sentenced to a year in prison and ordered to pay $250,000 each for inflating mileage and falsifying records. (3-88-00814-9

- Five persons formerly associated with a hospital in Washington State, including the former administrator, controller and corporate lawyer, were given prison sentences for embezzlement, filing false Medicare reports and income tax evasion. (X-88-00253-9

- A self-styled credit doctor and his associate were sentenced to jail in Texas for credit and Social Security number fraud, and ordered to pay a total of $374,600 in restitution and fines. (6-89-00827-6

- A PHS regional director of health services delivery was convicted for using his position to attempt to steer a PHS contract to a community health center. (3-88-00046-4

- In one State, a joint Federal, State and local project investigating welfare fraud led to mass indictments of over 40 persons.

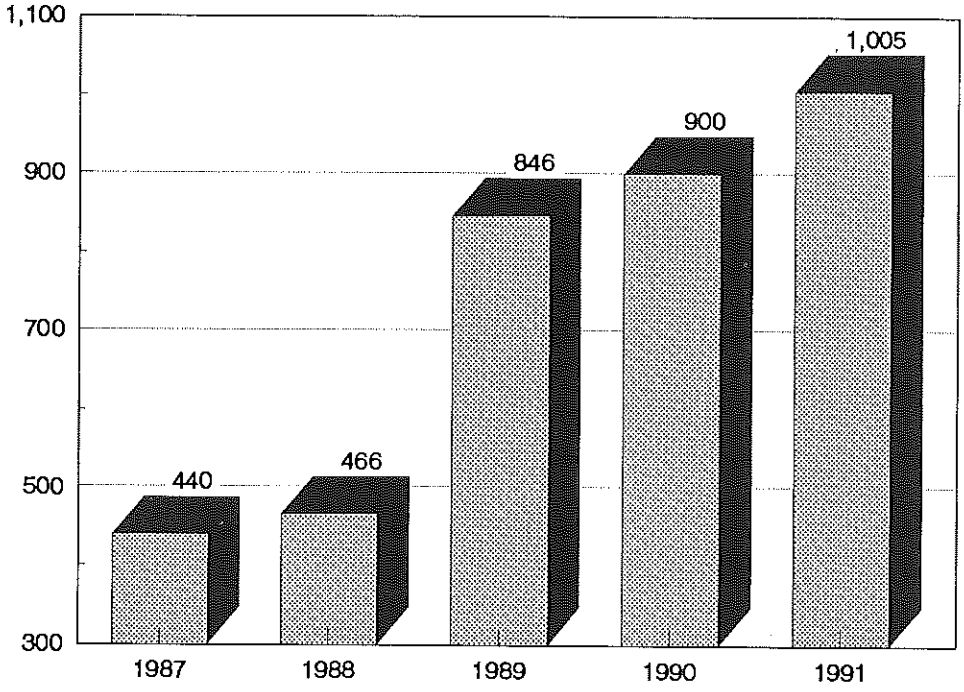
- In Iowa, a woman was sentenced to prison for diverting to her own use Supplemental Security Income benefits intended for her granddaughter, who had cerebral palsy and had been taken from the woman's custody. (8-89-00651-6

- A Texas woman was jailed for cashing her brother's Social Security benefits checks for 27 years. (6-89-00365-6

- A California woman was sentenced to life imprisonment for poisoning her husband, whose Social Security benefits checks she cashed. (9-90-00384-9

Administrative Sanctions - Since FY 1987, numerous health care providers and suppliers or their employees were administratively sanctioned with program exclusions or civil monetary penalties (CMPs) for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries, or for controlled substance abuse or loss of licenses.

ADMINISTRATIVE SANCTIONS EFFECTED
1987 - 1991



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

- A court of appeals upheld a CMP of $20,000 against a Texas doctor who inappropriately transferred a woman in labor from a hospital emergency room to a hospital 170 miles away. (6-87-30510-9

- A Georgia-based medical corporation paid a $2.7 million CMP for billing Medicare for items not provided. (4-90-00285-9

- A California durable medical equipment supplier paid a $2.9 million settlement for billing Medicare for supplies not delivered.

- A Michigan psychologist whose license was revoked for failing to meet minimal standards of practice was excluded indefinitely.

- Two individuals and their corporation, once the Nation's largest supplier of home health services, were excluded for 15 years for falsifying employee records.

- The owner of a California diagnostic clinic signed a CMP settlement of $950,000 for paying kickbacks for patient referrals. (9-89-26005-9

- A Massachusetts podiatrist was excluded for 30 years for false license applications and practicing without a license. (1-91-40081-9

- A New York physician was excluded indefinitely for practicing abusive and dangerous medicine. (2-89-40972-6

Significant Recommendations for Program and Management Improvement - The following items pertaining to quality of care, the welfare of beneficiaries, and program and management effectiveness highlight OIG findings, recommendations and activities during the second 6 months of the fiscal year:

- Federal funding for science at colleges and universities has reached $9.2 billion per year, of which about $2.5 billion is for indirect costs. The OIG identified strategies for addressing issue areas associated with HHS funding of biomedical research, and options for ensuring that limited funds are equitably apportioned for the direct and indirect costs of research conducted by these institutions. (See page 74)

- In response to public health concerns and at the request of the Surgeon General, OIG conducted a survey of youth and found that more than half of all 7th through 12th graders have had at least one drink in the last year and that 8 million drink regularly. More than 5 million students in this group have binged (had more than five drinks in a row). More than 7 million students are able to buy alcohol despite minimum age laws. (See page 75)

- The OIG found a number of weaknesses in the Indian Health Service (IHS) oversight of the its Youth Alcohol and Substance Abuse programs. The IHS has not established regional treatment centers in all service areas, nor has the Bureau of Indian Affairs completed establishment of emergency shelters for substance abusers. (See page 77)

- The OIG determined that, despite progress toward an equitable, national organ distribution system, current practices fall short of congressional and professional expectations. The OIG made a number of recommendations to address this issue, including the development of a single, unified list of patients awaiting transplantation and the development of medical practice guidelines addressing organ transplantation. (See page 30)

- Medicare carriers assign numbers to providers of Part B services that are used in processing claims and in establishing Medicare pricing and utilization profiles. The OIG reviewed HCFA's oversight and management of these processes and found that HCFA did not provide sufficient oversight and direction for these functions. (See page 42)

- In the first report Governmentwide under the Chief Financial Officers Act of 1990, OIG assessed SSA's performance and program management. Included is OIG's opinion on SSA's 1990 financial statements, a discussion of SSA's internal controls and compliance with laws and regulations, and an identification of problem areas. (See page 57)

- An OIG review revealed that staff reductions and workload processing changes in SSA field offices have combined to create certain staffing imbalances, requiring public contact employees to do clerical work on a routine basis. As a result, significant increases were found in pending post-eligibility workloads and reductions were noted in the levels of some secondary public services. (See page 59)

- The OIG studied 14 Federal and 4 nonfederal employers' systems for automatic collection of child support by means of garnishment of the noncustodial parent's salary. The OIG found that employers are encountering several administrative impediments to timely and effective processing of garnishment orders in compliance with the law. (See page 90)

TABLE OF CONTENTS

PAGE

CHAPTER I HHS AND GOVERNMENTWIDE OVERSIGHT

Introduction 1

The Federal Managers' Financial Integrity Act 2

Internal Control Weakness 3

Governmentwide Implementation of FMFIA 3

Internal Control Reviews of Time and Attendance Practices 3

Time and Attendance Practices in Regional Offices 4

The Chief Financial Officers Act of 1990 4

Resolving OIG Recommendations 5

A. Questioned Costs 5

B. Disallowances from OIG Questioned Costs 6

C. Funds Put to Better Use 13

Legislative and Regulatory Review 14

Governmental Accounting 15

A. Excess Reserves in Pension Trust Funds 15

B. Self-Insurance Funds: North Carolina 16

C. Self-Insurance Funds: Alabama 16

Nonfederal Audits 16

A. Technical Assistance 16

B. Quality Control 17

C. Analysis of Reports 17

Audit Assistance to Small Federal Agencies 18

A. National Mediation Board 18

PAGE

B. Postal Rate Commission 18

Controls over Obligations for Advisory and Assistance Services 18

Employee Fraud and Misconduct 19

Investigative Prosecutions and Receivables 20

Program Fraud Civil Remedies Act 23

Cooperation with Other Law Enforcement Agencies 23

Successful Ombudsman Programs 24

AoA Discretionary Grants 24

CHAPTER II HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and OIG Activities 27

Internal Control Weaknesses 29

Solvency of the Medicare Trust Funds 29

Distribution of Organs for Transplantation 30

Hospital Patient Transfers 31

Skilled Nursing Facility Benefit 31

Medicare Outpatient Credit Balances 32

Reimbursement for Outpatient Facility Services 33

Unnecessary and Poor Quality Upper GI Endoscopies 34

Postoperative Office Visits for Cataract Surgery 34

PRO Fraud 35

False Claims 35

Medicare Secondary Payer: Extent of Unrecovered Funds 37

MSP Procedures at Carriers 37

Conditional Payments by Blue Cross of Massachusetts 38

Pension Plan Termination and Reversion 38

PAGE

Contractor's Segmented Pension Costs 39

Sanction Authorities 39

A. Patient and Program Protection Sanctions 39

B. CMPs 40

Carrier Maintenance of Medicare Provider Numbers 42

Intermediary Payment Safeguard Savings 42

Medicare Prepayment Utilization Savings 42

Kickbacks and Joint Ventures 43

Carrier Performance 44

Medical Transportation Fraud 44

Embezzlement 45

Monitoring Services Provided in Physicians' Offices 46

Impact of Laboratory Roll-ins on Medicare Expenditures 47

Separately Billable Drugs and Blood Services 47

Low Cost Ultrasound Equipment 47

Pocket Dopplers 48

Trends in Home Oxygen Use 48

Oxygen Concentrator Costs 48

Fraud Involving DME 48

State Regulation of Long Term Care Insurance 50

Reimbursement for Multiple-Source Prescription Drugs 51

Medicaid State Tax and Donation Programs 51

Medicaid Payments to Disproportionate Share Hospitals 51

Strategies to Reduce Medicaid Drug Expenditures 52

State Medicaid Fraud Control Units 52

PAGE

CHAPTER III SOCIAL SECURITY ADMINISTRATION

Overview of Program Area and OIG Activities 55

Internal Control Weaknesses 56

Management and Financial Audit: FY 1990 57

Audit of Financial Statements: FY 1989 57

Social Security Client Satisfaction: FY 1991 58

Effect of Staff Reductions on Field Offices 59

First Month of Eligibility 59

Combined Family Maximum Provision 60

Coverage of Employer-Provided Lodging 60

Fraud Involving Deceased Beneficiaries 61

Representative Payees Serving Multiple Beneficiaries 62

Representative Payees for Multiple Drug Addicts and Alcoholics 63

Representative Payee Fraud 63

Disability Benefits Fraud 64

Policies Concerning Drug Addicts and Alcoholics 64

SSI Delayed Notices of Planned Action 65

SSI Benefits Fraud 65

Role of the SSN Card in Immigration Control 66

Fraudulent SSNs 66

Collection and Deposit Controls 68

Revising Criteria for Waiver of Overpayments 69

Overpayment and Underpayment Resolution for Nonresident Aliens 69

Decentralized Earnings Correspondence Process 69

Payment History Update System 70

Frequent Callers to the 800 Number 71

PAGE

Social Security Offices Calling the 800 Number 71

Employee Relocation Practices and Procedures 72

CHAPTER IV PUBLIC HEALTH SERVICE

Overview of Program Area and OIG Activities 73

Internal Control Weaknesses 74

Federal Research Funding to Colleges and Universities 74

Youth and Alcohol 75

Alcohol, Drug and Mental Health Services for Pregnant Addicts 76

IHS Youth Alcohol and Substance Abuse Programs 77

IHS Medicare and Medicaid Payments 78

Fraud and Abuse in IHS 78

Selected Management Functions at IHS Area Office 79

Food Safety Inspections 79

Clinical Investigator Conflict of Interest 80

Generic Drug Investigations 80

Evaluation of FDA Drug Master File Reviews 81

Review of Promotional Activities 81

Hospital Reporting of Adverse Drug Reactions 81

Drug Industry Visits to FDA Employees 82

FDA Imprest Fund Accounting 82

Prescription Drug Promotion 83

Drug Abuse Treatment Waiting List Reduction Grant Program 83

Movement of Hazardous Property 83

Performance Indicators for State Medical Boards 83

Community Based Organization Projects for Prevention of Human Immunodeficiency Virus 84

PAGE

Embezzlement of Grant Monies 84

Audit of ATSDR Costs 85

HRSA Control over Audit Disallowances 85

CHAPTER V ADMINISTRATION FOR CHILDREN AND FAMILIES

Overview of Program Area and OIG Activities 87

Readiness to Expand Head Start Enrollment 88

CSE: Medical Support 88

CSE: State Insurance Laws 89

CSE: Incentive Payments 90

Garnishment Orders for Child Support 90

Follow-up on AFDC Absent Parents 91

Welfare Fraud 91

Foster Care Administrative Costs: District of Columbia 92

Foster Care Maintenance Payments: Michigan 92

Federal Medical Assistance Percentages 92

Income and Eligibility Verification System 93

SLIAG Expenditures 93

Community Services Discretionary Grant 93

APPENDIX A - Implemented OIG Recommendations to Put Funds to Better Use: April 1991 through September 1991 ..... A-1

APPENDIX B - Unimplemented OIG Recommendations to Put Funds to Better Use B-1

APPENDIX C - Unimplemented OIG Program and Management Improvement Recommendations C-1

APPENDIX D - Congressional Hearings D-1

APPENDIX E - Successful Prosecutions by Federal District and State Authorities E-1

PAGE

LIST OF ACRONYMS . . . . . **Inside back cover**

HHS AND GOVERNMENTWIDE OVERSIGHT

Chapter I

HHS AND GOVERNMENTWIDE OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities. The Department will spend $236 million in Fiscal Year (FY) 1991 to provide overall direction for departmental activities and to provide common services such as personnel, accounting and payroll to departmental operating divisions.

The OIG's departmental management and Governmentwide oversight include reviews of payroll activities, accounting transactions, implementation of the Federal Managers' Financial Integrity Act and the Prompt Pay Act, grants and contracts, the Department's Working Capital Fund, conflict resolution and adherence to employee standards of conduct. The OIG also participates in interagency efforts through the President's Council on Integrity and Efficiency (PCIE) and the President's Council on Management Improvement to prevent losses to and abuses of Federal programs.

In addition, OIG has oversight responsibility for audits conducted of certain Government grantees by nonfederal auditors, principally public accounting firms and State audit organizations. The Office of Management and Budget (OMB) Circulars A-87, A-88, A-110, A-128 and A-133 assign audit oversight responsibility to OIG for about 50 percent of all Federal funds awarded to State and local governments, hospitals, colleges and universities, and nonprofit organizations.

Also included in this chapter is the Administration on Aging (AoA), which reports directly to the Secretary. Established by the Older Americans Act of 1965, AoA serves as an advocate for older persons within the Department and with other agencies at the national level. In addition, AoA is charged with assisting and supporting the efforts of the other components of the national aging network: the State and area agencies on aging, and the agencies and organizations providing direct services at the community level. Among the issues of particular interest to OIG in this area are nutrition, service provision and integration, abuse of the elderly, administrative costs and the nonmedical aspects of long-term care.

The Federal Managers' Financial Integrity Act

The Congress enacted the Federal Managers' Financial Integrity Act (FMFIA) of 1982 (Public Law 97-255) in response to continuing disclosures of waste, loss, unauthorized use, and misappropriation of funds or assets across a wide spectrum of Government operations. The goal of this legislation was to help reduce fraud, waste and abuse, as well as to enhance management of Federal Government operations through improved internal control and accounting systems.

The FMFIA program, as established by law and reinforced by OMB Circulars A-123 and A-127, placed with management the primary responsibility for adequate internal control and accounting systems. It requires agency heads to report annually to the President and the Congress on the status of the Department's internal controls and accounting systems, including the disclosure and correction of material weaknesses.

The Act provides the necessary Governmentwide discipline to identify and remedy long-standing internal control and accounting system problems that hamper effectiveness and accountability, cost the taxpayer potentially billions of dollars and erode the public's confidence in Government.

The OIG has been actively involved in the Department's FMFIA program because effective internal control systems are a primary mechanism for preventing and detecting fraud, waste and abuse.

The OIG's role in the Department's program includes:

- evaluating the adequacy of the Department's segmentation process to ensure that all inherent risk areas, particularly programmatic ones, are included in the FMFIA reviews;

- ensuring that systems reviews under Section 4 of the FMFIA (Section 4 reviews) for both financial and program areas are performed adequately, which is especially important in light of the requirements for preparing and auditing financial statements in the Chief Financial Officers Act of 1990;

- monitoring corrective actions taken to correct weaknesses identified by OIG, the General Accounting Office, and the operating and staff divisions of the Department;

- advising top management on internal control issues; and

- reviewing and reporting on the Secretary's FMFIA annual report to the President and the Congress on the status of internal controls.

During this fiscal year, OIG assisted in the development of the Department's FMFIA strategy for FY 1991; continued to focus the attention of managers and the Management Oversight Council on segmentation; evaluated selected Section 4 reviews; performed tests of internal controls and selected internal control reviews completed by managers; and identified material internal control weaknesses within the operating divisions and one departmentwide.

Internal Control Weakness

- As a result of the previously identified material internal control weakness in departmental headquarters' time and attendance practices (discussed in the Spring 1991 Semiannual Report), OIG expanded its time and attendance review to include regional office operations. The OIG found that supervisors failed to implement essential time and attendance procedures in a majority of the regions, leaving the system vulnerable to employee fraud and abuse. The OIG believes that the pervasiveness and gravity of these problems underline the need for the Department to report and correct the previously identified material weakness in the time and attendance system. (CIN: A-01-90-02511) (See page 4)

Governmentwide Implementation of FMFIA

In support of the President's Management by Objective program, PCIE surveyed the implementation of FMFIA at selected agencies. The HHS OIG was asked to gather data on techniques used by agencies in fulfilling FMFIA requirements. The survey results from 20 agencies indicated that there are significant differences in how agencies have implemented the law. Several "recommended practices" seemed to be effective. These included: using active steering committees in conjunction with management oversight councils to plan, direct and assess the program; providing training to managers to emphasize the importance of the program; increasing the focus on program areas; and analyzing pervasive weaknesses to identify agencywide or Governmentwide problems. While all participants in the survey used some of the techniques, OIG concluded that the program would be enhanced if the practices were implemented throughout the Government. (CIN: A-12-90-00024)

Internal Control Reviews of Time and Attendance Practices

The OIG reviewed the effectiveness of selected internal control reviews (ICRs) of the time and attendance function. The ICRs were prepared under the provisions of FMFIA to

strengthen controls and reduce the risk of fraud, waste and abuse in the payroll process. The OIG believes that the Department's ICR program has not been totally effective in identifying and correcting time and attendance weaknesses. In a significant number of offices included in its review, OIG found that time and attendance ICRs had not been performed; those ICRs which were completed were not thorough in the testing of key controls; and corrective actions for identified weaknesses were not timely or effective.

The OIG recommended that the Assistant Secretary for Management and Budget coordinate with the Assistant Secretary for Personnel Administration (ASPER) to ensure the performance and accuracy of time and attendance ICRs, and the timeliness and effectiveness of corrective actions. (CIN: A-12-90-00048)

Time and Attendance Practices in Regional Offices

In reviews of the regional offices' time and attendance recording and reporting practices, OIG identified 16 types of internal control weaknesses which were prevalent in a majority of the regions. Overall, OIG found that timekeepers had not followed procedures and supervisors were not enforcing basic internal control procedures. As a result, the time and attendance system was vulnerable to fraud and abuse by employees. The OIG recommended that ASPER coordinate with regional directors to improve enforcement of supervisory controls and ensure the integrity of the time and attendance system. In response to OIG reports issued within each region and to ASPER, corrective actions were accomplished or are underway. The ASPER is monitoring adherence to essential time and attendance controls through improved internal control reviews. (CIN: A-01-90-02511)

The Chief Financial Officers Act of 1990

The passage of the Chief Financial Officers (CFO) Act of 1990 set before OIG a large complement of interrelated responsibilities. To conform with the requirements of the Act, OIG will expand its financial statement audit activity. Approximately 60 HHS trust funds, revolving funds and commercial activities fall under the Act. For FY 1991, OIG is conducting financial statement audits of 50 funds comprising 8 reporting entities, including the Social Security Administration, Medicare, and 4 divisions of the Public Health Service: the National Institutes of Health, the Food and Drug Administration, the Indian Health Service and the Health Resources and Services Administration.

The OIG will be very involved with all the CFO's efforts to improve financial management. For years OIG has recommended many of the changes mandated by the Act: improving internal controls; working towards more uniform departmental accounting systems; establishing systems to produce information needed for financial managers; and interrelating FMFIA activities with financial statement preparation. The OIG will also be assisting the Department in attaining other objectives contained in the 5-year financial management plan required by the Act.

Resolving OIG Recommendations

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

A. Questioned Costs

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

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

	Number	Dollar Value (in thousands)	
		Questioned	Unsupported
A. For which no management decision had been made by the commencement of the reporting period[1]	257	$257,617	$35,460
B. Which were issued during the reporting period	299	$242,029	$10,401
Subtotals (A + B)	556	$499,646	$45,861
Less:			
C. For which a management decision was made during the reporting period:	290	$141,494	$30,172
(i) *dollar value of disallowed costs*[2]		$103,807	$6,357
(ii) dollar value of costs not disallowed		$37,687	$23,815
D. For which no management decision had been made by the end of the reporting period	266	$358,152	$15,689
E. Reports for which no management decision was made within 6 months of issuance[3]	15	$130,082	$5,201

[1] The opening balance was adjusted to reflect a reclassification of recommendations in two reports and an upward reevaluation of recommendations in a number of reports, resulting in an upward reevaluation of total recommendations in the amount of $127.3 million.

[2] See detailed listing for both halves of FY 1991 beginning on page 6.

[3] Audits on which a management decision had not been made within 6 months of issuance of the report: resolution of CIN: A-07-90-00262, Review of Asset Reversions from Pension Plan Terminations Occurring after the Implementation of the Prospective Payment System ($92,000,000), and CIN: A-07-89-00134, Medicare Is Losing Millions of Dollars from Terminations of Pension Plans ($27,600,000), will be through the departmental conflict resolution process. 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 these audits, resolution of these outstanding recommendations is expected before the end of the next semiannual reporting period: CIN: A-02-91-14405 and CIN: A-02-91-14535, Bedford Stuyvesant Restoration Corporation ($1,009,868); CIN: A-03-90-00562, District of Columbia Independent Living Grant ($20,450 on Table I and $623,156 on Table II); CIN: A-03-90-06158, District of Columbia Energy Office ($944,811); CIN: A-03-91-14545, Commonwealth of Pennsylvania ($8,160,892), CIN: A-03-91-14988, Maryland Department of Health ($243,703); CIN: A-04-90-04009, Contract Closing - Lab Animal Breeding and Services ($23,444 on Table I and $224,668 on Table II); CIN: A-05-90-05561, Mille Lacs Band of Chippewa Indians ($1,442); CIN: A-09-91-05149, Arizona Department of Economic Security ($1,528). The following audits were outstanding as of September 30, 1991, but have been cleared subsequently: CIN: A-06-90-00079, Office of Community Services Grant 88-1-FN-TX-044 ($37,641); CIN: A-09-90-00118, Office of Community Services Grant 88-1-MS-CA-095 ($33,596); CIN: A-09-91-05128, Marshalls Community Action Agency ($1,836); CIN: A-09-91-05221, Walker River Paiute Tribe ($2,500).

B. Disallowances from OIG Questioned Costs

The following schedule represents significant examples of the dollar amounts identified for recoupment during FY 1991 as a result of management decisions in favor of audit and inspection findings and recommendations. Disallowances for the year totaled $445.5 million and were comprised of OIG audit and inspection disallowances of $383.7 million and Health Care Financing Administration (HCFA) program disallowances of $61.8 million.

Audit and Inspection Disallowances

- Unallowable administrative costs claimed under the New York City Department of Social Services Aid to Families with Dependent Children and Foster Care programs (CIN: A-02-87-02016) $92,115,299
- Improper Medicare payments for nonphysician outpatient services under the prospective payment system (CIN: A-01-90-00516) 45,637,765
- Disallowance of Medicaid expenditures for the maintenance of a bad debt and charity care pool (CIN: A-02-90-07542) 23,060,265
- Improper payments for outpatient services claimed by the Illinois Department of Public Aid (CIN: A-05-89-00101) 21,902,471
- Overcharge of Federal Government pension costs by West Virginia (CIN: A-03-90-00453) 19,724,786
- Refund of medical assistance payments made by the New York State Department of Social Services for clients between the ages of 21 and 64 at area hospitals (CIN: A-02-90-01006) 17,762,539
- Restoration of the Federal equity in the Alabama self-insurance fund (CIN: A-04-90-00018) 13,780,619
- Unallowable interest expenses applicable to capital lease agreements in New York (CIN: A-02-88-02018) 11,886,973
- Medicaid overpayments to community hospitals in California (CIN: A-09-89-00165) 11,183,898
- Improper claim of Medicare hospital patient transfers reported as hospital discharges (CIN: A-06-89-00021) 8,400,000
- Reimbursement of questioned costs by the Virginia Department of Social Services (CIN: A-03-91-14630) 8,197,641
- Ineligible foster care maintenance payments to the District of Columbia (CIN: A-03-88-00551) 5,888,086
- Single audit disclosed unallowable charges to HHS programs by California (CIN: A-09-91-05007) 5,129,154
- Single audit disclosed unallowable charges to HHS programs in New Jersey (CIN: A-02-90-07553) 5,061,597

Audit and Inspection Disallowances (continued)

- Refund of Medicare's share of the total pension asset reversion in Illinois (CIN: A-07-90-00306) $4,796,847
- Disallowance of costs claimed under the Medicaid program for services provided to recipients residing at South Mountain Restoration Center (CIN: A-03-89-00153) 4,097,991
- Unallowable costs for social services under title IV-E by the Michigan Department of Social Services (CIN: A-05-90-00132) 3,947,232
- Single audit disclosed unallowable charges to HHS programs in Tennessee (CIN: A-04-90-05173) 3,778,751
- Reimbursement of Medicare's share of the total pension asset reversion in Minnesota (CIN: A-07-90-00263) 3,650,000
- Reimbursement for payments in excess of the Health Care Financing Administration's (HCFA's) aggregate upper limit for claims not coded as "brand medically necessary" (CIN: A-03-89-00233) 3,152,092
- Refund of medical assistance payments made by the New York State Department of Social Services for outpatient mental health services claimed by area medical centers (CIN: A-02-89-01025) 3,131,180
- Reimbursement for personal ueeds funds recovered from deceased Medicaid recipients with no next of kin and transferred to the State's general revenue account (CIN: A-01-89-00006) 2,761,798
- Single audit disclosed unallowable charges to HHS programs by Pennsylvania (CIN: A-03-91-14545) 2,676,367
- Credit due the Federal Government for its share of identified overpayments not previously credited on the HCFA-64 reports (CIN: A-03-90-00228) 2,647,556
- Improper claim of capital lease payments for Federal financial participation by the Michigan Department of Social Services (CIN: A-05-90-00095) 2,482,414
- Disallowance of claimed costs of a Head Start grantee (CIN: A-02-86-65035) 2,443,001
- Disallowance of administrative and termination costs incurred under Part B of the Health Insurance of the Aged and Disabled program in New York (CIN: A-02-89-01028) 1,790,147
- Single audit disclosed unallowable charges to HHS programs by the District of Columbia Department of Human Services (CIN: A-03-90-06151) 1,618,542
- Reimbursement for the Federal share of the proceeds from the sale of Office of Community Services discretionary grant project property (CIN: A-06-90-00052) 1,590,600
- Overpayments to independent dialysis facilities under Medicare's end stage renal disease (ESRD) program (CIN: A-03-90-02002) 1,500,000
- Disallowance of Federal financial participation claimed by a State agency for services provided to ineligible recipients (CIN: A-05-91-00003) 1,319,733

Audit and Inspection Disallowances (continued)

- Improper payments for services related to family planning by the New York Medicaid program (CIN: A-02-90-01011) $1,158,375
- Refund of questioned costs in unobligated fund balances and request that appropriate action be taken to protect the Federal interest in remaining assets (CIN: A-07-91-14802) 1,126,072
- Refund of financial adjustments for expired checks for which Federal programs had not received credit (CIN: A-02-87-02015) 1,122,479
- Disallowance of improperly claimed administrative costs incurred under Part A and Part B of the Health Insurance for the Aged and Disabled program (CIN: A-05-90-00013) 1,101,549
- Improper Medicaid cost claims for services provided by an Indiana hospital (CIN: A-05-89-00091) 1,019,701
- Refund of Federal share of an overcharge to users of data processing services during FYs 1984 through 1988 (CIN: A-08-90-00261) 1,011,166
- Disallowance of admiuistrative costs claimed under Part A and Part B of the Health Insurance for the Aged and Disabled program in San Francisco (CIN: A-09-90-00149) 1,006,515
- Improper Medicaid payments for less than effective (LTE) drugs to the California Department of Health Services (CIN: A-03-89-00228) ..... .962,691
- Disallowance of admiuistrative costs claimed under Part B of the Health Insurance for the Aged and Disabled program by Pennsylvania Blue Shield (CIN: A-03-89-02005) ..... .880,846
- Overpayments for separately billable blood and drugs uuder Medicare's ESRD program (CIN: A-02-91-01003) ..... .829,551
- Overclaim of title IV-E Foster Care program funds (CIN: A-05-90-00071) ..... .828,883
- Reimbursement of unallowable indirect medical education costs (CIN: A-01-90-00513) ..... .785,073
- Refund of Federal share of funds from the sale of the Blue Cross of California principal corporate office building (CIN: A-09-90-00069) ..... .717,305
- Improper Medicaid payments for LTE drugs to the Georgia Department of Medical Assistance (CIN: A-03-89-00225) ..... .716,705
- Reimbursement of Federal share of surplus in internal service funds and unallowable interest included in operating expenses of the internal service funds (CIN: A-05-90-00126) ..... .701,000
- Single audit disclosed unallowable charges to HHS programs by the Narragausett Indian Tribe (CIN: A-01-90-05013) ..... .671,332
- Unallowable administrative costs incurred under Part B of the Health Insurance for the Aged and Disabled program (CIN: A-09-90-00085) ..... .647,364
- Improper Medicaid payments for LTE drugs by the New York State Department of Social Services (CIN: A-03-89-00229) ..... .647,081
- Reimbursement of fringe benefit costs improperly charged to the Child Welfare Services program (CIN: A-09-90-07640) ..... .645,988

Audit and Inspection Disallowances (continued)

