

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Annual Report

MADE PURSUANT TO SECTION 204(a) OF
PUBLIC LAW 94-505

January 1, 1981 - December 31, 1981



March 31, 1982

TABLE OF CONTENTS

	<u>PAGE</u>
Statutory Excerpts.	ii
CHAPTER I : Overview and Executive Summary. . .	1
CHAPTER II : Social Security Administration. . .	7
CHAPTER III: Health Care Financing Administration.	38
CHAPTER IV : Grants and Internal Systems	74
CHAPTER V : Operations Summary.	109
APPENDICES :	
Appendix A -- Status Report of Corrective Action by the Department on Recommendations in the IG's 1980 Annual Report.	1-7
Appendix B -- OIG Hotline Complaints.	1
Appendix C -- Medicare and Medicaid Cases Presented to Department of Justice in 1981	1-8
Appendix D -- Audit Reports Issued on HHS Programs--Calendar Year 1981. . .	1-4

STATUTORY EXCERPTS

Requirement for the Inspector General's Annual Report and duties of the Inspector General follow:

P.L. 94-505--Section 204(a) of the law states:

"...Such report shall include, but need not be limited to --

(1) an identification and description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of the Department disclosed by such activities;

(2) a description of recommendations for corrective action made by the Office with respect to significant problems, abuse, or deficiencies identified and described under paragraph (1);

(3) an evaluation of progress made in implementing recommendations described in the report or, where appropriate, in previous reports; and

(4) a summary of matters referred to prosecutive authorities and the extent to which prosecutions and convictions have resulted."

Statutory Duties of the Inspector General

Section 203(a) of the Inspector General law states:

"It shall be the duty and responsibility of the Inspector General --

(1) to supervise, coordinate, and provide policy direction for auditing and investigative activities relating to programs and operations of the Department;

(2) to recommend policies for, and to conduct, supervise, or coordinate other activities carried out or financed by the Department for the purpose of promoting economy and efficiency in the administration of, or preventing and detecting fraud and abuse in, its programs and operations;

(3) to recommend policies for, and to conduct, supervise, or coordinate relationships between the Department and other Federal agencies, State and local governmental agencies, and non-governmental entities with respect to (A) all matters relating to the promotion of economy and efficiency in the

administration of, or the prevention and detection of fraud and abuse in programs and operations administered or financed by the Department, or (B) the identification and prosecution of participants in such fraud or abuse; and

(4) to keep the Secretary and the Congress fully and currently informed,...concerning fraud and other serious problems, abuses, and deficiencies relating to administration of programs and operations administered or financed by the Department to recommend corrective action concerning such problems, abuses and deficiencies, and to report on the progress made in implementing such corrective action."

CHAPTER I

OVERVIEW AND EXECUTIVE SUMMARY

This report covers the calendar year 1981 activities of the Office of Inspector General (OIG) for the Department of Health and Human Services (HHS). The report responds to the requirements of Section 204(a) of P. L. 94-505.

These 1981 activities are presented on a functional basis, with separate chapters devoted to each of the following program areas:

- Social Security Administration
- Health Care Financing Administration
- Grants and Internal Systems

Each chapter details the accomplishments of our team of auditors, investigators and systems analysts and the overall effect of blending the skills of these different disciplines.

Inspector General Confirmed

For the first time in over a year, the Department had a confirmed Inspector General. Shortly after Richard P. Kusserow was confirmed as Inspector General on June 10, 1981, he began a shift in priorities and allocation of staff effort.

Improved Departmental Efforts

Calendar year 1981 marked a steady improvement in the Department's attention to matters of fraud, abuse and waste. Significant efforts were made to resolve outstanding audit recommendations and to recover debts owed to the Department by individuals and organizations. For instance, by the end of 1981, there were no unresolved audits over six months old.

In addition, a number of Operating Divisions implemented regulatory or policy changes which we recommended. One of the most noteworthy efforts was made by the Social Security Administration. Social Security started a major reexamination of its capacity to solve many of the problems involving its computer systems. This has resulted in a recently released master plan to update and improve these

systems. We believe that these positive responses to our efforts contribute to the economy and efficiency of this Department.

This report highlights a number of serious problems within this Department's programs. This is in keeping with the Congressional requirements for the Annual Report.

Nevertheless, if this report is read together with our previous Annual Reports, it is clear that continuous progress has been made in improving management and in avoiding fraud and abuse.

This year's report is not intended to negate these real accomplishments. It is intended, however, to point out that much still remains to be improved.

The Scope of HHS

In 1981, the Department of Health and Human Services was allocated approximately 35 percent of the total Federal budget. More than 144,000 HHS employees were responsible for overseeing the expenditure of over \$240 billion--an amount greater than the total expenditures of any Government in the world with the exception of those of the Soviet Union and the United States.

Nearly 60 percent of these expenditures went to over 36 million beneficiaries of the Social Security Trust Fund Programs. Another 24 percent went to over 29 million Medicare beneficiaries and over 22 million Medicaid beneficiaries. The remainder of the funds was expended on a wide range of public health and human services programs.

The Accomplishments of OIG -- Highlights

During calendar year 1981, we conducted a number of significant investigations, audits and reviews.

As a result of our investigatory activities, 184 individuals were convicted in 1981. In addition our special agents aided investigators in other agencies with another 58 convictions and provided 2,900 instances of assistance to various Federal, State and local law enforcement agencies. As a direct result of these efforts, \$34.9 million in recoveries, fines, restitutions and savings were accrued.

Auditors released 5,483 reports on Department operations--1,250 were prepared by the OIG Office of Audit and 4,233 by non-Federal auditors. Recommended financial adjustments totalled \$230.3 million--a \$140 million increase over last year. Department Operating Divisions (OPDIVS) concurred with recommended financial adjustments of \$136.3 million.

Of even more significance, several areas were identified where loose regulations caused excessive expenditures to Federal programs. In some cases, legislation is needed to correct identified problems. If recommended action is taken, it is estimated that nearly \$1 billion can be saved. These savings are mainly in the area of Social Security (\$846.5 million) and Health (\$276 million). Some significant highlights:

Social Security Administration

- An estimated one million AFDC recipients are receiving heating and shelter allowances under two Federal programs. This duplication could be costing the Government about \$500 million annually. (See Page 29)
- Reducing the time (float period) between the issuance of Title II checks and the actual transfer of Trust Fund monies to the Treasury could save an estimated \$91 million. (See Page 20)
- Millions can be saved if SSA would seek legislation requiring a more timely deposit schedule for Social Security contributions. (See Page 8)
- Continued weaknesses were noted in security controls at SSA computer facilities. (See Page 10)
- SSA's annual wage report process was found to be poorly organized and directed--billions in FICA earnings were improperly posted. (See Page 18)
- Twenty percent of work-related Social Security numbers issued to aliens were issued erroneously to aliens not authorized to work or to visiting aliens. (See Page 12)

- A lack of effective controls over the issuance of Social Security numbers has allowed serious frauds and abuses to occur. (See Page 14)
- Many Social Security and welfare-related programs are losing significant amounts and many frauds are occurring because of failures to terminate benefits after the recipient's death. (See Page 21)

Health Care Financing Administration

- Recommendations made in the Inspector General's 1980 Annual Report--with estimated savings of \$276 million--have not been implemented. (See Pages 40 and 52)
- Problems continue with States claiming Medicaid reimbursement for services provided to certain individuals institutionalized for mental diseases. Immediate management attention could save up to \$125 million annually. (See Page 44)
- Substantial Medicaid savings are possible if States place restrictions on recipients abusing drug purchases. (See Page 47)
- OIG computer screens have detected improper Medicaid billings. Millions can be saved if these screens are used nationwide. (See Page 45)
- The incidence of nursing home fraud remains too high. Many cases result from filing false Medicaid cost reports. (See Page 47)
- State Medicaid Fraud Control Units continue to make progress. Convictions increased by 73 percent and fines and recoveries increased by 91 percent over the previous fiscal year. (See Page 50)
- Improper payments for laboratory services under Medicaid/Medicare are continuing. Laboratories bill for tests on an individual basis which were actually made as part of a series on automated equipment. (See Page 67)

Grants and Internal Systems

- Billing third party insurers and financially able individuals could save the Indian Health Service millions. (See Page 75)

- We launched a probe of physicians who are delinquent on Health Professions Student Loans. (See Page 79)
- Follow-up review of the National Cancer Institute's contracting procedures calls for additional improvements. (See Page 77)
- HHS grantees are continuing to draw substantial Federal funds in excess of cash needs. These grantees earn substantial interest at the expense of the Federal Government. (See Page 99)

New Directions--1982 and Beyond

Calendar year 1981 marked a number of major economic and political transitions which require the efforts of the Office of Inspector General for 1982 and 1983 to reflect different assumptions from the past. As a result, they require shifts in priorities for the future. These shifts not only will bring greater savings to the Department but they can be accomplished by better utilization of existing resources.

One of the OIG's principal roles is to act as an "Agent for Change" within the Department. Previously, success was measured by statistics, financial findings and criminal prosecutions. Now, most of our efforts are directed to identifying the processes which give rise to fraud, waste and abuse in our programs. It is somewhat analogous to a physician who avoids treating the symptom, but instead uses the symptom to identify and treat the disease. Through new initiatives, the OIG can provide management with the information needed to make programs more efficient and cost effective. More management efficiency and accomplishment audits and reviews will be performed. This will enable those funds that, in the past, have been lost to fraud, abuse and waste, to reach the recipients for whom they were intended.

Past audit efforts were encumbered by the Office of Management and Budget (OMB) requirements to review over 5,000 university and nonprofit agencies, and to review State and local cost allocation plans. Auditors also were mandated to respond to Federal procurement regulations by conducting numerous contract close-out audits. The result was that substantial audit effort was devoted to reviews of formula and project grants, university audits, and contract closing--e.g., 20 percent of FY 1981 audit staff

years spent on university audits were devoted to 3 percent of the Department's budget. Insufficient staff was available to devote to the largest Federal responsibilities within the Department: Social Security (\$173 billion), Medicare (\$49 billion) and Medicaid (\$18 billion). Our 1982-1983 workplan reflects a redirection of audit effort in response to new OMB initiatives requiring that single audits be conducted, preferably by non-Federal auditors. Furthermore, OMB is requiring significantly greater attention to internal program and Departmental controls.

Major changes will also be reflected in investigative efforts. Although heavy emphasis will continue on criminal fraud prosecutions, more emphasis will be placed on civil fraud prosecutions, and on administrative sanctions and debarments.

In addition, efforts will be made to distill the findings of past reviews to make them more relevant to future regulatory, policy and operational decisions within the Department. Greater emphasis will be placed on reports which bring together the remedial findings from audits, reviews or investigations. And the development of our OIG information system will make more accessible results of prior reviews on such topics of importance as improper use of X-rays, unnecessary hospital stays and excessive hospital beds.

Beyond reorganization efficiencies, more effective use of staff can be achieved by increasing cooperative ventures with other Inspectors General and with the President's Council on Integrity and Efficiency. Similarly, greater effectiveness can be achieved by a closer working relationship with the Department of Justice, the Federal Bureau of Investigation, the Secret Service and other investigative agencies.

These new directions and priorities require an altered organizational structure to obtain maximum effectiveness. Thus, we are taking the steps necessary to implement an OIG reorganization plan to provide a greater deterrent to fraud and improved programs to make operations more economical and efficient.

CHAPTER II

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration's Income Maintenance and Assistance programs represent the largest portion--about 70 percent, or over \$173 billion--of the Department's budget for FY 1982. These programs include the federally administered Retirement and Survivors' Insurance (RSI), Disability Insurance (DI), Supplemental Security Income (SSI), and Black Lung benefits (claims filed before 1974) and the State-administered Aid to Families with Dependent Children (AFDC).

A comparison of the program costs of these five programs for FY 1982 illustrates the dominance of the Trust Fund (Title II of the Social Security Act) programs--RSI and DI--in terms of Federal dollars spent:

<u>Program</u>	<u>FY 1982 Estimated Program Costs</u>
Retirement and Survivors Insurance (RSI)	\$138.2 billion
Disability Insurance (DI)	18.4 billion
Supplemental Security Income (SSI)	7.9 billion *
Black Lung Benefits	1.1 billion
Aid to Families with Dependent Children (AFDC)	7.6 billion
Other	<u>.4 billion</u>
Total	\$173.6 billion

* Not including the approximately \$2.1 billion in federally administered State supplement payments.

All entitlement programs have grown rapidly in recent years under the influence of inflation and unemployment. In particular, however, growth in the Trust Fund (RSI and DI) programs--about a 36 percent increase in the last three years alone--has reached an alarming rate due primarily to an expanding beneficiary population and higher benefit levels (currently indexed to inflation).

During 1981, the Office of Inspector General (OIG) intensified its reviews of SSA's operation and management of these programs. Special projects were initiated to detect fraud and abuse and strengthen management controls. We also reviewed physical security over SSA's telecommunications system, data processing facilities, computers and computer record files. Projects relating to the State-administered program of AFDC continue to identify improper and incorrectly claimed costs.

OIG ACCOMPLISHMENTS

In calendar year 1981, 127 audits were issued recommending financial adjustments of \$63 million. Seven ongoing reviews identified an additional \$52.8 million in questionable program expenditures and additional lost Trust Fund interest of \$180 million annually based upon this year's and previous audits. If regulations or legislation are changed to correct problem areas, our audit reports estimate a potential additional savings of \$846.5 million.

This year our criminal investigative activities resulted in 124 convictions (including 31 convictions in a special Federal-State AFDC project) and \$26.6 million in recoveries, fines, restitutions and savings.

We conducted a number of reviews and service delivery assessments which focused on ways to improve the economy and efficiency of program operations.

This chapter highlights some of our audit, investigative and management review activities.

Although we are pleased with the progress the Office of Inspector General (OIG) and the Social Security Administration (SSA) have made in some areas, much remains to be improved. As a result, in 1982, we will be devoting a significantly greater proportion of our staff efforts to the Trust Fund programs of SSA.

PROBLEMS REQUIRING LEGISLATIVE CHANGE

A Liberal Deposit Schedule for Social Security Contributions Has Cost the Trust Fund Some \$1.1 Billion in Lost Interest Income

Although private sector employers are required to deposit Social Security withholdings weekly, semi-monthly,

biweekly, or monthly depending on the amount withheld, the deposit schedule for State and local governments is much more liberal. (About 9.4 million, 73 percent, of State and local government employees are covered by Social Security.) Regulations required States to report wages and salaries paid to covered employees and to deposit both the employers' and employees' contributions within 30 days after the end of each calendar quarter. Thus, State and local governments were permitted to keep these contributions an extra two to three months more than private employers. States invested these funds and earned interest income in the millions while somewhat proportionate losses accrued to the SSA Trust Funds. In fact, according to the General Accounting Office, SSA Trust Funds could have earned about \$1.1 billion in additional interest (during calendar years 1961 to 1979) had States been required to deposit taxes more frequently--monthly instead of quarterly.

The Department attempted to tighten up the deposit schedule in 1978 by requiring deposits on the 15th day after the end of each month except on the third month of a quarter where an extra 30 days was given. (This is referred to as the 15-15-45 proposal.) Even under this proposal, State and local governments could still earn an estimated minimum of \$50 million annually from short-term investments before making the required deposits.

The recently enacted Social Security Disability Amendments of 1980 (P.L. 96-265) mandated a 30-30-30 deposit schedule. The new schedule was intended to ease the transition to the Department's 15-15-45 proposal. However, with the inception of annual reporting in calendar year 1981 the 15-15-45 proposal became obsolete because quarterly reconciliation by employers of wage reports with deposits was no longer required. Without that time consuming requirement, a 15-15-15 deposit schedule would allow States adequate time to make deposits. Adoption of a 15-15-15 deposit schedule could increase interest income by an estimated \$240 million over the next four years (FY 1982-85). In view of the impact on the Trust Funds, SSA should continue to seek legislation to accelerate the State and local deposit schedule.

SSA COMPUTER OPERATIONS

SSA Computer Complex

To record the earnings and benefit payments for millions of wage earners and beneficiaries, SSA maintains one of

the largest computer complexes in the country. Included in the complex are 16 large scale computers, over 900 tape and disk drives, 3,800 telecommunication terminals, and 6,500 programs. Recent SSA Congressional testimony revealed (1) that the current computer systems are undocumented, uncontrolled, obsolete and inefficient and (2) there is a SSA priority to redesign their computer systems hardware and software. SSA has just announced a comprehensive long-term program to update their systems and to create an ongoing program to keep the systems current. In line with GAO standards, the OIG will assume an active role during 1982 in monitoring this redesign, including participation in the design, development and modification of data processing systems/applications.

During calendar year 1981, we reviewed SSA controls over selected computer operations. The highlights in these areas follow.

Review of SSA Program Service Center Discloses More Weaknesses with Security of Computer Facilities

In our review of a Program Service Center we evaluated controls over Social Security benefit payment data received from SSA central office. Similar problems to those reported in a 1980 audit of another Program Service Center were noted. Both reviews disclosed problems with unrestricted access to computer facilities. Persons, such as maintenance personnel, programmers and clerical staff, not directly involved with computer operations were permitted unrestricted entry to the facility.