- Refund of incorrect payments to hospital-based ESRD facilities and physicians for the cost of ESRD drugs, and to hospital-based facilities for the cost of administering those drngs (CIN: A-06-90-00015) $632,607
- Overcharge of FICA taxes by the Oklahoma Office of State Finance (CIN: A-06-90-00041) 606,310
- Refund of payments for Medicaid patients improperly billed to Medicare (CIN: A-01-90-05018) 600,000
- Single andit disclosed unallowable charges to HHS programs in Maine (CIN: A-01-91-05001) 554,790
- Refund of grant funds from the Harlem Commonwealth Council, Inc. (CIN: A-02-91-14845) 551,845
- Single audit disclosed unallowable charges to HHS programs in Kansas (CIN: A-07-90-06860) 542,874
- Overpayments to independent ESRD facilities for nonroutine drug and blood claims by Blue Cross and Blue Shield of Maryland (CIN: A-14-90-00212) 540,057
- Disallowance of administrative costs incurred under the Medicare program by Blue Cross and Blue Shield of Texas (CIN: A-06-90-00068) 537,004
- Disallowance of an intermediary's claim of nonroutine services under Medicare's ESRD program (CIN: A-05-90-00111) 517,474
- Reimbursement of payments for ESRD separately billable drugs and blood-related services that did not meet HCFA guidelines (CIN: A-04-90-01012) 461,935
- Overpayment for potential acuity meter tests improperly billed as visually evoked potential response studies (CIN: A-04-90-02017) 456,527
- Overpayments to independent ESRD facilities for separately billable injectable drugs and blood aud blood-related services (CIN: A-04-90-01011) 424,340
- Single audit disclosed improper charges to HHS programs in New Jersey (CIN: A-02-91-14690) 415,787
- Refund of misappropriated Federal funds from a nonprofit educational institution (CIN: A-09-90-00143) 410,624
- Refund of medical assistance payments made by the New York State Department of Social Services for clients under the age of 65 at area psychiatric hospitals (CIN: A-02-89-01031) 399,404
- Overclaim of employee health insurance costs by Blue Cross and Blue Shield of Kansas (CIN: A-07-90-00331) 395,180
- Refund of improperly claimed costs to the Foster Care program (CIN: A-07-90-00336) 362,427
- Overpayment for services from the American Social Health Association (CIN: A-04-90-04020) 359,984

Audit and Inspection Disallowances (continued)

- Overpayments to a Medicare carrier for duplicate anesthesia payments (CIN: A-02-91-01013) $333,199
- Disallowauce of improper claim for Federal financial participation for services provided by a Pennsylvania State hospital (CIN: A-03-89-00152) 310,879
- Refund of Federal institution for mental diseases funds claimed for patients under 65 in a Washington State mental institution (CIN: A-10-89-00166) 303,528
- Improper Medicaid payments for services to the mentally retarded by the Minnesota Department of Human Services (CIN: A-05-90-00036) 285,401
- Disallowance of administrative costs claimed under Part A of the Health Insurance for the Aged and Disabled program by Blue Cross of Greater Pennsylvania (CIN: A-03-89-02004) 267,732
- Single audit disclosed unallowable charges to HHS programs in New Jersey (CIN: A-02-90-07555) 262,883
- Refund of Federal share of overcharges iucluding related indirect costs and interest for payments to overfunded pension plan (CIN: A-08-90-14066) 260,221
- Overpayments to independent ESRD facilities for injectable drugs and blood services under Medicare's ESRD program (CIN: A-03-90-02001) 257,009
- Disallowance of administrative costs incurred under Part B of the Health Insurance for the Aged and Disabled program (CIN: A-09-91-00053) 237,564
- Reimbursement for interest expense improperly charged to Federal programs for capital leases (CIN: A-06-90-00099) 232,168
- Refund of interest expense from a Public Health Service (PHS) grantee (CIN: A-03-91-14381) 228,546
- Single audit disclosed unallowable charges to HHS programs by Massachusetts (CIN: A-01-91-05003) 227,090
- Improperly claimed abortion and abortion-related costs under the New Jersey Medicaid program (CIN: A-02-88-01016) 221,094
- Audit of the Bronx Ambulatory Care Network, Inc. disclosed unallowable charges (CIN: A-02-90-06282) 221,038
- Overclaim for training costs under the title IV-E Foster Care program (CIN: A-06-90-00091) 201,237
- Disallowance of interest earned on advances of Federal funds by a PHS grantee (CIN: A-02-90-06312) 199,525
- Reimbursement of excess funds claimed for Medicare ESRD program (CIN: A-05-90-00112) 198,798
- Disallowance of administrative costs claimed under Parts A and B of the Health Insurance for the Aged and Disabled program (CIN: A-02-89-01029) 196,826

Audit and Inspection Disallowances (continued)

- Audit of financial statement of an Indian Health Service (IHS) grantee identified questioned costs charged to PHS (CIN: A-09-91-05179) $185,599
- Overpayments to the Maine Department of Human Services (CIN: A-01-89-05082) 180,873
- Single audit disclosed unallowable charges to HHS programs in North Carolina (CIN: A-04-91-05002) 180,497
- Overpayments for independent dialysis facilities in Alabama (CIN: A-04-90-01010) 178,117
- An IHS grantee charged excess costs to PHS (CIN: A-09-91-05034) 162,866
- Disallowance of Federal financial participation for Nebraska Medicaid case management services (CIN: A-07-91-00397) 155,660
- Return of funds from the sale of a grant investment and the interest accrued on the account (CIN: A-07-90-14075) 151,829
- Refund of unallowable FICA sick pay by the State of Texas (CIN: A-06-91-00002) 145,389
- Reimbursement for ineligible Medicare bad debt allowauce payments (CIN: A-03-90-00056) 144,724
- Single audit disclosed unallowable charges to HHS programs by Massachusetts (CIN: A-01-89-05031) 143,225
- Reimbursement for duplicate advance by the Pouca Tribe of Oklahoma (CIN: A-06-90-06254) 140,671
- Refund of provider overpayments (CIN: A-08-91-14225) 131,090
- Improperly claimed pass-through costs by a Peuusylvauia hospital (CIN: A-03-90-00055) 114,400
- Reimbursement of allowable costs in the Arapahoe County, Colorado's Central Service cost allocation plan (CIN: A-08-90-14091) 114,168
- Refund for fringe benefit expeuses claimed by the Long Island Jewish Medical Center (CIN: A-02-90-02510) 113,925
- Disallowance of overstated costs in the Medicare complementary credit program (CIN: A-07-90-00330) 109,173
- Disallowance of costs of Head Start grantee (CIN: A-02-88-05285) 108,320
- Improperly claimed administrative costs by a Medicare carrier (CIN: A-04-91-02007) 106,934
- Reimbursement for overpayments for blood, blood-related services and separately billable drugs for ESRD program patients accordiug to HCFA guidelines (CIN: A-04-90-01013) 102,895
- Disallowance of questioned costs claimed under an AIDS research grant (CIN: A-03-90-03328) 102,321
- Refund of unallowable interest expenses for capital leases by the Louisiana Department of Health and Human Resources (CIN: A-06-90-00102) 100,044

Disallowances under $100,000 ..... $13,928,429

TOTAL DISALLOWANCES $383,710,076

HCFA Program Disallowances

- Overpayments to carriers $14,300,000
- Direct services reimbursed as administrative expenditures 10,600,000
- Services provided to patients under Medicaid in institutions for mental diseases 10,100,000
- Invalid provider agreements 10,000,000
- Medicaid payments exceeded State plan for disproportionate share payment 3,700,000
- Office billing cost allocation 2,600,000
- State Medicaid agency claimed ineligible training costs 2,200,000
- Part B deductible and coinsurance amounts not covered in Medicaid State plan 2,200,000
- Administrative rates incorrectly computed and the number of Medicaid days overstated 1,500,000
- Failure to reduce Medicaid expenditures by available credits 1,200,000
- Nonemergency costs charged as medical assistance rather than as administrative expenses 1,000,000
- State Medicaid claim for ineligible State/local administrative expenditures ..... .800,000
- Medicaid management information system (MMIS) change orders not approved ..... .800,000
- Unallowable drug utilization contract and MMIS change order payments ..... .700,000

Disallowances under $100,000 ..... .$100,000

TOTAL HCFA PROGRAM DISALLOWANCES $61,800,000

C. Funds Put to Better Use

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

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

	Number	Dollar Value (in thousands)
A. For which no management decision had been made by the commencement of the reporting period[1]	68	$636,246
B. Which were issued during the reporting period	53	$7,341,179
Subtotals (A + B)	121	$7,977,425
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	28	$586,976
(b) based on proposed legislative action[2]	1	$637,000
Subtotals (a+b)	29	$1,223,976
(ii) dollar value of recommendations that were not agreed to by management	21	$72,470
Subtotals (i + ii)	50	$1,296,446
D. For which no management decision had been made by the end of the reporting period[3]	71	$6,680,979
E. *Prior decisions implemented in the period (See Appendix A)*[4]		
(i) based on management action	12	$779,900
(ii) based on legislative action	7	$2,877,300

[1] The opening balance was adjusted to reflect a downward reevaluation of recommendations in the amount of $1,155.2 million.

[2] The OIG has reported as "management decisions made during the period" those line items in the President's FY 1992 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 2 reports. The Health Care Financing Administration has taken no action on OAI-01-86-01330, Organ Acquisition Costs ($4,000,000); however, a new report will be issued during the next semiannual reporting period which will supersede this report. Resolution of CIN: A-09-90-07111, Yomba Shoshone Tribe ($12,832) is delayed pending ongoing actions by the Internal Revenue Service. Additionally, two reports detailed in the footnote to Table I had unresolved funds put to better use recommendations totaling $847,824.

[4] The OIG reports implemented savings on line E of its Table II which includes management and congressional actions. Management reports final action on line C of its table when management has taken all actions deemed necessary and within its authority to implement the OIG recommendation. Implemented savings reported by OIG are based upon completion of both management's final action and congressional action in the case of recommendations implemented through legislation.

Legislative and Regulatory Review

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. In carrying out its responsibilities under Section 4(a), OIG reviewed 146 of the Department's regulations under development and 257 legislative proposals during this reporting period.

In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigative 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.

The OIG also develops regulations for civil monetary penalty (CMP) and exclusion authorities which the Inspector General administers. During the reporting period, the following regulations were published:

National Practitioner Data Bank

The Health Care Quality Improvement Act of 1986 established specific requirements for the reporting and disclosure of information concerning payments made as a result of medical malpractice actions, claims and adverse actions revoking the licenses and clinical privileges of physicians and dentists. The Act required the Secretary to establish a National Practitioner Data Bank to collect required information and, upon request, disclose it to hospitals, other health care entities, State licensing boards and professional societies. The Act also established new CMP authorities for the failure to report medical malpractice payments to the National Practitioner Data Bank, and for improper disclosure of information reported or furnished pursuant to the Act. The OIG final CMP rule, a companion to PHS final rules previously published, was published in June.

Health Maintenance Organizations

Prior to 1986, the only recourse available to the Department for abuses committed by health maintenance organizations (HMOs), competitive medical plans, health insuring organizations or other organizations contracted to provide health care items or services to Medicare beneficiaries or Medicaid recipients, was to initiate contract termination proceedings. Public Law 99-509 extended the Secretary's authority to impose intermediate sanctions and levy CMPs against contracting organizations that substantially fail to provide Medicare or Medicaid enrollees with required medically necessary items or services; engage in certain marketing, enrollment, reporting, claims payment, employment or contracting abuses; or directly or indirectly employ or contract with any individual or entity excluded from participation in Medicare or Medicaid for the provision of health care, utilization review, medical social work or administrative services. The notice of proposed rulemaking was published in July as a joint OIG/HCFA proposed rule.

Safe Harbors

Section 1128B(b) of the Social Security Act provides criminal penalties for individuals and entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce business reimbursed under the Medicare or State health care programs. Since the statute is so broad, Public Law 100-93 required the Department to publish regulations outlining various payment or business practices (safe harbors) which would not be considered kickbacks for purposes of criminal or civil remedies. The final anti-kickback safe harbor regulations were published in July. A public briefing on these final regulations was held in August.

Misuse of Certain Terms and Symbols

In recent years, the Department received numerous complaints regarding mail solicitations and advertising claims that made use of certain program terms, acronyms or agency symbols. The symbols and wording were used in such a way as to mislead or falsely represent the fact that the items being offered were approved or endorsed by the Department, the Social Security Administration (SSA) or HCFA. The Congress addressed these concerns by giving HHS new statutory authority through Public Law 100-360, section 428(a), to impose CMPs for such violations. The OIG final rule was published in August.

Governmental Accounting

Each year, State and local government entities receive over $100 billion in Federal grant funds. It is estimated that Federal agencies pay at least $6 billion for administrative costs of State and local governments. As part of its Governmentwide cognizance responsibilities as defined in OMB Circular A-87 to ensure that administrative costs are being charged in accordance with the appropriate Statewide cost allocation plan, OIG has continued its efforts to identify cost containment areas and/or areas where costs are being inappropriately charged.

A. Excess Reserves in Pension Trust Funds

Under the County Employees Retirement Law of 1937, California counties are required to establish reserves to protect pension trust funds against unexpected losses. These contingency reserves are to be funded by surplus investment earnings. The OMB Circular A-87 states that contributions to contingency reserves are not allowable for reimbursement for Federal programs.

An OIG review determined that 22 California counties improperly excluded $836.5 million in reserves for contingencies from the calculation of pension contribution rates. As a result, OIG estimates that about $67.4 million will be charged to Federal programs through excessive pension contribution rates. (CIN: A-09-90-00073)

B. Self-Insurance Funds: North Carolina

An OIG review disclosed that as of June 30, 1989, North Carolina had accumulated excess reserves of $49 million in its self-insurance funds, of which $5 million was directly related to overcharges to Federal programs. Of the excess reserves, $8.7 million was transferred out to other funds, $3.7 million in interest was lost on the transfers, and $36.6 million in premiums was charged in excess of claims and operating expenses.

The OMB Circular A-87 states that no provision for profit or other increment above cost is intended, and contributions to a contingency reserve or any similar provision for unforeseen events are unallowable. The OIG recommended that the State make financial adjustments totaling $5 million to the Federal Government, and ensure that charges to Federal programs are in accordance with OMB Circular A-87 and the statewide cost allocation plan agreement with the Department's Division of Cost Allocation. (CIN: A-04-90-00020)

C. Self Insurance Funds: Alabama

An OIG review of Alabama's self-insurance funds disclosed that they had accumulated an excess reserve balance of $81 million as of September 30, 1987, contrary to Federal cost principles. The OIG recommended that the State make a financial adjustment of $10 million for the Federal share of the excess reserve fund balance of $81 million. (CIN: A-04-90-00018)

Nonfederal Audits

The OIG has oversight responsibility for audits of certain Government grantees conducted by nonfederal auditors, principally public accounting firms and State audit organizations. The OMB Circulars A-87, A-88, A-110, A-128, and A-133 assign audit oversight responsibility to OIG for about 50 percent of all Federal funds (approximately $50 billion) awarded to State and local governments, hospitals, colleges and universities and nonprofit organizations. All but 3 of the 50 States receive more funds from HHS than from any other department. The OMB has assigned HHS audit cognizance of 23 State and 703 local governments. In addition, OIG is assigned cognizance at about 75 percent of all colleges and universities. The OIG analyzes audit reports for indicators of grantee noncompliance with Federal regulations, initiates conflict resolution procedures on reported recommendations, provides technical assistance and maintains a quality control review process to identify substandard audit work. The most recent guidance included in OMB Circular A-133 requires biennial reviews of nonprofit institutions, but encourages annual reviews.

A. Technical Assistance

The OIG has been very active in providing technical assistance to nonfederal auditors, the accounting profession and the grantees. Technical assistance is provided through a toll-free number on a daily basis. In addition, during the past 6 months, training has been provided to members of the American Institute of Certified Public Accountants (AICPA), the National

Association of College and University Business Officers, State Societies of certified public accountants, the Association of Government Accountants, the Society of Research Administrators, the National Education Institute, State auditor staff, the President's Council on Management Improvement, grantee groups and departmental officials.

To assist in ensuring that adequate accounting and auditing guidance is available to auditors and others, OIG evaluates and provides suggested improvements to draft guidance. During the past 6 months, comments and suggestions have been provided on guidance developed by AICPA, OMB, PCIE and the Financial Accounting Standards Board.

B. Quality Control

To ensure that all audits meet generally accepted Government auditing standards, uniform procedures are used to review nonfederal audit reports. During this reporting period, OIG reviewed and processed 1,636 nonfederal audit reports. The reports also identified many opportunities for improving management operations. The following table summarizes those results:

Reports issued without changes or with minor changes	1,212
Reports issued with major changes	374
Reports with significant inadequacies	50
Total audit reports processed	1,636

During the review period, nine audits were referred to State officials and professional organizations for appropriate action. Several other referrals are pending. The OIG referrals of inadequate audit work result in significant disciplinary action against the accounting firms involved.

C. Analysis of Reports

Of the 1,636 audit reports discussed above, recommendations for improving management operations for cost recoveries totaling $68.7 million were identified for resolution within HHS. In addition, areas were identified for follow-up by OIG auditors.

To more efficiently accomplish its nonfederal responsibility, OIG is in the process of consolidating the function in Kansas City, Missouri. Currently, 6 of the 8 regions are part of the consolidated unit, with the remaining regions planned for consolidation by the end of the calendar year.

Audit Assistance to Small Federal Agencies

Until the Inspector General Act Amendments of 1988 (Public Law 100-504) created "mini-Inspectors General" for 33 designated entities, small Federal agencies typically did not have Inspectors General. Even after the 1988 amendments, some small agencies did not have audit capability. Recognizing the vulnerability of these circumstances, OMB required these agencies to obtain audit coverage from existing Inspectors General or certified public accountants under the provisions of OMB Circular A-73, "Audit of Federal Operations and Programs."

A. National Mediation Board

The OIG conducted a follow-up audit to the June 1989 report on the financial operations of the National Mediation Board (NMB). The audit included an assessment of the effectiveness of the NMB's FMFIA program in preventing waste, fraud and abuse. The review disclosed that four of the five minor weaknesses previously reported had been corrected. However, OIG noted the need to improve depreciation practices for capital assets. In addition, OIG identified an opportunity to improve operations through updating the NMB accounting manual; proposed that NMB take better advantage of FMFIA through expanded segmentation of operations and better documentation of internal control reviews; and recommended additional training for the NMB staff in implementing the FMFIA program. (CIN: A-12-91-00001)

B. Postal Rate Commission

During this small agency review, OIG assessed internal controls and compliance with regulations related to time and attendance recording and reporting at the Postal Rate Commission (PRC). Based on a sample of time and attendance records and interviews with various timekeepers and supervisors, PRC was found to be in substantial compliance with regulations. However, OIG noted that improvements in internal controls regarding separation of duties and periodic reconciliations of time and attendance documentation would reduce the potential for fraud or abuse. (CIN: A-12-91-00013)

Controls over Obligations for Advisory and Assistance Services

The law directs the Inspector General to submit to the Congress an annual evaluation of the Department's progress in improving the accuracy and completeness of the information on advisory and assistance services (AAS) provided to the Federal Procurement Data System (FPDS), and establishing effective management controls over contracted AAS. This year's review concentrated on PHS, but included some issues of departmentwide concern. The OIG concluded that the Department is reporting inaccurate and incomplete data on PHS' AAS obligations to FPDS and the Congress. In addition, without an effective centralized accounting or management information system in place to monitor and control AAS spending, neither the Department nor PHS can ensure that all AAS expenditures are being reported against the congressional AAS spending limitations. The OIG made a number of

recommendations. Among them were proposals that the Department reemphasize that all evaluation projects are AAS, and establish a centralized accounting or management information system to control AAS spending. (CIN: A-15-91-00022)

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:

- A former PHS employee was sentenced to 10 months imprisonment, followed by 2 years supervised release, for conspiracy and bribery. While a regional director of health services delivery, he helped a community health center prepare an application for a PHS grant and promised to use his position to assure selection of the center. He used inside information to help the center mount a negative advertising campaign against competitors. He also advised the center to set up a not-for-profit organization to apply for the grant while concealing the organization's shared directorship. A broker for several group health plans was given the same sentence for his part in the conspiracy. No money was involved since the contract with the center was never approved. (3-88-00046-4

- A former claims representative with SSA in Arkansas was sentenced to 6 months in prison and 6 months home detention for theft of Government property. She diverted 27 Supplemental Security Income checks totaling $20,200 to the address of the car wash she owned. Her crime was discovered while she was on vacation and a claimant called the Social Security office about benefits not received. (6-90-00558-6

- A former imprest fund clerk in the Minneapolis office of the Food and Drug Administration (FDA) was sentenced to 3 years probation for embezzlement. After taking an overage from the fund, she used unpaid vouchers to cover the theft and to replenish the fund. She was ordered to make restitution of $2,700. (5-89-00402-4

- A former SSA claims representative in California was convicted and sentenced for using a false Social Security number (SSN) to obtain a driver's license. While employed by SSA, she issued herself an SSN under another name with which she applied for credit at a used car dealership as well as a driver's license. She was sentenced to 5 days in county jail and 3 years probation, and ordered to pay a $735 fine. (9-90-04158-6

Investigative Prosecutions and Receivables

During this semiannual reporting period, OIG investigations resulted in 614 convictions. Also during this period, 1,050 cases were presented for prosecution to the Department of Justice and, in some instances, to nonfederal prosecutors. New criminal charges were brought by prosecutors in 945 cases.

In addition to terms of imprisonment and probation imposed in the judicial processes, more than $41.5 million was ordered or returned as a result of OIG investigations. Total fines, savings, restitutions, settlements and recoveries accruing from judicial or administrative processes resulting from OIG investigative findings for FY 1991 amounted to over $87.1 million. The following table represents details of these returns, including both actual and ordered recoupments for the Treasury of the United States, the Social Security and Medicare trust funds, and departmental programs victimized by fraud and abuse.

Recoveries and Criminal Fines and Restitutions

- Generic drug company made false statements, obstructed Federal investigation (W-89-00044-3) $10,242,840
- California durable medical equipment (DME) supplier illegally billed Medicare and Medi-Cal for transcutaneous electrical nerve stimulation (TENS) units and incontinence supplies (9-88-01154-9) 3,813,260
- Arizona hospitals paid kickbacks as helicopter set-down fees and billed Medicare (9-89-00803-3) 2,382,570
- Florida peer review organization authorized Medicare payments to hospitals for cases it had not reviewed (4-88-00956-9) 1,904,000
- New York medical school official and friends embezzled grant funds (2-90-00779-4) 1,705,500
- Alabama Medicare carrier made clerical errors in cost reports (4-89-00094-9) 1,554,270
- New York DME company overbilled Medicare (2-86-00442-9) 1,369,000
- Administrator kept Medicare check carrier erroneously issued to Texas hospital (6-90-20243-9) 1,081,209*
- Generic drug company paid gratuities to FDA employee (W-88-00110-3) 1,025,850
- Michigan DME company billed Medicare for items not medically necessary for beneficiaries' condition (5-89-00581-9) 662,900
- Florida chiropractor and wife falsely billed Medicare for vascular tests as ordered by a medical doctor 638,000
- Minnesota company billed Medicare for life support transportation when it performed wheelchair transportation (5-89-00106-9) 621,200
- Texas hospital was overpaid Medicare funds throngh electronic keying error (6-90-00379-9) 617,000
- Ohio man used paper ambulauce company to bill Medicare for van trips (5-88-00113-9 ... 544,320
- Owners of Pennsylvania ambulance service inflated mileage and falsified records (3-88-00914-9) 500,100

**Also includes judgment amount*

Recoveries and Criminal Fines and Restitutions (continued)

- Union officials embezzled Philadelphia hospital funds that included Medicare and Department block grants (3-88-00001-9) $380,590
- Florida HMO official used Medicare fnnds to pay defense lawyer in fraud case (4-86-00002-9) 355,030
- Virginia psychiatrist billed Medicare for honr sessions that lasted 15 minutes (3-87-00084-9) 277,150
- Maine contractors were paid for weatherization work not done (1-86-00069-2) 255,170
- Hnsband and wife owners of Georgia ambulance service billed Medicare for town car trips to dialysis centers as emergency services (4-90-00324-9) 189,170
- Execntive director of Pennsylvania methadone clinic embezzled funds and threatened witness .(3-89-00367-4) 184,270
- Mississippi hospital purchasing agent paid contractor for non-delivered supplies (4-84-00460-4) 175,290
- Pennsylvania administrator embezzled money from HHS-funded hospital by paying "ghost" employees (3-88-00836-9) 162,800
- New York woman cashed deceased mother's benefit checks for 21 years (2-79-00807-6). 153,000
- Medical clinic employee in Wisconsin embezzled Medicare fnnds (5-90-00287-9) 148,290
- Michigan physician charged Medicare for excessive laboratory tests (5-90-00599-9) ... 137,590
- Florida physician prescribed TENS units that were not medically necessary, falsified tests 136,940 (4-88-00648-9
- Nevada anesthesiologist billed Medicare for more time units than documented (9-90-00685-9) 130,050
- New York crime figure engaged in extortion while receiving disability benefits (2-86-00450-6) 128,180
- Missouri physician npgraded services on claims submitted to Medicare (8-90-00568-9) 123,670
- Florida man concealed work to obtain disability benefits (4-87-01414-6) 119,450
- Texas day care center enrolled ineligible children to obtain title XX funds (6-88-30290-9. 119,360
- North Carolina man concealed work to obtain disability benefits (4-89-00207-6) 113,900
- Pennsylvania man concealed work to get disability benefits (3-86-00611-6) 112,600
- Michigan physician distribnted drugs paid for by Medicare (5-89-00524-9) 110,000
- Missouri DME snpplier submitted Medicare claims for purchase of previously rented equipment as new .(8-86-00633-9) 110,000
- New York policeman concealed work while receiving disability benefits (2-89-00674-6) 109,430
- Texas DME company billed Medicare for separate parts of ostomy kits (6-89-00637-9) 107,970
- California man lied about birth date to obtain retirement benefits (9-87-04741-6) 105,720
- Georgia man concealed work to obtain disability benefits (4-91-00009-6) 100,000

Civil Judgments and Settlements

- New York home health agency falsified personnel files (2-89-30619-9) $4,750,000
- California hospital employees upgraded Medicare billing codes (7-90-20402-9) 3,708,900
- Massachusetts billing service billed Medicare for claims already reimbursed to eye clinic 3,025,780 (1-89-20152-9)
- California owner of DME companies billed Medi-Cal for supplies not provided (9-90-30241-9) 2,954,000
- Georgia psychiatric hospital included nonallowable expenses in Medicare cost reports 2,709,970 (4-91-30010-9)
- California clinic and hospital chain billed Medicare for cardiovascular tests as hospital outpatient tests (9-88-24005-9) 1,531,630
- New York laboratory billed Medicare for tests performed by hospital technicians 1,078,000 (2-87-20572-9)
- Texas ophthalmologists billed Medicare for fragmented, nonmedically necessary and duplicate services (6-88-30290-9) ..... .630,000
- New York transportation company billed Medicare for ambulance services when it used ambulettes (2-86-20664-9) ..... .588,350
- Florida HMO ordered routine tests without documenting need (4-89-20003-9) ..... .476,540
- New York physician billed Medicare under brother's provider number (2-86-20472-9) ..... .469,520
- Texas anesthesiologist billed time double to Medicare (6-89-00673-9) ..... .435,630
- Owners of Pennsylvania mobile hearing testing service submitted Medicare claims for medically unnecessary tests (3-90-20719-9) ..... .425,000
- Pennsylvania hospital billed Medicare for duplicate claims, and educational costs as medical (3-87-20039-9) ..... .300,000
- New York ophthalmologist billed Medicare as primary surgeon for operations at which he only assisted (2-86-20489-9) ..... .300,000
- Massachusetts podiatrist billed Medicare and Medicaid for surgical procedures when he performed routine foot care (1-89-30192-9) ..... .259,955
- California ophthalmologist overcharged Medicare for laser eye surgery (9-88-20532-9) 250,000
- Texas anesthesiologist falsified Medicare claims for amount of anesthetist employees' time (6-87-30394-9) ..... .250,000
- Pennsylvania laboratory submitted Medicare claims for medically nnnecessary tests for attorneys to use in lawsuits (3-89-20622-9 ..... .245,000
- Massachusetts anesthesiologists billed Medicare separately for services included in surgery claims (1-88-30043-9) ..... .238,000
- Maryland surgeon billed Medicare separately for services already reimbursed as part of surgery (3-89-20471-9) ..... .200,000
- Department employee made payments to fictitious vendor (W-90-20075-5) ..... .195,850

Civil Judgments and Settlements (continued)

- Texas optometrist billed Medicare and Medicaid after being suspended from these programs (6-85-30740-9) $180,000
- Florida hospital turned away medically indigent and noninsured patients from emergency room (4-87-30502-9) 150,000
- Pennsylvania nursing home required "contributions" as condition for admission (3-87-20087-9) 150,000
- Radiologist and laboratory paid kickbacks to a Pennsylvania hospital (3-90-20643-9) 127,100
- Iowa psychiatric group routinely billed Medicare for 45-minute patient sessions which ran considerably less (5-88-30456-9) 125,000
- Missouri man concealed ownership of business to obtain disability benefits (8-88-00358-6) . 114,300
- Otolaryngologist group in Pennsylvania wrote orders for tests used to submit false Medicare claims (3-88-20127-9) 100,000
- Maryland company paid National Cancer Institute employee to obtain contracts 100,000

(W-90-20189-4)

Other receivables which did not meet the $100,000 threshold for individual reporting $28,365,971

Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act (PFCRA), passed in October 1986, established administrative penalties for anyone who makes a false claim or a written false statement to a Federal agency. It was loosely modeled after the CMP law for the Medicare and Medicaid programs, which OIG is responsible for enforcing. Under PFCRA, any person who makes a claim or statement to the Department knowing, or having reason to know, that it is false, fictitious or fraudulent may be held liable in an administrative proceeding for a penalty of up to $5,000 per claim or statement. In addition, that person may be subject to an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims or statements, and for reporting at the end of each fiscal year investigations completed under PFCRA and referred for administrative action.

During this reporting period, OIG entered its first settlement agreement under PFCRA. A dentist agreed to pay $22,765 plus interest for submitting claims to the Indian Health Service (IHS) in Oregon for stainless steel crowns when his charts clearly showed that plastic crowns were used. The crowns were all put on children, for whom the IHS dental program does not cover plastic crowns. The dentist was also excluded from participation in Medicare and State health programs for 3 years because his license was surrendered while a formal disciplinary hearing was pending before the State's licensing board. (X-88-80465-4)

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 the cases in which OIG participates result in monetary fines, recoveries, restitutions or savings for these agencies. During this period, the monies accruing from these cases amounted to more than $11 million for other public or private entities.

Successful Ombudsman Programs

Performance Indicator

The OIG issued three reports on the State Long Term Care Ombudsman Program. The program, which was established in response to growing concern over the poor quality of care in nursing homes, provides advocates for the institutionalized elderly. The OIG studies developed performance standards to rate each program, and identified twelve successful programs in which ombudsmen visit nursing homes frequently and resolve complaints expeditiously. The OIG recommended that AoA develop model operational guidelines for ombudsman programs, and a performance measurement system to compare State programs, measure progress and target technical assistance accordingly. (OEI-02-90-02120; OEI-02-90-02121; OEI-O2-90-02122)

AoA Discretionary Grants

Performance Indicator

The OIG evaluated the dissemination practices for discretionary fund projects supported by AoA. The OIG found that AoA primarily relies on its grantees, whose capabilities vary widely, to take the lead responsibility for dissemination of project results; the point value which AoA assigns to dissemination activities in evaluating grant applications has declined over the years; and despite AoA's expanded instructions to grantees regarding dissemination, there has been little observable difference in the quality of the dissemination plans submitted by grantees in the past two years as compared to previous years. The OIG also determined that AoA does not adequately assess project outcomes to determine the utility of the information to others and that AoA pursues a broad dissemination strategy with too limited resources.