SSA agreed to implement our recommendations for limiting unrestricted access to the computer facilities in all Program Service Centers

Telecommunication Security

Auditors recently followed up to find out what action SSA had taken on two prior reports covering SSA's Data Acquisition and Response System and the Advance Record System. Both are involved in the communication network for district offices. The principal thrust of the prior reports was that controls were inadequate to restrict unauthorized terminal access and use.

Our current review showed that while some corrective action was taken, many system security deficiencies still

exist. For example, we found instances where: terminals were located in areas easily accessible to unauthorized personnel, key stations were unlocked and unattended, and security controls used to pilot test the use of personal identification numbers were weak and needed improvement.

SSA agreed with almost all our findings, but their approach will address most of them with a single, generalized solution rather than setting up individual projects for each item covered. While SSA is confident that their approach is the more efficient one, we shall monitor their progress to ensure that their approach is effective.

Weaknesses in Internal Computer Software Controls of SSA's Batch Data Transmission System

The Batch Data Transmission System (BDTS) is used to transfer large volumes of batched data between SSA's central computer center and SSA field offices, Medicare intermediaries and carriers, and State welfare agencies. Audit identified that "multipoint" terminal connections (similar to a telephone party line) were not adequately secured to protect sensitive private information from unauthorized access. Tests showed, for example, that data intended for a Michigan Medicare contractor could be accessed by a Maryland based contractor.

Recommendations (in which SSA concurred) called for improvements in controls over the data transmission, including use of a secret password and employee identifier be entered into the computer.

Computer Security Project--President's Council on Integrity and Efficiency (PCIE)

In the summer of 1981 the President's Council on Integrity and Efficiency voted to sponsor a project on computer security and asked the OIG to formulate a plan and take the lead in the project.

We surveyed Council members to obtain clarification of their computer security requirements. We found that to a great extent priority has not been given to problems related to computer systems and further that the OIG community had few staff members with the necessary expertise to adequately address the complex technical issues that automated systems present.

The project will examine the extent of computer-related crime and abuse in the Federal sector. We expect the project to raise the level of awareness to these problems governmentwide, and aid in the definition of future computer expertise resource requirements. Other participants in the project are DOD, USDA, Commerce, SBA, NASA, Treasury and GAO.

The project is scheduled to be completed during calendar year 1982.

SOCIAL SECURITY NUMBER PROBLEMS

Review Finds Serious Problems with Social Security Number Issuance System

As reported in the 1980 OIG Annual Report, alarmed by the rapid increase in Social Security Number (SSN) fraud cases since 1978, the Inspector General initiated a study of the SSA Social Security Number Issuance System. The review combined traditional audit techniques with management review and computer analysis methods, examined management practices, the validity of SSN application data, vulnerability and deterrent/detection capabilities of the computer system, and finally, trends in issuance of SSN's to aliens who are not authorized to work. In February 1981, we issued our final report.

The report contained the following major findings and recommendations:

- While U.S. citizens may use SSN's for any purpose for, which an SSN is needed, SSA issues two types of SSN's to aliens: (1) Work-related numbers for those aliens authorized to work by the Immigration and Naturalization Service, and (2) nonwork numbers to those aliens, who do not have work authorization but need the SSN's for other purposes (e.g., driver's license). In the two cities reviewed (New York, N.Y. and Washington, D.C.), we found that almost half of all persons of all ages obtaining work-related Social Security numbers were aliens. Of these, 20 percent were issued erroneously either to illegal aliens or to visiting aliens not authorized to work. In addition, at least 24 percent of the numbers issued to aliens for nonwork purposes were indeed being used for work.

- These high error rates were the result of poor SSA headquarters' guidance. SSA's evidence certification process lacked controls, supervision and document training.
- SSA had not provided its district offices with clear instructions for issuing SSN's to aliens without work authorization nor instituted any deterrents to the abuse of these numbers.
- There was no national fraud awareness nor effective central office guidance to the field on how to control fraud and misuse. In the void, regional and field offices were setting up ad hoc procedures to deal with the problems.
- Because there was no effective case control or reconciliation procedures, numbers could be fraudulently issued with little probability of detection.
- SSA has recently piloted a more automated system for processing SSN applications, which makes extensive use of the telecommunication system. As mentioned in our previous discussion, because the SSA telecommunication system lacks effective access controls, personal accountability, and a password system, all enumeration is vulnerable to compromise.
- Though illegal aliens are known to have paid over \$100 for a blank Social Security Number Card, controls over the printing, distribution, and storage of blank Social Security Number Cards were found to be totally ineffective. Some field offices obtained huge inventories when not needed; blank cards were found in empty desks; a stack of over a thousand blank Social Security Number Cards was found on the floor of an unlocked empty room after working hours.
- In addition to lacking controls mentioned above, the SSN computer system had weaknesses in edit routines, poor back-up and recovery procedures, and no audit trails.

Response to Our Report

We provided SSA with over 50 recommendations for improvement in the issuance process. Recommendations that have

been acted upon include those procedural ones dealing with document verification and authentication training, national fraud awareness programs, control over the printing and storage of blank card stock, increased use of quality assurance techniques and other management reviews and general awareness of the importance of the process within the SSA overall mission.

In addition, Congress has acted on our recommendation to amend the Social Security Act by raising the maximum penalty for SSN fraud from \$1,000 to \$5,000 and by putting a specific provision into the Act making it illegal to counterfeit, alter, buy, or sell Social Security cards. Congress also made such acts felonies and allowed a maximum five year sentence.

SSA is also implementing an expanded SSN telecommunications input process and "log on/log off" procedures which they assert will vastly improve security control over the SSN Issuance System. We are concerned, however, that SSA fails to address all of our recommendations for more predictable and effective controls requiring computer systems enhancements. SSA will be unable to provide an effective SSN fraud deterrent and detection program if reliance is placed primarily on procedure measures which are labor-intensive and can be easily bypassed. Procedural measures do not get to the heart of the problem; i.e., control and accountability where the majority of SSN fraud occurs--the district office.

In 1982 we plan to track implementation by SSA of those recommendations that they have accepted.

SSN Fraud Cases

As mentioned above, our initial review of the SSN Issuance System was triggered by a growing number of fraud investigations involving illegal aliens and Social Security numbers and/or Social Security employees. Unfortunately, until preventive measures are taken to fix the SSN system, we expect SSA fraud and employee corruption cases to continue.

In 1980 the Office of Inspector General launched an initiative in concert with the Immigration and Naturalization Service (INS) to investigate Social Security number fraud involving nonimmigrant and illegal aliens. Many of these cases are investigated jointly by

OIG, SSA and INS with other agencies including the FBI, U.S. Postal Service and Internal Revenue Service. To date, over 60 convictions and 1,000 deportation proceedings have resulted.

The following are 1981 examples of criminal activities involving Social Security numbers:

- OIG investigation revealed that an illegal alien furnished a fraudulent Social Security number to the Texas State Commission for the Blind. Before the alien was convicted on charges of using a false Social Security number to gain Federal benefits, he had obtained \$5,060 in medical benefits.
- The State Department requires nonimmigrant aliens such as tourists and students from certain countries to provide documentation that they will not be a burden on our society. Acceptable documentation is an affidavit of support. Many of the OIG's cases involve individuals who have falsified these affidavits. Five notaries public pled guilty this year to charges relating to notarizing documents materially relied upon by the U.S. State Department to issue visas. In one of the cases the investigation showed fourteen individuals were receiving fraudulent AFDC benefits. In another case a "dealer" in Social Security cards was convicted after 84 Social Security number applications for Polish tourists had been mailed to his residence and to two post office boxes registered in his name.
- In a bribery case involving an SSA employee who provided SSN's fraudulently, the investigation showed the suspect also wrote fraudulent letters to the American Embassy in Nicaragua, guaranteeing employment to three Nicaraguan citizens. Further, the suspect was obtaining W-2 Forms for illegal aliens who had returned to Nicaragua and was filing tax returns to obtain refund checks which were converted to his own use. He was convicted on March 31, 1981.
- A Social Security employee was convicted for her role in selling Social Security cards and numbers to individuals for the purpose of establishing new identities.

- Three individuals pled guilty to charges relating to their providing stolen Social Security cards to illegal Haitian aliens who used them to obtain unauthorized employment and welfare benefits. They were also involved in a marriage fraud scheme which would allow the aliens to remain in the United States.
- Trafficking in counterfeit Social Security cards is another mechanism for exploiting the system. The Dallas field office investigated three separate cases involving over 1,000 counterfeit Social Security cards each. All three cases trace back to suppliers in Chicago and a national distribution system. Five individuals have been convicted in the Dallas region this year.
- Most OIG field offices report significant workload involving counterfeit Social Security cards. For example, in Chicago an undercover purchase of 10 "identification packets" resulted in the arrest of a Cook County Deputy Sheriff and his subsequent conviction. Similar cases were also concluded with convictions in New York and Kansas.
- Our Dallas office reports an investigation of an illegal alien who worked five years with an "impossible" Social Security number. He died and now his family has been ruled eligible for retirement and survivors benefits.
- Two individuals pled guilty to charges relating to their obtaining valid Social Security numbers by submitting false information and claiming over 36 false IRS refunds. This activity is not limited to defrauding the Federal Government. In August 1981, a Louisville, Kentucky woman was convicted for filing false State income tax returns and receiving thousands of dollars in unentitled refunds. She used false Social Security numbers in the scheme.

OTHER SOCIAL SECURITY ADMINISTRATION TITLE II PROBLEMS

Serious Deficiencies Found in System to Prevent Payment of Benefits to Deported Aliens

The SSA's Foreign Payment System currently makes payments of some \$1 billion annually to approximately 330,000

beneficiaries living in 60 countries. SSA is required by law to deny or suspend benefits to deported aliens. To comply with the law, SSA has designed and installed the "Alien Non-payment System." The denial or suspension of benefits is based on information which is provided on a regular basis to SSA by the Immigration and Naturalization Service (INS).

Our draft report stated that the Alien Non-payment System cannot at this time effectively prevent deported aliens from receiving benefits. Among the problems found is the lack of adequate control and accountability for deportation notices received from INS, and evidence of erroneous payments to deported aliens.

We are urging SSA to upgrade the Alien Non-payment System by improving accountability and accuracy of deportation notices, by providing tighter control over storage and disposition of these notices, by completing the updating process for the computerized file, and finally by employing more effective error detection techniques.

Inconsistent Eligibility Determinations Were Made for Individuals Having A Child-in-Care

Under Title II of the Social Security Act, spouses are eligible for benefit payments based on their spouse's earnings. Eligibility for such payments require that the spouse be either over age 62 or responsible for the support and welfare of the wage earner's minor child. If a spouse under age 62 is not living with the eligible child, benefit payments may be made only when the spouse exercises parental control and responsibility for the child.

In the Boston region, we tested the SSA eligibility determinations of nine wives/widows under age 62 where the eligible child resided in a State institution for the mentally retarded. In our opinion, all nine applicants were ineligible since all decisions concerning the children's welfare were made by the institution without consulting the parents. Initially SSA approved five of the claims; but reduced that to three after our review.

Our review raised the question of whether SSA's eligibility criteria for child-in-care benefits may be too general, allowing for varied interpretations on a nationwide basis. We recommended that the SSA Claims Manual be

amended to provide more specific instructions for determining eligibility in child-in-care cases. In addition, we recommended that these cases be systematically identified and eligibility periodically redetermined.

SSA ADMINISTRATION ISSUES

Audit Finds SSA Lax on Administering/Controlling Annual Wage Reports

Tentative findings show that SSA did not properly plan or adequately prepare to effectively carry out the administrative and operational responsibilities of receiving, processing, reconciling, reporting and posting annual wage data reported on magnetic tape for tax years 1978 and 1979.

More specifically, the audit showed that the annual wage report process was poorly organized and directed, policy matters were addressed on an ad hoc basis, operating instructions were vague, verbal and constantly changing, computer programs malfunctioned and were ineffective, and the data base containing technical tape data and administrative information was incomplete, inaccurate and unreliable.

Because of these problems, SSA was unable to account for all the wage reports received and could not ensure that wage reports were processed accurately and timely:

- About 1.4 million wage reports for tax year 1978 and 688,000 for tax year 1979, valued at \$8.1 billion and \$3.6 billion, respectively, were processed and posted twice to employee earnings records.
- Half of the 30,000 employers, with FICA wages totalling nearly \$175 billion for about 40 million employees were rejected from the initial processing necessitating time-consuming effort, cost and resources to re-input rejected wage reports.
- Tax year 1978 wages of \$78 million for 12,750 employees had not been picked up as received and, therefore, were not processed--three years after they were submitted to SSA.

- Literally millions (exact number unknown, no accounting) of unreconciled, missing and discrepant 1978 wage reports representing IRS adjustments have not been reviewed by SSA.

Although SSA has made some improvements, more aggressive action needs to be taken to not only eliminate tax year 1978 problems, but to further strengthen internal controls and eliminate problems that hamper current operations. To this end, we have made 71 recommendations; 59 affect current operations and 12 recommendations concern the 1978/1979 period.

Improvements Needed in SSA's Accounts Receivable Reporting

Tentative findings show that \$1.9 billion in debt owed by the public as reported by SSA was significantly understated because:

- Overpayments of Title II, SSI, and Black Lung benefits were understated by an estimated \$290 million. The "earnings enforcement program" which identifies overpayments was suspended for calendar years 1978 and 1979.
- Unrecovered disallowances of costs claimed by States under the Aid to Families with Dependent Children and Child Support Enforcement programs were not recorded as accounts receivable (amounts indeterminable).
- An estimated \$11 million in Black Lung overpayments were not accounted for because of a system deficiency.

Our report also notes that delayed implementation of the penalty interest assessments provision of the Federal Claims Collection Act caused by systems inadequacies was costing the trust funds and general funds an estimated \$15 million per month in lost interest.

Prior to our review, SSA was implementing an agency-wide accounts receivable system that provides automated billing, interest charging, follow-up, and comprehensive information to facilitate debt management. SSA has made substantial progress in correcting identified problems. Among other things, SSA has resumed running the "earnings enforcement program" and performed statistical analyses

of debts owed by the public for the purposes of aging, quantifying and developing profiles of case characteristics.

The Department plans to issue a policy statement which will require disallowances to be brought under accounting control.

Revised Cash Transfer Policy Could Increase Interest Income to Trust Funds by About \$91.5 Million Annually

Under the Title II program, checks are issued to beneficiaries on the third of each month. Treasury procedures allow a two-day float (three or four days when the third of the month falls on a weekend or holiday) before trust fund monies are transferred to the Treasury to cover issued Title II checks. The float period is the elapsed time between the issuance of a monthly Title II benefit check and the actual transfer of Title II trust fund monies to the Treasury.

We reviewed 3,000 Title II benefit checks processed by the Treasury in December 1980 and found that it took an average 5.2 days for these checks to clear through the banking system. We believe that the Treasury should adopt a policy under which SSA would transfer trust fund monies, on a daily basis, equal to the value of Title II benefit checks paid by the Federal Reserve banks for that day. Adoption of this policy could result in as much as \$91.5 million in additional interest being earned annually by the trust fund.

Significant Weaknesses Found in SSA Motor Vehicle Management

Audit reviewed SSA's management of motor vehicles leased by Headquarters in Baltimore from the General Services Administration (GSA). Among the results:

- Controls over U.S. Government National Credit Cards were inadequate to detect unauthorized purchases of gasoline and oil.
- Daily Automotive Vehicle Reports were not being prepared by drivers, making it impossible to reconcile monthly vehicle utilization and account for total miles driven.

- 36 of 41 passenger vehicles did not meet GSA's minimum quarterly utilization requirements.

We recommended measures to strengthen control over motor vehicle usage. SSA has or is in the process of implementing the recommendations.

SSA Employees Abusing Compensatory Time for Religious Observances

SSA central office employees were taking off unusual amounts of time for alleged religious observances on days other than traditional religious holidays. During eight selected pay periods in FY 1980, about 75,000 hours of compensatory time for religious observances were taken by SSA employees. This caused problems with work scheduling, accounting for time and employee morale. Most of this religious leave was requested for days before and after holidays--Fridays and Mondays. On some days, work units were paralyzed when up to 75 percent of the work force was absent for religious observance on days other than traditional religious holidays.

A survey by SSA after our sample period showed that this condition may have been worsening: for a four-day period during calendar year 1980, 2,500 employees took more than 40,000 hours off for religious observances.

There were a couple of underlying problems: (1) Office of Personnel Management (OPM) regulations do not provide sufficient guidelines for the effective administration of religious leave, and (2) an OPM opinion pointed out that employee requests must be accepted at face value without supervisory inquiry into the nature of the religious belief.

We recommended that SSA and the Assistant Secretary for Personnel Administration implement stricter policies for granting time off for religious observances. Implementation of improved policies is in process.

SSA DEATH TERMINATIONS

Benefits Not Terminated After Death

Each year, SSA processes about 1.5 million death reports, primarily through voluntary reports from third-party

sources such as relatives, funeral directors and the U.S. Postal Service. Past studies have shown that erroneous payments to deceased beneficiaries due to unreported deaths, late reports, or delays in processing, occur because SSA has no systematic means of obtaining death information.

The Secretary is required by P.L. 97-123, to report to Congress by the end of March 1982 on the matter of SSA death terminations.