The OIG recommended that AoA assure the establishment of and adequate funding for a permanent function responsible for dissemination of results of discretionary fund projects. Responsibilities should include: providing a focus for AoA's various dissemination activities; reconsidering the dissemination criterion and the point value assigned to it; establishing and maintaining a process to assess project outcomes for utility to others; developing methods to assist grantees who lack the resources and expertise to target replicable results to potential users; evaluating the role of clearinghouses in an overall dissemination strategy and using clearinghouses accordingly; and establishing and implementing a role for Federal regional offices on aging in disseminating project results.

The AoA has begun to address the issues and recommendations from the report. The 1992 discretionary grant program will include the award of a 3 year cooperative agreement to evaluate and disseminate title IV grant products. (OEI-04-91-00110)

HEALTH CARE FINANCING ADMINISTRATION

Chapter II

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and OIG Activities

In Fiscal Year (FY) 1991, the Medicare program will provide health care coverage for an estimated 34 million individuals. Medicare Part A (hospital insurance) provides, through direct payments for specified use, hospital insurance protection for covered services to persons 65 or older and to certain disabled persons. Financed by the Federal Hospital Insurance Trust Fund, FY 1991 expenditures for Medicare Part A are expected to exceed $68 billion.

Medicare Part B (supplementary medical insurance) provides, through direct payments for specified use, insurance protection against most of the costs of health care to persons 65 and older and certain disabled persons who elect this coverage. The services covered are medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services, and certain other medical and health services. Financed by participants and general revenues, FY 1991 expenditures for Medicare Part B are expected to be over $44 billion.

The Medicaid program provides grants to States for medical care for more than 27 million low-income people. Federal grants are estimated at $48 billion in FY 1991. Federal matching rates are determined on the basis of a formula that measures relative per capita income in each State. Eligibility for the Medicaid program is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). States may also cover certain individuals who are not eligible for SSI or AFDC. In recent years, significant changes in Medicaid have expanded eligibility and services for pregnant women and children, especially low-income women and children who, for various reasons, are ineligible for assistance under the AFDC program. The Omnibus Budget Reconciliation Act (OBRA) of 1990 includes a provision to phase in coverage of children through age 18 below 100 percent of the poverty level.

The Office of Inspector General (OIG) activities that pertain to the health insurance programs administered by the Health Care Financing Administration (HCFA) help ensure cost-effective health care, improve quality of care, and reduce the potential for fraud, waste and abuse. Through audits, evaluations and inspections, OIG recommends changes in

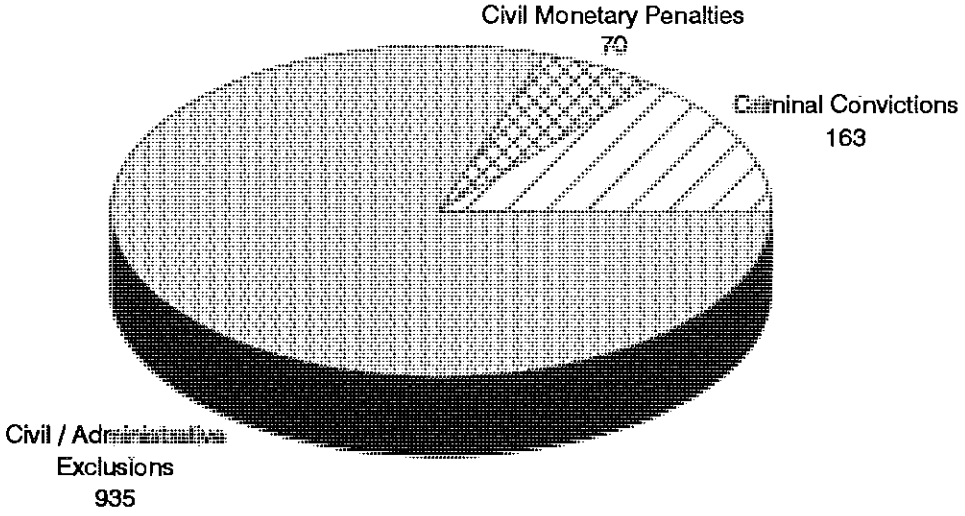
legislation, regulations and systems to improve inefficient health care delivery systems and reduce unnecessary expenses.

The OIG is focusing on several health care issues, including: the financial impact of the prospective payment system (PPS) on hospitals; the implementation of a PPS for reimbursing inpatient capital costs; Medicare as secondary payer; the cost implications of changes in health care technology and delivery; medical effectiveness; the implementation of physician payment reforms and the Clinical Laboratory Improvement Amendments of 1988; Medicare contractor operations; reimbursement for durable medical equipment (DME); and the auditing of financial statements. The OIG is also examining such Medicaid issues as access to care, coverage of the working poor and small businesses, and financing Medicaid cost increases.

The OIG's reviews assess the adequacy of internal controls, identify innovative cost containment techniques, probe for improper cost shifting and validate the adequacy of intermediary audits of hospitals' Medicare cost reports. The OIG also seeks to identify mechanisms to contain increasing Medicaid costs, including monitoring States' collection of overpayments and costs claimed for treating patients residing in institutions for mental diseases and facilities for the mentally retarded.

Fraud and abuse of the Medicare and Medicaid programs or their beneficiaries may result in criminal, civil and/or administrative actions against the perpetrators. During this fiscal year, OIG was responsible for a total of 1,168 successful actions against wrongdoers.

HEALTH CARE PROGRAMS
Successful Criminal, Civil and Administrative Litigations



Internal Control Weaknesses

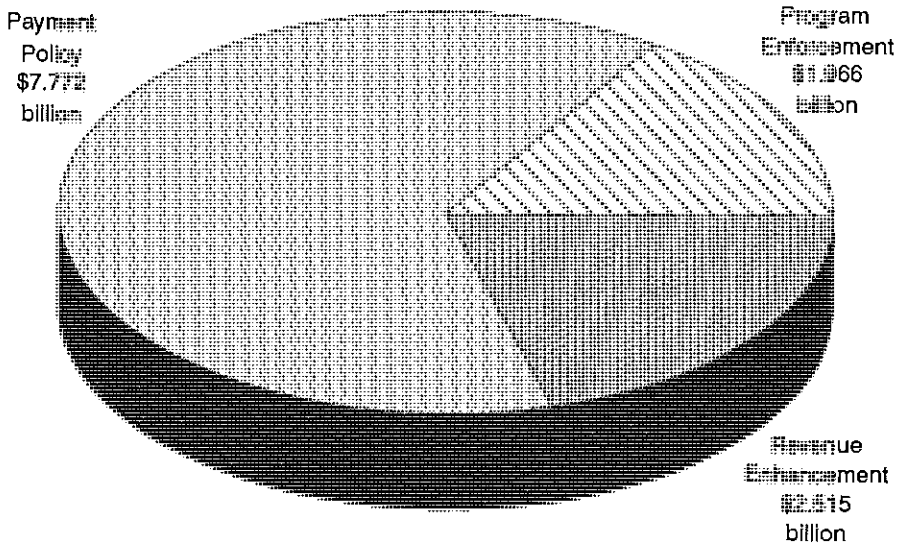
- The OIG found that overpayments were made to hospitals reimbursed under Medicare's PPS because patients were improperly reported as having been discharged when in fact they were transferred to another PPS hospital for further treatment. The HCFA intends to list this as a material weakness in the Secretary's FY 1991 Federal Managers' Financial Integrity Act (FMFIA) report. (CIN: A-06-89-00021) (See page 31)

- The OIG noted a material weakness due to HCFA's lack of adequate controls for separate billable drug and blood service claims paid by intermediaries. The OIG estimates that nationally, intermediaries overpaid about $17.2 million to independent dialysis facilities for these services between December 1987 and September 1989. (CIN: A-01-90-00502) (See page 47)

Solvency of the Medicare Trust Funds

The financial picture for the Medicare Parts A and B trust funds is very grim. According to Government actuarial projections, the Part A fund may very well be depleted within 15 years unless additional sources of revenue are found or major reductions are made in covered services or payments. Part B costs are expected to escalate dramatically, further straining the Federal budget and the finances of the aged and disabled. The OIG has long recognized the financial difficulties facing the Medicare trust funds, and accordingly, has made a number of recommendations to help shore up the funds. Over the last 5-year budget cycle, almost $28 billion in savings, settlements, fines, restitutions and receivables have resulted from OIG work. Medicare realized most of these savings. In addition, OBRA 1990 contains about $29 billion in 5-year Medicare savings that pertain to OIG recommendations. The OIG has made additional recommendations that include a variety of innovative approaches, from enhancing program revenues to establishing more equitable payment policies, to enforcing program requirements better. If fully implemented, these additional recommendations could save Medicare over $12 billion a year, as illustrated below.

$12.253 BILLION SAVINGS IN A YEAR



Approximately 92 percent of these savings would be recurring. (CIN: A-09-91-00099)

Distribution of Organs for Transplantation

Performance Indicator

The OIG determined that, despite progress towards an equitable, national organ distribution system, current practices fall short of congressional and professional expectations. The access of patients to donated organs remains unequal in some important respects. Organ distribution remains heavily controlled by the individual transplant centers and confined primarily within the individual service areas of 72 organ procurement organizations (OPOs). At the transplant center and OPO levels, the sense of local ownership that some transplant professionals have towards organs they have procured impedes the development of an equitable national system for the distribution of organs.

The OIG recommended that the Public Health Service (PHS), in collaboration with the Organ Procurement and Transplantation Network: issue regulations requiring each OPO to establish a single, unified list of patients awaiting transplantation and to distribute donated organs to those patients on a first come first served basis; issue regulations requiring each transplant center and donor hospital in an OPO service area to adhere to the centralized organ distribution policies of the OPO governing that area; and support the development of

medical practice guidelines addressing organ transplantation. In addition, HCFA and PHS should support research efforts to help reduce racial disparities in organ allocation, and, before granting Medicare recertification to an OPO, assure that it is distributing organs equitably among patients and is conducting a rigorous, soundly based organ procurement effort. The HCFA and PHS agreed with the recommendations directed to them. (OEI-01-89-00550)

Hospital Patient Transfers

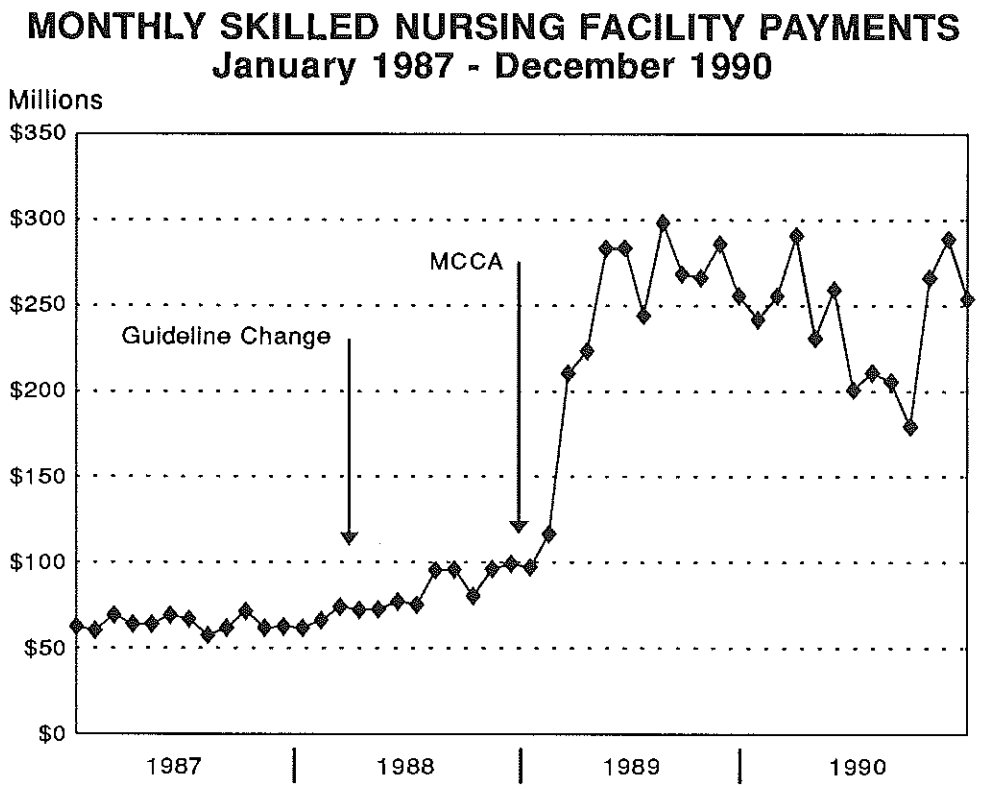
The OIG issued a management advisory report presenting the interim results of a review of overpayments to hospitals reimbursed under Medicare's PPS. Under the Medicare program, a full PPS payment is made for the appropriate diagnosis related group (DRG) when a patient is discharged from care. However, a per diem payment is made when a patient is transferred to another PPS hospital for further treatment. A transfer improperly reported as a discharge results in an overpayment since both hospitals receive full PPS payments for the DRG.

An ongoing OIG pilot project in one region resulted in recovery of $8.4 million in overpayments which had occurred because Medicare claims were erroneously reported and paid as discharges for patients who were actually transferred to other PPS hospitals. The OIG identified over 163,000 potential errors nationwide which it believes represent significant overpayments that can be effectively recovered and returned to the Medicare program. The OIG recommended that HCFA provide OIG's listings of potential errors to its respective regional offices nationwide and require recovery efforts by the intermediaries. Further, OIG proposed that HCFA develop and implement internal controls to identify and correct future erroneous payments of this kind. (CIN: A-06-89-00021)

Skilled Nursing Facility Benefit

Performance Indicator

The OIG conducted a study to determine whether recent changes to the Medicare skilled nursing facility (SNF) benefit have left the program vulnerable to unpredictable growth in expenditures. The OIG found that Medicare's expenditures for the SNF benefit more than tripled between 1988 and 1989.



The clarification of the SNF benefit coverage guidelines in 1988 accounted for more than 27 percent of the increase. A slight increase in the length of stay and a small increase in admissions accounted for most of this increase. The Medicare Catastrophic Coverage Act (MCCA) of 1988 resulted in an increase in Medicare expenditures which exceeded 300 percent. Much of this increase came from the expansion in the number of Medicare certified skilled nursing home beds and a reduction in patients' coinsurance. While the MCCA has been repealed, it appears unlikely that admissions and payments will return to the levels experienced before its implementation. (OEI-05-89-01590)

Medicare Outpatient Credit Balances

A Medicare outpatient credit balance account occurs when a hospital's accounts receivable record shows that reimbursement for an outpatient service exceeds the hospital's charges for that service. This occurs as a result of an accounting error or an overpayment. A hospital must review each Medicare outpatient credit balance separately to determine if a Medicare overpayment occurred so that a refund can be made to the intermediary.

An OIG review showed that most hospitals were not routinely reviewing their Medicare credit balance accounts and that the fiscal intermediaries (FIs) often were not detecting and

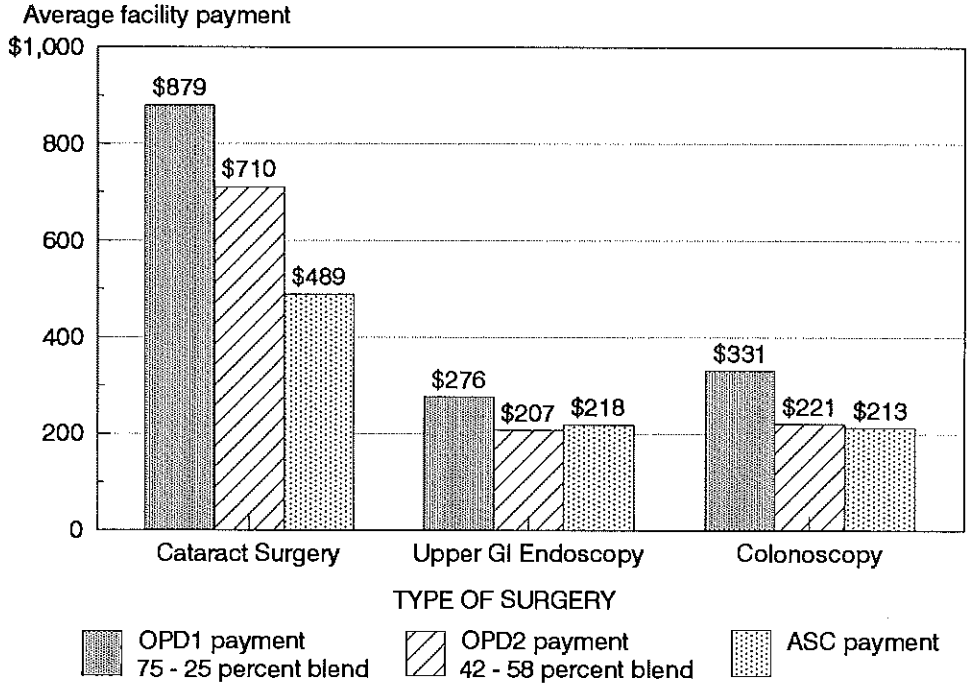
collecting these overpayments. The OIG estimated that 40 hospitals serviced by 1 FI received and retained about $1.2 million in Medicare overpayments that should have been refunded to the program. Additional audit work is currently under way at 14 hospitals serviced by 5 FIs. Preliminary results of these reviews show that a nationwide problem exists in the identification and recovery of Medicare overpayments for credit balance accounts.

The OIG recommended that the audited hospitals establish procedures to review their Medicare outpatient credit balance accounts and refund all overpayments to the FI in a timely manner. In addition, OIG proposed that HCFA require FIs to review Medicare outpatient credit balance accounts during their hospital audits and that it review the FIs' compliance with this requirement during its annual contractor evaluations. (CIN: A-03-91-00028)

Reimbursement for Outpatient Facility Services

In 1987, HCFA began reimbursing hospital outpatient departments (OPDs) the lesser of the hospital's reasonable or customary charges for outpatient surgical facility services, or a blend of current OPD hospital-specific costs and the ambulatory surgery center (ASC) prospective payment rates for each procedure. For cost reporting periods beginning in FY 1988, the blended rate was 75 percent of the OPD hospital-specific cost and 25 percent of the ASC rate, and for cost reporting periods beginning October 1, 1988, the blended rate was 50 percent of the OPD hospital-specific cost and 50 percent of the ASC rate. The OBRA 1990 reduced hospital-specific costs by 5.8 percent effective January 1991, and this reduced amount was used in the new blended rate of 42 percent of the OPD hospital-specific costs and 58 percent of the ASC rates. To compare reimbursement rates at the two types of facilities, OIG used 1988 data on three high-volume Medicare procedures: cataract extraction with intraocular lens implant, upper gastrointestinal (GI) endoscopy and colonoscopy. The following chart compares the OPD payments under the two blended rates to ASC payments.

DIFFERENCES EXIST IN OPD AND ASC FACILITY FEE PAYMENTS



The OIG recommended that HCFA seek legislation to pay the lower of ASC or OPD payments, estimating that the following savings would be achieved nationwide: $107.61 million for cataract surgery, $5.62 million for upper GI endoscopies and $4.53 million for colonoscopies. The HCFA agreed and had already prepared a proposal that is in the FY 1992 budget. (OEI-09-88-01003)

Unnecessary and Poor Quality Upper GI Endoscopies

The OIG estimated that in 1988, Medicare spent $45.3 million for medically unnecessary procedures and $95 million for poor care rendered to beneficiaries for upper GI endoscopies and colonoscopies. The OIG recommended that HCFA reduce the incidence of payments for unnecessary and poor quality endoscopies. This could be accomplished by having the peer review organizations (PROs) and Medicare carriers target their reviews on providers whose practice profiles indicate a higher than average likelihood of unnecessary or poor quality care. (OEI-09-88-01006)

Postoperative Office Visits for Cataract Surgery

Surgical services usually are reimbursed under a global fee that includes not only the costs of the operation, but also those of certain procedures and management services from

preoperative through postoperative stages. Medicare carriers determine which preoperative, operative and postoperative services should be included in the global fee and which should be paid separately. The OIG found that Medicare could have saved at least $5 million in 1988 if the 11 carriers in the survey had consistently applied a global fee for cataract surgery. The OIG believes that this finding supports the need for HCFA to issue a definition of global surgery that includes a standard 90-day postoperative period. The HCFA has published a draft rule containing the definition suggested by OIG. (OEI-09-88-01007)

PRO Fraud

An OIG investigation revealed that the PRO for Florida had authorized Medicare payments to hospitals for thousands of cases it claimed to have reviewed but had not. It also had failed to review the medical files in other cases in which it reversed Medicare payment denials. As a consequence of the PRO's plea of guilty to criminal charges resulting from this investigation, it agreed to a premature termination of its contract with HCFA. In addition, as a result of the investigation, HCFA reviewed vouchers submitted by the PRO, found it had been overpaid $1.9 million and initiated recovery of the overpayment. (4-88-00956-9)

False Claims

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:

- An Ohio ophthalmologist was sentenced to 5 years imprisonment after pleading guilty to 65 of 135 counts which included illegal trafficking in drugs, corrupting another with drugs, sexual battery, and Medicare, Medicaid and private insurance fraud. Himself addicted to drugs, the ophthalmologist wrote unneeded prescriptions for patients who filled them and turned part over to him. He admitted to addicting two other persons and to using false Medicare billings to repay a patient from whom he had borrowed $40,000. (5-90-00017-9

- A chiropractor and his wife, operators of several vascular diagnostic centers in Florida, were sentenced for conspiracy in defrauding Medicare and private insurance carriers from 1985 through 1990. The couple submitted billings for vascular testing as being ordered by a medical doctor when they were actually ordered by the chiropractor himself. They also practiced deceptive advertising, backdated diagnostic prescriptions, used unauthorized signatures of various medical doctors, altered patient medical records and obstructed a criminal investigation. The chiropractor was sentenced to 51 months imprisonment, his wife to 37 months. In addition, the pair were ordered to make restitution of $637,000. (4-85-01003-9

- For filing false claims and unauthorized dispensing of a controlled substance, a Virginia psychiatrist was sentenced to 10 years in prison, ordered to make restitution of $722,000 and caused to surrender his license and drug certification. He billed Medicare, Medicaid, the Civilian Health and Medical programs of the Uniformed Services, and Blue Cross Blue Shield for hour psychotherapy sessions which lasted only 15 minutes. (3-87-00584-9

- An anesthesiologist's corporation was sentenced in Illinois to 5 years probation, fined $50,000 and ordered to make restitution of $152,000 obtained by submission of false Medicare claims. The claims exaggerated the time spent and the condition of the patient in order to obtain higher reimbursement. The corporation is also to be audited annually to ensure no further false billings. (5-87-00714-9

- A New Jersey man was sentenced to 10 months in prison and 5 years probation for filing false Medicare claims. He was also ordered to pay $16,200 in restitution and a $450 special assessment, and to perform 500 hours of community service. He billed Medicare for nerve block injections which were really acupuncture treatments. He billed some of the treatments during dates when he was on a trip to China. (2-87-00211-9

- A Massachusetts psychiatrist entered an Alford plea in State court (admitting the prosecution had evidence to convict but not admitting guilt) to six counts related to Medicare and Medicaid program fraud. He was given a suspended 3- to 5-year prison sentence, placed on probation, and ordered to pay $40,000 in restitution and $1,000 to the victim witness program within 60 days. He billed the Medicaid and Medicare programs for psychiatric services which were really social worker visits. He also billed for individuals who were deceased, inpatients who were not hospitalized, nursing home residents who were actually in hospitals and other individuals he never saw. (1-87-00230-9

- Three owners of a home health agency in Tennessee were each sentenced for Medicare fraud to 3 years probation, fined $3,050 and ordered to perform 200 hours of community service. They had included in the Medicare cost reports expenses such as carpet, furniture and draperies for their homes, as well as clothing and other personal items. (4-88-00361-9

Medicare Secondary Payer: Extent of Unrecovered Funds

Performance Indicator

The OIG conducted a study to determine the extent of unrecovered funds related to Medicare secondary payer (MSP) provisions and to develop viable options to deal with MSP overpayments. The OIG found that significant overpayments continue to occur due to failure to identify primary insurance sources. Losses to the Medicare program were projected to be at least $637 million for FY 1988. Ninety-seven percent of the identified overpayments were the result of unidentified spousal insurance coverage.

As in a prior report (CIN: A-09-89-00100), OIG again recommended that HCFA revise all Medicare claims forms to require the submission of spousal insurance information before the claims can be paid. In addition, HCFA should prioritize the information received from the Social Security Administration and develop those cases with an indication of a working spouse. The OIG also recommended the establishment of a voluntary disclosure and recovery program whereby insurers, employers or third-party administrators would be allowed to make restitution of improper payments without threat of future Government action on those claims. Finally, OIG recommended that HCFA propose legislation to require insurers to provide their health insurance data, including eligibility and claims information, to HCFA and to require Medicare contractors to match their private health insurance records with Medicare files. (OEI-07-90-00760)

MSP Procedures at Carriers

Performance Indicator

In June 1990, auditors found that the Florida carrier was not processing MSP claims. An inspection was then conducted to evaluate the procedures used by other Medicare carriers to identify primary payment sources. The OIG found that the FY 1990 budget reductions for MSP activities have adversely affected the carriers' ability to handle the MSP workload. Carriers were identifying most MSP cases, but they lacked the resources to recover overpayments created when previous claims were improperly paid by Medicare. In addition, OIG identified inconsistencies in methods used to identify and calculate savings.

Consistent with a recommendation contained in an earlier report (CIN: A-09-89-00151), OIG again proposed that HCFA continue to pursue additional funding to ensure that carriers restore operations of the MSP units to a level at least equivalent to that of FY 1989, so that they can resume and aggressively conduct all MSP activities. In addition, HCFA should consider the development of a legislative proposal that would allow for demonstration programs to evaluate the effectiveness of a carrier incentive program for MSP recoveries, and modify contractor performance plan standards to evaluate carriers on their MSP identification and recovery efforts. Such an incentive program could generate savings ranging from $199 to $361 million. Further, HCFA should provide clear and uniform procedures for counting MSP savings. The HCFA indicated that it had taken action to

provide clear, uniform procedures for counting MSP savings and did not agree with the remaining recommendation. (OEI-07-89-01683)

Conditional Payments by Blue Cross of Massachusetts

Performance Indicator

In accordance with Federal regulations and implementing HCFA guidelines, Medicare FIs should not make conditional payments on behalf of beneficiaries for services covered under automobile medical, no-fault or liability insurance, unless there is written substantiation that the claims are being contested or delayed over 120 days by the insurance companies. An OIG analysis showed that Blue Cross of Massachusetts (BC) did not establish proper procedures to ensure that the provider of services first billed the automobile insurance company, the primary payer. In addition, OIG identified certain deficiencies in BC's accounting controls as a result of which the compulsory medical insurance coverage amount provided under a no-fault insurance plan was not applied or recovered in a timely manner. Based on the statistical sample, OIG estimates that approximately $2.7 million in Medicare conditional payments could have been avoided had the proper internal controls been established.

The OIG recommended that BC: implement procedures to ensure that all medical claims for Medicare beneficiaries involved in automobile accidents are properly researched and resolved before a Medicare payment is made; initiate recovery of improper Medicare conditional payments from no-fault automobile insurance carriers or providers; advise providers on the proper procedures for medical claims related to automobile accidents under the Massachusetts no-fault insurance provision; and establish a centralized accounts receivable system and controls to ensure proper and timely recovery of conditional payments. As a result of this pilot study, OIG plans a nationwide review to be completed in FY 1992. (CIN: A-01-90-00519)

Pension Plan Termination and Reversion

When the Health Care Service Corporation (HCSC), a Medicare intermediary, terminated its defined pension plan on December 31, 1985, it did not revert or credit any of the excess assets to Medicare as required by Federal regulations. The termination action resulted in pension assets significantly exceeding the actuarial liability for the accrued pension benefits, primarily due to the advance funding of future benefits that would no longer be earned. Since Medicare shared in financing the accumulation of pension assets for the payments of the pension plan, it should receive an appropriate adjustment for its share of the reversion. Accordingly, OIG recommended that HCSC credit the Medicare program for its share of the total pension reversion, nearly $4.8 million, through either a direct refund or a reduction in contract costs. (CIN: A-07-90-00306)

Contractor's Segmented Pension Costs

An OIG review showed that Transamerica Occidental Life Insurance Company, a Medicare contractor, had understated the Medicare segment of its pension plan assets by more than $3.3 million as of January 1, 1988, and that it was using an unacceptable actuarial cost method. As a result, pension costs charged to Medicare were being overstated. Identifying the additional $3.3 million as Medicare segment assets and using an acceptable actuarial cost method will result in lower Medicare pension costs in future years. It will also result in Medicare receiving higher reversions/refunds in the event of a pension plan termination or a termination of the Medicare contract. (CIN: A-07-91-00391)

Sanction Authorities

During this reporting period, OIG imposed 440 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 loss of license to practice, conviction of program-related crimes, or conviction of controlled substance abuse or patient abuse.

A. Patient and Program Protection Sanctions

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, and Block Grants to States for Social Services programs. Exclusions can now be made 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. Exclusion is mandatory for those convicted of program-related crimes or patient abuse. The following cases are examples of some of the sanctions imposed during this reporting period:

- An administrative law judge (ALJ) affirmed OIG's exclusion of two individuals and their corporation for 15 years from participation in Medicare and State health care programs. At one time, the corporation was the Nation's largest supplier of home health services. As its principal executive officers, the two individuals engaged in massive fraud by falsifying and altering training certificates and other credentials of personal care aides and home health care aides employed by the company. In 1988, the corporation pled guilty to falsifying personnel files and grand larceny. In September 1990, it agreed to pay $4.75 million to resolve liabilities under the civil monetary penalty (CMP) law, the Civil False Claims Act and New York State statutes. The OIG considered the 15-year exclusion justified because of the millions of dollars lost by the New York State Medicaid program and the potential for harm to program beneficiaries resulting from treatment by untrained and unqualified aides. (2-89-40616-9

- A Massachusetts podiatrist was excluded for 30 years after engaging in fraudulent practices since 1976, when he was convicted of Medicare fraud. He concealed his convictions in applying for licenses and practicing in other States, or practiced without a license. He was subsequently convicted of both Medicare and Medicaid fraud. The overpayment associated with the last conviction amounted to more than $145,000. (1-91-40081-9

- A New York podiatrist was convicted for allowing unlicensed personnel to render patient services and for providing cheap stock foot molds, which could have caused harm to patients, instead of the custom-made molds for which he billed Medicaid. The damages to the Medicaid program amounted to over $600,000. He was excluded for 15 years. (2-90-40726-9

- A New York nursing assistant was excluded for 8 years after being convicted of crimes related to patient abuse. He had variously punched, struck and stomped on elderly patients at a nursing home. (2-91-40275-9

- A Michigan psychologist whose license was revoked was excluded indefinitely. The State revoked his license for failing to conform to minimal standards of acceptable practice: he told a patient that she was possessed by spirits and demons, and had sexual relations with her. (6-90-40137-9

- A Pennsylvania physician, convicted of submitting claims to a private insurance company for medical tests which were not performed, was excluded for 7 years. (3-90-40703-9

- A Texas pharmacy was excluded for 10 years because one of its owners, who was also a managing employee, was convicted of Medicaid fraud. (6-91-40140-9

- After being excluded by the State for practicing abusive and dangerous medicine, a New York physician was excluded indefinitely. The physician repeatedly prescribed controlled substances for long periods of time to patients who had records of substance abuse. The State calculated that he had been overpaid approximately $1 million. (2-89-40972-9

B. CMPs

Under the CMP authorities enacted by the Congress, health care providers may be assessed thousands of dollars in fines and penalties for a wide range of violations against Medicare and Medicaid. One of these violations, termed patient "dumping," is the failure of a hospital or its physicians to provide appropriate screening and treatment, or to inappropriately

transfer or discharge individuals with emergency medical conditions and women in active labor. The following anti-dumping actions occurred during this period:

- A significant legal decision was rendered on a case in which a Texas doctor had transferred a woman in labor to a hospital 170 miles away without stabilizing her high blood pressure. The doctor appealed the OIG penalty of $20,000 to an ALJ, who upheld it. The doctor then appealed to the circuit court. The Fifth Circuit Court of Appeals upheld the penalty. (6-87-30610-9

- In another anti-dumping case, a California hospital agreed to a $19,500 settlement. The hospital had admitted two women on the same day to its emergency room, then inappropriately transferred them to a community hospital. Because of their conditions, the community hospital returned both to the originating hospital and both died. The hospital had kept one of them, a medically indigent woman, waiting for 3 hours in the emergency room before transferring her. By that time, her condition had deteriorated so badly that the community hospital put her back in the ambulance, where she died in transit. (9-89-30119-9

The following cases are examples of some of the other settlements OIG has obtained:

- A Georgia-based medical corporation with subsidiary hospital facilities entered into a settlement for $2.7 million. The parent company billed Medicare for items allegedly provided in the subsidiary facilities when the items were not provided there, were not reimbursable under Medicare or both. (4-90-00285-9, 4-91-30010-9

- A California man agreed to pay close to $3 million in settlement of civil claims for Medicaid fraud, and was excluded from the Medicare and Medi-Cal programs for 30 years. In 1990, he pled guilty to Medi-Cal fraud and paying kickbacks. His scheme entailed setting up DME companies and an elaborate system of salesmen to obtain Medi-Cal eligibility numbers from beneficiaries and institutions. The numbers were used to bill Medi-Cal for incontinence supplies which, for the most part, were not provided. (9-90-30241-9

- A Pennsylvania physician signed a $32,000 agreement in settlement of improper separate billing of procedures rather than submitting them as part of a comprehensive service. (3-90-30685-9

Carrier Maintenance of Medicare Provider Numbers

Medicare carriers assign numbers to providers of Part B services which are used in processing claims, and in establishing Medicare pricing and utilization profiles. The OIG found that inadequate direction by HCFA to the carriers has resulted in problems with carrier control of Medicare provider numbers.

The OIG recommended that HCFA require carriers to update provider records periodically; deactivate all provider numbers without current billing history; and establish adequate controls to ensure that providers not legally authorized to practice are identified and their provider numbers deactivated. In addition, HCFA should evaluate carrier provider number controls as part of its regular carrier contractor performance evaluation program, and negotiate with State licensing authorities to obtain license and registration information at a minimum cost to the Medicare program. While HCFA acknowledged the need to improve its instructions to Medicare carriers regarding the maintenance of provider numbers, it did not concur with all of OIG's recommendations. Subsequent meetings with HCFA may result in a memorandum of understanding on those issues. (OEI-06-89-00870)

Intermediary Payment Safeguard Savings

Medicare FIs are required to perform payment safeguard activities and to ensure the integrity of the paid claims. Payment safeguard activities have been categorized into three areas: medical and/or utilization review, Medicare secondary payer and provider audit.

The OIG identified certain types of savings reported by intermediaries that were not primarily attributable to the funded payment safeguard activities. In OIG's opinion, the current method of reporting savings does not provide an accurate measure of payment safeguard activities. The OIG recommended that HCFA revise its monitoring procedures over intermediary reporting practices, and explore additional reporting methods to distinguish between savings directly attributable to payment safeguard activities and those attributable to other sources. (CIN: A-04-89-02114)

Medicare Prepayment Utilization Savings

This study was undertaken to determine if carrier savings reported as a result of prepayment controls could be verified. The OIG randomly sampled listings of the claims used to prepare the medical review report at 7 carriers, and was able to verify the accuracy of the reported savings for 192 of 195 claims. Twenty-nine of the 195 sampled claims had insufficient information on the control sheet used to create the report to allow ready verification of the savings. Further investigation, however, determined that these claims were valid as well. (OEI-07-89-01681)

Kickbacks and Joint Ventures

Referrals are an integral part of many organizations' business when special outside expertise, services or items are required. The giving of discounts, credits, goods and other benefits in exchange for referrals is often standard, acceptable practice. The medical profession relies heavily on referrals because of its pervasive specialization. If referrals related to Medicare or Medicaid patients are made in exchange for remuneration, however, both the giver and receiver may violate the Federal anti-kickback statute.

Outright payments for referrals are clear examples of kickback violations, and they may directly or indirectly increase Medicare/Medicaid costs. Where physicians have a financial interest in and share the profits of a health care organization to which they make referrals, such as a partnership or joint venture, payment for referrals is more subtle, but may still be illegal. These arrangements also can result in overutilization of services. During this reporting period, OIG published regulations related to the most recent revisions to the anti-kickback statute, clarifying areas of specific payment practices which would not be subject to criminal prosecution or administrative sanctions (safe harbors).

Over the years, close to 500 convictions, judgments and settlements have been obtained as a result of OIG investigations of violations of the anti-kickback statute. The following actions in this area were taken during this reporting period:

- The former president of a Massachusetts health maintenance organization (HMO) was sentenced to 27 months in prison for accepting kickbacks from a contractor. The two men set up dummy corporations to conceal the gift of a $260,000 condominium to the president, in exchange for which the contractor's company was given a $2.2 million contract for the HMO. The contractor was sentenced to 24 months in prison and ordered to pay more than $971,000 in restitution and fines. His company was fined $4,000. (1-88-00096-9

- The owner of a diagnostic clinic agreed to pay more than $950,000 to settle a civil suit for kickbacks and false Medicare claims. He and a California hospital chain overcharged Medicare by billing cardiovascular tests as hospital outpatient tests. He also paid kickbacks to two physician partnerships in exchange for patient referrals for tests at hospitals where he had exclusive contracts for testing. He agreed to a 2-year exclusion from the Medicare and Medicaid programs, and a lifetime exclusion for his corporation. The case against the hospital chain, which began as a qui tam complaint, was settled earlier for $581,000. (9-89-26005-9

- As a result of information supplied by convicted members of a Pennsylvania hospital staff, civil cases were filed against three physicians, a dentist and a laboratory for paying kickbacks to secure hospital contracts. During this

reporting period, a radiologist and the laboratory entered into consent judgments whereby they paid $52,000 and $75,000, respectively, for their wrongdoing. (3-90-20563-9

- Two years ago, OIG initiated a joint project in Michigan with the Federal Bureau of Investigation, State law enforcement officials and a major private insurer, to identify and prosecute medical practitioners and others dealing in illegal drugs, fraudulent prescriptions and false Medicare, Medicaid and private health insurance billings. Thus far, 12 persons have been convicted, including 7 physicians, and about $1 million has been returned in fines, restitutions and recoveries. Of the five persons convicted during this reporting period, one was a physician involved in a kickback arrangement with a laboratory 200 miles away from his office. He provided testimony involving two other physicians who had a similar arrangement with the same laboratory. Other indictments are scheduled as a result of this project. (5-89-00629-9

Carrier Performance

Performance Indicator

Pursuant to a request from the Secretary and HCFA, OIG conducted an audit of the performance of the Medicare Part B carrier in Georgia, AEtna Life Insurance Company, and of Healthcare COMPARE (HCC), the carrier's subcontractor for medical review/utilization review. The audit was performed to address the specific concerns of the Georgia physicians as they related to the processing of claims by AEtna and HCC. The OIG found that the carrier processed 36 percent of the sampled routine claims incorrectly. In addition, the carrier mishandled about 9 percent of the sampled claims with respect to Medicare regulations on coverage and reimbursement. The OIG also found that HCC correctly reviewed 221 of the 223 sample claims reviewed. The OIG recommended that HCFA continue to monitor AEtna-Georgia's activities to ensure that it corrects the claims processing errors identified and that it continues to make overall improvements in its handling of Medicare claims. (CIN: A-04-90-02015)

Medical Transportation Fraud

The OIG continues to obtain convictions of ambulance companies and their officers for Medicare and Medicaid fraud, as illustrated by the following examples:

- A husband and wife, managers and former owners of an ambulance service company, were sentenced in Pennsylvania for Medicare fraud. Each was sentenced to 1 year incarceration and 2 years probation, and ordered to pay $250,000 in restitution. A statistical sampling of the thousands of claims they submitted is believed to have contributed to the severity of their sentences. For virtually every ambulance trip claimed, they inflated the

mileage and falsified the purpose, origin, destination and condition of the patient. (3-88-00814-9

- In Ohio, a civil judgment of $300,000 was ordered against a man and his two companies. He had formed a paper corporation to file Medicare claims, at a higher ambulance reimbursement rate, for services performed by his van company. The owner is currently in prison after being convicted previously of Medicare fraud. (5-90-20018-9

- The husband and wife owners of a Georgia ambulance service company were ordered to make restitution of $169,000 for submitting fraudulent Medicare claims. They also were sentenced to 4 months home detention and fined $10,000 each. Their company transported Medicare patients in a Lincoln town car to dialysis centers but charged Medicare for emergency ambulance services to a hospital. (4-90-00324-9

- The former owner/operator of a California ambulance service was sentenced to 5 years probation and ordered to pay $10,000 in restitution after pleading guilty to theft of Government monies. After losing his certification, he continued to transport patients in minivans while billing Medicare for ambulance service. (9-89-04155-9

Embezzlement

During this reporting period, convictions were obtained against several persons for embezzlement of funds which included Medicare monies administered by the Department:

- Five persons formerly associated with a hospital in Washington State were given prison sentences for embezzlement, filing false Medicare cost reports and income tax evasion. The hospital's corporate lawyer was sentenced to 5 years in prison, his wife was sentenced to 18 months, and his mother, who served as office secretary, was sentenced to 1 year. The former hospital administrator and the former controller were sentenced to 20 months in prison. The lawyer, his wife and his mother submitted false invoices to the hospital which the administrator and the controller approved and ushered through for payment. (X-88-00253-9

- Over a 10-year period, a Wisconsin woman embezzled more than $200,000 in Medicare checks from her employers, a Milwaukee urological group. She converted checks payable to the group to her own checking account. She used the funds to buy a home and a lake house, fund her children's

college education, and set up a pension program and savings account. She was sentenced to 15 months incarceration. (5-90-00287-9

- The manager of the refund unit of Blue Cross Blue Shield of Alabama was sentenced to 15 months in prison for embezzling Medicare funds. The manager began cashing returned Medicare refund checks in 1987. Later he turned to reissuing checks in the names or derivatives of names of several friends. Indicted for embezzling more than $70,000 in this fashion, he pled guilty to all charges. In addition to prison time, he was sentenced to 3 years supervised probation, during which he must repay the total amount embezzled. (4-91-00110-9

- A Texas woman was sentenced to 8 years imprisonment for forging and negotiating Medicare, private insurance and private patients' checks payable to physicians for whom she worked. She used the physicians' signature stamps to establish bank accounts in their names, listing herself as trustee for the accounts. She then used the stamps on the backs of incoming checks and deposited them into the unauthorized accounts or her personal bank account, from which she made cash transfers. Although her embezzlement was estimated to be in the hundreds of thousands of dollars, she could only be tied directly to about $50,000 because of poor legibility of bank records. She was ordered to make restitution of that amount and fined $1,000. (6-91-00126-9

Monitoring Services Provided in Physicians' Offices

The OIG found that private sector monitoring of physicians' services provided in their offices is limited but emerging. Few managed care/utilization review (MC/UR) programs focus on services provided in physicians' offices. A few MC/UR firms use sophisticated computerized software systems to contain costs of physicians' services and to develop appropriate patterns of ambulatory care based on diagnoses. Most MC/UR firms employ some specific quality assurance techniques. In addition, trade groups are developing strategies to address ambulatory care.

The HCFA's efforts to explore new ways to monitor physician services have resulted in various initiatives. The Blue Cross Blue Shield (BCBS) of Arizona private business preferred provider organization (PPO) and Capp Care PPO of California are demonstration sites; each is required by HCFA to maintain a structured quality assurance program. The HCFA has entered an agreement with BCBS of North Dakota for the development of diagnosis-based patterns of care MC/UR screens. In addition, BCBS of Indiana and BCBS of Arkansas have been funded by HCFA as "flexibility control carriers," and given greater flexibility to find innovative ways to improve Medicare operations. The OIG concluded that HCFA appears to be on the cutting edge of activity to improve the monitoring of services

provided to Medicare beneficiaries by physicians in their offices and to explore alternative service delivery systems for beneficiaries. (OEI-02-90-00410)

Impact of Laboratory Roll-ins on Medicare Expenditures

This study examined the potential financial impact of including payment for laboratory services in Medicare's recognized charges for physician office visits. This bundling approach, called a laboratory roll-in (LRI), appears to be a promising option to help contain rising laboratory costs. The OIG found that LRIs could save Medicare over $1 billion in the first year and more than $12 billion over 5 years. The OIG also found that LRIs would provide sufficient funds for most physicians, in most specialties, to cover the costs they would incur in securing laboratory work. The OIG recommended that HCFA research and develop the LRI reimbursement mechanism for laboratory services, and propose legislation to implement it within 2 years. (OEI-05-89-89151)

Separately Billable Drug and Blood Services

Medicare pays a composite rate per treatment to reimburse independent renal dialysis facilities and hospital-based facilities. This is a comprehensive payment for all services related to dialysis treatment except for physicians' patient care services, blood, and certain drug and laboratory services that are separately billable. Reimbursement to independent dialysis facilities for separately billable services is based on prescribed limits set forth in HCFA guidelines.

An OIG review disclosed that FIs made approximately $17.2 million in overpayments to independent dialysis facilities for separately billable drug and blood services. The review at 19 FIs disclosed that most did not have adequate internal controls to ensure that the claims for separately billable drug and blood services were paid in accordance with HCFA guidelines. The OIG recommended that HCFA advise the Department to report this as a material weakness. The HCFA should develop and implement a corrective action plan that includes increasing its monitoring efforts to ensure that all FIs have established procedures to reimburse independent dialysis facilities in accordance with prescribed payment limits, and coordinating with FIs to establish a uniform coding system and a standardized fee schedule for separately billable drug and blood services. In addition, HCFA should instruct the FIs to determine and recover the actual overpayments made to independent dialysis facilities, and make the appropriate refund to the Medicare program. (CIN: A-01-90-00502)

Low Cost Ultrasound Equipment

The OIG determined that Medicare reimbursements for certain types of low cost ultrasound equipment were inappropriate. Because procedure codes do not distinguish among types of equipment or the expected quality of tests, Medicare reimbursement is the same for an ultrasound test from a 5-minute scan by a $300 pocket doppler as for a 1-hour scrutiny of multiple arteries by sophisticated state of the art equipment. The OIG recommended that

HCFA prohibit payment for tests conducted with pocket dopplers, and revise procedure codes and reimbursement rates to reflect the various levels of sophistication and quality of diagnostic information provided in ultrasound tests. (OEI-03-88-01401)

Pocket Dopplers

In response to the report on low cost ultrasound equipment, HCFA asked OIG to identify the frequency with which these less sophisticated ultrasound devices were used. The OIG studied the type of equipment that was used in four procedures performed in physician offices and found that pocket dopplers were used 7 percent of the time. Medicare allowed $2 million in charges for procedures performed with pocket dopplers in 1988. The HCFA has announced that it will no longer cover ultrasound procedures performed with pocket dopplers. The OIG estimates that this will save about $30 million over the next 5 years. (OEI-03-91-00461)

Trends in Home Oxygen Use

Medicare currently pays for oxygen on a modality-neutral basis. Reimbursement is the same whether liquid, gaseous or concentrator systems are used. The modality-neutral fees are based on 1986 data. At that time, oxygen concentrators, the least expensive modality, were a slight majority of the market (66 percent). The President's FY 1992 budget proposes a 5 percent reduction in oxygen reimbursement. The rationale for this cut is that the fee schedule needs to be rebased because oxygen concentrators are now a higher proportion of the market. The OIG found that, according to refined and updated Medicare data, oxygen concentrators constituted 78 percent of the stationary oxygen supplies provided to beneficiaries in 1989. (OEI-03-91-00710)

Oxygen Concentrator Costs

An OIG review requested by HCFA found that, on the average, amounts Medicare allowed for oxygen concentrators were 174 percent higher than the amounts paid by the Department of Veterans Affairs (VA). A sample of 35 VA hospitals found that their 1991 payments ranged from $40 to $175 per month, and averaged $101. Amounts allowed in 1991 by Medicare for hospitals ranged from $233 to $340 per month, and averaged $276. The OIG found no instances where the amount allowed by Medicare was lower than the VA's. (OEI-03-91-00711)

Fraud Involving DME

Fraud in the DME industry is a continuing major concern to OIG. Seat lift mechanisms, transcutaneous electrical nerve stimulators, oxygen equipment, home dialysis systems and similar equipment are reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers throughout the country circumvent this requirement through aggressive sales practices, tricking physicians into

signing authorizations and even forging their signature. Some suppliers simply bill for items never delivered; others bill carriers in States which pay high Medicare reimbursement, regardless of where the sale took place.

Among the deceptive practices aimed at obtaining undeserved Medicare and Medicaid reimbursement are "unbundling" (submitting separate claims for parts of a single item, such as ostomy kits) and billing for dressing kits used to treat decubitus ulcers, or bedsores, as though they were surgical dressing kits. The latter abuse has reached proportions that prompted an early alert report to HCFA warning of a potential material weakness. Investigations by OIG have revealed instances where DME suppliers have billed for one to three kits a day for each nursing home patient for each bedsore, totaling $1,200 to $54,000 a month for a single patient. In one small northeastern nursing home, these claims for one patient amounted to $100,000 in at least 1 month. Overall, Medicare payments for surgical dressing kits have increased more than 500 percent over the past 4 years.

Investigations of DME fraud by OIG have resulted in more than 90 convictions and CMP settlements over the past 4 years. The following cases are examples of various actions taken against suppliers during this reporting period:

- In Wisconsin, the manager of a DME company was sentenced to 1 month in jail and 1 month in a half-way house for forcing employees to bill Medicaid for adult diapers when children's diapers were supplied, thereby obtaining almost double reimbursement. A Medicaid overpayment of $19,450 was collected earlier from his company. On the basis of this case, an undercover project was conducted at four companies in the Milwaukee area to determine whether others were executing a similar scheme. Although none of the undercover purchases were found to be improperly billed, the companies were found to be receiving overpayments. A total of $46,000 was collected and returned to the Medicaid program.
(5-89-00181-9, 5-90-00048-9

- The former owner of two Texas DME companies was sentenced to 4 years probation and 4 months home detention, and ordered to repay $16,600 she obtained by filing false Medicare claims. Using prescription slips she took from a doctor for whom she had worked, she and her former husband billed Medicare for equipment for imaginary patients. The DME companies were essentially paper operations, with no offices, equipment or bank accounts. The ex-husband was sentenced earlier to 5 years probation and 1 month home detention, and ordered to make restitution of $11,900. (6-90-00356-9

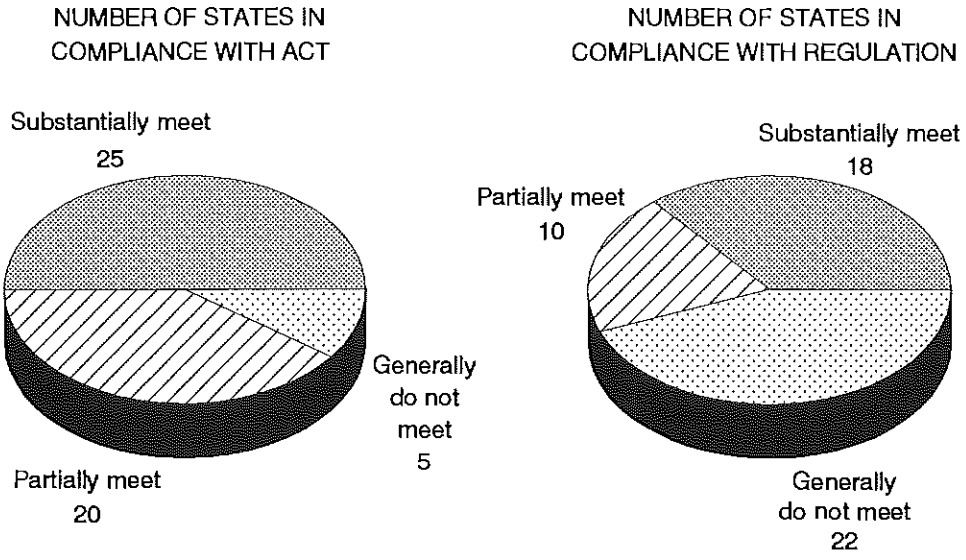
- A DME salesman was the final defendant convicted in a scheme in which elderly persons were told that Medicare or private insurance would pay for seat lift chairs, or the sellers would reimburse them. Convicted of theft by

the deception, the salesman was given a suspended sentence and fined, as was another salesman earlier. The owner of the DME company was sentenced earlier to 5 years in prison. (8-90-00318-9, 8-90-00319-9, 8-90-00314-9

State Regulation of Long Term Care Insurance

As a result of a congressional request, OIG conducted an inspection to obtain current information on consumer problems and State regulation concerning private long term care (LTC) insurance. The National Association of Insurance Commissioners (NAIC) developed an LTC insurance model act and regulation to provide States with minimum standards to use in crafting LTC insurance laws and regulations. The model act contains some provisions that are not incorporated into the model regulation, and there are others that are included only in the model regulation. The OIG determined that, although all 50 States have LTC insurance laws, only 17 States substantially meet both the model act and model regulation minimum standards.

STATE COMPLIANCE WITH MODEL ACT AND REGULATION



The OIG found that LTC insurance complaint data are incomplete and inconclusive. States reported little enforcement action against LTC insurance companies and agents, and most

insurance counselors, consumer advocates and industry representatives contacted felt that State enforcement and monitoring needed to be strengthened.

The OIG recommended that if the Congress decides to impose minimum Federal standards for LTC insurance, it should consider several issues, such as, that opinion is divided on whether the NAIC model act and regulations provide adequate consumer protection; mandating more stringent protection may increase premiums; and strong laws and regulations have limited effectiveness if they are not adequately monitored and enforced. (OEI-09-91-00700; OEI-09-91-00701)

Reimbursement for Multiple-Source Prescription Drugs

The OIG compared Ontario, Canada's reimbursement prices with those on HCFA's upper limit drug list. Results showed that more drugs had lower prices on the HCFA upper limit list. However, more than half of the commonly used multiple-source drugs had lower prices in Ontario. A review of five high usage States showed that Medicaid could save $2.2 million annually if the lower Ontario prices were paid. The OIG recommended that HCFA review their upper limit list for these drugs for possible savings. The HCFA did not concur. (OEI-03-91-00470)

Medicaid State Tax and Donation Programs

Currently, States are able to use revenues generated by provider tax and donation programs in determining the nonfederal share of their Medicaid expenditures. This has led several States to devise programs which effectively increase Federal financial participation in reimbursing providers for services rendered to Medicaid beneficiaries. In a follow-up to a previous review which had been requested by HCFA, OIG found that these tax and donation programs have been increasing at an alarming rate. This could cost the Federal Government almost $3.8 billion in FY 1991 alone and about $12.1 billion by the end of FY 1993. The OIG recommended that HCFA take action to control these provider tax and donation programs, and prepare emergency legislation to severely narrow or eliminate States' use of such programs to generate Federal matching funds. At a minimum, congressional action is needed to restrict or cap the amount of Federal funds that can be realized through these programs. The HCFA is aggressively acting on correcting this problem and is taking all possible actions in light of statutory restraints. (CIN: A-14-91-01010; CIN: A-03-91-00203)

Medicaid Payments to Disproportionate Share Hospitals

Performance Indicator

The OBRA 1981 required State Medicaid agencies to establish hospital payment rates that take into account hospitals serving a disproportionate number of low-income patients with special needs. At HCFA's request, OIG conducted a review to determine the amount of disproportionate share hospital (DSH) payments and to analyze the methods used by State

Medicaid agencies to establish DSH payments. The review identified over $1 billion in DSH payments in 41 States during a recent annualized period and found that DSH payments are increasing very rapidly. Budget estimates for FY 1992 by six States showed DSH payments of $2.3 billion, in contrast to payments of $358 million by these States during OIG's original 1990 field work. Further, OIG found that State Medicaid agencies are making DSH payments that favor selected types of hospitals, while payments to other DSHs are relatively minimal and have no significant financial impact on the institutions.

Because of the inequities in the way DSH payments are currently being made by the States and the rapid increase in the amount of these payments, OIG fully supports any departmental legislative proposals which would correct abuses in DSH payments. The OIG believes that unless these payments are limited, the Federal Medicaid budget will be severely strained. (CIN: A-06-90-00073)

Strategies to Reduce Medicaid Drug Expenditures

Performance Indicator

In 1989, Medicaid State agencies paid more than $3.6 billion for prescription drugs. As a result of increasing congressional and State concern about these escalating costs, OIG conducted an inspection to evaluate strategies currently used by State Medicaid agencies and Canadian provinces to reduce their Medicaid prescription drug costs. The OIG recommended that HCFA reduce its financial participation in Medicaid prescription drug costs by proposing legislation to establish State specific cost reduction targets based on a comparison of individual State drug prices with national and international drug price data; set specific drug price limits for brand name drugs similar to those in place for multi-source drugs; and/or negotiate directly with drug manufacturers for prescription drug discounts and rebates. The OBRA 1990 included provisions that involve HCFA in gathering and monitoring drug price data and negotiating rebate agreements with drug manufacturers on behalf of the States. (OEI-12-90-00800)

State Medicaid Fraud Control Units

Medicaid health care provider payments currently exceed $64 billion dollars annually, representing a 270 percent increase over the $18 billion dollars expended in 1978. Medicaid fraud control units (MFCUs) are currently responsible for investigating fraud in more than 91 percent of all Medicaid health care provider payments.

Thirty-nine 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 second half of FY 1991, OIG administered $27.5 million in grants to the MFCUs. The MFCUs reported 344 convictions and $19 million in fines, restitutions and overpayments collected for the period January 1 through June 30, 1991.

SOCIAL SECURITY ADMINISTRATION

Chapter III

SOCIAL SECURITY ADMINISTRATION

Overview of Program Area and OIG Activities

Fifty-six 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 Retirement and Survivors Insurance (RSI) program, and the Disability Insurance (DI) program, popularly called Social Security, are the largest of the Social Security Administration (SSA) programs. In Fiscal Year (FY) 1991, SSA will pay approximately $269 billion in cash benefits to approximately 40 million beneficiaries. The program is financed almost entirely through payroll taxes paid by employees, their employers and the self-employed. Benefits are distributed to retired and disabled workers, spouses, certain divorced spouses, children and disabled children of retired and disabled workers. Benefits are also provided to widows and widowers, certain surviving divorced spouses, children and dependent parents of deceased insured workers.

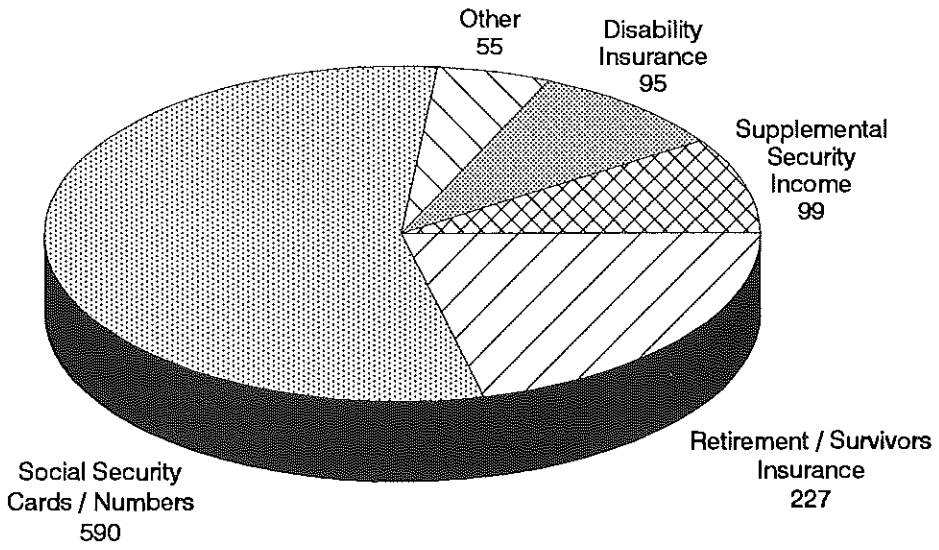
The Supplemental Security Income (SSI) program is a federally administered, means-tested assistance program that provides a nationally uniform, federally funded floor of income for the aged, blind and disabled. Beginning January 1974, SSI replaced State and county run assistance programs for the aged, 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 1991, SSA will pay SSI benefits in excess of $16 billion to over 4 million recipients.

In addition, program expenditures under the Black Lung program will total approximately $900 million. These monies pay eligible miners, their dependents and survivors. The SSA continues to administer certain claims, although administration of the program was transferred to the Department of Labor in 1973.

The Office of Inspector General (OIG) is reviewing a number of areas within SSA's programs and operations, such as client satisfaction with SSA services; the quality of service provided in SSA field offices; the disability determination process; procurement activities; and systems modernization.

As illustrated in the following chart, investigations resulted in a total of 1,066 convictions during this fiscal year.

SOCIAL SECURITY PROGRAMS
Successful Judicial Prosecutions



Internal Control Weaknesses

- During the review of SSA's financial statements for the fiscal year ended September 30, 1989, OIG identified a material weakness in controls over the financial information regarding beneficiary overpayments. It was found that the related accounts receivable balance in SSA's general ledger had not been reconciled with the detailed subsidiary records. Further, OIG determined that the overpayment system lacked other essential requirements to comply with prescribed accounting standards for Federal agencies. (CIN: A-13-90-00036) (See page 57)

- During its FY 1990 audit, OIG identified misstatements of $8.8 billion in each of two line items from SSA's draft statement of cash flows. The source for the cash flow line items was the Department of the Treasury's accounting reports. These line items were misstated when SSA mistakenly adjusted the amounts reported by Treasury while preparing its financial statements. Reliable information was available within SSA to verify the accuracy of the Treasury reports. Had SSA used this information, the incorrect adjustments could have been avoided. Although OIG believes a misclassification of $8.8 billion is material, this weakness is pending a determination of materiality by the agency. (CIN: A-13-91-00210) (See page 57)

Management and Financial Audit: FY 1990

Based upon its work at SSA during FY 1990, OIG prepared a report to the Department in accordance with the Chief Financial Officers (CFO) Act of 1990. The report presented OIG's opinion on SSA's 1990 financial statements, and a discussion of SSA's internal controls and compliance with laws and regulations. It identified problem areas such as accounting for debt management, property management and the certification of wages for Tax Years 1978 to 1989. It also took note of a problem in the accounting for underpayments in the SSI program. In general, SSA agreed with OIG's recommendations concerning internal controls.