Our survey highlighted the following points:

- The scope of the problem, either nationwide or across program lines, is unknown because no projections can be made from the rather narrow studies to date.
- Using worst case assumptions, we obtained a rough, unscientific estimate for planning purposes that shows that these programs may be losing as much as \$100 million annually in unrecovered overpayments and interest lost to trust funds.
- OIG projects (described below) have shown that these programs are indeed losing significant amounts.

One long-range solution is a national death index which could be used for administrative purposes. The current index maintained by the National Center for Health Statistics, however, is restricted by statute from administrative use. Such a solution also risks possible conflicts with State privacy laws, although these might be avoided by restricting the administrative death index to fact of death rather than cause of death. Several bills requiring the establishment of a national death record data base were introduced in the last session of Congress. We recommend that such legislation be carefully considered by the Department and the Congress.

Project 90 Plus

In order to further assess the problems resulting from failure to have a system in place to eliminate payments to beneficiaries who died, we conducted several experiments. The first such project was piloted in Chicago and was called "90 Plus." Project 90 Plus consisted of a match of all Social Security beneficiaries in the State

of Illinois over 90 years old against Illinois death records. We found cases in which benefits were not promptly terminated. We also found cases where a strong possibility of fraud existed. These were referred to the U.S. Secret Service for investigation. Jointly, OIG and the U.S. Secret Service have recovered over \$115,000 to date. Two individuals were indicted in 1981.

Medicare Match

Due to the diversity of vital statistics records across the country, an alternate source of information was sought for a national project. OIG successfully matched the Health Care Financing Administration's records of deceased Medicare patients against the Social Security Administration's Master Beneficiary Records (MBR). Some 8,300 cases were identified where benefits were being paid to individuals who could be deceased. At the beginning of the project 7,958 cases were in current pay status, and some 400 cases had suspensions or terminations significantly after the date of death shown on the source document. SSA has since corrected the program to automatically terminate such cases and is assisting OIG in the investigation of these cases.

Verification procedures to date have resulted in 4,818 cases being terminated; 1,742 of the beneficiaries of record were found to be alive. In addition, approximately 1,400 beneficiaries have been suspended or are in the process of being suspended. The projected savings from this project may exceed \$20 million. Recoveries to date are: \$3.8 million in uncashed treasury checks; \$0.9 million in remittances as repayments; and \$76,000 in recoveries of other agencies' funds such as the Veterans Administration and the Railroad Retirement Board. The total amount recovered by the end of December was \$4.8 million. U.S. Attorneys have expressed interest in prosecuting 183 cases.

The first conviction from this project came on a guilty plea when OIG Special Agents discovered that a New Mexico man accepted and converted to his own use some \$7,000 in benefits payments which had been deposited in his deceased mother's bank account.

Supplemental Security Income--Death Terminations

For the most part, investigation of beneficiary fraud in the SSI program is handled by SSA investigators. But

when Federal employees are involved, OIG Special Agents or the FBI conducts the investigation. An example of a recently completed case involved a SSA service representative. Through the manipulation of the SSA computer, a SSA employee generated at least \$28,000 in SSI checks using the accounts of recently deceased SSI recipients. The checks were sent to and cashed by two accomplices, one of whom was on probation for armed robbery. The service representative and both accomplices pled guilty in 1981.

BLACK LUNG PROGRAM

OIG Computer Match Identified "Millions" in Black Lung Payments to Deceased Beneficiaries

We recently matched Black Lung payment records on 237,000 widows and spouses (receiving current benefit payments) with SSA's Master Beneficiary Record (MBR). Some 1,200 individuals were listed as deceased on the MBR records but still receiving Black Lung payments. SSA, in a cooperative effort with the OIG, reviewed these cases and determined that 829 cases should be terminated. Overpayments of about \$4.6 million were identified through this effort. Thirty-four cases of possible forgeries were given to the Secret Service for review and analysis.

We attributed these overpayments to system deficiencies within both the Title II and Black Lung programs. We recommended and SSA generally agreed to: (1) Establish controls to ensure that all death notices are processed to the Black Lung master files, (2) obtain and record on the Black Lung master files the SSN's for all dependent spouses already reported to SSA, (3) initiate a joint payment system for miners with dependent spouses, and (4) periodically match the MBR to the Black Lung master files to ensure that individuals terminated on the MBR are not receiving current Black Lung payments.

Legislation Is Needed to Permit Enforcement of Earnings Test Provisions of the Black Lung Program

Due to an Internal Revenue Service ruling in early 1981, SSA is prevented from using wage data reported under Social Security (which IRS considers to be tax return information) to enforce the earnings test provisions of the Special Benefits for Disabled Coal Miners (Black Lung) Program. As a result, a proven means of identifying possible fraud and overpayments to Black Lung

beneficiaries with earnings above the exempt amounts cannot be utilized by SSA or the Inspector General. A legislative proposal has been drafted by SSA staff to permit the use of tax return information in Black Lung earnings enforcement.

We recommended that SSA expedite submission of this legislative recommendation since enforcement operations conducted prior to the IRS ruling as well as our recent efforts identified significant numbers of potential overpayment cases.

On February 19, 1982, the Department submitted a legislative proposal to OMB for approval that should correct this problem.

Computer Screen Finds Black Lung Payments Being Made to Ineligible Children/Students

Under the Black Lung program, payments are made to recipients for their children until they reach the age of 18, or if they are students, until they become 23 or complete four years of post-secondary education, whichever comes first. Using a computer screen, we identified 2,951 children or students whose age exceeded this eligibility standard. At our request, SSA is reviewing all case folders to determine whether actual overpayments were made. Through December 1981, SSA reviewed 1,760 cases and identified 631 who were ineligible and overpaid \$908,235. SSA is in the process of recovering overpayments.

DISABILITY INSURANCE

State Agency Reimbursement for Disability Determinations

States are reimbursed for the cost of developing medical, vocational and other evidence to determine if a disability exists as part of the disability determination process for the Title II (DI) program. Fifteen audit reports released during the past year identified unallowable State charges for administration of \$912,500 and raised questions as to the allowability of an additional \$10.6 million due to the lack of supporting documentation.

The most significant costs questioned involved non-compliance with State indirect cost negotiation agreements or cost allocation plans (\$350,000), over-drawdowns under the letter-of-credit system (\$184,000), and rental costs exceeding allowable limits

(\$201,000). Other reports identified over-claims resulting from deviations from budget ceilings, unsupported liquidated and unliquidated obligations and isolated breakdowns in payroll controls.

During fiscal year 1982, we will summarize disability administrative cost findings reported over the past several years. Trends will be developed and analyzed to assist SSA in developing long-term solutions to these repetitive problems.

Fraud Investigations in the Disability Insurance (DI) Program

The following are examples of OIG investigations involving fraudulent schemes either to obtain disability benefits or conceal facts affecting ongoing eligibility:

- In a case referred by the Inspector General of the Department of Agriculture which involved Housing and Urban Development funds, AFDC funds and DI funds in excess of \$45,000, the subject was gainfully employed under an assumed name and drawing disability benefits. He was convicted.
- A SSA Office of Hearings and Appeals clerk admitted to altering an official hearing transcript to show that her brother-in-law was eligible for disability insurance benefits after his hearing denied him these benefits.
- In another DI fraud scheme jointly investigated by the U.S. Postal Service and the OIG, a Louisville, Kentucky man received workman's compensation after retiring from the U.S. Postal Service with a disability. He subsequently took a job as a truck driver and later was injured in an unrelated fall. His application for disability insurance did not disclose that he was receiving workman's compensation. The man pled guilty.

SUPPLEMENTAL SECURITY INCOME (SSI)

Highlights of OIG Efforts

The SSI program ensures a minimum level of income for needy, aged, blind and disabled people. The program which was implemented in 1974 to replace State administered programs, provides uniform benefit levels and eligibility requirements nationwide. In 1981, about 4.1

million persons received about \$8.5 billion in SSI benefits, including \$1.9 billion in State supplementation payments. SSA administers State supplementation payments for 26 States and the District of Columbia. Our highlights which concern these supplemental programs follow:

- Under provision for mandatory supplementation of the SSI program, States are reimbursed for certain administrative costs for furnishing recipient data to SSA. In 1981, we reviewed \$2.6 million of these costs in five States, and identified nearly \$120,000 as unallowable.
- Under Section 405 P. L. 95-216, States which overpaid SSI supplemental benefits during calendar year 1974 as a result of incorrect information furnished by SSA may submit claims to SSA, under some circumstances, for overpayment amounts. One State claimed \$1.1 million for about 9,400 alleged overpayments during one year. Using statistical sampling techniques, we found this claim over-stated by nearly \$910,500. An appropriate financial adjustment was recommended. SSA has incorporated this adjustment in its determination of the amount due the State, but the State has not yet accepted it as correct.

Bribery and attempted bribery also occur with respect to the Supplemental Security Income program. A Kentucky man applied for SSI and DI benefits. Upon finding out that his application was denied, he offered a \$500 bribe to the SSI claims representative to alter the records to make him eligible. The employee agreed to participate in the investigation which utilized consensual telephone monitoring. The subject pled guilty to charges relating to his attempt to bribe an SSA employee.

CANCELED, LOST AND STOLEN BENEFIT CHECKS

Canceled Benefit Checks not Credited to Federal Programs

We reported in last year's Annual Report that States were retaining and not crediting Federal programs for their portion of uncashed AFDC benefit checks and other collections. Some \$30 million was identified as due the Federal Government. During 1981, 15 audits identified \$9 million due Federal programs.

Last year, we recommended that the Commissioner of SSA issue regulations requiring the timely return of the Federal portion of uncashed benefit checks and other credits. SSA officials subsequently developed regulations which would have standardized the return of the Federal portion of uncashed benefit checks and other credits. However, the proposed new rules were delayed pending a review of all proposed new Federal regulations. SSA now advises us that regulations requiring the return of the Federal portion of these checks within 180 days should be issued shortly.

Delay in issuing these regulations is needlessly costing the Federal Government some \$12-15 million in interest costs annually. Priority needs to be given to immediate correction of this problem.

Alternative Check Delivery Methods: A Means to Combat Losses Through the U.S. Postal Service System

U.S. Treasury checks and other beneficiary payments made on behalf of the Department of Health and Human Services (HHS) are being stolen or lost through the U.S. Postal Service system and subsequently illegally negotiated. The actual number of checks that are lost or stolen in that manner is unknown. However, the number being reported stolen and subsequently negotiated illegally appears to be in the hundreds of thousands. HHS and the Department of Agriculture (USDA) are responsible for administering four major programs under which each year more than 500 million checks and authorizations valued at over \$100 billion are mailed to individual beneficiaries.

As a follow-up to hearings held by a subcommittee of the House Committee on Government Operations, OIG agreed to conduct a review of related Federal and State efforts underway to combat losses through the U.S. Postal Service System. In the OIG review, an assessment first was conducted of the Pennsylvania and Cook County, Illinois systems of delivery of welfare checks and authorizations to purchase food stamps. The intent was to determine potential for savings, and the applicability of those systems to other States. Following the State assessments, an update was obtained of other efforts underway at the Department of Treasury and within HHS to avoid these losses. In each case we found that these efforts were cost effective.

Based on our review of alternative check delivery methods, we made the following recommendations:

- SSA should seek with the Department of Treasury, to expand the current usage rate of the Direct Deposit program, as well as continue to explore other alternatives to safely deliver benefit payments to SSA beneficiaries.
- SSA should conduct a cost benefit assessment for the use of electronic fund transfer (initial start-up and operational costs) versus other traditional delivery mechanisms--from both the viewpoint of SSA Federal beneficiary payments as well as that of SSA's State/Federal beneficiary payments.
- SSA should continue efforts to reduce abuses by SSA recipients who incorrectly report non-receipt of their benefit payments.
- SSA should expand where appropriate their efforts with the U.S. Secret Service to detect and refer for action those cases where individuals have fraudulently received and negotiated duplicate SSA benefit payments.
- SSA's Office of Family Assistance should obtain information from the States regarding losses incurred through beneficiary payments stolen or lost through the U.S. Postal Service System.
- SSA and the Department of Treasury should review and determine whether interest or other penalty charges can be imposed on banks or other financial institutions who knowingly receive and retain on deposit Electronic Funds Transfer payments for SSA beneficiaries who are known to have died.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

AFDC Recipients Are Receiving Duplicate Heating and Shelter Allowances Costing the Government Millions Annually

An estimated one million AFDC recipients in 41 States reside in housing that is subsidized by the Department of Housing and Urban Development or a State agency. These

same recipients are also receiving shelter allowance in their monthly AFDC benefit payment. Since current legislation makes it optional for States to consider subsidies in determining the AFDC assistance payment, we believe the Department should seek a legislative amendment to the Social Security Act requiring all States to consider these allowances in determining AFDC assistance payments. Currently, there are only nine States using this option.

This same condition also exists within the Low-Income Energy Assistance program. Our survey in one State disclosed that 300 households received about \$100,000 under this HHS program even though similar allowances were received from the Department of Housing and Urban Development. The Department has submitted legislation to require States to consider that portion of Low-Income Home Energy Assistance benefits which duplicate the energy portion of a State's payment standard as income in calculating AFDC benefits. This action alone will save \$175 million annually. Nationwide, we estimate that duplication of shelter allowances and energy assistance payments could be costing the Government as much as \$500 million annually.

OIG Computer Screen Used to Detect Multi-State Welfare Cheats

The Office of Audit matched the welfare rolls of 34 States and jurisdictions (this involved some 5.1 million AFDC records) to determine if welfare recipients were receiving benefits in more than one State. The results: some 3,500 tentative matches--recipients receiving assistance in more than one location--were made. Data on these matches were sent to the involved States for review. Where duplicate payments have been made, States will initiate administrative action, recovery of improper payments and, where appropriate, prosecution--as much as \$6 million in duplicate payments could be involved.

AFDC Fraud Cases

Over the years a variety of initiatives have been tried to assist State and local investigators develop and prosecute fraud in the AFDC program. The Department identified the cases with a high potential for success and referred them to the State and local authorities. For

the most part, the role of the Office of Inspector General was one of technical assistance. In some instances, however, OIG special agents conducted the investigations when the cases were interstate in nature.

An experimental project was started in the OIG's Sacramento office designed to expedite receipt of SSA data extracts and certified photocopies of checks for use by local prosecutors. About 50 percent of potential AFDC criminal cases involving concurrent SSI or SSA benefits were not prosecuted because an average of 1 1/2 years (and as long as 2 to 3 years in some cases) was required for the Federal Government to provide SSA records and Treasury checks as evidence of Social Security or SSI benefits to AFDC recipients who may not report that income. OIG direct involvement reduces this time to a few weeks for records and an average of 4 months for checks. In 1981, 31 individuals were convicted as a result of OIG participation in this project.

Special agents and auditors of the Office of Inspector General developed a pilot project in Connecticut which will be expanded next year. The project, "Missing Kids," identifies AFDC children who do not exist, or, if they exist, are not living in the AFDC family unit.

The basis for the project is the assumption that children between ages 2 and 16 years will receive some kind of medical care within the previous two years. Since AFDC recipients are also eligible for Medicaid, the Medicaid record should show some utilization for that period. If in fact a recipient did not receive medical services under Medicaid, the school attendance records are then checked. The results to date are: Seven indictments, two convictions and a \$5,000 fine. Currently, four major metropolitan areas in Connecticut are involved in the project.

In Tennessee, State prosecutors and welfare fraud investigators, OIG special agents and auditors from HHS and the Department of Agriculture, and Federal prosecutors launched a project which cross-matches AFDC rolls, USDA food stamp rolls and Tennessee State Employment Security rolls. Through these matches, individuals are identified who are obtaining AFDC benefits and food stamps illegally. Since its inception in December of 1980, the project has resulted in the opening of 83 investigations by OIG, over 70 indictments and 27 convictions in 1981 (17 Federal and 10 State). Because of the

success of this project, similar work has been initiated in additional states.

Other examples of AFDC fraud cases in 1981 include the following which resulted from several OIG computer match initiatives:

- A match of Federal payroll tapes against AFDC tapes revealed instances of Federal employees fraudulently receiving welfare. Two cases involving Veterans Administration employees were investigated jointly by special agents of the OIG and the FBI. Both subjects were found to have concealed their Government employment when applying for AFDC. One subject pled guilty and the other entered a pretrial diversion program.
- In a similar case based on a complaint regarding a SSA employee fraudulently receiving public assistance, OIG investigation disclosed that the employee misinformed New York Social Service officials about her employment status. The deception resulted in nearly \$16,000 of AFDC over-payments. The subject pled guilty in State court.
- OIG special agents and auditors conducted a match between the Providence, Rhode Island city employment rolls and the AFDC rolls. It revealed that a city government worker received AFDC benefits while concealing his employment with the city. The amount of the AFDC overpayment was almost \$26,000. The case was prosecuted by the Justice Department's Economic Crime Enforcement Unit and resulted in the first case ever of an individual being incarcerated in the State of Rhode Island for defrauding the AFDC program.
- As part of an OIG North Carolina AFDC task force, investigators identified a recipient who had made false statements in qualifying for AFDC funds. The subject had claimed that her son lived with her, when the son was actually living with an aunt. The false statements resulted in AFDC over-payments amounting to \$4,500. The subject pled guilty to the charges.
- OIG special agents participated in an investigation with the Contra Costa County, California Welfare Department. Investigation disclosed that the

suspect had obtained AFDC funds through falsified documents, claiming a child who was nonexistent. The suspect pled guilty in County Court.