As mentioned above in the section on internal controls, OIG identified misstatements of $8.8 billion in each of two line items from SSA's draft statement of cash flows. The misstatements occurred when SSA mistakenly adjusted the amounts reported by the Department of the Treasury, even though reliable information to verify that data was available within SSA.

The report also presented OIG's assessment of SSA's performance during the year in several important programmatic and operational areas. Overall, SSA's performance in 1990 was good. However, a number of important areas require continued management attention, including: the backlog of disability claims; accounting problems in the area of debt management; excessive busy signals in the 800 number telephone service; unposted wages; unresolved differences in the amount of wages reported by employers to the Internal Revenue Service and SSA; and problems with property management. The OIG expects that the report will contribute importantly to the development of the Department's 1991 CFO report submission. (CIN: A-13-91-00210)

Audit of Financial Statements: FY 1989

The OIG examined SSA's financial statements and reported on SSA's system of internal accounting controls and on SSA's compliance with laws and regulations for the fiscal year ended September 30, 1989. The OIG found that several improvements were needed in the overpayments accounting system to bring it into compliance with Federal standards. The OIG recommended that SSA expedite the development and implementation of the new debt management system (DMS) and report the nonconformances as material under the Federal Managers' Financial Integrity Act (FMFIA). The DMS improvements would result in better service to beneficiaries. In addition, OIG noted the need for improved internal controls over the garnishment of benefits and over the use of correct files in processing overpayment transactions. The SSA concurred with the OIG recommendations for improvement in these areas.

In the SSI program, OIG identified opportunities to improve internal controls relating to financial management. These included determining the amount of funds needed to cover

shortfalls and preparing financial reports for regulatory agencies. The OIG recommended that these control weaknesses be reported as material under FMFIA. Other recommended changes to the financial accounting system should bring it into full conformance with accounting system requirements for budget execution and funds control. The SSA did not agree with several recommendations for improved internal controls over the SSI program. (CIN: A-13-90-00036)

Social Security Client Satisfaction: FY 1991

Performance Indicator

Since September 1984, periodic assessments of how well SSA serves the public have been conducted by the General Accounting Office or OIG. In the seventh such survey, OIG found that, despite sizeable staff reductions since 1984, SSA has been able to sustain high overall client satisfaction, as indicated in the chart below.

This appears to be due to SSA's emphasis on systems automation, increased use of the telephone for conducting business, and use of scheduled appointments to better control interview workloads and reduce waiting times in field offices. The telephone has clearly become clients' preferred way of dealing with SSA.

Client rating of the understandability of SSA's mail continues to decline. This year, the number describing SSA mail as easy or very easy to read fell to 63 percent, a decline of 13 percent since early 1988. However, the number of clients contacting SSA for help in understanding the mail also continued to decline. The clarity of SSA notices is being reviewed in another OIG inspection. (OEI-02-90-00670)

Effect of Staff Reductions on Field Offices

The OIG performed a review of the effects of staff reductions on operations in SSA field offices (FOs). The review showed that staff reductions and workload processing changes have combined to make certain SSA FO operations more efficient. However, downsizing has also created staffing imbalances, which require public contact employees to do clerical work on a routine basis and spend less time on assigned workloads. Consequently, significant increases were found in pending post-eligibility workloads and reductions were noted in the levels of some secondary public services. The SSA should determine the most economical mix of clerical and public contact employees for each FO and hire accordingly.

In addition, OIG found that SSA's distribution of computer terminals to FO employees did not meet employee needs. Some offices lost more staff than others and terminal shortages were disproportionate for comparable offices. The SSA should determine the number of terminals that each FO needs based on staffing levels and employee responsibilities. The SSA responded that it had taken actions on staffing imbalances, computer terminal shortages and other areas in order to improve service to the public. (CIN: A-13-90-00038)

First Month of Eligibility

In 1981, the Social Security Act was amended to delay eligibility for reduced retirement benefits until the first month throughout which the individual was age 62. The effect of this amendment was that most individuals electing reduced retirement benefits at age 62 were required to wait one additional month to become eligible for their first payment. This also changed the number of months in the reduction formula applied to the benefit amount, so that monthly payments in such cases were between two and three percent higher than under previous law. Thus, the legislation resulted in a short term cost reduction due to the delay in payment, but a long term cost increase based on a higher monthly benefit.

Moreover, the 1981 amendments caused beneficiaries to be treated inconsistently when applying for age-based benefits. Those electing full retirement benefits at age 65 and those applying for reduced survivor benefits at age 60 continued to be eligible for benefits in the month of age attainment. Inconsistent definitions of month of eligibility cost the SSA trust funds approximately $900 million over a 5-year budget cycle. The OIG recommended that SSA submit a legislative proposal establishing a consistent definition of month of eligibility for age-based retirement and survivor payments. The SSA disagreed with this recommendation. (OEI-12-89-01260)

Combined Family Maximum Provision

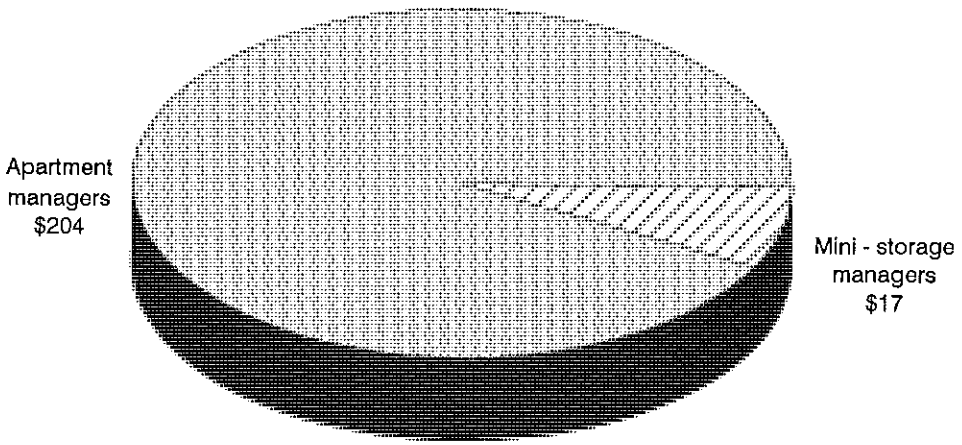
A prior OIG review found that numerous errors were made in administering the combined family maximum (CFM) provision. As a result, it was estimated that as of February 1988, overpayments of $10.8 million and underpayments of $3.9 million had occurred. The OIG recommended that SSA identify and correct the CFM records to reflect overpayments or underpayments, and remind all personnel of the need to process these cases correctly. The SSA generally agreed.

A follow-up audit showed that SSA took corrective action which resulted in the identification of $5.3 million in overpayments and $1.3 million in underpayments on CFM records as of August 1990. The SSA also issued reminders to personnel regarding policies and procedures applicable to these cases. The follow-up audit also disclosed that some CFM records were still incorrect, but that SSA was in the process of developing a new automated systems procedure to identify the cases. (CIN: A-07-90-00308)

Coverage of Employer-Provided Lodging

An OIG management advisory report discussed the policy of excluding employer-provided lodging from Social Security coverage. For two groups studied, apartment managers and mini-storage managers, the value of lodging represented a significant portion of their compensation. The OIG found that including lodging for coverage purposes would raise workers' future benefit levels, and estimated that revenue generated for the Social Security and Medicare trust funds would total $221 million for these two groups alone.

ESTIMATED REVENUE
FROM THE TAXATION OF LODGING
(in millions)



TOTAL REVENUE $221

Because hundreds of thousands of workers would benefit, OIG recommended that SSA resubmit a legislative proposal to include employer-provided lodging as wages for Social Security coverage purposes. The SSA did not support the recommendation since such a provision would result in this type of compensation being treated differently for Social Security tax and income tax purposes and would therefore be difficult to administer. (CIN: A-09-90-00050)

Fraud Involving Deceased Beneficiaries

Benefits may continue to be sent to a deceased beneficiary because the person's death goes unreported to SSA or because relatives or friends deliberately conceal it from SSA. Deliberate concealment of death and conversion of benefits constitute fraud against SSA programs. Since the success of OIG's computer matching project Spectre in the early 1980s, matches of State death records against SSA beneficiary rolls have become a required mechanism for detecting this kind of fraud. These and other computerized matches result in a continuing investigative workload for OIG. The following cases are representative of those successfully concluded during this reporting period:

- A dentist was sentenced to 4 months house arrest for Social Security benefits fraud. He was also fined $23,000 and ordered to pay a $50 special assessment on each of the 45 counts on which he was convicted. He cashed benefit checks amounting to $55,000 which continued to be sent to his deceased mother. Earlier he repaid the amount defrauded. (3-89-00374-6

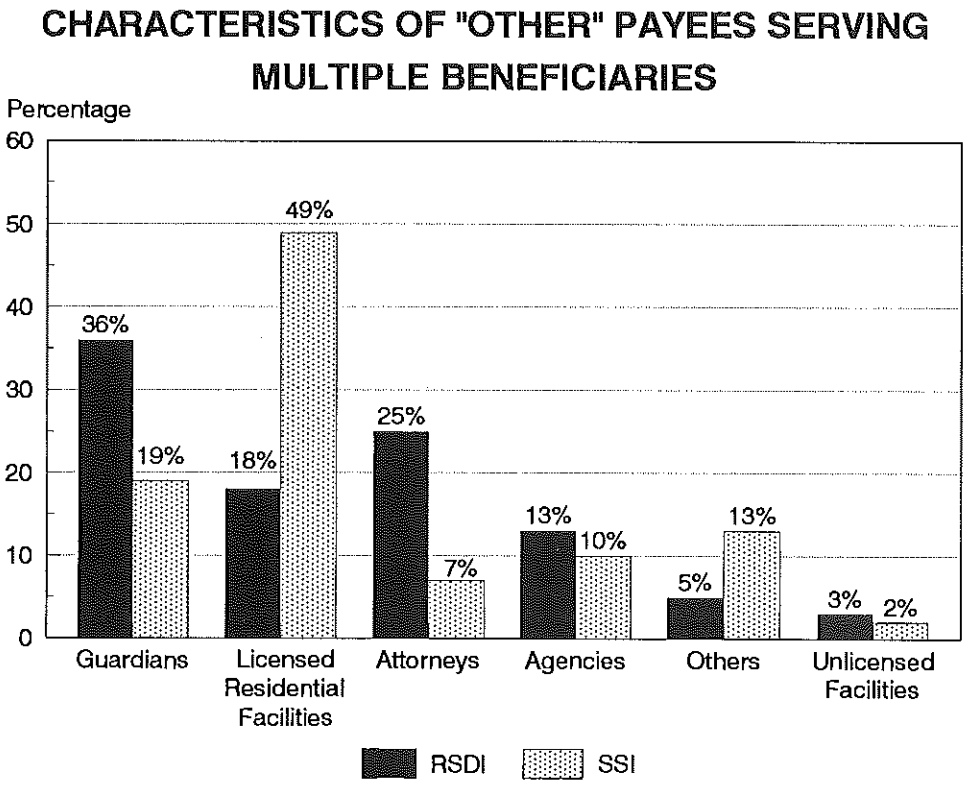
- A woman was sentenced to 2 years in prison in Minnesota for cashing Social Security benefit checks amounting to $10,200 intended for her deceased mother. Indicted in October 1987 in Iowa, the woman became a fugitive. After persistent attempts to locate her, investigators finally found her in Minnesota, where she was convicted and sentenced. (8-86-00590-6

- In Louisiana, two sisters were discovered cashing Social Security checks issued to their mother after her death. One, who was representative payee for her mother, was sentenced to 3 years supervised probation during which she must repay $10,748. Her sister was placed on a pre-trial diversion program for having cashed three of the checks. (6-87-00313-6

- A California woman was sentenced to life imprisonment without possibility of parole after being convicted of murdering her husband. She cashed her husband's Social Security benefit checks after his death by arsenic poisoning. Evidence of the check cashing was used to prove financial gain as a motive, which constituted special circumstances that mandated the harsh penalties under California law. (9-90-00384-6

Representative Payees Serving Multiple Beneficiaries

In support of the Secretary's program direction plan, and at SSA's request, OIG conducted a study to identify the types of individuals who serve as payees for multiple individuals and to determine the extent to which such payees maintain contact with beneficiaries. Relatives and public institutions are the most common type of payee. Less frequently, payees are private institutions, social service agencies, financial institutions and public officials. Unrelated individuals, coded by SSA as "other" in its computer records, also serve as payee. The OIG found that there were few "other" payees serving multiple beneficiaries, that the number of problem payees in this category was small, and that many were miscoded or inappropriately coded as "other". Most were professionals serving in an official capacity, as illustrated below.



Most reported regular contact with beneficiaries, and were subject to monitoring by the courts and other agencies. The OIG recommended that SSA resolve the incorrect coding of payee type uncovered in the study; develop a coding scheme for type of payee that would be more useful in monitoring payees; and contact the payees who did not respond to the survey to determine their continued suitability. Generally, SSA agreed with the recommendations and began taking action to more accurately identify payees under a new system. (OEI-02-90-00900)

Representative Payees for Multiple Drug Addicts and Alcoholics

Representative payees are appointed for Social Security beneficiaries who are disabled due to drug addiction or alcoholism. Frequently the payees selected in these situations are neither related to the beneficiaries nor serving in an official capacity. A potential vulnerability exists when this type of individual serves as payee for a number of drug addicts and alcoholics. In a study to determine how widespread this practice was and under what circumstances it occurred, OIG found that payees serving more than two drug addicts or alcoholics were few in number. Moreover, most of these payees appeared to have a professional relationship with the recipient and to be reputable. The few problems noted concerning mail drops and nonresponding payees were referred to SSA for determinations of payee suitability. (OEI-02-91-00951)

Representative Payee Fraud

By falsifying or concealing events or relationships, some individuals hope to capitalize on the possibility of obtaining and using benefits intended for minors or incapacitated persons. The following cases are examples of successful actions resulting from OIG investigations of these individuals:

- A Texas woman was sentenced to 52 months incarceration and ordered to pay a $7,940 restitution and a $30,000 fine for stealing her brother's Social Security benefits. In 1966, the brother was briefly hospitalized for a nervous breakdown and the woman promptly filed as his representative payee. When the brother turned 65 years old and filed for retirement benefits, he found the sister whom he had not seen in 23 years had collected at least $87,000 on his behalf. Although the judge could not order full restitution because of current sentencing guidelines, civil charges will be filed to collect the entire amount. (6-89-00365-6, Emma Brinkman)

- In Minnesota, a man was given a suspended prison sentence and ordered to pay $100 month for 20 years after he and his daughter swindled a 90-year old woman and her retarded nephew out of $120,000. After being hired to clean the old woman's condominium, the pair schemed to have the nephew marry the daughter, who became the woman's representative payee and cashed all her checks, including SSA benefits. The father and daughter put the woman in a nursing home, sold the condo and bought a house, and borrowed money in the nephew's name. As a result of the investigation, the daughter's marriage was annulled. She pled guilty earlier and also was sentenced to pay $100 a month for 20 years. (5-88-00282-6

Disability Benefits Fraud

The two primary ways individuals manage to obtain disability benefits fraudulently are by feigning a disability condition or using false Social Security numbers (SSNs) to conceal employment or other income. During this reporting period, several persons were successfully prosecuted for disability fraud:

- A New York woman was sentenced to 2 months imprisonment, 2 months confinement to a community center, 3 years supervised probation and full restitution of $88,280 in disability benefits she obtained fraudulently. A Postal Service employee, she failed to notify SSA that she went to work in 1981. She continued to collect benefits for herself and two children until 1988. She was also ordered to sign over one-half of her Postal Service benefits to SSA upon her termination, as payment toward the restitution. (2-90-00223-6

- A woman was sentenced in Virginia to 6 months in jail and ordered to pay $8,500 in fines and special assessments. Earlier she had made restitution of over $63,000 in disability benefits, Medicare premiums and benefits, and investigative costs. She claimed disability while operating a lucrative cleaning and painting business. (W-88-00134-6

- In Texas, a disability benefits recipient worked under his wife's SSN so that he could continue to receive payments. When questioned, he claimed he did it to enable his wife to obtain retirement benefits under her SSN. He entered a pre-trial agreement to pay back the $64,160 he collected fraudulently. (6-89-00294-6

- An Arizona man was sentenced to 5 years probation and full restitution of $45,690 he obtained while working under his deceased son's SSN. Receiving disability benefits since 1983 for partial paralysis from a gunshot wound, he concealed employment as a precision hand finisher of metal products from 1985 through 1989. (9-89-00472-6

Policies Concerning Drug Addicts and Alcoholics

The Social Security Act requires that SSI recipients disabled due to drug addiction or alcoholism have a representative payee, participate in an approved treatment program when available and appropriate, and allow their participation in that treatment program to be monitored by SSA. In a review to assess SSA's implementation of those requirements, OIG found that SSA was mostly unaware of the treatment status of these individuals and provided very little monitoring. Moreover, unclear guidelines have resulted in inconsistent interpretations of the law. The OIG recommended, in part, that SSA work with the Public Health Service and the Health Care Financing Administration to develop clearer definitions

for drug addiction and alcoholism status, treatment and successful rehabilitation. The SSA agreed that significant improvements are needed in this process, and identified the cooperative efforts that are either planned or underway to make the indicated improvements. (OEI-02-90-00950)

SSI Delayed Notices of Planned Action

Preliminary OIG work revealed that little has changed since an earlier study conducted by an SSA regional office. That study found that timely actions by field offices to reduce, suspend or terminate SSI benefits during redeterminations could reduce SSI overpayments. When field offices choose to allow the system to automatically generate notices of adverse action rather than taking direct action to generate such notices, one or more months of SSI payments are frequently made unnecessarily. While procedures exist for this manual action, the process is somewhat labor intensive and SSI workloads have increased. Consequently, field offices are not maximizing their opportunities for overpayment avoidance. The SSA requested that OIG defer further action pending its initiation of a comprehensive review of this situation which is scheduled to begin in FY 1992. Though OIG agreed, it has put SSA on notice that the review should focus on a systematic solution that will automate the process, thereby alleviating the burden on field office staff. (OEI-04-90-02160)

SSI Benefits Fraud

A common violation of the SSI program involves the concealment of earned or unearned income in order to continue receiving benefits. The following cases are examples of some of the successful prosecutions completed during this reporting period:

- In Iowa, the grandmother of a girl with cerebral palsy was sentenced to 10 months imprisonment for diverting the child's SSI benefits to her own use. The girl was taken away from her grandmother after being left alone for long periods in dirty diapers and suffering other abuse, but the grandmother continued to use her benefit monies. Her crime was discovered when the girl's foster parent, who subsequently adopted her, applied for SSI benefits. The grandmother was also ordered to get a job and make restitution of the $68,000 she had stolen, which is to be turned over to the girl. (6-89-00657-6

- In separate cases in Louisiana, two women were convicted of making false statements about the SSI eligibility of relatives who were serving prison terms. Both were sentenced to 4 months in a halfway house and restitution of a combined total of $30,300. One failed to report that her brother, for whom she was representative payee, had been sent to prison. The other woman, who concealed the fact that her son had entered prison, had earlier also failed to report that another son receiving benefits had been sent to prison. (6-90-00199-6, 6-90-00668-6

- An Iowa SSI beneficiary signed a pre-trial diversion agreement after being indicted for making false statements to SSA. In February 1988, he applied for and subsequently received disability benefits, claiming no income. Investigation showed he made more than $49,000 in 1988 and 1989 selling scrap metal to salvage companies. A videotape taken during an SSA redetermination session, in which he claimed a net income of only $400 a year, helped persuade him to enter the pre-trial agreement. He agreed to make restitution of $16,320 to the SSI and Medicaid programs.(8-89-00328-6

Role of the SSN Card in Immigration Control

The OIG performed a follow-up audit of actions on recommendations included in the General Accounting Office (GAO) report entitled "Immigration Control: A New Role for the Social Security Card." The OIG determined that GAO's recommendations have either been carried out or are under further study. However, OIG took exception to SSA's plans to fund on-line access to an Immigration and Naturalization Service (INS) data base to verify INS documents for aliens applying for SSNs. The OIG believes that INS, not SSA, should take SSN applications for aliens. The INS data available to SSA is not updated to reflect recently arrived aliens and INS is in a better position to verify alien status. Moreover, this would eliminate a troublesome and complicated workload for SSA field offices that was created by the Immigration Reform and Control Act of 1986.

The OIG recommended that SSA negotiate with INS to have INS certify the work eligibility of aliens applying for original SSN cards and process the SSN applications. The SSA agreed to explore with INS various issues related to INS certification. However, in August 1991, INS advised SSA that it could not undertake this project. (CIN: A-13-90-00039)

Fraudulent SSNs

Along with birth certificates and drivers' licenses, SSNs are fundamental in creating false identifications. Persons who have committed crimes use false SSNs to conceal their identities. In the northwest, OIG has been engaged in following up leads from SSA employees on suspicious applications for SSNs. The project has resulted in identification of at least 15 fugitives, such as persons wanted for the following crimes:

- a California man who kidnapped his daughter. (Guillermo Eduardo Bonilla
- a Connecticut woman who escaped prison, to which she had been sentenced for murder. (Catherine Kraft
- a man wanted for a $1.4 million theft in California. (James Gravley
- a man with an extensive record, wanted in Montana for theft, who had been arrested for assault and child abuse. (Darrell Hall

- a man who embezzled funds from his employer in Alaska and evaded Internal Revenue Service liens. (Ray Hurst
- an Alabama prison escapee, convicted of drug trafficking. (Robert Wildman
- a man wanted for child molestation in Wisconsin. (Roger Horton
- a man evading child support responsibilities in Oregon. (Kreeg Peeples

In another project in California, OIG and the Federal Emergency Management Agency identified seven persons trying to capitalize on the Loma Prieta earthquake. They used false SSNs in applying for federal disaster relief benefits when they had suffered no related property damage, did not reside where the damage occurred or reported damage on buildings that did not exist. Two persons have been sentenced, three others are awaiting sentencing, and trials are pending for two.

False SSNs are used in crimes resulting in losses in the billions of dollars, with most of the cost being passed on to the consumer in higher prices. Investigations by OIG resulted in about $11 million in fines, restitutions and recoveries from crimes in which use of a false SSN was a major factor. The following cases are examples of the wide range of crimes involving false SSNs:

- A Canadian man was sentenced to 2 1/2 years in jail for using a fraudulent SSN in attempting to negotiate a stolen certificate for 192,800 shares of a pharmaceutical company. The certificate, worth more than $7 million at the time, was one of several stolen from a courier in London. The man deposited the certificate with a stockbroker in Virginia, using an SSN issued last April to an infant in South Carolina. As part of his plea, he agreed to cooperate in tracing the movement of the other certificates. Total value of the certificates is estimated at $70 million. (3-90-00479-6

- A man was sentenced in Texas to 60 months in jail and ordered to pay $351,000 in fines and restitutions for SSN violations in an equity skimming scheme. Over a 2-year period, he intentionally defaulted on at least 12 mortgage loans insured by the Veterans Administration and the Federal Housing Administration. (6-90-00585-6

- A self-styled credit doctor and his associate were sentenced in Texas for credit and SSN fraud. The credit doctor was given 27 months incarceration, ordered to pay $282,900 in restitution and fines, and placed on 3 years supervised release. Using his position with a credit bureau, he found the SSNs of persons with good credit and sold them for $800 to individuals with like names who had bad credit. He also falsified tax returns and employment verifications in helping clients complete credit applications. At least 62 entities were victimized, including credit card companies,

automobile dealers, banks, finance companies, department stores and an air conditioning company. His associate was sentenced to 3 years incarceration and ordered to pay $91,700 for his own fraud and $83,000 jointly. (6-87-00827-6

- A man was sentenced in Rhode Island to 6 months in jail, to be followed by deportation. An illegal alien, he had been arrested for posing as a United States citizen and misusing an SSN in filing a fraudulent insurance claim. While on bail, he filed a second fraudulent claim for $52,000. (1-90-00345-6

- A Pennsylvania man was sentenced to 5 years in prison for using a false SSN to purchase firearms. He created a false identity through which he purchased at least 10 handguns which later turned up in drug-related crimes up and down the east coast. One of the guns was used in the shooting of a policeman. (3-89-00107-6

- A New Jersey man was sentenced to 3 months in jail for employing more than 100 illegal aliens at his South Carolina textile plant. He must pay $5,960 in court costs and he must pay the Government for the cost of jailing him. He pled guilty to conspiring with others to hire aliens, harboring illegal aliens and falsifying payroll records with fraudulent SSNs. Several plant officials were sentenced earlier for their part in the scheme and more than 80 aliens were deported. (4-89-00457-6

- A Massachusetts man was sentenced to 18 months incarceration for using the SSN of a friend in obtaining a driver's license. Using the friend's identity, he committed numerous traffic violations and several larcenies. He was caught only after the friend was arrested for his crimes. (1-90-00369-6

Collection and Deposit Controls

The OIG conducted an audit to determine if SSA effectively monitors its cash management practices, and efficiently collects and deposits receipts to the Department of the Treasury for credit. In general, OIG found that SSA's cash management practices were effective. However, two weaknesses were identified in the internal controls regarding the collection and deposit of receipts for program overpayments. Remittances are not date stamped upon receipt at three of the six program service centers (PSCs). Consequently, the remittances are not controlled until they are batched for processing and the processing times for the batches cannot be accurately measured. Also, five PSCs do not identify and separate large remittance amounts ($1,000 or more) as the remittances are received. As a result, large remittances are not being deposited within 1 day of receipt, as required by the Treasury Financial Manual. The OIG recommended that SSA strengthen internal controls by ensuring that all six PSCs uniformly date stamp remittances upon receipt and separate large

remittances to facilitate their deposit within 1 day of receipt. The SSA agreed with the recommendations. (CIN: A-05-90-00104)

Revising Criteria for Waiver of Overpayments

The OIG found that during the period April 1984 through March 1985, over $9 million in overpayments were waived (permanently excused) for beneficiaries who were under age 59 and whose earnings in the 4 years subsequent to the waiver decision provided them with sufficient resources to make repayment. These waivers were granted in accordance with current SSA policy. Most overpayments were waived because the individuals were determined to have been without fault in causing the overpayment and recovery would have caused financial hardship at the time.

The OIG recommended that SSA seek a regulatory or 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 due process considerations of their financial condition using the current criteria for financial hardship. However, if SSA determined that the individual's current financial condition did not permit repayment, collection efforts would be suspended or terminated rather than waived. The SSA could then resume collection efforts if and when it was discovered that the debtor had the financial ability to repay the overpayment. The SSA disagreed with the recommendation. (CIN: A-05-90-00034)

Overpayment and Underpayment Resolution for Nonresident Aliens

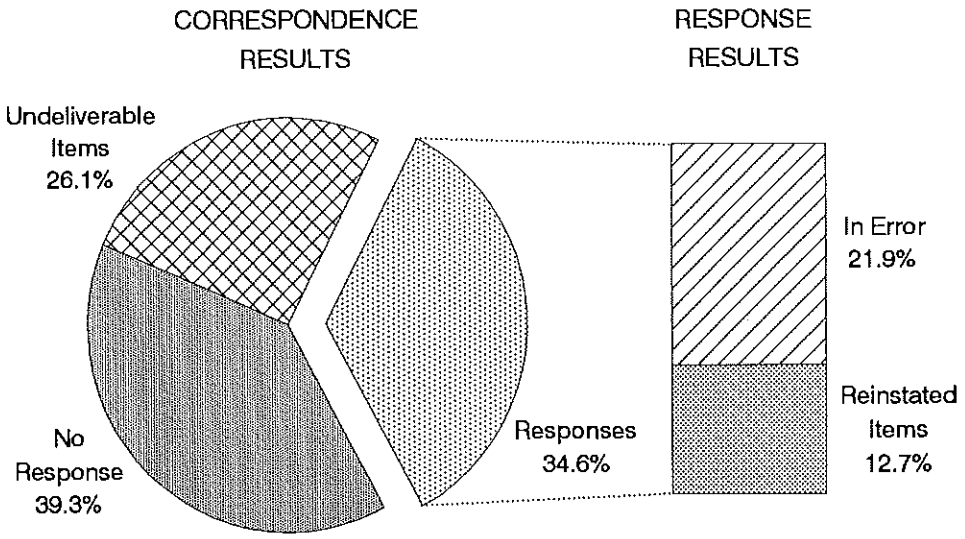
A prior OIG review found that the absence of formal guidelines prevented SSA from collecting overpayments and resolving underpayments for nonresident alien beneficiaries. There was a backlog of almost 8,000 cases involving approximately $12.4 million in overpayments and $2.6 million in underpayments. The OIG recommended that SSA revise its procedures and automated systems. In a follow-up review, OIG determined that SSA had implemented revised procedures and modified its system. As a result, cases were being processed as detected and the backlog was being reduced. However, OIG proposed that this could be done more efficiently if further systems enhancements were made. The SSA agreed that these enhancements should be expedited. (CIN: A-13-90-00037)

Decentralized Earnings Correspondence Process

The OIG reviewed SSA's decentralized earnings correspondence (DECOR) process and other related operations used to correct name and SSN errors in reports of earnings. The OIG found that DECOR was only marginally effective in correcting the name and SSN errors that prevented these earnings from being credited to individual earnings records. For Tax Year 1988, SSA processed 12.3 million wage items with name and SSN errors through

DECOR. As illustrated by the following chart, only 12.7 percent of these wage items were corrected through this process.