- In one southwestern city, local investigators, frustrated by the low priority placed upon their cases by prosecutors, convinced OIG special agents to take their cases to Federal court. We selected eight cases to investigate. The total over-payments for the cases were nearly \$50,000, ranging in individual amounts from \$1,500 to \$19,000. In addition, the cases included food stamp violations. All eight subjects pled guilty.

There was a great deal of local publicity which had a deterrent effect. During the month following the initiative there were more than 200 voluntary terminations from the AFDC program in that city. This was the highest level of voluntary terminations that the city had experienced. A spot check of a sample of those who removed themselves from the AFDC rolls documented that fraud was present in many of the cases examined. In addition, for several weeks the welfare department received allegations of wrongdoing in the AFDC program at least 10 times greater than their normal experience. Most importantly, the local prosecutor has agreed to accept cases from the welfare fraud investigators.

PROBLEMS IN AFDC PROGRAM ADMINISTRATION

AFDC Administrative Cost

Our audit effort in the AFDC program was primarily directed toward determining the allowability/propriety of administrative cost claimed for Federal Financial Participation. In CY 1981, 20 reviews (some of which are still ongoing) identified \$45.8 million in unallowable charges to this program. Typically, improper charges fall in the following general categories: Deviations from approved cost allocation plans, duplicate claims charges that did not benefit Federal programs and inclusion of unallowable cost. In one State alone, improper charges amounted to \$17.3 million for the above reasons. We found another State that did not have an adequate system in place to account for about \$311 million in Federal funds.

Because of higher priority work and limited audit resources, we do not plan on performing additional reviews in this area. We will, however, issue a summary report to SSA highlighting the various problems noted and recommend specific procedural improvements. Future audits will be performed in line with OMB Circular A-102 by non-Federal auditors.

Continued Surveillance Needed Over the AFDC Vendor Payment Program

Normally, AFDC assistance payments are made directly to clients with whom the children are living. However, in certain cases, the State can make payments directly to individuals or agencies furnishing food, living accommodations, or other goods and services to the AFDC families (called vendor payments). Before the payments could be made (under the law in effect during our audits), three requirements must be met: (1) The client must have an identified money management problem, (2) the State must attempt to solve the problem by providing social services and (3) the client must be able to be removed from the vendor payment program within two years.

Audits in three States disclosed that States did not comply with these provisions. In some cases, States placed recipients in vendor payment status when housing or utility bills were not paid even though no money management problem had been identified. We also found instances where social services were not provided to alleviate money management problems. We recommended financial adjustments in three States totaling \$49.4 million because of noncompliance with the vendor payment provisions.

We recommended that SSA strengthen procedures to periodically monitor State agency implementation of vendor payment provisions.

CHILD SUPPORT ENFORCEMENT

Child Support Collections Not Returned to Federal Government

Title IV-D of the Social Security Act established the Child Support Enforcement (CSE) program for the purpose of enforcing the support obligations owed by absent parents to their children, locating absent parents, establishing paternity and obtaining child support. As a

condition of eligibility for financial assistance under AFDC, a family must assign its child support rights to the State. Since the Federal and State governments share the financial assistance provided to AFDC recipients, the State must reimburse the Federal Government for its share of funds collected from support payments.

Our audit of one State showed that the Federal Government did not receive full credit for its share of child support collections. The State used an average of all Federal Financial Participation (FFP) rates in the AFDC program to determine the Federal share of collections. Our audit showed, however, that almost all (96 percent) of the collections were from an assistance category that had the highest FFP rate. As a result of using an average rate instead of the actual FFP rate, the Federal share of child support collections was understated by \$4.4 million over a three-and one-half-year period. We recommended this amount be returned.

Child Support Program Assessment

This Service Delivery Assessment (SDA), requested by the Secretary, examined client and service provider experiences with the Child Support Enforcement (CSE) program and their views on the effectiveness of the program.

The key findings are:

- Federal, State and local officials generally consider the program to be successful.
- Court cooperation is the key factor to program success.
- Most State and Federal program staff consider the Federal Parent Locator Service ineffective in locating absent parents.
- Program staff at the State and local levels generally give priority to the easiest cases.

At the Secretarial briefing on November 5, 1981, the Secretary and Under Secretary assigned the following actions to CSE:

- An options paper on alternatives for Federal funding for CSE administrative costs is to be prepared.

- CSE is to work with the Health Care Financing Administration and place increased emphasis on State Medicaid/Child Support Enforcement agreements.
- CSE is to evaluate the strengths and weaknesses of the Federal Parent Locator Service and make recommendations for change.

SSA has initiated action in the areas assigned by the Secretary. The President's FY 1983 budget includes a legislative initiative to restructure the current method of financing the Child Support Enforcement program.

OTHER INITIATIVES

LOW INCOME ENERGY ASSISTANCE

To help offset low income households' high costs to heat or cool their homes, the Federal Government has provided some energy assistance since 1977. Title III of the Crude Oil Windfall Profit Tax Act of 1980 gave HHS responsibility to administer the one-year Low-Energy Assistance Program (LIEAP) of 1981. A total of \$1.7 billion was appropriated for allocation by HHS in the form of block grants to States and Indian tribes submitting program plans to the Department. Assistance could be provided directly to these households, to vendors on behalf of eligible households, and to operators of some subsidized housing on behalf of eligible tenants.

Requested by the Secretary this SDA assessed how clients were affected by various methods of delivering energy assistance, who received aid and what impact the aid had on clients.

Our chief findings were that:

- Mild winter weather, moratoriums on heat and electricity shut-offs, and service delivery problems related to outreach contributed to lower than expected demand for aid.
- The late start-up of the program, as well as attempts by States to minimize administrative costs contributed to a failure to reach many eligible people.

- Outreach was a major shortcoming of LIEAP 1981.
- There appears to be increasing interest in longer-range solutions which would link energy assistance with weatherization and conservation education.

REFUGEE RESETTLEMENT

The Refugee Act of 1980 was enacted for the purpose of providing systematic procedures for the admission and resettlement of refugees admitted to the United States. HHS/SSA is responsible for the Refugee Resettlement Program under Title IV of the Act, and provides reimbursement to States for cash assistance, medical assistance, child welfare services, and support services to eligible refugees.

This SDA on Refugee Resettlement served as a follow-up to a 1979 SDA on the status of Indochinese refugees. It expanded on the earlier study and examined refugees' progress toward self-sufficiency, and HHS services to refugees.

The study found that:

- Resettlement efforts have increased, but are not as successful as they were when the SDA was conducted in 1979. This is largely due to the 1980 influx and the lower literacy and skill levels of the newer refugees.
- Lack of English is the major barrier to refugee self-sufficiency.
- English language instruction is generally not available to the extent needed, and the teaching methods being used are usually not optimal.
- Providers believe that the Federal Government has done a poor job of balancing refugee influx with resettlement resources, particularly in FY 1980.

CHAPTER III

HEALTH CARE FINANCING ADMINISTRATION

The Health Care Financing Administration was established in 1977 to combine the two largest departmental health programs, Medicaid and Medicare, under one organizational structure. This was done to promote better coordination of policies and regulations concerned with the cost of coverage of medical services provided to the elderly, poor, and disabled.

The need for coordinated administration of Medicaid and Medicare, with particular emphasis on controlling program costs, was then, and is now, supported by such statistics as:

- Health care expenditures, in general, have risen from 6 percent of the Gross National Product in 1965 (when Medicaid and Medicare were established) to 9.6 percent in 1981.
- Health expenditures have grown at an annual average rate of 12.6 percent from 1965 to 1980 and they are escalating even faster today.
- At current growth rates, the FY 1981 budget for Medicare and Medicaid will triple to \$171 billion by 1990.

The largest share of the anticipated three-fold increase in HCFA outlays by 1990 is attributable to Medicare. Medicare is currently more than 2 1/2 times larger than Medicaid.

One of the few potential controls available to the Department over both the quantity and cost of medical services provided by Medicaid and Medicare is the statutory authority to ensure that health services reimbursed by the Federal Government are "reasonable and necessary."

The terms "reasonable and necessary" are the foundation of all policy development and program operations

by the Health Care Financing Administration. Specifically, the goal of all HCFA program efforts should be to ensure that Medicare and Medicaid provide necessary health services to eligible participants at reasonable cost to the Government and patient.

Over the past fifteen years, both the Congress and the Department have attempted, through statutory amendments, regulations and program guides, to define better the meaning of "reasonable and necessary." Elaborate management strategies have been put in place to plug apparent loopholes in a financing system that, for the most part, pays the providers of health services what they ask.

The Medicaid and Medicare programs, although administered through disparate administrative structures, are geared toward quick payment of providers. The methods of reimbursement do not take into account management efficiencies. Our policies make no distinction between those health providers who are efficient and effective (and keep cost down) and those who, by their inefficiency or intent to defraud and abuse, escalate cost further.

The Office of Inspector General devotes considerable resources to detect and prevent fraud and abuse, and encourage efficiency in the Medicaid and Medicare programs. Particular attention was paid to evaluating systems controls designed to prevent excessive/unallowable or unnecessary charges to these programs.

OIG ACCOMPLISHMENTS

In calendar year 1981, 423 audit reports were issued concerning HCFA and its programs recommending financial adjustments of \$97.7 million. Fourteen ongoing reviews identified an additional \$103.7 million in questionable program expenditures. The potential for an additional estimated savings of \$401 million exists by changing regulations or in one case by giving immediate management attention to correct problem areas identified.

This year our criminal investigative activities resulted in 47 convictions and \$5.2 million in recoveries, fines, savings and restitutions.

We conducted a number of reviews and service delivery assessments which focused largely on improving the efficiency of the operation of these programs. In addition, we played an important role in reviewing proposed regulations for their fraud and abuse potential and made appropriate recommendations.

During 1982, we will devote significantly increased resources to reviewing and evaluating the Medicaid and Medicare programs. We plan to focus more on systemic causes of fraud and abuse and increase our use of techniques such as computer screens and matches.

This chapter focuses on highlights of our audit, investigative, review and service delivery assessment activities.

MEDICAID

During FY 1982 an estimated \$18 billion will be spent on medical care for the low-income population. Audit activity in this program area in calendar year 1981 centered on assessing the adequacy of Federal/State controls over reimbursement mechanisms. Specific attention was given to payments by States to medical providers and costs claimed by States for administration. In addition, we checked to see if prior Inspector General recommendations were implemented. Several significant problems surfaced.

PROBLEMS REQUIRING LEGISLATIVE/REGULATORY CHANGES

The Inspector General's 1980 Annual Report noted two areas where significant savings were possible if Medicaid regulations were clarified. Corrective action on these matters still has not been taken.

HCFA Regulations Covering Reimbursements For Housekeeping Services Under Medicaid Need Clarification

Auditors found that one State charged housekeeping services (e.g., shopping, ironing) for certain recipients to the Medicaid program without requiring that they be medically necessary--by being linked to a "physician's plan of treatment." Although HCFA regional staff advised State officials on several occasions that these services

were not allowable for reimbursement under Medicaid, Federal regulations were not clarified and these charges continued.

We pointed out to HCFA that such laxness has led to substantial excessive costs. We found that one State alone made claims of \$15 million over a fifteen month period for non-medically necessary housekeeping services because of this very condition. We estimate that improper claims for these services could run nationwide as high as \$30 million annually.

Although HCFA is currently reviewing this regulation, to date, they have not taken any action to correct this problem.

Medicaid Regulation Not Clear on What Services Are Medically Justifiable and What Constitutes a Billable Encounter for Psychiatric Services

At selected facilities visited, we found psychiatric services were not limited to traditional modalities of treatment, but included a broad spectrum of services and treatment under specially designed programs--usually provided at an off-site location. It appeared that many of these services were of a social, recreational, or educational nature and were suspect for reimbursement under Medicaid. The lack of clarity with respect to what constitutes "medically justifiable" services, coupled with the failure to define "billable encounters", in our opinion has and could result in significant abuses.

Procedures at one facility visited called for Medicaid to be billed for psychiatric services provided in the patient's room...when the only documentation found in the case file to support such billings was entries such as "patient attended basketball game"... "seen today"... "patient seen in baking group", or... "patient played checkers". In each instance, Medicaid was billed at the authorized clinic rate of \$54 per visit. At two selected clinics reviewed, billings for a twelve month period totaled over \$4.5 million. On a national basis, some \$10 to \$20 million could be involved.

We recommended that HCFA determine the extent of these problems in additional States and revise its regulations to further define covered psychiatric services.

There has been no substantial progress in implementing this recommendation.

Similar problems have been found in nursing homes. Several cases have been declined for prosecution which involved questionable "billable encounters" by physicians to nursing home patients. Lack of adequate definition continues.

Problems in State Administration of Medicaid

Audits in twenty-one States (nine of which are still ongoing) surfaced significant problems and questionable program expenditures of \$176 million. The most pervasive problems centered on establishing the payment rate and classifying and/or certifying long term care facilities.

These problems, which resulted in substantial amounts being erroneously claimed for Federal reimbursement, are not new. They have, in fact, continued to exist for extended periods of time even though HCFA officials were aware of the situations in question. Highlights of the more significant areas follow.

MEDICAID IMPROPER PAYMENT PROBLEMS

Medicaid Costs Claimed at Wrong Reimbursement Rate

Audits in five States disclosed that costs charged the Medicaid program were claimed at the wrong reimbursement rate. Financial adjustments of \$42.7 million were recommended. For example, in one State, we found that all abortion services, whether performed for medical or therapeutic reasons, were claimed as family planning costs, reimbursable at a ninety percent Federal Financial Participation rate. This was an incorrect assumption since some abortions were performed for medical reasons, reimbursable at only a fifty percent rate. In addition, the State could not document that any of these abortions were specifically performed for family planning.

Per Diem Rates for Facilities Improperly Established

Audit activities in five States disclosed that per diem rates used to reimburse Intermediate Care Facilities for the Mentally Retarded (ICFMRs) were incorrectly computed and resulted in overcharges to the Medicaid program totaling \$52.4 million.

In one State, we found the per diem rate was over-stated by \$12.71 per day because the cost of State ICFMRs was included twice in the rate computations. The total overcharge in this one State was estimated at \$33 million. In another case, we found the ICFMR rate included charges of \$6.5 million for educational services. Medicaid regulations do not allow reimbursement for these services which are the legal responsibility of the State Department of Education.

Over-payments/Credits Not Returned to the Program

We identified six States where various credits/over-payments totaling \$27.5 million were not returned to Federal programs.

In one State alone, we identified recoveries from audit settlements of \$18.1 million (Federal share) that were not credited to the Medicaid program. The State agreed to make a financial adjustment for this amount.

Duplicate Payments

Medicaid regulations provide that monthly premiums paid for prepaid health plan enrollees constitute full payment for medical services. One audit showed that during the period August 1, 1977 through June 30, 1980, Federal Financial Participation of \$3.2 million was claimed for medical services provided under fee-for-services reimbursement to Medicaid recipients enrolled in a prepaid health plan.

This problem was previously reported by the State Auditor General, the General Accounting Office, and the Office of Inspector General who identified some \$16 million in improper charges.

Other Improper Payments

Auditors identified \$4.9 million in additional unallowable costs charged to the Medicaid program in fourteen States.

Nursing homes in two States did not apply patient income to the cost of care before billing Medicaid. This resulted in the Medicaid program being over-charged \$1.8 million. Another \$1 million was charged to Medicaid in one State by twenty-seven nursing homes for improper lease transactions between related parties and companies. Our review of sterilizations/hysterectomies charged to Medicaid found that in one State, sterilizations/hysterectomies billed at \$234,000 were not supported by completed consent/acknowledgement forms. In another case, \$788,000 in interest earned on Medicaid funds recovered from providers was not credited to the Medicaid program. In addition, we found \$248,000 in improperly allocated costs in one State, and \$830,000 in other unallowable costs in eight States.

CLASSIFICATION, CERTIFICATION AND ELIGIBILITY PROBLEMS

Institutions for Mental Diseases Improperly Classified as Skilled/Intermediate Care Nursing Facilities

The Medicaid program specifically precludes Federal Financial Participation for services provided to individuals between the ages of 21 and 65 in institutions for mental diseases. We have previously reported to HCFA that States are claiming reimbursement for such services. However, these improper charges continue. This year we identified \$3.5 million in unallowable charges for this same problem.

We recommended that HCFA develop a structured plan to review additional States to find out if similar problems exist and if so, work with these States to eliminate improper claims. We estimate that immediate management attention could save the Medicaid program up to \$125 million annually.

Facilities Improperly/Not Certified

Audits in two States noted that facilities were not certified or did not meet certification standards.

Financial adjustments of \$34.6 million will be recommended.

In addition to the problems identified with long-term care facilities, audits in several other areas disclosed substantial improper charges and needed improvements in program management.

Ineligible Recipients

Under the Medicaid program, medical payments can be made on behalf of recipients classified as presumptively eligible while determination is made on their actual eligibility. During a three year period, we found one State claimed \$6.3 million in medical payments for presumptive eligible recipients who were later determined to be ineligible. In two other cases, similar findings totaled \$621,000. We recommended financial adjustments of \$6.9 million and improvements in the presumptive eligibility determination process.

MEDICAID--OTHER

OIG Computer Screens Help Weed Out Improper Medicaid Billings

The Inspector General's Office is continuing to develop new techniques to weed out fraud, abuse and waste in HHS programs. One technique developed by OIG auditors involves using computers to identify abnormal provider billing patterns by establishing various parameters (referred to as screens). Once the parameters are established, billings are scanned and all items that exceed these parameters are listed and identified for further review and investigation. Two such screens have been field tested and show very promising savings to the Medicaid program.

Physician Improperly Bill Under More Than One Provider Number

This screen identifies Medicaid billings by two or more physicians or by the same physician using different provider numbers for the same or closely related medical services for the same patient. We have used this screen in two States and identified potential improper charges of \$300,000. In one case, physicians billed Medicaid

twice for initial hospital visits for the same patient (only one charge was allowed). The State estimates that over-payments may run as high as \$200,000 for this problem. The other problem involves billings made by one or more physicians for the same or similar services provided to the same patient on the same day. The State has recovered \$100,000 for these improper charges from involved physicians.

If these improper billings are representative of practices in all 50 States, Medicaid may be over-charged an estimated \$7.5 million annually.

Physicians Billing Medicaid For Higher Paying Procedures

This screen identifies physicians who bill Medicaid using procedure codes paying the highest amount. For example, most States limit the number of times a physician can charge for an initial office visit (generally one per year). We have successfully applied this screen in two States and identified improper charges totaling \$457,000. The most pervasive problem involves cases where physicians bill for the initial office visit more than once a year. For example, one physician over-charged the program \$5,000 (covers one year) because the initial visit code was claimed instead of one for a follow-up visit at a lesser amount.

If the trend found in these two States continues nationwide, over-billing could exceed \$11 million.

Another screen has been developed that identifies excessive charges for surgical procedures. In many cases, the charge for the procedure covers pre- and post-operative care. This screen determines whether physicians are also billing separately for follow-up hospital visits.

We will also be using these screens in other health provider fraud initiatives which are designed to pinpoint abusive practices by institutional as well as individual providers.

INITIATIVES NEEDED

Substantial Savings Possible Under Medicaid If States Implement Drug Restriction Programs

We have found that in a number of States, a small but significant number of recipients overuse drug benefits. Frequently these drugs end up being sold to other drug abusers. Drug restriction programs generally include: establishing utilization standards...reviewing recipient usage data to see if standards were exceeded...restricting identified abusers to a single specified pharmacy...and placing automated controls to reject all drug claims by pharmacies other than the one specified.

We recently conducted a limited scope nationwide survey of States to determine what actions have been taken to implement drug restriction programs. Most States had voluntarily implemented a drug restriction program with substantial savings. For example, one State estimated its annual savings to be about \$1.3 million. However, some States, including those with major urban areas had not. In view of the substantial savings possible under this program, we recommended that HCFA work with the remaining States to implement such a program.

HCFA agreed in principle but has not taken any substantive action.

CRIMINAL INVESTIGATIONS

During calendar year 1981, the Office of Inspector General's first investigative priority in Medicaid was institutional fraud. A large proportion of our cases involved nursing home fraud, but other cases dealt with improper billing by practitioners and suppliers.

Institutional Fraud

Criminal activities in nursing homes and hospitals involve such fraudulent acts as falsifying cost reports and records of expenditures, kickback schemes, and pyramid schemes. Ten principals of thirty nursing homes, related organizations and key staff were convicted for fraud related to the Medicaid program in 1981.

Nursing Home Investigations:

- Many cases resulted from filing fraudulent Medicaid cost reports. The owner of nine nursing homes misrepresented the number of employees providing direct care to nursing home patients. He kept a dual set of records and fraudulently claimed an overpayment of approximately \$1.3 million. As part of the plea bargain, the subject agreed to repay this amount. He was also sentenced to serve five years in prison and was fined \$50,000. The plea culminated a six month joint investigation involving Office of Inspector General special agents and auditors, State investigators, the Federal Grand Jury and the FBI. Because of the discovery, it is estimated that \$1 million a year may be saved.
- Most investigations of nursing homes are based upon filing fraudulent cost reports. The president and two employees of a West Virginia nursing home pled guilty to charges relating to their claiming the costs of jewelery, gifts and furs as operating expense. OIG, State and IRS investigators participated in this case which resulted in \$40,000 in fines, \$57,000 in recoveries, one sentenced to public service and two pre-trial diversion agreements. Another case involved over-stating allowable costs by more than \$200,000. After pleading guilty, the owner was sentenced to three months incarceration and fined \$10,000.
- Pyramiding schemes are also detected by criminal investigations. A large scale investigation by OIG investigators and auditors of a nursing home pyramiding scheme involving owners of an investment company in Missouri resulted from Project Integrity I in 1977. Nineteen entities were indicted in the case by the Federal Grand Jury in 1980. Guilty pleas were accepted from four corporations on August 24, 1981. Fifteen other entities, including the two former stockholders of the companies, were in trial at the time of this writing.

- Kickback schemes between nursing home owners and vendors occur. A case was jointly investigated by the Office of Inspector General, Dallas Field office, and the New Mexico State Medicaid Fraud Control Unit. The case involved a kickback scheme between the supplier and the owner of two nursing homes. Validation of seized records and the appearance of fifty-four witnesses testifying before the Grand Jury resulted in the indictment. After the nursing home owner pled guilty, the corporation was fined \$10,000, made to repay \$13,000 and ordered to dispose of the two nursing homes.

Hospital Investigations:

- Allegations were received by an OIG/FBI task force that an administrator of a New Jersey hospital had converted patient, Medicaid and insurance funds to his own use. Investigation disclosed that the administrator, when he observed over-payments or duplicate payments to the hospital, made out checks to himself and a fictitious organization. He obtained \$160,000 in this manner, \$39,739 of which were Medicaid funds. The administrator pled guilty and was sentenced to five years probation.

Non-Institutional Provider Fraud

The bulk of the allegations involving Medicaid fraud are referred to the State Medicaid Fraud Control Units; the Office of Inspector General will conduct investigations in certain situations such as if no State Medicaid Fraud Control Unit exists. Four convictions were obtained in two non-institutional Medicaid provider cases in 1981.

Providers and Suppliers Investigations:

- A New Hampshire pharmacist pled guilty to five counts of Medicaid fraud. He was charged with generic substitution, unauthorized dispensing, and billing for services not rendered. The pharmacist was suspended from practice. The

court sentenced him to five years probation, a \$1,000 fine and ordered him to repay \$3,000 to the State's Medicaid program.

- An investigation of a Tennessee durable medical equipment supplier was initiated based upon a HCFA referral. During the course of the investigation, the owner of the firm received an extortion letter. Cooperating with the Memphis Police Department and OIG, the owner agreed to participate in an undercover investigation of the extortionist. Three individuals were arrested by the Memphis Police Department and indicted by a State Grand Jury. The first was convicted, sentenced to 11 months and 29 days incarceration, and fined \$1.00. The other two signed pre-trial diversion agreements.

Medicaid Fraud Control Units

The State Medicaid Fraud Control Units (SMFCU's) are a major component of States' efforts in Medicaid Fraud Control. Section 17 of Public Law 95-142, "Medicare/Medicaid Anti-Fraud and Abuse Amendments," authorized Federal financial support for these units. Acting upon an earlier Office of Inspector General recommendation, Congress subsequently provided, as part of the Omnibus Reconciliation Act of 1980 (P.L. 96-499), permanent Federal funding at a 90 percent match for the Units' initial three years, and at a 75 percent level thereafter.

The Division of State Fraud Control is responsible for the certification, recertification and continuing oversight of the SMFCU's. At the present time, there are 29 State units certified. These 29 States account for over 85 percent of all Medicaid expenditures. Total cost to the Federal Government for FY 1982 is estimated at \$39.1 million.

In FY 1981 the SMFCU's achieved significant increases in the number of convictions and in dollars recovered (and/or identified for recovery, including fines and penalties). The 275 convictions represented an increase of 73 percent over the previous year, and the dollars received and/or identified were \$38.0 million dollars,

an increase of 91 percent. Since the inception of the SMFCU program, \$78.6 million have been identified for recovery.

More importantly, we have stressed the impact the Units are having in upgrading the efficient management of the Medicaid program. The deterrent effect of an effective unit cannot be accurately measured although its importance must be stressed. For examples, dollars are an inadequate measure of the value of improvements in patient care caused by Unit investigations and prosecutions of patient abuse or neglect cases.

We plan to assist the Units in increasing their effectiveness by facilitating a greater exchange of information, particularly computer screens which can be used to detect fraud and abuse. Training and technical assistance to Units will focus on management and procedures improvement. The Office of Inspector General has committed additional staff to this important function.

MEDICARE

In FY 1982, an estimated \$49 billion will be spent for the Medicare program designed to serve the aged and disabled.

The Office of Inspector General devotes substantial resources to auditing, investigating and reviewing the Medicare program. Our audits identified \$7.3 million (including \$2.4 million in draft reports) in improper costs claimed and significant program problems. An additional estimated \$236 million could be saved if recommendations made in three problem areas are implemented.

The Office of Inspector General looked at Medicare problem areas such as intermediaries/carriers' systems for charging and allocating administrative costs, the rate setting mechanism for End Stage Renal Disease facilities, the allowability of costs claimed by Home Health Agencies and the quality of intermediary/carrier reviews and settlement processes for these facilities. We also reviewed proposed regulations for their adherence to anti-fraud and -abuse principles and followed up on prior recommendations made in the Inspector General's

1980 Annual Report to determine the adequacy of corrective action.

PROBLEMS REQUIRING LEGISLATIVE/REGULATORY CHANGES

Satisfactory progress has not been made in resolving problems with the reimbursement mechanism for paying hospital-based physicians and teaching physicians, and renal dialysis facilities. These matters were discussed in the Inspector General's 1980 Annual Report and action still needs to be taken.

Medicare Regulations Covering Payments for Physicians' Services Provided by Teaching Physicians Unclear

Auditors reviewed procedures and controls used by two Medicare contractors to assure that payments for physician services provided in a teaching setting at two institutions were made in accordance with Medicare regulations and guidelines.

Physicians who train interns and residents in teaching hospitals often maintain a regular medical practice in addition to their teaching activities. These teaching physicians use both their private and non-private patients to provide training to interns and residents. Under varying degrees of physician supervision, interns and residents, in some cases, actually provide essentially all of the physician services rendered to hospitalized patients.

Medicare guidelines provide that claims submitted by teaching physicians on a "fee-for-service" basis must be supported by specific medical records. These records must show that the services were furnished by the patient's attending physician or for a personal and identifiable medical service actually rendered by a physician to the patient. This is to differentiate these services from those provided by interns and residents. Interns and residents may not bill for their services as their salaries are paid by the hospital and are reimbursed as a cost of the institution.

We found that services billed by teaching physicians were not always supported by required medical records or documentation. Further, the Medicare contractors

audited were not reviewing these billings for compliance with Federal requirements. As a result, as much as \$1.2 million in Federal funds may have been improperly claimed and paid in a relatively short span of time at the two institutions reviewed. Since there are some 1,500 teaching hospitals, it is estimated that questionable claims for these services could be as high as \$75 to \$100 million annually.

On December 5, 1980, the President signed the Omnibus Reconciliation Act into law (P.L. 96-499), which specifies the conditions under which this program will pay charges for the services of teaching physicians. These new provisions are effective with hospital cost accounting periods beginning on or after January 1, 1981. HCFA plans to issue final regulations on reimbursement for services provided by teaching physicians by the end of September 1982. This action should resolve this situation and we will monitor the development of the implementing final regulations.

Medicare Procedures Lacking for Controlling the Reasonableness of Program Charges for Hospital-Based Physicians

These specialists (pathologists, radiologists, and anesthesiologists) who practice in a hospital setting are paid by or through the hospital. While there are various facets to the manner and measure by which these specialists receive compensation, we found that in sixty-one hospitals in two States extreme variances existed between amounts paid such specialists in hospitals of similar size, type, and location. Program charges were the largest where physicians were compensated under "percentage of charges" arrangements with hospitals and have increased substantially over the past few years: pathologists, up as much as 102 percent; anesthesiologists up as much as 111 percent; and radiologists as much as 74 percent.

HCFA estimates that about \$40 million per year in Federal payments could be saved if just the "percentage of charges" compensation arrangements could be brought under control.

Although HCFA agreed that Medicare lacks procedures to insure the reasonableness of payments for the services

of these specialists, regulations have not been revised to correct current practices. HCFA plans to issue final regulations on reimbursement for services provided by hospital-based physicians before October 1, 1982. We will be monitoring the development of these regulations to insure that these identified problems are adequately addressed and resolved.

Delays in Implementing Incentive Rates for Renal Dialysis
Defer Potential Savings in the Millions

Currently, free standing dialysis facilities are paid their charges for each dialysis treatment up to a set limit. Hospitals are reimbursed their costs, up to a set limit of \$138 per treatment (which excludes charges for physician supervision). On an exception basis this limit may be higher.

P.L. 95-292 (June 1978) required that the Department have a system in place by June 1979, to determine the costs incurred by renal dialysis facilities in providing treatment and to have an incentive system, using prospective or target rates, to encourage more efficient service delivery. By June 1979, these had not been implemented.

Our reviews of two free standing facilities showed their costs of providing dialysis services to be substantially lower than current charge limits. Similarly, preliminary data from intermediary audits of costs at a sample number of providers and free standing facilities suggests the incentive rates may be lower than current charges and result in substantial savings when in effect.

In January 1980, we contacted HCFA about the delay in this matter, noting that this area needed greater attention. Since then, HCFA has made progress in developing policies on the incentive rate methodology and data needed to compute the actual rates. HCFA issued a Notice of Proposed Rulemaking on September 26, 1980, to establish such a system. But as of February 1982--thirty-two months past the legislative target--the mandated systems have not been implemented.

Section 2145 of the Omnibus Budget Reconciliation Act of 1981 further required HHS to promulgate a prospective reimbursement system for outpatient maintenance

dialysis that promotes home dialysis and differentiates between hospital-based and independent dialysis facilities.

Data on the cost of home dialysis, needed to set rates as required by the Act, were not available. To assist HCFA in obtaining needed cost data, Office of Inspector General auditors visited each of twenty-five facilities selected by HCFA and reviewed its costs. HCFA used the cost information developed and computed the cost per treatment for each of three modes of treatment. The median home dialysis per treatment cost was determined to be approximately \$97.

HCFA published a Notice of Proposed Rulemaking on the prospective reimbursement rates and computation methodology in the Federal Register on February 12, 1982. HCFA expects to publish a final regulation before October 1, 1982. HCFA estimates that when in effect the prospective reimbursement rates will produce savings of \$121 million in fiscal year 1983 and comparable amounts in future years. We are continuing to monitor HCFA's progress since delays in implementing the prospective reimbursement rates defer such potential savings.

PROBLEMS IN PROGRAM ADMINISTRATION

Office of Inspector General audits and reviews document continuing problems in Medicare program administration. Substantial charges to the program result from costs which are improperly allocated, unallowable, excessive or unsupported. We also identified situations where needed corrective recommendations have not been implemented.

Payment for Durable Medical Equipment

The original Medicare law gave to the beneficiary the decision whether to rent or purchase durable medical equipment (DME). Both the General Accounting Office (GAO) and the Office of Inspector General (OIG) found that to rent DME (wheelchairs, commodes, walkers, canes, hospital beds, etc.) cost the program and the beneficiary far in excess of the purchase price. For example, at one carrier the twenty items of DME rented most often, during a twenty-seven month period disclosed potential savings of approximately \$1.3 million (less

co-insurance and deductible amounts) if the DME had been purchased. HCFA estimates an annual savings potential of \$50 million if lease-purchase arrangements were implemented.

Amendments to the Social Security Act in 1977 require that DME items be purchased whenever the expected duration of the medical need indicated that the purchase price of the equipment was less than total rental charges. However, HCFA instructed the Carriers to allow the beneficiaries to continue to decide for themselves whether to purchase or rent an item of DME until regulations and instructions could be issued.

Although HCFA has issued regulations, clarifying instructions to implement the regulation have still not been issued--some 4 1/2 years after the enactment of the 1977 amendments.

Problems Continue Regarding Payments for Home Health Services

The enactment of Medicare was the first comprehensive funding mechanism for delivering health services at a person's home. The number of home health agencies has climbed from 250 in 1963 to 3,169 to date. Medicare payments for these services went from \$70 million in 1972 to an estimated \$1.2 billion for FY 1982--providing virtually all the income for about one-third of these agencies.

Recent reviews by GAO and HCFA indicate continued problems in payments for home health services--GAO reported that a sample of beneficiary medical files at thirty-seven agencies showed that twenty-seven percent of the visits were not covered under the program or were "questionable" according to their nurse consultants. HCFA, in a similar review of 4,363 visits by eight agencies, found that twenty-four percent of the visits were not covered under Medicare.