DECENTRALIZED EARNINGS CORRESPONDENCE
Fiscal Year 1988



The OIG attributed the lack of an effective correction process primarily to inadequate management attention to a critical operation. The OIG made numerous recommendations to substantially improve SSA's capability for correcting name and SSN errors for reported earnings. The major changes proposed included: identifying, upon receipt, report formatting problems and working with employers to resolve these errors; enhancing automated routines to identify and correct errors; directing correspondence to employers instead of employees; and stressing the importance of resolving errors over processing goals. The SSA agreed with most of the recommendations, and began implementation of these as well as other actions proposed by its own work group. (CIN: A-13-89-00040)

Payment History Update System

Pursuant to the 1983 amendments to the Social Security Act, Social Security benefits became subject to Federal income taxation. As a result, SSA was required to prepare an annual benefit statement on each beneficiary of the Retirement, Survivors and Disability Insurance programs. The SSA created the payment history update system (PHUS) database

to capture actual payment history for these statements. An OIG audit was undertaken to assess the sufficiency of SSA's internal controls over PHUS and the resulting accuracy of PHUS information used to produce the benefit statements. Based on the testing performed and the procedures in place for the production of the benefit statements, OIG believes that SSA has sufficient controls in place to provide reasonable assurance that benefit totals are accurately calculated and benefit statements are produced. (CIN:A-04-90-03007)

Frequent Callers to the 800 Number

Performance Indicator

The SSA initiated the 800 number telephone service in October 1988 to provide improved service to the large number of clients who previously had to call or visit local field offices. Although the service was intended to serve individual clients, a recent analysis of billing tapes revealed that there were many frequent callers to the 800 number. The OIG identified over 6,400 numbers that called more than 30 times during a month and 120 numbers that called over 200 times. Of the 120 most frequently calling numbers, 68 percent belonged to organizations, such as government agencies, private businesses and hospitals. The majority of these calls appeared to have been made by employees calling for personal reasons. A notable exception was hospital personnel who called to verify Medicare coverage for patients. The hospital calls included those made by private hospitals for whom SSA was no longer to provide such information by phone. The SSA indicated that private hospitals were being notified of the client information policy change as the OIG inspection took place. This clarifies why there were calls from private hospitals at that time. The OIG recommended that SSA analyze frequently calling numbers on a regular basis and that SSA reevaluate its practice of providing client information by telephone to hospitals. (OEI-02-91-00222)

Social Security Offices Calling the 800 Number

In its study of the 800 number telephone service, OIG found that certain telephone numbers were each originating hundreds of calls to the 800 number in a single month. Upon further analysis, OIG identified seven Social Security offices as some of the frequent callers. Discussions with SSA staff revealed that these offices were most likely using a call forwarding process to switch the calls to the 800 number. Not only does this practice tie up two SSA lines for one call, but if left to continue, it could violate the congressional mandate to restore telephone access to local offices. The practice also fails to educate the public about the availability of the 800 number. In addition, SSA is paying for any costs incurred for installing and using the call forwarding feature. The OIG recommended that SSA take necessary action to evaluate the practice by some of its offices of redirecting calls to the 800 number and take appropriate corrective action. The SSA's response stated that all seven instances identified in the OIG review were evaluated and that there were reasonable explanations for each occurrence. (OEI-02-91-00221)

Employee Relocation Practices and Procedures

In 1983, the Congress authorized, as part of Public Law 98-151, that Federal employees be reimbursed for taxes paid on any reimbursement received for the expenses of relocating, and that agencies enter into contracts to provide relocation services to agencies and employees. A purpose of these changes was to retain quality employees who would otherwise leave Government service rather than bear the financial burden of Government-directed moves. The OIG conducted a review to determine whether SSA had developed and implemented policies, procedures and controls to ensure that employee relocations were conducted efficiently, effectively, economically and in accordance with the new law.

The OIG identified several ways in which the SSA employee relocation program could be improved. Opportunities exist for potential cost savings in the areas of home sales, house hunting trips and temporary quarters which would not cause undue hardship to employees. The SSA agreed with some of the recommendations, but disagreed with others in the belief that they would adversely affect employees. (CIN: A-13-89-00018)

PUBLIC HEALTH SERVICE

Chapter IV

PUBLIC HEALTH SERVICE

Overview of Program Area and OIG 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; Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), to conduct biomedical and behavioral research on mental and addictive disorders and to assist States in refining and expanding treatment and prevention services through ADAMHA's science-based leadership; Centers for Disease Control (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support through financial assistance the development of our future generation of health care providers; 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; and 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. The PHS will spend approximately $17.2 billion in Fiscal Year (FY) 1991.

The Office of Inspector General (OIG) continues to increase oversight of PHS programs and activities. The OIG concentrates on such issues as biomedical research, substance abuse, acquired immune deficiency syndrome and medical effectiveness. In addition, OIG conducts audits of colleges and universities which are awarded contract and grant funding by the Department of Health and Human Services (HHS). Recent congressional hearings and audits have raised questions concerning the propriety of charges made to research grants and contracts by colleges and universities, particularly in the area of indirect costs. The OIG will be examining the systems in place to ensure that research funds are monitored properly. Other areas of review will include grants management in general, food and drug programs, migrant health, community health centers, community mental health programs, infant mortality programs, student loans and IHS financial management.

Internal Control Weaknesses

- The OIG reported that NIH had generally weak safety procedures which were frequently not followed when moving property exposed to hazardous materials. The PHS stated that the weakness was combined with an earlier material weakness reported by NIH under the Federal Managers' Financial Integrity Act (FMFIA) concerning management of its personal property. The PHS agreed to expand the corrective actions regarding the previous weakness to include correction of the safety hazard condition. (CIN: A-15-89-00059) (See page 83)

- The OIG determined that current FDA regulations do not prevent clinical investigators from having a financial interest in companies for which they are testing products, posing a potential conflict of interest. (OI-HQ-91-003) (See page 80)

- The OIG found that FDA employees are circumventing or ignoring internal controls over imprest funds (petty cash) accounting. (OI-HQ-91-006) (See page 82)

Federal Research Funding to Colleges and Universities

The OIG report on the cost of Federal funding for research at colleges and universities included a summary of over 2,000 OIG audits conducted between October 1988 and February 1991. The report discussed OIG strategies for addressing issue areas associated with HHS funding for biomedical research, and some options for ensuring that limited funds are equitably apportioned for the direct and indirect costs of research conducted by these institutions. Issues identified in the report formed the basis for hearings held by the Committee on Appropriations, U.S. House of Representatives.

The OIG reported that Federal funding for science at colleges and universities has reached $9.2 billion per year, of which about $2.5 billion is for indirect costs and $6.7 billion is for direct research costs. Of the 276 colleges and universities receiving 96 percent of Federal funds, 237 are under the cognizance of HHS. The OIG report stated that over the years serious questions have been raised about the amount of Federal funding being diverted to indirect costs (unallocated overhead or burden). These issues have been underscored by recently identified questionable charges to indirect cost pools by certain schools.

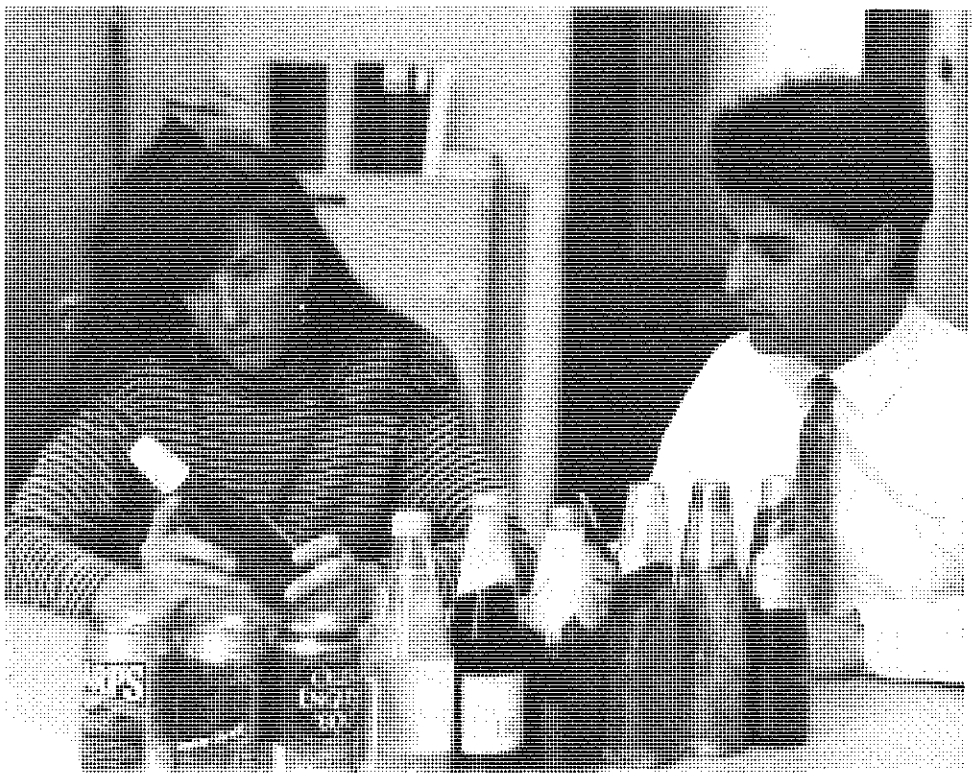
Options highlighted by OIG for better assuring the appropriate division of Federal funds between indirect costs and direct research costs included: revising the Office of Management and Budget Circular A-21, which provides guidance for determining the costs

applicable to direct research or indirect costs at the educational institutions; issuing block grant research dollars to universities; awarding research dollars to principal investigators; mandating a standardized accounting system for the major colleges and universities hosting Federal research grants; capping the indirect cost rate; limiting future indirect cost rates to a level that does not exceed the 1991 negotiated rate; limiting the indirect cost rate for Government research grants to the lowest level charged by the institution to other U.S. and foreign entities; mandating cost sharing for research; limiting indirect costs to only those expenditures that are added-on costs to the institutions for supporting research; increasing funding levels for Federal oversight efforts at educational and nonprofit institutions; eliminating Governmentwide rules and allowing granting agencies to negotiate the rates for their agencies' grant programs separately; and seeking legal authority for the actual recovery of inappropriate expenditures charged to indirect cost pools to be returned for programming for future funding of science. (CIN: A-15-91-00033)

Youth and Alcohol

In response to public health concerns, the Surgeon General requested that OIG survey youth to determine their views and practices regarding alcohol use. In one such survey of junior and senior high school students, OIG found that more than half of all 7th through 12th graders have had at least one drink in the past year and that 8 million students drink weekly. More than 5 million students in this group have binged (had five or more drinks in a row) and nearly half a million binge weekly. The average binger is a 16-year old white male in the 10th grade who took his first drink when he was 12 years old. Many students accept rides from friends who have been drinking. Moreover, 7 million students are able to walk into a store and buy alcohol, despite the minimum age laws. The survey also found that students lack essential knowledge about alcohol and its effects; that 9 million of them get their information about alcohol from unreliable sources; and that parents, friends and alcoholic beverage advertisements influence students' attitudes about alcohol.

In a separate survey, OIG found that two out of three students were unable to distinguish alcoholic beverages from non-alcoholic beverages. Even after reading the labels on all cans and bottles in a panel of beverages, less than half the students correctly identified the beverage containing the most alcohol. Students were especially unaware of the alcohol content of wine coolers, although coolers are favored almost two to one by students who drink alcohol.



The OIG recommended that the Surgeon General: consult with public and private agencies to develop, improve and promote educational programs to increase student awareness of alcohol's effects; collaborate with the appropriate public and private agencies to reduce the appeal of alcoholic beverage advertising to youth; work with the beverage industry, and State and Federal officials to improve the labeling and packaging of alcoholic and non-alcoholic beverages; and emphasize the need for law enforcement and State alcoholic beverage control agencies to prevent youth from illegally purchasing alcohol. In response to the recommendations, the Surgeon General has convened an interagency task force on alcohol labeling and packaging, including representatives from ADAMHA, FDA, the Bureau of Alcohol, Tobacco and Firearms, and the Federal Trade Commission. (OEI-09-91-00652; OEI-09-91-00653)

Alcohol, Drug and Mental Health Services for Pregnant Addicts

Performance Indicator

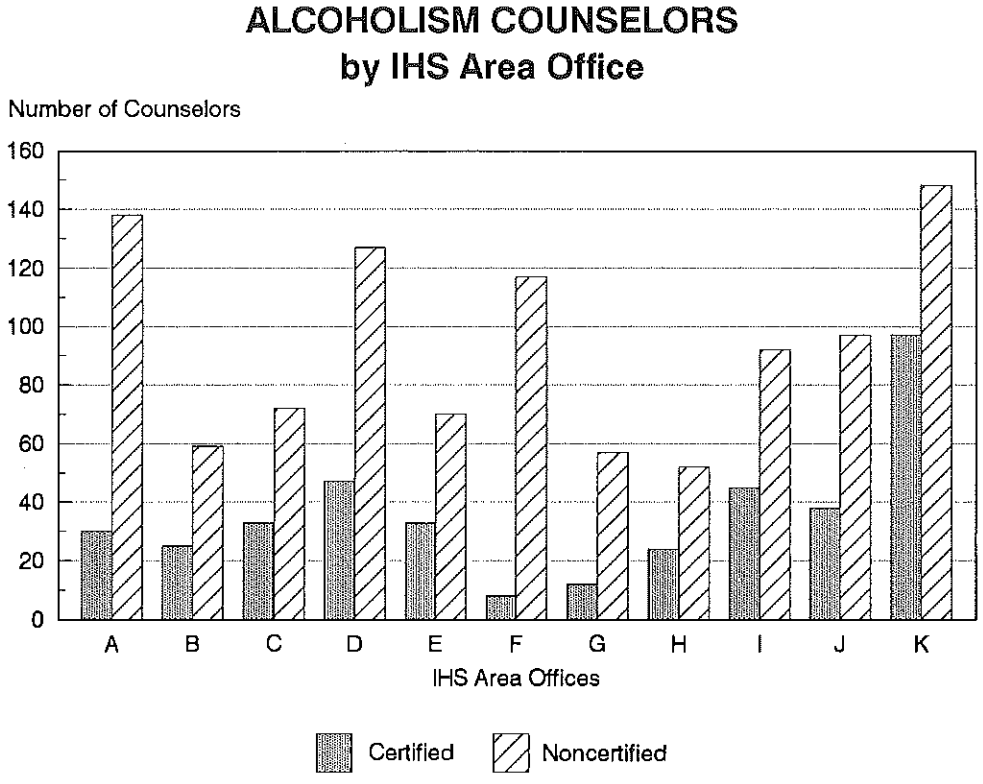
The OIG conducted an inspection to determine if those agencies receiving Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant funds were providing services to pregnant addicts. Because States are not required to provide specific funding figures on specific agencies to the Office of Treatment Improvement, individual grantees may be

unaware of the ADMS funds that their agency is receiving. Grantees are sometimes awarded one lump sum of money by their State agency without any breakdown of the funding sources. The OIG found that one half of the agencies polled served pregnant addicts, even though the addicts represented an extremely small portion of the total client population of these agencies. However, rather than being specialized, most of the services provided to the pregnant addicts were the same as those provided to the agencies' general populations. (OEI-05-91-00064)

IHS Youth Alcohol and Substance Abuse Programs

Performance Indicator

Public Law 99-570 mandates and funds the development of treatment programs and centers for Indian youth who are alcohol and substance abusers. In a study conducted to determine the extent of IHS implementation of this law, OIG found that a number of weaknesses exist in IHS's oversight program. The IHS has not established regional treatment centers in all service areas, nor has the Bureau of Indian Affairs of the Department of Interior completed establishment of emergency shelters for substance abusers. The IHS has not finalized alcoholism treatment standards or met its own quality assurance objectives. Nearly two-thirds of the alcoholism counselors are not certified.



Current management information systems are outmoded and ineffective for monitoring alcohol program activity. The OIG recommended that IHS take specific action to see that problems in these areas are corrected, and that regional treatment centers and emergency shelters are established in all IHS service areas. The IHS concurred with all recommendations. (OEI-07-89-00940)

IHS Medicare and Medicaid Payments

Current legislation requires that Medicare and Medicaid payments due IHS be held in the Secretary's special fund account and used exclusively for making improvements in hospital facilities to assure compliance with the Health Care Financing Administration's (HCFA's) conditions of participation in the Medicare and Medicaid programs. The legislation provides for the special account only until the Secretary certifies that substantially all the IHS facilities have met these conditions of participation. The OIG determined that all IHS hospitals meet HCFA's conditions of participation. Further, the special fund is vulnerable to abuse because monies can be used over the course of 3 fiscal years. The OIG recommended that the special fund be phased out. The PHS did not concur with the recommendation. (OEI-07-89-00941)

Fraud and Abuse in IHS

Over the past 5 years, OIG investigations into fraud and abuse in IHS have almost tripled. Moreover, a sizable proportion of these investigations have involved IHS employees, including high-level managers. Problems have included travel fraud, procurement improprieties and fiscal irregularities. The following examples are indicative of the problems at IHS:

- In Maine, a tribal representative and a contractor billed an Indian tribe for a sanitation system which was never installed. Investigation revealed that the tribal representative operated with little oversight, determining eligibility for program assistance, selecting the contractor, inspecting the completed work and initiating payment. He and the contractor conspired to split the money for the job. The contractor was convicted of theft of government property; the tribal representative died before charges were brought. (I-89-00219-4)

- The OIG reported to IHS the potential for conflict of interest in its contract health care program. The report was triggered by an investigation of a contract health specialist in Minnesota for allegedly causing services to be paid for illegally for herself and her family. Although the allegation was unfounded, it was noted that IHS had no system to prevent such abuse. Indeed, in an earlier case in South Dakota, an IHS administrative officer had caused unauthorized disbursement of funds for services for her son and her nephew. (5-90-00815-4; 8-89-00130-4)

Over the past 6 months, OIG has forwarded 11 complaints and matters for administrative action to IHS, all related to allegations of misconduct on the part of employees. Through redoubled attention and periodic evaluations, OIG intends to assist IHS in its efforts to eliminate fraud and mismanagement from its programs.

Selected Management Functions at IHS Area Office

In response to allegations of mismanagement and misuse of funds, OIG conducted a review at the IHS Bemidji Area Office. The OIG found that most of the Medicare and Medicaid reimbursement received in FYs 1987 through 1989 was used to support ongoing program operations instead of meeting or maintaining accreditation standards as required by law. In addition, OIG noted inconsistencies in the approval and payment of claims to health providers for contract health care services. During the review, OIG also discovered allegations of harassment and reprisal against Bemidji Area Office personnel who had reported fraud and mismanagement at IHS.

The OIG recommended that IHS immediately establish procedures to ensure proper use of Medicare and Medicaid funds in accordance with approved spending plans; strengthen its management controls to ensure consistency in the approval and payment of claims for contract health care services; and have a neutral party from outside IHS further investigate and take action on the alleged instances of harassment and reprisal against whistleblowers. (CIN: A-05-90-00078)

Food Safety Inspections

Performance Indicator

The OIG determined that FDA assigns a low priority to food inspections of low-risk firms, despite the potential for serious problems in these firms. Further, there are no national requirements for the inspection of low-risk firms, and not all food firms are known to FDA and the States. The OIG recommended that FDA delegate responsibility for inspecting these firms to the States while it assumes the role of oversight, developing standards and providing technical assistance to the States. The OIG also recommended that FDA design a uniform system to ensure systematic identification of all food firms, develop requirements for low-risk food safety inspections and certify which States meet these requirements. To fund these activities and the inspections to be carried out by the States (or by FDA in States that do not meet certification requirements), OIG proposed that FDA collect a user fee from all food firms which would be earmarked for food safety inspections. Although PHS concurred with the OIG recommendations, it noted that implementation would require significant changes in legislative authorities, State/Federal relationships and funding of FDA operations. (OEI-05-90-01070)

Clinical Investigator Conflict of Interest

The OIG reported a serious material weakness related to financial relationships between clinical investigators and sponsors of research leading to FDA approval for marketing products. During a recent OIG investigation into a Medicare provider kickback scheme, it was discovered that at least 100 of 125 physicians who were serving as clinical investigators for a firm in studies of new medical devices had been approached by the firm with investment proposals. Current regulations require that investigators be qualified experts, but are silent on the issue of their financial interest in firms which have selected them to study products the firms hope to market. The OIG recommended that FDA require sponsors to obtain and submit statements of potential investigators' financial relationship to the sponsors, to ensure the integrity of the marketing approval process.

While PHS did not agree that this issue constituted a material weakness, FDA has formed a task force to assess whether clinical investigators' ownership of equity interest in companies whose products they are testing affects the quality of information submitted in pre-marketing applications. The OIG is awaiting the task force's findings, which are anticipated in June 1992. (OI-HQ-91-003)

Generic Drug Investigations

Over the past 3 years, the generic drug industry has been rocked by a series of prosecutions resulting from OIG investigations. The prosecutions have occurred in two phases: a corruption phase, which involved the giving of illegal gratuities to FDA employees by generic drug companies, and a fraud and false statements phase, in which the companies engaged in various deceptions regarding the testing and manufacturing of their products.

Prosecutions are essentially completed on corruption charges resulting from these investigations. Over a 2-year period, three generic drug companies, five company officials and a consultant, and five FDA employees were convicted and sentenced for schemes in which the companies paid to receive favorable processing of their generic equivalents. As a result of the scandal, FDA is restructuring the approval process.

In the second round of prosecutions on charges of fraud, false statements and manufacturing malpractice, two companies have been sentenced for obstructing an FDA investigation into irregularities in the bioequivalency testing required for generic drug approval. A major generic drug company was fined $10 million, plus $380,000 in restitution for the cost of the OIG and FDA investigation, for substituting a brand name product for the company's generic product in testing for bioequivalency. The laboratory which conducted the tests was fined $200,000 for its part in the deception, which included replacing the brand name product with the generic when FDA investigators arrived on the scene. Further prosecutions and sentencings are scheduled. (W- 89-00084-3

Evaluation of FDA Drug Master File Reviews

The OIG was unable to determine the full extent of any failure by chemists in FDA's Division of Generic Drugs (DGD) to review drug master files (DMFs) during the generic drug review and approval process. The OIG found that DGD had not developed adequate policy and procedures, or established other effective internal controls to ensure that DMFs were accurately and completely reviewed in a uniform, consistent and comprehensive manner. This caused a wide variance in the number of DMFs selected for review in relation to the number of abbreviated new drug applications approved by individual chemists.

The OIG noted that this deficiency could impair the accomplishment of FDA's mission, which constitutes one of the criteria of a material internal control weakness under the FMFIA. Because the Secretary already reported a material weakness in the internal control structure for the generic drug evaluation process, this issue need not now be reported separately. However, OIG believes that FDA's comprehensive action plan should be revised to incorporate the current OIG recommendations in order to fully address and correct deficiencies in the DMF review process. (CIN: A-15-90-00004)

Review of Promotional Activities

The OIG alerted the Assistant Secretary for Health of a possible violation of Federal regulations pertaining to the pre-approval of an investigational new animal drug, bovine somatotropin (bST), under review by FDA. The OIG found that one of four firms pursuing FDA approval to market bST had produced and disseminated materials claiming that bST was safe and effective. The PHS agreed with OIG's findings, and FDA itself has completed a review of all pre-approval promotional materials of the four bST firms and the Animal Health Institute. The FDA's review concluded that some type of regulatory action was required in each case to ensure that the groups did not improperly promote an unapproved drug. (CIN: A-15-91-00007)

Hospital Reporting of Adverse Drug Reactions

The OIG surveyed over 800 hospitals and found that the majority knew how to report adverse drug reactions (ADRs) to FDA. In addition, the hospitals reported a variety of activities in support of ADR monitoring and reporting. The OIG noted, however, that several factors affected hospitals' reporting ADRs to FDA, including a hesitation to make such report when there was uncertainty that a drug had caused a given reaction. The OIG recommended that FDA clarify for hospitals the role of causality assessment when reporting ADRs to FDA. Further, OIG proposed that FDA conduct pilot studies to gain a better understanding of the reasons for which hospitals hesitate to report ADRs and to develop methods to encourage reporting by hospitals. (OEI-12-90-01000)

Drug Industry Visits to FDA Employees

The OIG reported on the problem of unscheduled and unsupervised drop-in visits at PHS' Parklawn building to application reviewers in FDA's Center for Veterinary Medicine (CVM) by representatives from the animal drug industry that CVM regulates. Drop-in visits provide an opportunity for industry representatives and others to attempt to improperly influence drug reviews or gain access to confidential information. Such improprieties, if they were to occur, could undermine the public's confidence in FDA's ability to protect the public from harmful or ineffective drug products. The OIG determined that because the Parklawn building was an open, unsecured facility and CVM did not establish effective internal controls, industry representatives had almost unlimited access to CVM staff and work space.

The OIG recommended that FDA issue a letter to the regulated industry stating that drop-in visits to CVM employees are strictly prohibited and establish adequate internal control procedures to enforce this prohibition. Since the issuance of the OIG report, CVM moved to new secure office space in Rockville, Maryland. The OIG has been assured by CVM management that access to application reviewers will be strictly controlled. Visitors will be logged in and an escort will be required to enter CVM offices. Also, CVM has notified the regulated industry, consumer groups and others of procedures to be used in scheduling meetings at the new facility. (CIN: A-15-91-00009)

FDA Imprest Fund Accounting

The OIG reported that internal controls in place for FDA's petty cash accounts, or imprest funds, are easily circumvented. Recent investigations uncovered instances in which:

- An imprest fund cashier in Minnesota was aware of when "surprise" audits were scheduled, and covered up embezzlement during that period.

- The cashier in a New York laboratory gave funds to an electronic technician upon verbal request, then failed to alert management to suspicious-looking documentation submitted later which turned out to be false.

- An FDA official in Georgia failed to alert management to questionable receipts submitted by a custodian.

- A district manager received $1,500 in cash advances by submitting three requests for $500, thereby circumventing the control of withholding payment for miscellaneous transactions over $500.

The OIG pointed out that these incidents were evidence of a material weakness and recommended that FDA take steps to ensure that their employees comply with FDA guidelines and requirements concerning imprest fund accounting. (OI-HQ-91-006)

Prescription Drug Promotion

The OIG found that pharmaceutical companies offered money and other items of value to physicians for a range of activities, from sponsoring important educational activities to actively promoting their products. Offers used for promotional purposes fell into four major categories: participation in studies, speaking engagements, program attendance and gifts. Promotional practices involving items of value appeared to affect physicians' prescribing decisions. New guidelines concerning promotional practices have been adopted by the American Medical Association and the Pharmaceutical Manufacturers Association, but their effect on promotional practices and physician behavior cannot yet be determined. (OEI-01-90-00480).

Drug Abuse Treatment Waiting List Reduction Grant Program

The OIG found that under this one-time grant, almost all grantees increased capacity and most reduced their waiting lists and periods for drug treatment. This improvement was, however, only a temporary solution to the problem. Additionally, waiting lists were found to be an inadequate indicator of treatment need. The OIG recommended that if grants of this type are contemplated in the future, waiting lists should be considered with other indicators of need. Also, the grant period should be longer and have a maintenance of effort clause. Finally, OIG recommended that ADAMHA develop a uniform definition of "waiting list" and a systematic way of maintaining waiting list data. (OEI-02-91-00420)

Movement of Hazardous Property

The OIG conducted a review in response to anonymous allegations that contaminated laboratory property, which was unsafe to move, was being moved from various NIH locations. The OIG found weaknesses in NIH's safety procedures which may have contributed to several hazardous property incidents that could have harmed NIH employees, contractors and the general public. The weaknesses are considered to be material under FMFIA. The PHS declared NIH's property management system a material internal control weakness in its FY 1990 FMFIA report, citing various problems including the need for improved controls over the safety of property being moved. The PHS agreed with OIG's recommendations and stated that corrective action would be taken to address the weaknesses identified. (CIN: A-15-89-00059)

Performance Indicators for State Medical Boards

In an effort to contribute to the development and use of performance indicators for State medical boards, OIG formulated a list of 20 basic questions and identified the extent to

which the annual reports of the boards provided answers to those questions. The study focused on questions concerning medical licensure and discipline. The OIG found that the annual reports provided few answers to the 20 questions. Among the 26 reports reviewed, two answered none of the questions; the others rarely provided trend data. Only three reports answered any of the three questions concerning processing time for cases under review.

The major value of performance indicators is the opportunity they provide to make comparative assessments and to raise questions on how performance can be improved. The OIG suggested that State legislatures mandate that boards establish a series of performance indicators and provide data on them in annual reports. Toward this end, the National Conference of State Legislatures, the National Governors' Association, the Council of State Governments, the Federation of State Medical Boards and PHS can play valuable supportive roles as agents for the exchange of ideas and information. (OEI-01-89-00563)

Community Based Organization Projects for Prevention of Human Immunodeficiency Virus

At CDC's request, OIG conducted 37 recipient capability audits to evaluate the financial management capabilities of potential grantees who had not previously received governmental grants or cost-reimbursement contracts. These audits involved applications for FY 1990 funds authorized by the Congress to provide technical assistance to minority community based organizations to work with their communities in achieving a reduction of the risk of human immunodeficiency virus transmission.

The audits disclosed a total of 177 deficiencies, mostly due to the absence of adequate time and attendance records or other labor certification systems; property management and equipment accountability; and policies and procedures for procurement, accounting systems and travel. As a result of the these audits, CDC denied funding to eight organizations, awarding funds to other organizations instead. It also classified 12 organizations as exceptional, thereby requiring them to comply with the rules of organizations showing evidence of poor program or business management, and required 27 organizations to submit monthly requests for advance payments to CDC for review. (CIN: A-04-90-04011)

Embezzlement of Grant Monies

Convictions were obtained in two major embezzlement cases which involved grant monies administered by PHS:

- A former official of a New York medical college and two co-conspirators were sentenced for embezzling almost $1.6 million from the school. More than $800,000 of this amount was grant money from NIH. The school official who managed grant funds and accounts payable diverted money

through "dummy" grants and payments to two men who were not associated with the school. The official was ordered to pay $513,660 immediately and another $750,000 within 10 years, and was sentenced to 2 to 6 years in prison. One co-conspirator was ordered to pay another $85,000 immediately and $215,000 within 10 years, and was sentenced to 90 days in the county jail. The other paid $18,000, must pay $72,000 within 10 years, must perform 250 hours of community service and was given 5 years supervisory probation with electronic monitoring. The conspirators' scheme was uncovered after a college employee questioned the authenticity of a signature on a payment request. (2-90-00779-4

- The former president and executive director of a Pennsylvania methadone clinic was sentenced to 27 months in prison for embezzlement. He was also ordered to make restitution of $187,000 after pleading guilty to embezzlement, retaliation against a Federal witness and income tax evasion. He had skimmed cash from receipts collected from patients, all the while telling State auditors the clinic accepted no cash. As a result of the loss of this income, the clinic's grant money was increased, including money from HHS. The clinic's former chief financial officer pled guilty earlier and cooperated in the case. (3-89-00367-4

Audit of ATSDR Costs

The ATSDR is funded through an interagency agreement with the Environmental Protection Agency (EPA). The ATSDR performs activities related to toxic substance contamination, such as health assessments at toxic waste sites. The OIG determined that ATSDR had not been timely in its actions to comply with EPA requirements to establish a system for identifying site-specific costs. Identification of costs by site is necessary to provide a defensible basis for recovery of costs from those who create hazardous waste sites.

By the close of OIG's review in January 1990, ATSDR had completed that part of a cost accounting system related to direct costs, but did not expect to have the part related to indirect costs operational until FY 1991. However, it did not plan to include in the new system about $19 million in costs incurred in FYs 1987 and 1988. At OIG's request, the agency consulted with EPA and the Department of Justice on whether it would be advisable to include these costs in the new system. The agency was advised that reconstructing these costs would not be an effective use of Superfund money. (CIN: A-04-88-04029)

HRSA Control over Audit Disallowances

An OIG audit of selected disallowance determinations processed in FY 1988 showed that HRSA had inadequate procedures for tracking disallowance determinations. As a result, of the 42 determinations OIG reviewed totaling nearly $2.2 million in disallowances, HRSA

had failed to pursue collection of a disallowance totaling approximately $104,000, and had not reduced a grant award authorization by the $49,000 required by a disallowance determination. In addition, for the determinations reviewed, HRSA had not assessed over $89,000 in late penalty charges, administrative costs and interest on delinquent accounts.

The OIG recommended that HRSA take action to collect the above amounts that remain outstanding and any similar amounts involving audit disallowances not included in the determinations reviewed. The OIG further recommended that HRSA improve its controls over the audit disallowance collection process. The PHS generally agreed with the findings and recommendations. (CIN: A-15-89-00035)

ADMINISTRATION FOR CHILDREN AND FAMILIES

Chapter V

ADMINISTRATION FOR CHILDREN AND FAMILIES

Overview of Program Area and OIG Activities

Effective April 15, 1991, the Secretary created a new operating division within the Department, the Administration for Children and Families (ACF), combining the programs of the Family Support Administration and the Office of Human Development Services, with the exception of the Administration on Aging. The new division was formed in order to heighten the emphasis on children and families at the national level, and promote the delivery of coordinated, complimentary and integrated services and assistance by the Department. The ACF provides Federal direction and funding for State, local and private organizations as well as for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. It also oversees a variety of programs that provide social services to the Nation's children, youth and families, persons with developmental disabilities and Native Americans.

Family support payments to States encompass: Aid to Families with Dependent Children (AFDC), a cooperative program among Federal, State and local governments which reaches 4.3 million families consisting of 12.4 million individuals each month; the Child Support Enforcement (CSE) program, which provides grants to States to enforce obligations of absent parents to support their children by locating absent parents, establishing paternity when necessary, and establishing and enforcing child support orders; and Child Care, which frees eligible welfare mothers for training and employment. Head Start is a $1.9 billion per year program which provides comprehensive health, educational, nutritional, social and other services primarily to pre-school children and their families who are economically disadvantaged. The Foster Care and Adoption Assistance program provides grants to States to assist with the cost of foster care and special needs adoptions, maintenance, administrative costs and training for staff; the program's goal is to strengthen families in which children are at risk, reduce inappropriate use of foster care, and facilitate the placement of hard-to-place children in permanent adoptive homes when family reunification is not feasible. The Low Income Home Energy Assistance program (LIHEAP) provides block grants to the States and Indian tribes to help offset the increased cost of fuel for low income households, including recipients of AFDC, food stamps and Supplemental Security Income. Other programs include Emergency Assistance, Refugee and Entrant Assistance, Community Services, Job Opportunities and Basic Skills Training (JOBS), and the State

Legalization Impact Assistance Grants (SLIAG) program. Expenditures for ACF programs will total $27.6 billion for Fiscal Year (FY) 1991.

The Office of Inspector General (OIG) performs reviews to assess the cost-effectiveness of the various social services and assistance programs, including determining whether persons participating are eligible, authorized services are provided and financial matching requirements are met. The OIG analyzes the programs to determine whether they are accessible to authorized participants and provide services appropriate to promoting self-sufficiency most effectively. Implementation of the Family Support Act of 1988 (Public Law 100-485) is one of the Department's highest priorities. The OIG is actively involved in monitoring that implementation to detect fraud, waste and mismanagement of Government monies. In addition, OIG is undertaking several inspections and audits to review the implementation of the strengthened CSE provisions of the Act, and the new provisions designed to help meet the costs of the new child care, training and other components of welfare reform. Studies also include work in the areas of Office of Community Services activities, programs for the homeless, refugee resettlement, LIHEAP, and the Head Start and Foster Care programs.

Readiness to Expand Head Start Enrollment

Performance Indicator

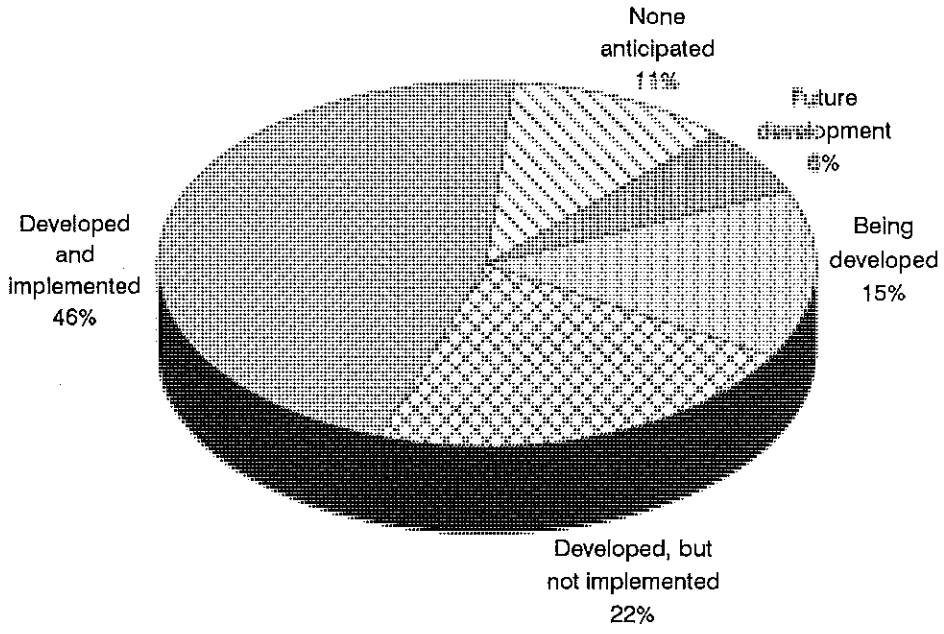
An OIG inspection was conducted at the request of the Assistant Secretary for Management and Budget to assess the capacity of the Head Start system to successfully manage the current and future expansion process. Two rounds of expansion funding took place in FY 1990, the first for $100 million, the second for $166 million. During FY 1991, expansion funding totaled $159 million. This expansion funding was expected to add about 148,500 new children to the program.

The OIG found that goals for the FY 1990 first round were met and grantees expected to meet the second round by September 1991. Grantees reported that acquiring space was the most serious expansion problem. The OIG also determined that the Federal capacity to manage expansion was limited because of inadequate regional and headquarters staff resources, problems of communication between headquarters and regions, and the lack of timely data on grantee enrollment. The OIG made a number of recommendations to address these problems. (OEI-02-91-00741)

CSE: Medical Support

Federal regulations requiring all State CSE agencies to develop written criteria to identify cases with a high potential for obtaining medical support went into effect in March 1989. Nevertheless, OIG found that as of June 1, 1990 less than half the States had implemented criteria to target such cases. The following chart depicts the status of targeting criteria development in the States.

STATUS OF TARGETING CRITERIA DEVELOPMENT
(June 1, 1990)



In addition, less than half the States were able to modify existing court orders for the sole purpose of including medical support. The OIG recommended that ACF enforce regulations regarding the targeting of medical support and place additional emphasis on its importance. Further, OIG proposed that ACF require the States, as a condition of receiving Federal matching funds, to allow CSE agencies to modify court orders for the sole purpose of including medical support in the support order. Final rules were published in May 1991 implementing this last recommendation. The ACF agreed with the other recommendations and has taken action to implement them. (OEI-07-90-00120)

CSE: State Insurance Laws

Performance Indicator

In an earlier report, OIG noted that some private insurers limited coverage of a policyholder's dependents to those currently residing in the policyholder's residence. The effect of this policy was to deny medical support to AFDC children who no longer lived with an absent parent. This limitation in coverage cost the Federal Government at least $1 million annually. In that report, OIG recommended that ACF and the Health Care Financing Administration (HCFA) pursue a legislative remedy requiring States, as a condition of receiving matching funds, to implement legislation prohibiting discrimination in insurance plans on the basis of place of residence.

Self-insured employers providing group health benefits to their employees are subject to the requirements of the Employee Retirement Income Security Act (ERISA) of 1974 and are exempt from State regulation of insurance. These self-insurers can therefore continue to discriminate against dependents on the basis of place of residence despite State legislation generally prohibiting this practice. Because of the growing number of self-insurers, this loophole leaves much of the coverage problem identified in the earlier OIG report unresolved. The OIG recommended that HCFA and ACF address ERISA preemption problems when drafting a legislative proposal to require States to prohibit discrimination in insurance plans on the basis of place of residence. (OEI-12-91-01420)

CSE: Incentive Payments

At the request of the Department's Policy Council in connection with their review of child welfare programs, OIG examined the types of activities and projects that States fund with Federal child support enforcement incentive payments. The OIG found that most States have no laws relating to the use of these incentive payments. However, most States do use these monies for ongoing CSE activities. All States share incentive payments with counties or political subdivisions, as required, where these entities share in the cost of the CSE program. Ten States deposit some or all of the incentives into their general funds. Where this occurs, the end use of the incentive payments cannot be determined. (OEI-05-91-00750)

Garnishment Orders for Child Support

The OIG performed a study of 14 Federal and 4 nonfederal employers' garnishment systems. The OIG found that Federal and nonfederal employers have a system in place that generally allows for the timely and efficient processing of child support garnishments in compliance with Federal regulations. However, OIG determined that Federal and nonfederal employers have encountered several impediments to timely and efficient processing of child support garnishments. These impediments include: lack of detailed guidance regarding State and Federal laws for child support garnishments; lack of standardized forms for court orders; State and court requests for data that require departure from their normal pay and disbursement cycles; and lack of electronic fund transfer capability by State withholding agencies and other collection authorities. The OIG also found that only one Federal and one nonfederal employer are currently collecting fees to cover the costs of processing child support garnishments. The OIG provided several recommendations for improving the process. Audit reports have been issued to the individual States examined. The ACF has several initiatives underway which should improve the garnishment process. (CIN: A-12-90-00016)

Follow-up on AFDC Absent Parents

The OIG conducted a follow-up on a series of 1987 studies relating to CSE in AFDC cases. The OIG found that most AFDC absent parents earning over $10,000 in 1985 earned at least that amount in 1986 and 1987. Also, more AFDC absent parents cross that $10,000 threshold each year. Average earnings for these absent parents increased from $17,787 in 1985 to $19,522 in 1987 as illustrated below:

ABSENT PARENTS EARNING OVER $10,000

1985 - 1987

Year	Over $10,000	Percentage of Universe	Average Earnings
1985	1,277	27%	$17,787
1986	1,349	29%	$18,587
1987	1,426	31%	$19,522

The OIG recommended that the Office of Child Support Enforcement (OCSE) perform an annual data match with Social Security records or Internal Revenue Service records relying on data submitted by the States. The OCSE should require all States to participate in the annual match unless a State performs its own annual, or more frequent, match. The OCSE should ensure that CSE agencies use information in the annual match to establish, modify, and enforce court orders, as appropriate, in accordance with legislative and regulatory requirements. The ACF indicated that it is implementing or has completed implementation actions on the OIG recommendations. (OEI-05-89-01270)

Welfare Fraud

Welfare assistance provided under the AFDC, Medicaid and Food Stamp programs is based on State determinations of eligibility. As a result, welfare fraud is usually perpetrated by making false claims 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 compensation rolls or income tax returns.

Most of OIG's success in investigating welfare fraud is attributable to working on joint projects or task forces that include State and local public assistance agencies, and grouping cases for mass prosecutive action. Grouping the cases, which individually can involve relatively small amounts of money, improves their appeal to busy prosecutors and heightens public attention and subsequent deterrent impact. In one State, a task force effort resulted in two mass indictment actions in which more than 40 persons were charged with defrauding the AFDC, Medicaid, Food Stamp and general assistance programs. The amount of fraud involved totaled $161,700. During its life, the task force completed investigations involving more than 230 cases and over $2 million in welfare fraud.

Foster Care Administrative Costs: District of Columbia

The OIG found that the District of Columbia (D.C.) claimed administrative costs of $15.7 million under the Foster Care program between October 1, 1984 and September 30, 1987, of which $5.7 million ($2.8 million Federal share) was not eligible for Federal reimbursement. In addition, OIG could not determine the reasonableness of $9.6 million ($4.8 million Federal share) that D.C. allocated to the program on the basis of quarterly time studies which were flawed. The OIG recommended that D.C. make certain procedural improvements, refund about $2.8 million to the Federal Government and coordinate with ACF to adjudicate the questionable $9.6 million. (CIN: A-03-89-00553)

Foster Care Maintenance Payments: Michigan

An OIG follow-up to a 1988 audit revealed that the State of Michigan had made the originally recommended financial adjustment of $4.4 million for FYs 1983 and 1984. In addition, the State made adjustments of $4.7 million for FYs 1985 and 1986, and $10.3 million for FYs 1987, 1988 and 1989. The adjustments were necessary because in each year the State had improperly included social services costs and other unallowable costs in its Foster Care maintenance payment claims. However, OIG found that the State had not revised its procedures to preclude further unallowable claims, and reiterated the recommendation that it do so. (CIN: A-05-90-00132)

Federal Medical Assistance Percentages

Performance Indicator

As prescribed by the Social Security Act, the Federal medical assistance percentage (FMAP) establishes the Federal share of each State's costs for four federally assisted programs: Medicaid, AFDC, Foster Care and Adoption Assistance. In addition, the Congress has created four new programs that will use the FMAP as the Federal matching rate for specific types of costs: JOBS, Child Care and Supportive Services, Transitional Child Care and At-Risk Child Care.

During passage of the original FMAP legislation, congressional deliberations and committee reports indicated that the Congress intended to distribute Federal assistance according to a

State's ability to share in program costs as measured by State per capita income relationships. The formula used to establish the FMAPs generally follows these relationships. However, OIG identified three provisions of the formula that modify them. Two give higher income States a significant level of Federal assistance beyond the amount the formula would have provided if based solely on the per capita income relationships. If the formula remains unchanged, the net costs of these two provisions over the next 5-year budget cycle will be about $57.2 billion for Medicaid, $12.8 billion for AFDC and $2.3 billion for Foster Care and Adoption Assistance combined. Two OIG reports discussed modifications to the formula which would result in distribution of Federal funds more closely reflecting per capita income relationships, and recommended that the Congress be consulted regarding these two provisions. (CIN: A-06-90-00056; CIN: A-06-89-00041)

Income and Eligibility Verification System

The income and eligibility verification system (IEVS) is a matching system, usually automated, involving Federal and State data bases. The States use IEVS to verify the accuracy of financial information provided by clients applying for AFDC, Medicaid and Food Stamps. An OIG inspection, done at the request of the President's Council on Integrity and Efficiency, involved an analysis of 10 recent studies and site visits to these States related to the implementation of IEVS by the States. These studies indicated that the States' ability to effectively implement IEVS is limited by deficiencies in Federal data bases, problems resulting from Federal requirements and the States' limited resources. The OIG concluded that specific IEVS matches warrant additional review by OIG. In addition, the Department of Health and Human Services, along with the Department of Agriculture, should consider a basic reexamination of IEVS. The ACF indicated that it is working with HCFA and the Department of Agriculture to amend regulations to allow States more flexibility while still operating within the constraints of the Social Security Act. (OEI-01-90-00510)

SLIAG Expenditures

The OIG conducted an inspection to determine if SLIAG appropriations are adequate to cover the States' program costs through FY 1992 and to estimate the State' expenditures through FY 1994. The study was done at the request of the Senate Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee. Using a model developed to project cost data, OIG estimated that the amount of appropriations needed for the States' portion of SLIAG in FY 1992 is between $171.1 and $532 million, and that the States will incur SLIAG costs of $3.241 billion through FY 1994. The OIG concluded that a conservative appropriation is indicated for FY 1992 because of the difficulty in developing precise cost estimates. (OEI-07-91-00670)

Community Services Discretionary Grant

The OIG conducted a review of the Hough Area Development Corporation (HADC), a defunct grantee in Ohio which received $12.7 million in Federal funds between 1968 and

1981. The OIG found that the Federal Government had a 90 percent interest in 11 of 21 properties owned by HADC. The properties were no longer being used and were deteriorating. Their net value was estimated at $59,000, considering outstanding liens, taxes and other costs. This value will diminish as taxes, penalties and liens continue to mount, and idle buildings further deteriorate. Further, legal determination would have to be made to identify Federal interest in cash assets amounting to $120,000.

The OIG concluded that prompt action needs to be taken to ensure that these assets are returned to use for the social and economic benefit of the Hough community or disposed of so as to protect Federal interests. Deficiencies found in the administration of HADC grants underscore the need to improve important parts of the grants process, including: financial accountability; acquisition, use and disposal of property; grantee performance; and reporting and records maintenance. (CIN: A-05-90-00051)

APPENDICES

APPENDIX A

Implemented OIG Recommendations to Put Funds to Better Use
April 1991 through September 1991

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. Total savings during this period amounted to $3,657.2 million.

OIG Recommendation	Status	Savings in Millions
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) of 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.	$810
Overvalued Procedures: The Health Care Financing Administration (HCFA) shonld seek legislation to reduce Medicare reimbursement by the full amount that procednres are overpriced. (CIN: A-09-89-00082; OAI-09-86-00076; OAI-85-IX-046)	Section 6104 of OBRA 1989 and section 4101 of OBRA 1990 each further reduced payments for procedures which had been identified as overpriced.	547.3
PPS Update Factor: Any PPS updates should take into account large Medicare profits being earned by hospitals. (CIN: A-07-88-00111)	Section 4002(a) of OBRA 1990 limited the PPS update factor for large and other urban hospitals below the Medicare economic index for Fiscal Year (FY) 1991 through FY 1995. Section 4002(c) sets the update factor for rural hospitals for FY 1991 through FY 1995.	540
Division of Cost Allocation Savings: Reviews and negotiations of indirect cost rates and cost allocation plans conducted by the Department's Division of Cost Allocation (DCA) resulted in the savings shown. The OIG provides audit support to DCA in conducting some of the negotiations.	The DCA negotiated rates for FY 1990, resnlting in the savings shown.	523.5
Social Security Coverage for State and Local Government Employees: Require mandatory Social Security coverage for all noncovered State and local government employees who are not participating in a public employees' retirement system. (CIN: A-02-86-62604)	Section 11332 of OBRA 1990 extends Social Security coverage to most State and local employees not participating in a public employee retirement system. The effective date is July 1, 1991.	

OIG Recommendation	Status	Savings in Millions
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 FY 1991 and by 10 percent in FYs 1992 through 1995.	$195
Elimination of National Laboratory Fee Schedule: The HCFA should request that the Congress repeal the requirement to base laboratory reimbursement on a national fee schedule beginning in 1990. (OAI-04-88-01080; OAI-02-89-01910)	Section 6111(a) of OBRA 1989 eliminated the requirement for a nationwide fee schedule effective January 1, 1990.	190
Intraocular Lenses in Ambulatory Surgical Centers and Hospitals: In a 1988 report, OIG recommended that HCFA establish a national Part B reimbursement cap of $200, with a handling fee not to exceed 10 percent, for any intraocular lens (IOL) billed to Medicare. After later studies found that IOLs were available for lesser amounts, OIG issued a report in June 1990 recommending that Medicare pay a flat $150 for all IOLs. (OEI-07-89-01664; OAI-07-89-01662; OAI-07-89-01661; OAI-07-89-01660; OAI-09-88-00490; OAI-85-IX-046)	Section 4063 of OBRA 1987 mandated a reduction in payment rates for IOL implants. On February 8, 1990, final regulations were published in the Federal Register (55 FR 4526 No. 27). Section 4151(c) of OBRA 1990 maintains the $200 IOL allowance provided for in the regulations as part of the ambulatory surgical center amount, through December 31, 1992.	95
Nursing Home Institutions for Mental Diseases: The HCFA should require California to discontinue claiming Medicaid reimbursement for institutional care provided to non-elderly patients in nursing homes identified as institutions for mental diseases (IMDs). (CIN: A-09-90-0092)	California has accepted financial responsibility for the care and treatment of persons under 65 in nursing home IMDs.	62.5
Child Support Payments Other than Aid to Families with Dependent Children: States should perform systematic review of all child support cases, including those from sources other than Aid to Families with Dependent Children, targeting those where absent parents earn more than $10,000 annually, establish new or modify existing child support orders. (OAI-05-88-00340)	The Administration for Children and Families has encouraged States to begin periodic review of all child support cases, and where appropriate, establish new orders or modify existing ones. Many States have taken the recommended action with positive results.	54.2
Cranial-Intracranial Arterial Bypass The HCFA should reevaluate Medicare coverage of extracranial-intracranial (EC/IC) bypass surgery. (CIN: A-09-87-00005)	A final notice withdrawing coverage of EC/IC arterial bypass surgery for the treatment or prevention of stroke was published on February 27, 1991.	46.5

OIG Recommendation	Status	Savings in Millions
Hospital Patient Transfers: The HCFA should recover Medicare claims erroneously reported and paid as discharges for patients who were actually transferred to other PPS hospitals, and implement computer edits to prevent further overpayments. (CIN: A-06-89-00021)	The HCFA has implemented the recommended computer edits to prevent future overpayments of this nature.	$36
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 has amended its Program Results Audit Guide to reflect the medical support regulations and has penalized negligent States.	32
Cost Standards for Disability Determination Services: The Social Security Administration (SSA) should expedite Cost Effectiveness Measurement System validation efforts and begin to formulate Disability Determination Services cost-per-case (CPC) standards as quickly as possible. (OAI-06-88-00822)	The SSA is implementing the CPC process nationally in FY 1991.	13.8
Social Security Combined Family Maximum Provision: The SSA should identify and correct overpayments and underpayments made in processing combined family maximum records. (CIN: A-07-86-62618)	The SSA has reviewed combined family maximum records where there are more than two beneficiaries, and identified approximately $5.3 million in overpayments and $1.3 million in underpayments.	4
Cash Management Practices: The Public Health Service (PHS) should require that institutions participating in the Health Professions Student Loan and Nursing Student Loan programs return interest income earned on excess funds. (CIN: A-05-87-00061)	The PHS has developed a method for identifying and recovering unreported investment income.	3.2
Zip Code Software: The SSA should acquire commercial zip code software to help ensure accurate address information and quicker mail delivery. (CIN: A-13-87-02656)	The SSA began using the 9 digit zip code for Supplemental Security Income (SSI) benefit checks in November 1990 and for Retirement, Survivors and Disability Insurance (RSDI) benefit checks in March 1991.	2
Improper Cashing of Benefit Replacement Checks by RSDI and SSI Beneficiaries: The SSA should establish centralized RSDI record systems and make modifications to the SSI automated processing system to improve control and recovery of overpayments resulting from improper cashing of benefit replacement checks. (CIN: A-13-86-62635)	The SSA implemented a manual process to ensure proper processing of double check negotiation notices received from the Department of the Treasury.	1.3

OIG Recommendation	Status	Savings in Millions
Abortion and Abortion-Related Costs: The HCFA should require New York to identify and refund 1988 overclaims for abortion-related physician services. (CIN: A-02-88-01026)	New York has identified overclaims and has made a financial adjustment.	$0.9

APPENDIX B

Unimplemented OIG Recommendations to Put Funds to Better Use

This schedule represents potential annual savings or one-time recoveries which could be realized if 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
Indirect Medical Education: Modify Medicare payments to teaching hospitals by reducing the prospective payment system (PPS) adjustment factor. (ACN: 14-52018; ACN: 09-62003; CIN: A-09-87-00100; CIN: A-07-88-00101)	The President's Fiscal Year (FY) 1992 budget and legislative program includes a proposal to reduce the indirect medical education adjustment factor from 7.75 percent to 4.4 percent in FY 1992 and to further reduce the factor in subsequent years.	$1,045
Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89151)	The Health Care Financing Administration (HCFA) is considering this recommendation.	1,000
Identify and Recover Medicare Secondary Payer Claims: Seek legislation to facilitate the identification and recovery of Medicare secondary payer (MSP) claims. (CIN: A-09-89-00100)	Recent legislation has helped in the MSP area but more work needs to be done.	900
Revise Accounting for Penalties and Interest: The Social Security Administration (SSA) should support a legislative change to restore equity to the accounting process by requiring the Internal Revenue Service (IRS) to compensate the trust funds for interest and penalties collected which exceed the cost of IRS' administration of the Social Security tax. (CIN: A-13-86-62640)	Based on information from IRS, SSA does not believe that the current accounting method disadvantages the trust funds. The OIG has requested that the Department of the Treasury undertake a study of the current accounting method.	844
Hospital Diagnosis Related Group Rates: Rebase Medicare hospital PPS rates to correct for inclusion of overstated operating costs and to take into account hospital profitability. (ACN: 09-62021; CIN: A-08-87-00003; CIN: A-07-88-00111)	Although PPS rates have not been rebased, OBRA 1990 provides for the following update factors for large and other urban hospitals, applicable to payments for discharges occurring on or after January 1, 1991: for FY 1991, the market basket percentage increase minus 2 percentage points; for FY 1992, the market basket minus 1.6; and for FY 1993, the market basket minus 1.55.	640

OIG Recommendation	Status	Savings in Millions
State Legalization Impact Assistance Grant: The level of program funding required by the States for FY 1992 ranges from $171.1 million to $532 million. (OEI-07-91-00670)	The OIG conclusions were reported to the Congress which will determine the appropriate funding level for FY 1992.	$588
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to various functions performed by the Food and Drug Administration (FDA), possibly including premarket review and approval for drugs and devices. (OEI-12-90-02020)	Various legislative proposals are being considered which would result in the expansion of user fees across FDA functions. The President's FY 1992 budget includes proposals for user fees.	587
Extend Secondary Payer Provision: Extend the MSP provision for end-stage renal disease (ESRD) beneficiaries beyond the current 1-year limit to the period of time that ESRD beneficiaries are covered by an employer group health plan (EGHP). (CIN: A-10-86-62016)	The OBRA 1990 provisions partially implemented the OIG recommendation by extending the MSP provision for ESRD beneficiaries covered by an EGHP to 18 months.	503
Clinical Laboratory Tests: Set the Medicare lab fee schedules at amounts comparable to what physicians are paying and ensure that profile tests are appropriately reimbursed. (CIN: A-09-89-00031)	The OBRA 1990 provisions reduced payments for laboratory tests by limiting the annual fee schedule increase to 2 percent and reducing the national cap to 88 percent.	426
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt payment policy. (CIN: A-14-90-00339)	The HCFA is considering OIG's recommendation.	400
Medicaid Premium Matching Rates: Eliminate premium matching rates under Medicaid. (ACN: 03-60223)	The proposal was not included in the President's FY 1992 budget and legislative program.	360
Limit Participation in Foster Care Administrative Costs: To contain the rapid increase in State claims for administrative costs in foster care, controls or caps are needed. (CIN: A-07-90-00274)	The President's budget for FY 1992 includes a proposal to limit participation.	340
Reduce Payments of Medicaid Drug Expenditures: The HCFA should implement restricted drug lists. (OEI-12-90-00800)	The HCFA rejected this proposal since OBRA 1990, in its opinion, prohibits such restrictions.	226

OIG Recommendation	Status	Savings in Millions
Recover Retirement, Survivors and Disability Insurance and Supplemental Security Income Benefits through Income Tax Refund Offset: Actively support legislation to allow offset of income tax refunds to recover certain Retirement, Survivors and Disability Insurance (RSDI) overpayments. Take administrative action to recover certain Supplemental Security Income (SSI) overpayments through income tax refunds. (OAI-12-88-01290; OAI-12-86-00065)	The OBRA 1990 grants the legislative authority to recover RSDI overpayments through income tax refund offset. The SSA is in the process of implementing the recommendation. The SSA continues to negotiate with IRS to administratively implement the SSI refund offset by FY 1993.	$193.7
Reduce Payments for Intraocular Lenses: Medicare should pay a flat $150 for all intraocular lenses (IOLs). (OEI-07-89-01664)	The HCFA is currently prohibited by law from reducing the IOL reimbursement rate below the $200 cap until 1992. However, HCFA agreed to consider a reduction in the IOL reimbursement rate and use the information provided by OIG when they update facility payment rates effective July 1, 1992.	169
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)	The Treasury is conducting an in-house study before considering whether to endorse the proposal.	134
Recover Medicare Funds From Terminated Pension Plans: Recover Medicare's share of pension asset reversions from terminated pension plans. (CIN: A-07-90-00262; CIN: A-07-88-00134)	The HCFA is considering submitting a legislative proposal.	119
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services at the lower of cost or charges. (CIN: A-05-89-00055)	The HCFA disagreed with the proposal, stating that payments for less than 1-day stays are part of the overall PPS formula which is designed to average out the payments among all Medicare cases.	118
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
Extracorporeal Shock Wave Lithotripsy: Apply inherent reasonableness factors to charges for extracorporeal shock wave lithotripsy (ESWL). (CIN: A-09-89-00082)	Although OBRA 1990 reduced payments for ESWL, these procedures are still overpriced.	110
Conventional Eye Wear: Exclude conventional eye wear from Medicare coverage for beneficiaries receiving IOL implants. (CIN: A-04-88-02038)	The OBRA 1990 limits coverage to one pair of eyeglasses following cataract surgery with an IOL implant.	72

OIG Recommendation	Status	Savings in Millions
Use Credit Reporting Agencies to Help Collect Debts: The SSA should seek legislative authority to use credit reporting agencies to locate debtors and report certain delinquent debtors to credit reporting agencies. (CIN: A-03-89-02610)	The SSA will assess the utilization of income tax refund offset before considering whether to seek authority to use credit reporting agencies.	$52.4
Recover Medicare Payments Made for Beneficiaries Eligible for Other Government Health Insurance: Recoup part of unauthorized Medicare payments made on behalf of the Uniformed Services Treatment Program members. (CIN: A-14-90-00325)	The HCFA agreed to the recommendation. The OIG will verify the effectiveness of HCFA's corrective action plan.	50
Repay Mortgages Early: Use trust fund money to liquidate the remaining mortgage balances on three program service center buildings. (CIN: A-09-88-00131)	The SSA reduced the mortgages, but has not paid them off. The tight budget of the last few years has not provided ample discretionary funds to pay off the mortgages, nor will any be available in the foreseeable future.	48
Inpatient Psychiatric Care Limits: New limits should be developed to deal with the high cost and changing utilization patterns of inpatient psychiatric services. (CIN: A-06-86-62045)	The proposal was not included in the President's FY 1992 budget and legislative program.	48
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
Improve Recovery of SSI Overpayments through Cross Program Adjustment: More aggressively pursue cross program adjustment as a means of collecting the outstanding debts owed by former SSI recipients who are current RSDI beneficiaries. Resubmit a legislative proposal authorizing the adjustment of RSDI payments to recover overpayments from former SSI recipients. (OAI-12-87-00029)	This proposal was included in the Department's FY 1992 budget. The OIG continues to believe that cross program adjustment is an appropriate way to recover SSI overpayments.	36
Age Attainment: The SSA should define attainment of age as occurring on one's birthday instead of following the common law that age attainment occurs on the day before a person's birthday. (CIN: A-09-89-00073)	The SSA did not concur since it believed administrative costs would outweigh savings and that short term savings would be offset by long range costs.	21.4
Premature Admissions: Minimize premature admissions for Medicaid elective surgeries. (CIN: A-09-86-60213)	The HCFA's issuance of a notice of proposed rulemaking that will address these issues has been delayed until at least July 1993 by Section 4755 of OBRA 1990.	18.5