Recent reviews by Office of Inspector General auditors continue to identify problems regarding payments for home health services. We evaluated intermediary procedures for reviewing and settling Medicare cost reports

at six home health agencies and found: (1) Unallowable costs of \$324,000 which had not been questioned by prior intermediary audits; (2) that the intermediary had not established procedures to evaluate the reasonableness of certain charges, and (3) that three home health agencies claimed costs for durable medical equipment which exceeded the customary/prevaling purchase price by about \$74,000. We recommended that procedures be established to identify and evaluate out of line costs and that cost reports be adjusted to exclude unallowable costs. There is substantive evidence to indicate the need for increased monitoring of costs claimed by this category of providers.

Medicare Contractor Administrative Cost

Fifteen reviews identified unallowable charges of about \$7 million. The most frequent problems identified pertained to: improperly allocated program costs (\$3.7 million); understated complementary insurance credits reflecting contractor use of Medicare information in their non-Federal business (\$1.1 million); costs claimed without obtaining prior HCFA approval (\$1 million); unallowable termination costs (\$930,000); state tax assessed on the contractors' commercial line of business (\$211,000); and costs for unnecessary audits of providers participating in an experimental contract (\$125,000).

Historically, we have been responsible for audits of contractors' annual cost reports which have consumed significant resources available for Medicare work. As a result, we have not been able to devote sufficient resources to audits of program operations and policy issues.

In 1982 we plan to limit the use of our resources on administrative cost audits. We will prepare an issue paper discussing the problem areas found in these audits, and the alternatives for satisfying the audit requirement by other means.

Deletion of Comparability Provision at a Medicare Carrier

Medicare legislation imposes certain limits on amounts allowable for physician and other medical services.

The amount allowable for reimbursement under Medicare (for comparable services under comparable circumstances) should not exceed that paid for such services under the contractors' private insurance program. To insure that Medicare is charged for the lower of the various rates, a computer edit (referred to as a screen) is used to determine the maximum allowable payment.

Based on instructions from HCFA, a Medicare Carrier deleted a comparison screen designed to limit Medicare reimbursement to those paid for comparable services under the Carrier's private insurance program. The deletion of this screen will cause Medicare payments and beneficiaries' co-insurance payments to increase in fiscal year 1981 by about \$5 million and \$1.2 million respectively, and causes increases in beneficiaries' future premiums for complementary insurance.

HCFA stated that the Carrier was instructed to delete the screen primarily because of lack of documentation for its files pertaining to the Carrier's calculation and application of the private insurance screen. The Carrier would not provide documentation for HCFA files because of fears that the information would be made available to its competitors. HCFA officials, however, visited the Carrier and reviewed data that supported the Carrier's comparability screen.

We recommended that HCFA (1) immediately reinstate the comparability provision at this one carrier and (2) revise the existing regulations to improve the comparability definition and broaden its application to private health insurance plans.

Terminating HCFA's Office of Direct Reimbursement Could Achieve Substantial Savings to the Medicare Program

Providers of health care services have the option of receiving payment through a public or private agency (fiscal intermediary) or electing to receive payment directly from the Federal Government. Those electing the latter option are referred to as direct dealing providers. Responsibility for performing this fiscal intermediary function for these providers is delegated

to HCFA's Office of Direct Reimbursement (ODR). ODR's functions include planning, directing and performing the examination, review, and authorization of payment of medical bills submitted by providers. For FY 1981 ODR cost of operations was determined to be about \$13 million.

We asked a local intermediary to develop cost estimates for handling ODR's workload and audit/reimbursement activity. These estimates were based upon ODR's FY 1981 activity. This intermediary estimates it could perform ODR's function at an annual savings of \$3.2 million.

While this estimate may not be precise, we do believe that ODR's functions can be handled more economically by private sector intermediaries. We recommended that HCFA initiate a competitive initiative to obtain reliable data on actual expected cost savings.

Action Needed by HCFA to Implement Debt Collection Procedures

We advised HCFA that \$73.9 million in actual and potential debts were not accounted for or reported as accounts receivable in accordance with Department policy (an additional \$179 million owed directly to intermediaries were not subject to formal Departmental accounting/reporting procedures). Also, delay in implementing the Federal Claims Collection Act's penalty interest assessment provision was costing the Health Insurance Trust Fund an estimated \$3.1 million per month in lost income.

We recommended that HCFA implement procedures to formally account for and report applicable debts as accounts receivable and to assess and collect penalty interest on delinquent debts. HCFA expressed some reservations about accounting for the \$73.9 million but indicated an intention to conform with Departmental guidelines prescribing accounting treatment when developed. With respect to the assessment of interest on delinquent debt, HCFA stated that draft regulations for assessing Medicare providers are undergoing review and that procedures to begin assessing Medicaid grantees are in place.

GAO Report "Hospitals in the Same Area Often Pay Widely Different Prices for Comparable Supply Items"

GAO reviewed prices paid for the same or similar routine supply items at thirty-seven hospitals in six cities and found significant differences in prices. In some instances, the highest price for an item was more than 300 percent higher than the lowest price.

GAO recommended that the Secretary direct the Administrator of HCFA to instruct the Medicare intermediaries to (1) gather and compile price information in various areas on the five items GAO identified that appeared to offer the greatest potential for cost savings and (2) communicate such information to the hospitals they service. GAO also recommended that the intermediaries be instructed to periodically monitor their hospitals' purchases of these items and report back to HCFA in order to (1) assess the extent that this activity may result in cost savings and (2) determine whether it should be expanded to include other hospital supply items.

GAO's recommendation have not been implemented to date. HCFA proposed to initiate a pilot test of GAO's recommendations at several sites. To date, the hospital association and intermediaries in selected sites have declined to participate.

As part of our responsibility to monitor implementation by the Department of GAO recommendations, we will continue to monitor this important area.

CRIMINAL INVESTIGATIONS

For the most part, the vulnerabilities of the Medicare program are the same as those in the Medicaid program. Basically these are false cost reports by institutions and home health agencies, and fraudulent claims by practitioners and suppliers. Since Medicare is a Federal program, almost all of the Medicare cases are investigated by Federal agencies, particularly the Office of Inspector General, the FBI and the U.S. Postal Service.

Nursing Home Investigations

- Based upon information from the Oregon State Medicaid Provider Auditing Unit, our special agents and auditors opened an investigation of an Oregon nursing home. They found that the owners claimed Medicare and Medicaid reimbursement for personal residence utilities, personal gifts and domestic labor expenses unrelated to the operation of the nursing home. Subsequent to these findings, the United States Attorney requested the Department of Agriculture and the IRS to investigate other suspected violations under their purview. The two nursing home owners were convicted and the husband was sentenced to five years incarceration, ordered to return \$40,802 and fined \$515,519. The wife was sentenced to three years incarceration and ordered to return \$14,365 and fined \$25,000. Savings to the Government may be in excess of \$1 million.
- A New Jersey nursing home administrator pled guilty to Federal charges of Medicare fraud for having received about \$50,000 in kickbacks from vendors in 1977 and for including about \$50,000 in unallowable expenses on his 1978 cost report. He also admitted filing a false 1978 personal income tax return. The investigation was conducted jointly by OIG and the FBI. He was sentenced to serve six months in prison and pay a \$15,000 fine.

Hospital Investigations

- In three unrelated cases involving falsification of hospital cost reports, six individuals were convicted. In one case, which was investigated jointly by OIG and the IRS, the Administrator of a North Carolina hospital received kickbacks of \$50,000 from two contractors for repair work. The Administrator was convicted and received a sentence of five years incarceration

and five years probation. He was fined \$16,000. The two contractors were convicted and one received a sentence of 18 months incarceration; the other received one year incarceration, five years probation, a \$1,000 fine and 200 hours community service.

- In the second case, investigated jointly by the OIG and Tennessee investigators, the Director of Purchasing for a Tennessee hospital and his purchasing agent inflated the cost of medical supplies. They also sold, for personal gain, goods which had been purchased for the facility. Both pled guilty, and were sentenced to two years confinement in the Tennessee State Penitentiary.
- The third case involved an OIG investigation of a bookkeeper for a Kansas hospital. She billed Medicare for services in amounts that exceeded the costs of services that patients received and diverted the proceeds to her own use. She pled guilty and was placed on probation in lieu of jail.
- Some fraudulent cost reports are unwittingly falsified by nursing homes and hospitals because of frauds perpetrated by contractors. An OIG surveillance of a Colorado speech therapist documented that she was not performing all the services she was reporting to her contract employer. The employer in turn billed numerous nursing homes and caused them to submit erroneous cost reports. In a plea bargaining agreement, the speech therapist pled guilty and agreed to repay \$25,000. Her sentence was five years probation and a fine of \$12,500.
- Another case involved a contract laboratory operating in a California hospital. The lab's president submitted false billings for lab tests, which had not been ordered, performed, or reported in patient medical files. The subject was sentenced to probation and 200 hours community service and a \$7,500 fine. The subject was also ordered to make full restitution to both Medicare and Medicaid.

Home Health Agency Investigations

Reimbursement for home health agency services are also contingent upon cost reports. Three individuals in two cases were convicted in 1981 for falsifying reports required from their home health agencies.

- A four year investigation by the OIG and FBI culminated with the conviction of a former president of a home health agency. His associate had been convicted two months previously. The convictions were based upon false statements about their financial conditions made to the California Administration for Public Services, HHS and FDIC insured bank. They both received sentences of 18 months incarceration.
- An operator of a Texas home health service corporation, was sentenced to serve three years for over-billing Medicare more than \$40,000 over a two year period. Numerous personal expense items had been inserted in the billings.

Practitioners Investigations

Six physicians in five unrelated cases were found guilty on charges relating to their submitting falsified claims to the Medicare program. For the most part, these individuals billed for services not rendered or misrepresented services.

- One was a well-known cardiologist and author who pled guilty. He admitted to filing nearly \$1 million in false Medicare, Social Security and Workers Compensation claims. He was sentenced to seven years incarceration, five years probation and a \$300,000 fine. In a separate civil matter, this same physician and his wife agreed to settle a false claims suit for \$500,000, the largest amount made under the False Claims Act in the Southern District of New York. Postal Inspectors and special agents from the Department of Labor participated with OIG special agents in this investigation.

- In another case, an Arizona osteopath and clinic owner directed his employees to submit false claims. He was convicted on mail fraud charges and was sentenced to three years probation and one day a week of community service for one year.
- An anesthesiologist pled guilty to charges relating to his billing for services rendered in procedures not requiring anesthesia. During the investigation, the subject was arrested for threatening a witness. After pleading guilty to the Medicare charges he was sentenced to jail for six months placed on probation for five years and fined \$25,000.
- Two New York practitioners, a psychiatrist and a psychologist, pled guilty to filing false Medicare claims. The two had conspired to bill for psychiatric services not rendered including passing off the psychologist's services as those of the psychiatrist. They also inappropriately prescribed controlled substances. The psychiatrist was sentenced to two years in prison, a twenty month suspended sentence, with five years probation and payment of a \$10,000 fine. The psychologist was sentenced to a two year suspended prison term, five years probation, and payment of a \$10,000 fine.
- Investigation of a HCFA referral resulted in a Georgia radiologist being convicted of false statements in the Medicare program. Our investigation disclosed that he had billed patients for treatment while receiving Medicare payments for the same services. He was sentenced to a suspended six month jail term, two years probation and fined \$2,000. He was ordered to repay the beneficiaries and perform four hours community service each week.

Suppliers Investigations

- An OIG investigation substantiated allegations of multiple billings by an ambulance service

in North Carolina. The subject pled guilty to assignment violations and was sentenced to three years suspended incarceration, 25 hours a month public service during a five year probation period, repay \$10,268, and fined \$6,000.

- Five individuals were convicted in three different cases involving fraud by durable medical equipment providers. Three of the subjects specialized in transcutaneous nerve stimulation (TNS) units.

--A joint investigation with the Texas State Medicaid Fraud Control Unit resulted in two individuals being convicted for submitting false claims for durable medical equipment. Both received six months suspended sentences, nine months probation and were ordered to repay the over-payment.

--In a case referred to the OIG by the California State Medicaid Fraud Unit, Medicare was defrauded by two subjects who billed both Medicare and the patients for TNS units. Both subjects pled guilty and were each sentenced to three years probation, payment of \$1,000 in fines and restitution of \$100.

--In the third durable medical equipment case a Pennsylvania TNS distributor pled guilty to forging physicians' names to medical necessity certificates. OIG special agents found that the subject provided nerve stimulators to Medicare patients with questionable need for them. He was sentenced to incarceration for a year and a day.

Check Issuance Investigations

Two separate OIG investigations of employees at an Illinois Medicare carrier resulted in three convictions.

- Former employees of a Chicago Medicare carrier pled guilty to charges of conspiracy and forgery in connection with the theft and forgery of over \$450,000 in Medicare checks taken from the carrier. One subject was sentenced to five years probation and fined \$2,000. The other is yet to be sentenced.
- A former correspondence clerk of an Illinois Medicare carrier pled guilty to theft and mail fraud charges for issuing false beneficiary checks and converting the proceeds to her own use. She submitted false claims which caused over \$16,000 in benefit checks to be issued to herself. She cashed these checks and filed \$5,500 in additional false claims but was not able to obtain checks for this amount. The subject was sentenced to serve one year in a Federal correctional center, to be followed by three months on a work-release program and five years probation.

Home Health Services

We conducted a service delivery assessment of Medicare home health services which include nursing care, physical, occupational or speech therapy, medical social services, and services from a home health aide. This study examined the processes through which elderly individuals gain access to in-home services (particularly home health services) and changes occurring in the universe of Medicare certified home health providers.

This study found that:

- Competition for patients among home health providers is intense, but price is not considered a selection criteria because Medicare pays for care--and the per charge differentials among providers are considerable.
- Home health services are becoming more widely available and more expensive. This is in large measure due to the growth of proprietary, non-profit, and hospital-based home health providers

which generally have higher charges than traditional, public and private charity providers.

- Hospital discharge planning, the key link to home health services, is lacking in the areas of patient identification, physician involvement, and assessment and referral.

MEDICAID AND MEDICARE

CONTINUING PROBLEMS

Office of Inspector General audits identified two continuing, major problems affecting both the Medicaid and Medicare programs.

Recurring Problems Found in Health Facility Certification Function

HCFA contracts with fifty-five State agencies to certify eligibility of health care providers for Medicare and Medicaid under Sections 1864/1902 of the Social Security Act. These State agencies, are reimbursed by HCFA for their costs in providing this service. We have previously reported to HCFA that the States' claims for this service have included: duplicated and unsupported costs, and charges primarily for State licensing activities. Audits in eleven States disclosed unallowable charges of \$10.1 million. For example, four States included \$3.5 million for functions and activities relating to State licensing activities.

Since these matters have been reported to HCFA on several different occasions, we are not going to continue to use our limited audit resources in this area. We will, however, prepare a summary report discussing the numerous problems and suggest planned corrective action that can be applied on a nationwide basis.

Although Highlighted Several Years Ago, Problems with Payment Process for Laboratory Services Under Medicare/Medicaid Are Continuing

Since 1976, extensive cases of fraud and abuse connected with laboratories, such as kickbacks, claims for services

not rendered, claims for tests not ordered by physicians, and price discrimination against Medicaid/Medicare have been reported to HCFA.

In the Fall of 1980, the Office of Audit initiated a review in six States focusing on the Medicaid payment process for lab services. We found that serious problems continue despite the attention given this area, the many reviews and investigations that have been made, and the widespread publicity. These problems are applicable to Medicare as well. Specifically, we found:

- Fees for laboratory services were excessive;
- Labs billed Medicaid at a higher rate claiming tests were made on an individual basis while they were actually made as part of a series on automated equipment;
- Labs billed Medicaid for tests they were not certified to perform; and
- Duplicate payments were made to different providers for the same test.

HCFA concurred with our findings and recommendations and reported that a definitive action plan to correct this problem should be completed shortly.

CRIMINAL INVESTIGATIONS

An allegation was received that a former California Professional Standards Review Organization president misappropriated approximately \$3,000 in Federal funds which were mostly reimbursement for fictitious travel. Investigation by OIG verified the allegation and also revealed that the subject used phony credentials to get himself into the Navy's Officer Candidate School as well as a medical discharge from the Navy--a discharge that led to two years' worth of disability checks. The subject was arrested while serving as an Assistant Professor of Marketing at a Florida University where he claimed to hold two Ph.D's, neither of which could be verified. The subject pled guilty to embezzlement of \$2,359. He was sentenced to three years incarceration.

OTHER INITIATIVES

Long Term Care Assessments

Long term care is not a program but an assortment of government and private efforts to meet the needs of the chronically ill and disabled. Long term care represents almost thirteen percent of all health expenditures, public and private, or some \$31 billion out of \$237 billion in 1980. In FY 1980, forty-four percent of the \$31 billion was Federal dollars. Of the \$31 billion, sixty-one percent went to nursing homes, eighteen percent went to hospitals and twenty-one percent to community based care.

The purpose of this Service Delivery Assessment (SDA) was to examine the broad scope of concerns and issues faced by clients of long term care services, their families, long term care service providers, and officials and advocacy groups involved in administering and monitoring services and care.

Our review found that demand for publicly supported long term care is likely to grow because of inflated costs of health care, precedents set by Medicare and Medicaid subsidies for health care and such special impacts as the aging of the "deinstitutionalized" mentally ill.

Our study also found that:

- Families avoid institutional care for relatives when ever possible, and there is concern that more community based services would offset some personal and family efforts;
- Current licensing and certification approaches to quality assurance in nursing homes over-emphasize paperwork and physical facilities factors, and underemphasize patient care.

Availability of Physician Services

We conducted two related SDAs which assessed the availability of physician service to Medicaid beneficiaries

and examined why physicians do or do not accept Medicare assignments and how this affects the Medicare beneficiary population.

With regard to the availability of physician services, our study found that:

- Many Medicaid clients do not know how to access the health care system effectively--that they do not know how to use their Medicaid card, about covered services or participating providers.
- Despite serious problems of non-availability of physicians in some areas, most Medicare clients are able to see a physician when needed.
- However, a substantial amount of primary care is provided to Medicaid eligibles in hospital emergency rooms where many respondents think that the number of Medicaid clients has increased considerably, and where costs are generally higher than treatment in a physician's office.

Our second assessment on Medicare revealed that:

- Office-based physicians reported accepting assignment in only about one-third of their Medicare cases. Over one-half of Medicare beneficiaries we spoke with reported that their physician never takes assignment, and most report their last visit to a physician was not taken on assignment.
- The two reasons generally given by physicians for not accepting assignment were that reimbursement for services to Medicare and Medicaid patients is lower than physicians' normal charges, and significant administrative problems are created by caring for Medicare and Medicaid patients.
- Administrative process improvements in both the Medicare and Medicaid programs are desirable and should be implemented.

Medicare and Medicaid Referrals to the Department of Justice

The Inspector General is required by Public Law 95-142, Section 4(c), to provide Congress with an analysis of the Medicare and Medicaid cases referred to the Department of Justice. (See Appendix C for a listing of the cases referred in 1981). In 1981, we referred 91 cases. Total cases handled in 1981 numbered 140, including 49 cases from previous years.

Disposition of Referred Health Care Cases
As of December 31, 1981
(includes cases referred in previous years)

ADJUDICATIONS	.38
Convictions.	31*
Indictments.	7
Acquittals	0
PENDING DECISION.	.53
PROSECUTION DECLINED.	.49
TOTAL DISPOSITIONS	140

*43 individuals were convicted in these 31 cases

Cases referred to the Department of Justice are submitted for prosecution to United States Attorneys' Offices.

Our Special Agents-In-Charge report that, for the most part, relationships between our investigative staff and United States Attorneys' have been very positive. They consider the responses by the United States Attorneys' Offices to Medicare and Medicaid fraud referrals to be receptive.

Special Agents-In-Charge also report examples of outstanding cooperation. In our Seattle region, the Special Agent-In-Charge noted the assistance from the United States Attorney's Office in a particularly complex health care fraud case had been extraordinary and reflected arduous effort by the United States Attorney's staff in organizing and presenting the case. Our Kansas City Field Office cited instances of excellent cooperation from the United States Attorney's Office involved in a case in St. Louis. The United States Attorney's Office had two assistants assigned for two years to the development and presentation of one case which resulted in a 34 count indictment returned against five individuals and 14 corporations.

More cases have been prosecuted successfully this year. This is documented by severe sentencing with combined fines and restitutions in Medicaid and Medicare cases in excess of \$2.5 million. Incarceration sentences were handed down for twelve subjects, totaling over 30 years. Over half of those sentenced were imprisoned for more than one year. Three subjects, two nursing home operators and a hospital administrator, were sentenced to one to five years in prison.

The United States Attorneys' Offices have extremely heavy caseloads. Many factors must be taken into account to fully appreciate the burdens under which they operate and which are reflected in the individual cases pursued. Workloads may be so heavy that lengthy delays in prosecution occur. Medicare and Medicaid cases compete for prosecution with many other cases, e.g., those involving violence, narcotics and counterfeiting.

There is a lag between the time a case is referred to a prosecutor and when it is terminated. In 1981, of the 43 individuals convicted in Medicaid and Medicare cases referred to the United States Attorneys, only 16 were from cases referred in 1981.

Decisions on which cases to prosecute are based on many factors. For example, some United States Attorneys indicated a reluctance to accept cases in which the application of regulations is a critical factor due to the oftentimes vague and inexact wording of many

of the health care regulations. A further problem experienced by many United States Attorneys is that of proving the specific intent in many Medicare and Medicaid violations.

Due to the foresight of Congress in passing the Civil Monies Penalty Bill and our increased emphasis on civil administrative remedies, we anticipate a significant increase in the number and type of sanctions imposed upon wrongdoers. Thus, in the future, even when a United States Attorney declines a referred case for small dollar amounts involved or other technical criteria, our office can still effect recovery of funds, and obtain penalties. These types of sanctions will serve as a material deterrent to fraud and abuse.

CHAPTER IV

GRANTS AND INTERNAL SYSTEMS

This year the Office of Inspector General (OIG) increased its efforts to strengthen and improve the efficiency of the Department's management of the programs it administers as well as to eliminate fraud and abuse. Audits, criminal investigations, reviews and service delivery assessments focused on Departmental administration.

This chapter describes our activities and accomplishments in two specific Operating Divisions, the Public Health Service (PHS) and Office of Human Development Services (OHDS), and overall Departmental administration. Management areas such as debt collection, maintenance of imprest funds, procurement, cash advances to grantees, and employee-related areas were reviewed and recommendations for improvement made. Our diverse activities are illustrated in brief project descriptions.

PUBLIC HEALTH SERVICE

PHS will spend an estimated \$7.4 billion in FY 1982 on health research, preventing disease and promoting public health in general. A breakdown on these estimated expenditures follow:

	Estimated FY 1982 <u>Expenditures</u> (millions)
Food and Drug Administration.....	\$ 328
Health Services Administration...	1,782
Centers for Disease Control.....	284
National Institutes of Health....	3,640
Alcohol, Drug Abuse and Mental Health Administration.....	846
Health Resources Administration..	289
Office of the Assistant Secretary for Health.....	226
Total.....	<u>\$7,395</u>

OIG ACCOMPLISHMENTS

During 1981, we conducted audits, reviews and assessments concerned with the PHS' administrations and their specific programs, as well as general management systems. Some of our activities, such as that at the National Cancer Institute (NCI), were follow-ups to findings and recommendations from earlier years' efforts. Others, such as a review at the Food and Drug Administration (FDA) were designed to be preliminary overviews leading to new, focused initiatives. And others, specifically our service delivery assessments requested by the Secretary, were efforts to quickly provide needed information.

The Office of Inspector General issued some 2,474 audit reports on PHS and its programs. Financial adjustments of \$19.4 million were recommended for improper expenditures (primarily in the research area). An additional report identified potential savings of \$33 million if legislation is changed. As a result of our criminal investigation efforts, 5 convictions and \$816,540 in fines, restitution, recoveries and savings were identified.

PROBLEMS REQUIRING LEGISLATIVE CHANGES

Billing Third Party Insurers and Financially Able Individuals Could Save Indian Health Service (IHS) Millions

Federal law allows Indians to receive free medical care from Indian Health Service (IHS) hospitals or private health care providers under contract with IHS. Auditors identified at least 1,700 Indians employed by the Department having Federal health insurance but receiving "free medical care" from IHS facilities costing about \$1 million in 1980. At the same time, the Department paid private insurance companies about \$970,000 in premiums for these employees. Thus, the Federal Government is paying a portion of the cost of health insurance for Federal employees who are Indians and paying to provide the same employees free medical care through IHS facilities.

IHS cannot obtain payments from these insurers. The reason: the statute is not clear whether authority

exists to charge Indians (or their insurers) who are financially able to pay for services rendered at IHS hospitals. The Office of General Counsel is currently reexamining this question. If Indians (or insurers) whether Federal or non-Federal employees, may be charged, we estimate some \$33 million annually could be saved.

PROBLEMS IN PHS PROGRAM ADMINISTRATION

Improved Indian Health Service Management Needed

The Indian Health Service (IHS) serves approximately 800,000 Indians and Alaskan native people living on or near Federal Indian reservations or in traditional Indian country such as Oklahoma and Alaska. It provides a comprehensive program of preventive, curative, rehabilitative and environmental services. The mission of IHS is two-part: (1) To assure the availability of high-quality comprehensive health services; and (2) To achieve the maximum participation of Indian people in Indian health programs. The FY 1981 operating budget was \$607 million.

We found that IHS suffers from a number of management deficiencies which seriously hamper its ability to achieve its mission in an efficient or effective manner. These include:

- Inadequate and misallocated resources;
- Poor internal communication;
- Insufficient centralized policy guidance;
- Lack of accountability in the tribal contract and Contract Health Service programs; and
- Lack of good data or a coordinated management information system.

Problems and recommendations consistent with our earlier ones have been identified and advocated by both General Accounting Office (GAO) and our auditors, in several follow-up reviews of IHS planning methodology, financial management, and procurement practices. A key problem, still in evidence, was discussed in a September 1981 GAO

report entitled, "Still No Progress in Implementing Controls Over Contracts and Grants with Indians."

We plan to follow-up on progress in implementing needed recommendations.

Improvements Still Needed in National Cancer Institute's Contracting Procedures

In the Inspector General's 1979 Annual Report, we reported on a review of contracting operations at the National Cancer Institute (NCI). At that time, NCI's contracting operations involved more than \$250 million yearly in contract awards (half of NIH's total awards and the Department's largest single program using contracts for major program support).

Our review identified several weaknesses in the contracting operations, and NCI began to institute needed changes. Our subsequent follow-up review in calendar year 1980 identified continuing problems. These deficiencies were among those matters addressed by the U.S. Senate hearings in June 1981 on NCI and included:

- Surveillance over the contracting functions was not fully satisfactory;
- Roles of members of peer review committees were often not understood or fully carried out;
- Weaknesses in obtaining realistic procurement planning, competition, necessary cost analysis, resolution of institutional review recommendations, etc., continued; and
- Contractor performance was not adequately monitored, partially because site visits and meaningful financial and technical progress reporting were not accomplished.

Because of the seriousness of these deficiencies and NCI's difficulties in correcting them in past years, the office of the Assistant Secretary for Management and Budget (ASMB) has taken an active role to assure that appropriate steps are taken to expeditiously correct the

deficiencies. ASMB, working with NCI and officials of NIH and PHS, developed a time-phased plan. The plan calls for deficiencies to be corrected promptly, for quarterly status reports to be submitted to ASMB, and for monitoring by the PHS. ASMB also provides status reports to OIG.

To ensure that the requirements of the plan were being met, ASMB conducted on-site reviews at NCI beginning in December 1980. Although important improvements were made in such areas as documentation of files and proposal review, significant problems continued. ASMB is continuing its surveillance until corrective action is completed and changes made are effective, and will continue to report progress to OIG.

Deficiencies Noted in Centers for Disease Control's Laboratory Testing Program

Auditors reviewed the program used by Centers for Disease Control (CDC) to test 1,000 laboratories engaged in interstate commerce. Problems were noted in three critical areas:

- Proficiency test samples are now mailed, usually on a quarterly basis, to labs for their analysis and subsequent reporting of test results to CDC. The labs are aware that they are working on test samples and thus give these tests special attention. These test results are not representative and may even be performed by other labs for the one being tested.
- When grading quantitative lab tests, CDC uses a system which virtually ensures acceptable results for 95 percent of the labs tested.
- There is no mandatory, formally graded testing program of proficiency in certain tests related to cancer detection. Regulations issued in 1966 require such tests.

Our final report recommended specific actions to correct the problems discussed above. In responding to our report PHS stated that the fundamental challenge is to design a more sensitive and affordable system whose decision criteria are based on the degree of accuracy

and precision required to make clinical judgments. They promised to convene a group of expert consultants by June 1982 to consider our specific recommendations, and to present their conclusions at a later public meeting if such is appropriate. As of February 1982, we were advised that these plans were being shelved for lack of funding.

PHS Continues to Approve HMO Grant Funds for Questionable Alterations and Renovations

Under the Health Maintenance Organization (HMO) Act of 1973, costs for alterations and renovations to complete an unfinished shell or new construction are allowable only in limited circumstances. We reported to PHS some years ago that grant funds for costs we considered unallowable were being approved. A recent follow-up audit disclosed the problem was continuing and that such costs, estimated at \$4 million, had been approved by PHS. Also, about 90 percent of these major improvements were made to properties owned by third parties and leased back to the HMO. Office of General Counsel attorneys have recently questioned whether HHS has any recovery authority to protect HHS investments in these major leasehold improvements should the HMO terminate their operations.

Corrective actions were promised by PHS program officials in response to our audit recommendations. We, however, recommended that the Assistant Secretary for Health assure that such actions are implemented and are effective in protecting Federal interests.

We continue to work with responsible HHS officials who are reviewing the effectiveness of current policies and procedures to prevent grant expenditures for unallowable costs.

Many Doctors Delinquent on Health Professions Student Loans

Congress enacted the Health Professions Student Loan and Nursing Student Loan program to establish a revolving loan fund at each eligible school (90 percent funded by the Department) to be used for long-term, low-interest loans for medical students. Federal funds of about \$700

million have been awarded to approximately 1,400 participating institutions since the inception of the program.

We began a nationwide review at 37 institutions to determine the incidence and reasons for unrepaid loans. As of June 30, 1981, PHS reported 59,053 loans totaling \$189.1 million outstanding. Of this amount, 6,698 accounts (\$5.2 million) were delinquent 90 days or more. PHS reports indicate that the institutions selected for review have over 70 percent of the delinquent loans to doctors.

Preliminary information already furnished to PHS shows:

- 80 delinquent doctors employed by the Department;
- 401 received payments of \$10.3 million for services under the Medicare/Medicaid programs while owing \$443,000 on loans;
- 83 are on the faculties of the institutions that made the loans;
- Definition of delinquency varies from institution-to-institution, ranging from one day to one year or more; and
- Statutory penalties on delinquent loans are nominal, \$1 for the first delinquent month and \$2 per month thereafter regardless of loan amount.

We are exploring the various administrative and legal options available including statutory changes to enforce collection of the outstanding debts and to establish more effective penalty charges.

Improvements Needed in Collection of Debts

As of September 30, 1981, debts due to PHS from the public totaled \$916.2 million on various programs but principally from student assistance and support (\$709 million).

Our periodic monitoring of debt collection activities disclosed that PHS did not have an effective system for aging, billing and collecting receivables, or for

charging interest on overdue accounts. PHS advised that a system would be in place by the close of FY 1981. However, replying to a subsequent follow-up inquiry in September 1981, PHS advised that unforeseen problems would delay full implementation of all necessary action until 1983. We are examining the reasons for the lengthy delay as part of our ongoing monitoring of PHS debt collection activities.

Controls Lacking Over Payments for Medical Services
Provided to Cuban/Haitian Refugees

During the period April 1, 1980 through March 31, 1981, PHS expended an estimated \$8.7 million for health care for Cuban/Haitian refugees. Bills for medical services are submitted by hospitals, clinics and doctors directly to the Health Services Administration (HSA) for approval and payment.

Our review of the HSA payment process disclosed several significant weaknesses. Automated and manual controls over payments made under this program were inadequate. The propriety of payments was not determined and the potential for fraud and abuse was increased.

- These payments were made with minimal assurance of the billing's legitimacy and reasonableness, or the need for the service. PHS had no agreements with providers regarding charges for medical services and there were no guidelines for assessing the validity of amounts billed. Over \$300,000, without close review, was paid to one provider even though a Professional Standards Review Organization had earlier reported problems with the services from the provider.
- Payments amounting to \$2.7 million were for services provided to ineligible recipients.
- At least \$397,000 in duplicate payments were made to providers, and the potential for other duplicate payments existed.

We recommended that HSA recover \$397,000 in duplicate payments, establish procedures to prevent improper payments, and establish guidance for determining the validity of billings.

Continuing Management/Accounting Problems Noted at Non-Profit Organizations

Reviews at grantees participating in a variety of PHS programs pointed out a continuing need for management improvements and, in general, closer monitoring and more timely action by PHS. Highlights of a few examples follow:

- The National Institutes of Health awarded a State agency a contract totaling \$900,000 to expand existing cervical cancer screening services and provide a new program among low income/indigent women. We found that for six of twelve entities providing services, State and local funding was cut and replaced with Federal funds. A financial adjustment of \$274,000 was recommended.
- We found one grantee which received about \$1.2 million from PHS and did not have an adequate accounting system to effectively account for grant funds. Grantee officials were alerted to the seriousness of these problems by both PHS and a private audit firm. However, PHS did not follow-up to make sure problems were corrected. As a result, no action was taken to correct identified problems. We identified \$260,000 in unallowable costs for items such as operating a State funded mental retardation program. A financial adjustment for this amount was recommended.
- A review of a family planning grantee disclosed that reported program expenditures were overstated by \$306,000, and included unallowable charges of \$22,000. A financial adjustment was recommended for these improper charges.
- An audit of a community health program recommended financial adjustments totaling \$423,000: \$145,000 in grant-related income that was not used to further grant objectives or reduce total costs, \$163,000 in costs not supported by available documentation, and \$115,000 in other unallowable costs. In addition, we could not express an opinion on the allowability of \$4.4 million in salary costs

because the grantee did not have adequate records. We recommended \$423,000 be returned.