OIG Recommendation	Status	Savings in Millions
Tax Equity and Fiscal Reform Act Outpatient Limitation: Expand the list of procedures subject to the Tax Equity and Reform Act outpatient limitation and apply the limitation to physician services in additional settings. (CIN: A-07-86-62041; CIN: A-05-89-00059)	The HCFA has proposed to expand the outpatient limit to include additional settings. However, it has also recommended reducing the percent reduction in payment fees from the current 40 percent to 20 percent in all settings.	$16.1
Halt Medicaid Payments for Less than Effective Drugs: Work with FDA to provide to all States periodic lists of less than effective drugs identified by FDA. (CIN: A-03-89-00320)	The HCFA is currently exploring a range of options in cooperation with OIG and FDA to further identify less than effective drugs.	16
Develop Cost Standards for Disability Determination Services: Formulate disability determination services (DDS) cost-per-case (CPC) standards as quickly as possible and adopt the reimbursement method for laboratory fees used by Medicare for use by the DDSs. (OAI-06-88-00822; OAI-06-88-00820)	The SSA plans to develop a CPC standard by 1991. Development of regulations will depend upon experience gained in FY 1991 with issuance of CPC targets in conjunction with productivity-per-work-year based annual planning amounts. A new draft notice of proposed rulemaking has been developed which would apply Medicare laboratory fee schedules for use by DDSs. The SSA will defer action however, until gaining a year's experience using the new consultative examination regulation which was published in the Federal Register on August 1, 1991.	15.3
Improve Reclamation Procedures: Deficient Treasury procedures related to reclaiming check payments involving unauthorized endorsements caused losses to the trust funds. The SSA should negotiate with Treasury for more direct involvement in the reclaiming of checks. (CIN: A-04-87-03005)	Several problem areas between SSA and Treasury are still in need of negotiation and resolution, including reclamation.	10.5
Modify Earnings Enforcement Process: The SSA should modify its earnings enforcement operation to include late posted earnings reports, suspense reinstatements, and earnings adjustments and corrections. (CIN: A-13-89-00031)	The SSA's automated data processing (ADP) plan now contains initiatives to include late posted earnings, suspense reinstatements, and earnings adjustments and corrections. However, SSA estimates actual savings will be much lower than OIG's projections.	10
Eliminate a Separate Carrier for Railroad Retirement Beneficiary Claims: Discontinue the use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)	The HCFA is currently evaluating OIG's recommendation.	9.1

OIG Recommendation	Status	Savings in Millions
Revise Criteria for Waiving Overpayments: The SSA should pursue a regulatory or statutory change in waiver criteria to eliminate waivers for persons under age 59 so that it could pursue collection when and if the individual developed an ability to repay. (CIN: A-05-90-00034)	The SSA disagreed with OIG's recommendation.	$9
Issue Social Security Numbers for Noncitizens: Issue original Social Security numbers for noncitizens based on electronic transfer of data collected by the Immigration and Naturalization Service (INS). (OEI-05-88-01060)	The SSA has begun negotiations with INS to address statutory, regulatory, operational and cost issues involved in implementation of this recommendation.	8.2
Collect Nonresident Alien Taxes: Use automated systems to identify and collect alien taxes involving benefit payments for retroactive periods. (CIN: A-13-90-00041)	The SSA's ADP plan now includes a project to address this issue.	7.7
Abandoned Reclamations: The SSA and Treasury need to improve policies and procedures regarding abandoned reclamations. (CIN: A-04-89-03021)	Several problem areas between SSA and Treasury are still in need of negotiation and resolution, including abandoned reclamations.	7.7
New Cards for New Brides: The SSA should actively pursue the acquisition of computerized marriage records from States having this capability. (OEI-06-90-00820)	The SSA agreed with this concept, but will study quantitative and cost issues before agreeing to implement.	5.5
Multiple Surgical Procedures: All carriers should uniformly limit reimbursement for second surgical procedures to 50 percent of reasonable charges. (CIN: A-03-86-62008)	Through physician payment reform, HCFA plans to establish payment for multiple surgeries based on 100 percent of the global fee for the highest value procedure, 50 percent for the next highest, 20 percent for the next highest, and 10 percent for each additional procedure.	5.2
User Fees for Attorneys: Determine administrative costs for processing attorney fee payments and assess user fees. (CIN: A-13-90-00026)	The SSA rejected this proposal since it believes it needs legislative authority.	5
Intercept Direct Deposit Transfer to Deceased Beneficiaries: The SSA should arrange for interception of erroneous direct deposit payments made to beneficiaries who died after the 23rd of the month. (CIN: A-13-89-00037)	The SSA rejected OIG's proposal.	2.9
Reimbursement for Multiple Source Prescription Drugs: The HCFA should review its prices on the upper limit list for possible savings. (OEI-03-91-00470)	The HCFA did not agree with the OIG recommendation. The OIG continues to believe that the recommendation is appropriate.	2

OIG Recommendation	Status	Savings in Millions
Community Based Organization Projects for Human Immunodeficiency Virus Prevention: Determine if the Centers for Disease Control (CDC) awarded funds to applicants based on the results of OIG's recipient capability audits. (CIN: A-04-89-00122)	The CDC agreed and awarded funds to 59 community based organizations and denied funding to 6 others based on the results of the OIG audits.	$1
Discontinue Payment for Broken Medical Appointments: The SSA should not pay State agencies for consultative exams that are canceled or otherwise not kept. (CIN: A-01-87-02004)	The SSA has deferred action until after a year's experience with the new consultative examination regulations has been acquired.	0.9

APPENDIX C

Unimplemented OIG Program and Management Improvement Recommendations

This schedule represents recent 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
Kidney Acquisition Cost: The Health Care Financing Administration (HCFA) should support demonstration projects incorporating kidney transplantation and acquisition under a diagnosis related group. (OAI-01-88-01330)	The HCFA did not concur with this recommendation. The HCFA and OIG agreed that HCFA would explore various options that might reduce expenditures. The OIG is still awaiting possible solutions from HCFA. The OIG is currently working on a follow-up report.
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 HCFA has provided no evidence that these problems have been resolved. The OIG plans to conduct a follow-up study to determine if effective actions have been completed.
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify the Department of Health and Human Services (HHS) disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to PHS, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040)	The OASH has taken the lead in this area and has met with headquarters operating division emergency preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved.
Coping With Twin Disasters - HHS 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.

OIG Recommendation	Status
Integrity of Medical Evidence in Disability Determinations: The Social Security Administration (SSA) should reemphasize its requirement that Disability Determination Services (DDSs) conduct an annual security evaluation and forward copies of their security profiles to the applicable regional security offices and disability program branches. (OAI-03-88-00670)	The SSA has developed the indicated procedural guidelines to implement the OIG recommendations. These guidelines will be issued in early Fiscal Year (FY) 1992.
Integrity of Medical Evidence in Disability Determinations: The DDS quality assurance procedures should include a sample check of physician reimbursements against the files containing the evidence for which payment was made. (OEI-03-88-00670)	The SSA is developing procedural guidelines which will require DDSs to conduct sample checks by its quality assurance units to compare medical evidence payment vouchers with the medical evidence in the file.
False Evidence Submitted to Obtain a Social Security Number: The SSA should systematically identify all original Social Security number (SSN) applications from U.S. born applicants over age 24 and require a second level review of such applications. (OEI unnumbered management advisory report, October 1987)	The SSA is conducting a nationwide study of selected SSN applications to validate the results of an earlier regional study before committing to a more intense review of selected high risk cases.
Recovery of Retirement, Survivors and Disability Insurance Overpayments through Income Tax Refund Offset: The SSA should determine the SSNs of the overpaid former auxiliary beneficiaries for whom SSNs are unknown. (OEI-12-91-00610)	The SSA has located SSNs for 1.4 million terminated auxiliary beneficiaries with outstanding overpayments and will now evaluate the cost-effectiveness of including these items in its refund offset work plan.
Social Security Payments for Vocational Rehabilitation: The 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 contacting all States to urge that more effective screening and referral mechanisms be put into place, and is requiring regional office tracking and reporting of State implementation plans.
Reclamation of Incorrect Electronic Fund Transfer Payments: The SSA should implement an accounts receivable system to account for incorrect payments, improve reclamation procedures and work with Treasury to clarify respective functions. (CIN: A-01-87-02003)	The SSA implemented an accounts receivable system. Since reclamation is a Treasury Department operation, further action to improve the process requires Treasury action.
Improvements Needed in Processing Controls for Retirement, Survivors and Disability Insurance Diary Actions: The SSA should emphasize to staff the importance of completing diaried actions, incorporate standards into managers' merit pay plans and perform internal control reviews after the proposed automated diary system is completed. (CIN: A-13-88-00024)	The SSA has issued regular reminders regarding prompt processing; rejected OIG's proposal to include items in merit pay plans; and incorporated plans to evaluate the effectiveness of the new system.

OIG Recommendation	Status
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.
Undeliverable Notices Need to be Better Controlled: The SSA needs better controls to make the undeliverable notice process an effective tool for detecting unreported deaths. (CIN: A-13-88-00035)	The SSA agreed to make improvements.
Representative Payee Procedures: The SSA should review acconntability reports to identify high risk cases and verify the information reported, and should also verify a random number of reports. (CIN: A-07-90-00266)	The SSA performed a study to determine high risk representative payees and developed plans to perform other verifications as additional resources permit.
Improved Controls Necessary in Field Office Processing of Death Alerts: The SSA should ensure that field offices comply with instructions for processing death alerts and issue monthly reports to management on cases pending over 60 days for beneficiaries in current pay. (CIN: A-09-90-00044)	The SSA agreed to remind field offices of procedures and to more closely monitor compliance. A systems capability to have on-line information is under consideration.
Improved Controls Necessary in Field Office Processing of Death Alerts: The SSA should provide for a separation of duties in death alert processing at field offices since staff are also involved in other claims data. (CIN: A-09-90-00044)	The SSA generally agreed to improve controls.
Equipment Inventory: The SSA should perform a physical inventory of all equipment, make necessary adjustments to the accounting records and establish better controls over the disposition of equipment. (CIN: A-13-87-00035)	The SSA has developed a control system and reported that it should be implemented in December 1992. Procedures to control equipment disposition have been established.
Further Improvements Necessary to 800 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 agreed to consider OIG's recommendations.
Employee Relocation Services: The SSA needs to improve its management of employee relocations so that they are done in a more economical and efficient manner. (CIN: A-13-89-00018)	The SSA agreed to review certain noted weaknesses.

OIG Recommendation	Status
Certification of Wages Subsequent to 1977: The SSA should base its certification of wages on the combination of the amount of wages recorded in the individual's earnings and suspense records, and an estimate of the amount of wages that may eventually be added to those records at some future date. (CIN: A-13-89-00045)	The SSA is considering OIG's recommendation, as well as the views of the General Accounting Office (GAO) and an independent accounting firm.
Review of HCFA's Cost Allocation System for Fiscal Year 1988: The Assistant Secretary for Management and Budget (ASMB) should provide HCFA with guidance on how to refine its cost allocation system and periodically monitor the system to ensure that it is being properly implemented and maintained. The HCFA should establish a system to document actual central office staff activities; distribute administrative costs to the trust funds and the general fund on the basis of actual employee activity; and identify costs contained in the administrative cost pool as either direct or indirect. (CIN: A-04-89-02036)	The HCFA and ASMB agreed with the recommendation. The cost allocation system has been revised and is being tested.
Follow-up to GAO Audit of the Medicare Healthchoice Demonstration Project: The HCFA should establish a divisionwide policy for data release using the Data Release User Guide developed by the Bureau of Data Management and Strategy (BDMS) as a model; require Privacy Act coordinators within each component to adhere to this policy; and designate BDMS as the focal point for the continued development of data release policies and procedures. These policies and procedures should be fully coordinated with HCFA's Privacy Act officer. (CIN: A-14-90-02048)	The HCFA originally concurred with GAO's recommendation and developed a "Data Release User Guide." However, HCFA has not yet issued the guide as divisionwide policy.
Follow-up to GAO Audit on Use of Medicaid Data to Monitor Controlled Substance Diversion: The HCFA should work with the Department of Justice (DOJ) to identify ways in which the Medicaid management information system (MMIS) controlled substance data can be used by regulatory, licensing and law enforcement agencies. It should also make information obtained from OIG's computer program for MMIS controlled substances data available through DOJ to law enforcement, regulatory and licensing agencies outside the Medicaid program. (CIN: A-14-90-02047)	The HCFA has developed a corrective action plan and implementation is underway.
Regulation of Hemoperfusion Medical Devices: The Food and Drug Administration should take action to remedy deficiencies noted in a review of the premarket notification submissions made by two competing companies. (CIN: A-15-90-00043)	The FDA concurred and has initiated corrective actions to remedy the deficiencies noted. The FDA will determine whether a competing company's devices pose a public health threat and whether it is adequately complying with the medical device reporting regulations. The FDA will also review and analyze the competing company's devices labeling complaints and submit its findings to the complainant.

OIG Recommendation	Status
Indian Health Service Contracting Practices: The Indian Health Service should implement post-award monitoring of contract compliance and document all contract compliance evaluations; establish post-award monitoring performance standards for all project officers; establish a process to ensure that project officers are provided with evaluations and data on a contractor's performance; and establish a process for the review and approval of public vouchers by the project officer. (CIN: A-06-89-00066)	The Oklahoma City Area Office concurred with all of OIG's proposals. Corrective actions were completed by PHS in all areas except for the establishment of a process to ensure that project officers are provided with evaluations and data on a contractor's performance. The PHS stated that a written policy is being developed to ensure that project officers receive this information.
Contract Pre-Award Audits for FY 1989: The PHS should assess the need for OIG to examine a greater number of the proposals being awarded by all PHS agencies. (CIN: A-02-90-02505)	The OASH indicated full concurrence with the need for a greater number of pre-award audits.
Commissioned Corps Identification Cards: The OASH should immediately perform a review of internal controls over the issuance of Commissioned Corps identification cards. (CIN: A-15-91-00010)	The PHS has scheduled the internal control reviews of card issuance for FY 1993.
New Cards for New Brides: The SSA should target its public information efforts to newlyweds. (OEI-06-90-00820)	The SSA is implementing this recommendation by developing public service advertisements, mailing posters to State Bureau of Vital Statistics offices and field offices for display in the community, and rewriting an employee pamphlet.
Project Clean Data: The SSA should develop, maintain and widely disseminate a software package for detecting invalid 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 will conduct a pilot test in FY 1992 to assess employer interest and use.
Availability of Representative Payees: The SSA should correct coding problems to facilitate ongoing monitoring of beneficiaries who require representative payees. (OEI-02-89-01420)	The SSA agreed and is taking corrective action.
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 agreed that significant improvements are needed in this process and identified the cooperative efforts that are planned to make the indicated improvements.
Delayed Notices of Planned Action: Because of the potential cost implications of field office failure to maximize opportunities for overpayment avoidance by using manual notices of planned action in the Supplemental Security Income program, OIG recommended that SSA initiate a review to determine the extent of the problem. (OEI-04-90-02160)	The SSA had already planned a comprehensive review of the same subject. The OIG will defer its actions until after the results of SSA's studies are compiled.
Carrier Maintenance of Provider Numbers: The HCFA should establish adequate safeguards for detection of abusive providers. (OEI-06-89-00870)	The HCFA did not agree with the OIG recommendation.

APPENDIX D

Congressional Hearings

The Office of Inspector General testified before numerous House and Senate hearings during the first session of the 102nd Congress. The following list summarizes these appearances during the first session of the 102nd Congress. Narrative descriptions highlighting OIG testimony follow the list.

Date	Topic	Congressional Committee/Subcommittee
February 26, 1991	Medicare Secondary Payer	House Subcommittee on Oversight, Committee on Ways and Means
March 7, 1991	Fiscal Year 1992 Appropriations	House Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Appropriations Committee
April 16, 1991	Indirect Costs of Research at Colleges and Universities	House Subcommittee on Health and the Environment, Committee on Energy and Commerce
April 25, 1991	Reauthorization of the Older Americans Act	House Subcommittee on Human Resources, Committee on Education and Labor
April 29, 1991	Safety and Quality of Care Problems at Surgical, Diagnostic and Immediate Care Facilities	House Subcommittee on Regulation, Business Opportunities and Energy, Committee on Small Business
May 9, 1991	Indirect Costs of Research at Colleges and Universities	House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce
May 9, 1991	Health, Welfare and Social Security Programs	House Committee on Ways and Means
May 13, 1991	Medicare Fraud Investigations: Durable Medical Equipment	Senate Budget Committee
May 21, 1991	Adoption (statement for the record)	House Committee on Ways and Means
May 23, 1991	Indian Health Service: Youth Alcohol and Substance Abuse Programs	Senate Select Committee on Indian Affairs
June 13, 1991	Reauthorization of the Older Americans Act	Senate Subcommittee on Aging, Committee on Labor and Human Resources
June 13, 1991	Medicare Fraud, Waste and Abuse	House Subcommittee on Health, Committee on Ways and Means
June 17, 1991	Medicare Fraud Investigations: Durable Medical Equipment (field hearing)	Senate Budget Committee

Date	Topic	Congressional Committee/Subcommittee
June 20, 1991	The Medicaid Program	House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce
June 21, 1991	Medicare Fraud Investigations: Durable Medical Equipment	House Subcommittee on Oversight, Committee on Ways and Means
July 10, 1991	Tax Exempt Hospitals	House Committee on Ways and Means
July 26, 1991	Medicaid Tax and Donation Programs	Senate Subcommittee on Health for Families and the Uninsured, Committee on Finance
September 12, 1991	Food and Drug Administration	House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce
September 24, 1991	National Science Foundation Management of Grants to Colleges and Universities	Senate Committee on Governmental Affairs
September 24, 1991	Durable Medical Equipment	Senate Budget Committee

Highlights of OIG Testimony

Medicare Secondary Payer

The House Subcommittee on Oversight, Committee on Ways and Means, held this hearing to review problems with the Medicare secondary payer (MSP) program. The OIG testimony summarized our audit, evaluation and investigation activities related to problems of noncompliance with MSP requirements. The OIG also outlined additional measures which could be taken to ensure that the MSP program functions as intended by the Congress.

Indirect Costs

The House Subcommittee on Health and the Environment, Committee on Energy and Commerce, held a hearing to discuss OIG's audits of indirect costs charged to research grants awarded to colleges and universities. The OIG testimony covered our strategy for reviews of financial and programmatic research activities for both direct and indirect cost issues, our findings to date and options for containing indirect costs.

Reauthorization of the Older Americans Act

The House Subcommittee on Human Resources, Committee on Education and Labor, conducted a hearing to discuss the Older Americans Act reauthorization. The OIG outlined four specific reports to the subcommittee, including: a reversionary interest report; a monitoring study and a dissemination study on discretionary grants; and a study to assess the experience of State programs for the elderly which provide in-home and adult day care services on a cost-sharing basis. In addition, OIG outlined a series of work plan items for future years, including an increased number of studies and audits on activities of the Administration on Aging (AoA).

Safety and Quality of Care Problems at Surgical, Diagnostic and Immediate Care Facilities

The House Subcommittee on Regulation, Business Opportunities and Energy, Committee on Small Business, held a hearing on patient safety and consumer protection issues involving outpatient surgical centers and diagnostic facilities. The OIG testimony addressed quality assurance guidelines in independent physiological laboratories, and the quality and necessity of surgery in hospital outpatient departments and Medicare-certified ambulatory surgical centers. Also, OIG referenced ongoing OIG studies regarding the quality of surgery performed in physicians' offices and the credentialing of all types of outpatient surgical facilities.

Grants and Contracts Awarded to Colleges and Universities
The House Snbcommittee on Oversight and Investigations, Committee on Energy and Commerce, requested that OIG testify on our experiences in auditing expenditures made under grants awarded to colleges and universities, and update the subcommittee regarding our oversight of this area. The OIG testimony summarized our recent audit experiences at schools across the country, and presented options for improved administration and Federal oversight of these costs.

Health, Welfare and Social Security Programs
The OIG testified before the House Committee on Ways and Means on the specific priority areas where legislative and administrative action are most needed. Included were discussions of OIG's audit of the Social Security Administration's financial statement, as well as a comprehensive listing of all OIG unimplemented legislative recommendations from the Cost-Saver Handbook (which could save $30 billion annnally) and the Program and Management Improvement Recommendations Handbook.

Medicare Fraud Investigations: Durable Medical Equipment
The OIG testified before the Senate Budget Committee on fraudulent practices involving durable medical equipment (DME). The testimony stated that Medicare payments increased an average of 12 percent from 1976 to 1988, but Medicare Part B payments, including payments for DME, increased at an annual rate of 18 percent over the same period, an increase of $2 billion pcr year. In view of these escalating costs, it is imperative that we do everything possible to assure that Medicare does not pay for needless DME providcd by nnscrupulous companies.

Adoption (statement for the record)
In a statement submitted to the House Committee on Ways and Means, OIG summarized our report "Barriers to Freeing Children for Adoption," which detailed how as much as $79 million conld be saved in 1 year if children whose permanent plan was adoption could leave care 1 year sooner. The report outlined several barriers, inefficiencies and delays in freeing children for adoption.

Indian Health Service: Youth Alcohol and Substance Abuse Programs
The OIG testified before the Senate Select Committee on Indian Affairs presenting the findings of its review of Indian Health Service youth alcohol and substance abuse programs. The OIG testimony discussed, among other items, the inefficient monitoring of quality assurance objectives, ontmoded and inefficient management information systems, and lack of certification of almost two-thirds of the alcoholism counselors in the youth alcoholism program.

Reauthorization of the Older Americans Act
At this hearing before the Senate Subcommittee on Aging, Committee on Labor and Human Resources, OIG discussed five specific reports: a management advisory report that recommended the development of an ongoing performance measurement system to help AoA evaluate the progress of State ombudsmen programs and target technical assistance accordingly; a reversionary interest report; a monitoring study and a dissemination study on discretionary grants; and a study to assess the experience of State programs for the elderly which provide in-home and adult day care services on a cost-sharing basis. In addition to the reports described, OIG outlined a series of work plan items for future years, inclnding an increased number of studies and audits of AoA activities.

Medicare Fraud, Waste and Abuse
The House Subcommittee on Health, Committee on Ways and Means, requested that OIG testify on our progress in investigating health care fraud, waste and abuse. Our statement noted that significant corrective action is necessary to ensure the financial viability of the Medicare program. In addition, OIG pointed out that of the approximately 2,200 snccessful criminal and administrative prosecutions we obtained last year, nearly half were directly related to programs of the Health Care Financing Administration.

Medicare Fraud Investigations: DME
This hearing held before the Senate Budget Committee discussed how DME suppliers take advantage of the current system by supplying items that are of little or no use to the beneficiary, have not been requested by the beneficiary and/or have not been ordered by the physician. The OIG suggested that standards for DME equipment and additional corrective action are required, and proposed that a national single pricing schednle be established for all DME that would take local market variations into consideration .

The Medicaid Program

The House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, conducted a hearing to discuss the Medicaid program. The OIG testimony outlined the numerous challenges facing the Medicaid program today. If current trends continue unabated, the Federal Government will be paying over $290 billion for Medicaid alone in the year 2000, and there will still be millions of Americans lacking health insurance or medically needy without access to the medical care and attention they require. The OIG discussed its numerous reports in the Medicaid program area.

Medicare Fraud Investigations: DME

The OIG testimony before the House Subcommittee on Oversight, Committee on Ways and Means, identified several schemes indicative of fraudulent activity in the industry. Problems included: overzealous marketing, abuse of certificates of medical necessity, carrier shopping, unbundling, misuse of the signature on file process and inadequate controls in the Medicare carrier provider number system.

Tax Exempt Hospitals

The OIG's statement before the House Committee on Ways and Means discussed our involvement with anti-dumping and anti-kickback investigations and their relationship to the tax exempt status of hospitals. The statement also detailed that, thus far, we have negotiated settlements with 16 hospitals involved in patient dumping and recovered $518,000. The testimony also suggested that joint efforts, such as ours with the Internal Revenue Service, are a major step in reducing abuses and assuring quality health care for all patients in need of such care.

Medicaid Provider Tax and Donation Program

The Senate Subcommittee on Health for Families and the Uninsured, Committee on Finance, held a hearing to discuss Medicaid financing, the Maternal and Child Health Block Grant and the Qualified Medicare Beneficiary program. The OIG announced the issuance of a third management advisory report on the Medicaid Provider Tax and Donation program. In a follow-up to a previous report, OIG found that these tax and donation programs have been increasing at an alarming rate. This could cost the Federal Government over $3.8 billion in FY 1991 alone, and at least $12.1 billion by the end of FY 1993.

Food and Drug Administration

The House Subcommittee on Oversight and Investigations of the Energy and Commerce Committee held this hearing as a follow-up to its inquiries into problems at the Food and Drug Administration (FDA) over the last few years. The OIG testimony cited that FDA needed to restore the integrity of the product approval process; vigorously detect and investigate potential fraud and abuse; invigorate its inspections of manufacturing and processing facilities; strengthen its response to individuals and businesses not in compliance with the Food, Drug and Cosmetic Act; and create data management systems to provide useful and necessary information for planning and oversight.

National Science Foundation Management of Grants to Colleges and Universities

The Senate Committee on Governmental Affairs held this hearing to review the National Science Foundation's management of research grants to colleges and universities. The OIG testified regarding its responsibilities for college and university audits under the single audit cognizance concept.

DME

The Senate Budget Committee held a field hearing to explore the problems of fraud and abuse involving DME provided to Medicare beneficiaries. The OIG testimony outlined the various fraud and abuse schemes identified in the course of OIG investigative cases, and cited problems noted at other similar hearings held this year.

APPENDIX E

Successful Prosecutions by Federal District and State Authorities

FISCAL YEAR 1991

Jurisdiction	FIRST HALF 1991	SECOND HALF 1991	TOTAL
Federal District			
Northern Alabama	13	6	19
Middle Alabama	2	1	3
Southern Alabama	1	3	4
Arizona	8	3	11
Eastern Arkansas	13	4	17
Western Arkansas	1	1	2
Central California	15	1	16
Eastern California	4	1	5
Northern California	5	2	7
Southern California	1	0	1
Colorado	18	13	31
Connecticut	1	7	8
District of Columbia	7	6	13
Delaware	0	1	1
Northern Florida	1	3	4
Middle Florida	15	11	26
Southern Florida	1	3	4
Northern Georgia	4	7	11
Middle Georgia	0	2	2
Idaho	0	1	1
Central Illinois	10	4	14
Northern Illinois	13	11	24
Southern Illinois	1	2	3
Northern Indiana	1	0	1
Southern Indiana	4	3	7
Northern Iowa	2	2	4
Southern Iowa	3	1	4
Kansas	3	2	5
Eastern Kentucky	7	0	7
Western Kentucky	3	0	3
Eastern Louisiana	7	14	21
Middle Louisiana	1	1	2
Western Louisiana	5	5	10
Maine	1	3	4
Maryland	12	5	17
Massachusetts	16	7	23
Eastern Michigan	25	30	55

Jurisdiction	FIRST HALF 1991	SECOND HALF 1991	TOTAL
Western Michigan	0	1	1
Minnesota	14	7	21
Northern Mississippi	0	3	3
Southern Mississippi	3	1	4
Eastern Missouri	3	8	11
Western Missouri	6	4	10
Montana	3	6	9
Nebraska	2	3	5
Nevada	0	1	1
New Jersey	19	14	33
New Mexico	7	6	13
Eastern New York	18	14	32
Northern New York	1	0	1
Southern New York	15	5	20
Western New York	14	6	20
Eastern North Carolina	5	1	6
Middle North Carolina	9	6	15
Western North Carolina	0	1	1
North Dakota	6	6	12
Northern Ohio	9	2	11
Southern Ohio	19	10	29
Northern Oklahoma	5	5	10
Eastern Oklahoma	0	2	2
Western Oklahoma	3	3	6
Oregon	2	7	9
Eastern Pennsylvania	26	24	50
Western Pennsylvania	1	1	2
Middle Pennsylvania	6	9	15
Puerto Rico	4	3	7
Rhode Island	0	6	6
South Carolina	7	5	12
South Dakota	4	2	6
Middle Tennessee	1	3	4
Western Tennessee	6	5	11
Eastern Texas	6	3	9
Northern Texas	21	12	33
Southern Texas	21	20	41
Western Texas	8	4	12
Utah	5	0	5
Vermont	1	0	1
Eastern Virginia	13	10	23
Western Virginia	1	0	1
Southern West Virginia	1	0	1
Western Washington	0	5	5
Eastern Wisconsin	12	6	18

Jurisdiction	FIRST HALF 1991	SECOND HALF 1991	TOTAL
Western Wisconsin	1	1	2
Wyoming	7	2	9
Subtotal	539	409	948
State Authorities			
Alabama	0	1	1
Arkansas	4	1	5
Arizona	1	0	1
California	14	19	33
Colorado	10	7	17
Delaware	0	1	1
Florida	1	2	3
Georgia	0	1	1
Iowa	9	11	20
Illinois	25	15	40
Indiana	16	2	18
Kansas	4	1	5
Kentucky	1	1	2
Louisiana	1	5	6
Maine	1	1	2
Maryland	20	27	47
Massachusetts	7	13	20
Michigan	2	5	7
Minnesota	5	1	6
Missouri	2	6	8
Mississippi	3	1	4
Nebraska	1	0	1
New Jersey	7	8	15
New York	7	9	16
Ohio	8	18	26
Oklahoma	3	0	3
Oregon	1	1	2
Pennsylvania	9	5	14
Puerto Rico	6	4	10
South Dakota	0	2	2
Texas	3	4	7
Tennessee	0	10	10
Utah	1	2	3
Virginia	6	16	22
Virgin Islands	1	0	1
Washington	8	2	10
Wisconsin	3	3	6
Subtotal	190	205	395

Jurisdiction	FIRST HALF 1991	SECOND HALF 1991	TOTAL
TOTAL	729	614	1,343

ACRONYMS

ACF	Administration for Children and Families
ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
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
ASPER	Assistant Secretary for Personnel Administration
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control
CFO	Chief Financial Officers
CMP	civil monetary penalty
CSE	child support enforcement
DCA	Division of Cost Allocation
DDS	disability determination service
DECOR	decentralized earnings correspondence
DME	durable medical equipment
DOJ	Department of Justice
DRG	diagnosis related group
EGHP	employer group health plan
ESRD	end stage renal disease
FDA	Food and Drug Administration
FI	fiscal intermediary
FMAP	Federal medical assistance percentage
FMFIA	Federal Managers' Financial Integrity Act
FO	field office
FY	fiscal year
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HMO	health maintenance organization
HPSL/NSL	Health Professions Student Loan/Nursing Student Loan
HRSA	Health Resources and Services Administration
ICR	internal control review
IEVS	income and eligibility verification system
IHS	Indian Health Service
INS	Immigration and Naturalization Service
IOL	intraocular lens
IRS	Internal Revenue Service
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance Program
LRI	laboratory roll-in
LTC	long term care
MCCA	Medicare Catastrophic Coverage Act
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
OASH	Office of the Assistant Secretary for Health
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
OPD	outpatient department
OS	Office of the Secretary
PCIE	President's Council on Integrity and Efficiency
PFCRA	Program Fraud Civil Remedies Act
PHS	Public Health Service
PHUS	payment history update system
PPS	prospective payment system
PRO	peer review organization
PSC	program service center
RSDI	Retirement, Survivors and Disability Insurance
SLIAG	State Legalization Impact Assistance Grant
SNF	skilled nursing facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
TENS	transcutaneous electrical nerve stimulator
VA	Department of Veterans Affairs

DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Office of Inspector General
330 Independence Avenue, S.W.
Washington, D.C. 20201