Preliminary Survey of Food and Drug Administration Identifies Areas for In-Depth Review

The Food and Drug Administration (FDA) employs some 7,700 people and expends about \$328 million annually to protect consumers' health and safety. The FDA has far-reaching and significant activities that help ensure the health of the American public. It is the Department's major regulatory agency in that it has the ability to control the manufacture, distribution and testing of certain foods, drugs and cosmetics.

The FDA has been the subject of numerous reviews and investigations by the private as well as the public sector and receives continual oversight from the Congress and the General Accounting Office. The Office of Inspector General has completed a survey of general internal FDA systems and procedures. The combined effort of auditors, management analysts and criminal investigators provided the skills necessary to perform this initial planning survey. This survey, which was conducted with the cooperation of the FDA Commissioner, will be used to advise the Commissioner as to what areas we feel would be most useful to examine in further detail.

Non-Federal Auditors to Perform Single Audits at Colleges and Universities

The OIG Office of Audit currently has audit responsibility for 98 percent of the nation's colleges and universities that receive some \$2 billion in research funds. During calendar year 1981, we identified unallowable expenditures of \$12.1 million at 23 institutions. We could not express an opinion on another \$121 million because of poor/non-existent accounting and workload distribution systems. The most common unallowable charges identified were for: labor charges which did not meet Federal standards, costs improperly transferred between Federal grants and contracts and violations of cost sharing agreements. We have reported these same problems for several years now.

Office of Management and Budget (OMB) Circular A-110 calls for a single audit of all Federal funds at non-profit organizations. The Office of Inspector General has been actively working with key colleges and universities, OMB, national private audit firms and national college associations. Specifically, we have:

- Pilot tested the single audit concept at several major universities;
- Designed an innovative on-line auditing approach currently being used at five universities which is a critical element of the single audit. This technique involves reviewing recent transactions rather than waiting several years; and
- Drafted a uniform industry-wide audit guide to be tested in these audits by colleges/universities, State and local auditors, and private audit firms.

As we move forward with the single audit concept, the Office of Audit will be redirecting resources previously spent on colleges/universities to more urgent areas.

PROBLEMS IN PROGRAM DELIVERY

National Health Service Corps Needs to Serve Neediest Health Areas

The National Health Service Corps (NHSC) provides health care personnel to those areas of the country which have insufficient resources to attract and retain health professionals.

This Service Delivery Assessment focused on the actual experiences of designated health manpower shortage areas in receiving health care through the NHSC, the impact on local health care for those health shortage areas without corps assignees, and the characteristics and conditions existing in areas which have been unable to recruit or retain corps staff.

The study found that:

- The NHSC is successfully producing local health care systems through small government investments

in areas which previously had little or no access to health care.

- Distribution inequities exist with many of the most needy areas without corps assignees.
- Mid-level corps staff (e.g., nurse practitioners) are more adaptable to remote areas than physicians.
- There are problems in the scholarship program including poor preparation for service in health manpower shortage areas.

Health Systems Agencies Assessment

The National Health Planning and Resources Development Act of 1974 authorized the creation of a network of local health planning agencies known as Health Systems Agencies (HSAs). The approximately 204 HSAs, funded primarily by the Bureau of Health Planning in PHS, are charged with (1) preparing and implementing plans to improve the health of residents, (2) increasing the accessibility, acceptability, continuity and quality of health services, (3) restraining the costs of providing health services and (4) preventing unnecessary duplication of health resources. The FY 1981 budget for HSAs was \$83 million.

This assessment reviewed the mission, resources, constituency, and impact of HSAs. Our study found:

- Most HSAs have had little success in the highly visible regulatory functions, with inconsistent Certificate of Need results, ineffective institution-specific appropriateness reviews, and pro forma Proposed Use of Federal Funds reviews.
- Most HSAs have had more success in the more informal and less visible functions such as negotiating with providers prior to certificate review, persuading providers to alter their health plans, providing an effective health forum at the local level, and serving as a catalyst for service and resource development in underserved areas.

- HSAs have little support at the State level and no natural and consistent constituency at the local level.

PHS GENERAL MANAGEMENT ISSUES

Weaknesses Found in the Health Services Administration Disbursing System

The Health Services Administration's Office of Fiscal Services (OFS) is responsible for providing accounting and fiscal services for the Office of the Assistant Secretary for Health; the Alcohol, Drug Abuse and Mental Health Administration; and the Health Resources Administration. HSA disbursed approximately \$1.4 billion in FY 1980. Two audits of HSA's disbursing systems disclosed several weaknesses. Auditors noted that physical security over ADP equipment and fiscal records maintained by OFS were inadequate to safeguard them against unauthorized use, damage, or destruction. Computerized controls did not effectively limit access to programs and data stored in computers. In addition, controls established in an automated payment system have broken down. These conditions were caused by a lack of management action on implementing an effective security program, even though the absence of ADP security at HSA has been acknowledged since 1977.

We recommended that HSA institute a number of procedures to correct this situation.

Significant Weaknesses Noted in Motor Vehicle Management

We audited PHS management of motor vehicles at three locations. Deficiencies were found at each location to varying degrees. Specifically:

- Security over motor vehicles and automotive parts was inadequate. Vehicles were parked at easily accessible locations--unlocked and with keys in the ignition in two instances.
- Controls over verification of General Services Administration credit card purchases and disposition of obsolete cards and license tags assigned to certain vehicles were faulty.

- Several vehicles were not used extensively--41 vehicles had 10,000 miles or less for a one year period--and could be declared surplus.

We recommended several measures to strengthen controls over motor vehicle management.

CRIMINAL INVESTIGATIONS

Five individuals were convicted as a result of investigations of Public Health Service programs. Three cases involved Rural Health Program grantees, one involved a Health Systems Agency and the other involved a family planning council.

- An OIG investigation of a former rural health clinic optometrist in Montana established that he converted \$5,000 worth of medical equipment to his private practice. The U.S. Attorney handled the matter as a pre-trial diversion and established a 12 month probation period.
- As a result of information referred to OIG by the Public Health Service, a former administrator of a rural Colorado medical services clinic was convicted for embezzling over \$7,000 in clinic funds. She was sentenced to serve 90 days in jail, two years probation and to pay \$10,000 restitution.
- A bookkeeper for a Minnesota Family Health Care Center established by the Rural Health Program admitted embezzling approximately \$4,000. The subject pled guilty and was sentenced to ten years probation and restitution of \$3,700.
- An Executive Director of a Health Systems Agency in California submitted travel vouchers for various personal trips and charged these expenses to the Government. He was indicted for submitting false claims and making false statements, and was convicted. He was sentenced to 3 years--suspended, 3 years probation, ordered to repay \$108 and fined \$5,000.
- A former Executive Director of a Family Planning Council in New Mexico submitted false claims and was reimbursed by the Government. He was

convicted and was sentenced to serve three years in prison for embezzling approximately \$800 in Federal funds.

OFFICE OF HUMAN DEVELOPMENT SERVICES

During FY 1982, the Office of Human Development Services (OHDS) will spend an estimated \$5.4 billion on providing a range of social services to the nation's children, youth, older Americans, the disabled and Native Americans. Estimated expenditures by program follows:

	<u>FY 1982</u> <u>Estimated</u> <u>(million)</u>
Block Grants to States	
Social Services.....	\$2,400
Community Services.....	342
Child Welfare Services.....	156
Foster Care.....	300
Adoption Assistance.....	5
Child Welfare Training.....	4
Head Start.....	912
Aging Programs.....	730
Other.....	95
Human Resources Research and Demo...	31
Work Incentives.....	246
Federal Administration OHDS.....	63
Federal Administration OCS	24
Total	<u>\$5,308</u>

The Department's FY 1983 budget for this OPDIV continues to allow great flexibility in State administration of program resources and to simplify Federal administrative oversight responsibilities.

OIG ACCOMPLISHMENTS

The Office of Inspector General is continuing to shift audit/investigative resources in consonance with actual budget and program changes. We are in the process of completing audits of programs which Congress included in "block grants". We are looking more deeply into programs more susceptible to large amounts of fraud, waste and mismanagement such as Social Security, Medicare and Medicaid.

However, during calendar year 1981, we conducted significant audits, reviews and service delivery assessments focusing on OHDS programs and administration. The Office of Audit reviewed \$1.5 billion in OHDS program expenditures and issued 2,213 reports. These reports identified questionable program expenditures of \$106 million. As a result of our criminal investigative efforts, 7 convictions and \$268,519 in fines, restitutions, recoveries and savings were identified. Details on the results of our efforts follow.

PROBLEMS IN PROGRAM ADMINISTRATION

Excess Cash Drawdowns by Head Start Grantees Cost Federal Government Millions

This program provides comprehensive support service and early childhood development for poor children from ages 3 to 5. Services are provided to approximately 378,000 children. Some 20,000 Head Start classrooms provide nutrition, education, health-related and other social services. During calendar year 1981, 1,646 reports were issued on Head Start grantees and recommended audit adjustments totaled \$15.8 million. The bulk of these reviews were performed by non-Federal auditors. The most pervasive problems surfaced by these reviews were poor internal controls, recordkeeping weaknesses and deficiencies in grantee administration.

The Office of Audit is currently performing a nationwide review of OHDS' management of cash advances to Head Start grantees. Work performed in just one region disclosed significant problems. Grantees in this one region accumulated cash of \$5.6 million in excess of their needs. Nationally, this problem of excess cash drawdowns could run as high as \$62 million. This has a twofold effect: (1) The Treasury incurs unnecessary interest charges estimated at \$11.2 million, and (2) these grantees invest excess cash and earn interest which they do not credit to the Federal program.

Improper Cost Claims by States for Work Incentive Program

The Work Incentive (WIN) program is designed to help Aid to Families with Dependent Children (AFDC) recipients find work. The Department of Labor provides for training and work incentives. HHS provides financial assistance and supportive social services, such as day care when necessary for the recipient to participate in training. Generally, registration in the WIN program was a condition of eligibility for an individual to receive AFDC payments. Federal participation in State expenditures is 90 percent. Fiscal year 1982 Federal expenditures are estimated at \$246 million.

During calendar year 1981 six audits recommended financial adjustments of about \$5.6 million. Problems were concentrated in four general areas:

- AFDC recipients were not registered for the WIN program as required.
- AFDC payments to recipients were not properly adjusted when the recipients' WIN status changed.
- Payments were made for social services provided to other than WIN registrants.
- Costs were not properly allocated between WIN and other Federal and State activities.

Based on audit experience, we estimate that as much as \$28 million may have been improperly claimed annually.

Improper Payments for Foster Care Payments to States Cost Federal Government Millions

Foster care offers alternative home care in situations where a judicial determination has been made that continuing care in a dependent child's home would be contrary to the child's well-being. For foster care payments (under Title IV-A of the Social Security Act) to be eligible for Federal financial participation, the child must have been (1) receiving or eligible for AFDC assistance, (2) removed from the home of a relative

under a court order or voluntary placement agreement and (3) placed in a foster family home, a private non-profit institution, or (beginning June 17, 1980) in a public institution which accommodates no more than 25 children.

The Inspector General's 1980 Annual Report identified some \$24 million in improper payments. Most problems were in two general areas (1) children were not receiving nor eligible for AFDC or were institutionalized without a court order and (2) institutions providing care were ineligible. Audits completed or underway during 1981 identified an additional million in unallowable charges for the same reasons.

Public Law 96-272, signed into law on June 17, 1980, provides that fiscal year 1978 Federal foster care payments to States will be used as a basis for allotments to States for fiscal year 1981 through 1984. GAO in a brief 1981 report (HRD-81-73) discussed the possibility of substantial improper payments being included in the amounts claimed by the States for Foster Care based on reviews in two States. GAO recommended that OIG complete audits of this program on a State-by-State basis to establish an accurate basis. Based on our previous audits, we believe that about \$24 million is being misspent annually.

Because of the possibly substantial costs savings and the necessity of adjusting future allotments, we plan to perform audits in 37 States during FY 1982.

Improvements Needed in the Management of Foster Care Programs

This study is the second phase of a two-part examination which began with an examination of the alleged misuse of Federal funds to support children in foster care in child care institutions operated by the People's Temple in Jonestown, Guyana. The purpose of this second phase was to inquire more generally into whether State standards for foster care institutions are being adequately monitored and enforced. We also examined some of the systems developments within the area of foster care in order to more fully describe and explain the nature and objectives of the monitoring and enforcement activities.

The major findings of our draft report included:

- Federal, State and local levels have not developed a method for determining and monitoring priorities.
- There is no clearly defined policy statement on the mission or objectives of the foster care program.
- State administrative support systems (e.g., case reviews) are either deficient in providing support for "front line" staff or expand the workload for the caseworker.
- States have not developed incentives to retain experienced staff on the "front line" where the need is critical to the effective and efficient delivery of services.

Title XX - Problems in States' Administration Cause Millions in Unallowable Charges

The Office of Inspector General examined various facets of the Title XX Social Service program through audits, a service delivery assessment and a review focusing on a related, proposed legislative amendment.

During FY 1982, Title XX of the Social Security Act will provide an estimated \$2.4 billion in Federal funds to assist States in furnishing social services to low income individuals and families.

Our audits during this past year focused primarily on determining if services provided by the States were allowable under Federal regulations and if the State's financial records adequately supported costs reimbursed with Federal funds.

Audits in 12 States during 1981 recommended financial adjustments of about \$85 million:

- \$31.2 million for services available to all States' residents regardless of whether they were participating in the Title XX program, or unallowable services provided by facilities in which the individual was living and activities were intrinsic to the purpose of the facility.

- \$22.3 million for costs that were not supported by accounting records.
- \$15.3 million for unallowable overhead costs, improperly allocated administration costs, and other unallowable purposes.
- \$10.2 million for excessive subcontract costs claimed for day care services which exceeded reasonable limits, and Foster Care costs improperly allocated to the program.
- \$3.9 million for State training activities not related to Title XX.
- \$2.5 million for improperly matching State funds donated by private institutions.

We are now in the process of completing our audits in this area since the program is now covered under recently enacted block grant legislation.

Title XX Assessment

This SDA took a broad look at Title XX. It examined the State decision-making process, the local service delivery system, purchase of services and coordination with other programs.

The major findings included:

- States like the flexibility provided by the block grant features of Title XX. States' use of this flexibility, however, is constrained by both the Title XX expenditure ceiling and tradition. Virtually all States are at ceiling in their Title XX expenditure and have become locked into traditional allocation patterns.
- Waiting lists for services are often encountered and there are insufficient funds to meet new needs.
- State accountability for Federal dollars is weak. Most services are contracted out to private providers or other public agencies.

- Subcontracting by public agencies is generally not tracked, and monitoring of services is given a low priority.

Recently, a number of Federal initiatives have been undertaken to address some of the problems facing Title XX. Several inquiries were made into the process of purchasing services. They were conducted by OIG Audit, by GAO (with special reference to in-home services), and by OHDS through its current management review. On the legislative side, Congress passed HR 3434, part of which is aimed at strengthening Title XX. Finally, OHDS has restructured the administration of Title XX to improve coordination.

Day Care Linkages to Health Care and Social Services Providers Need Improvement

This Service Delivery Assessment assessed whether day care providers who receive HHS funds are adequately identifying and linking to the existing health care and social service providers in their communities.

The major findings were:

- There are providers available to serve the health care and social service needs of day care children; however, some may be under-utilized.
- The critical and/or mandated health care and social services of day care children are being met. However, regular examinations and preventive care are often not provided, especially to children in unregulated day care centers.
- Systematic linkages between day care providers and health care and social service providers do not exist.

Home Delivered Meals Program Would Benefit from Improved Partnership With the States

Financed under the Older Americans Act, the Home Delivered Meals program provides meals for persons over 60 years of age who are homebound by illness, incapacitating disability or otherwise isolated.

The Service Delivery Assessment developed a profile of the Home Meal recipients, the characteristics and practices of the meal providers, and the impact of these services.

The key findings were:

- The Home Meals Program is helping older people stay out of nursing homes, improving their diets and reducing their social isolation.
- Most meal recipients are frail and of limited mobility, but a significant proportion (as many as 25 percent in some areas) are clearly not homebound.
- Client eligibility determinations are typically conducted on a quick and informal basis by individuals without health care training.
- The program is shaped by local groups and influences while State and local area aging agencies have little understanding of the program and seldom provide leadership.

As a result of the SDA, the Administration on Aging (AOA) reports that it has made changes in the operation of the home delivered meals program. Among the actions taken by AOA are the following: (1) Regional offices have provided technical assistance to the States in the development of specific eligibility criteria, the development of assessment tools, training, and the identification of methods to improve coordination at the State and local level, and (2) Regional offices have also sponsored training workshops for State agency personnel and (3) some Regional offices assisted States in improving the methods and technology used in meal delivery.

Child Protective Services--Much Remains to Be Done

Within the last ten years, HHS has become the major funding source for child protective and related services. Funding for these services to States, localities and public and private organizations is accomplished through the Social Services block grant, Title IV-B of the Social Security Act and the Child Abuse Prevention and Treatment Act.

This SDA examined what is being accomplished in the area of child abuse and neglect, whom services are reaching, how practical the services are, and what problems exist. In conducting this study, SDA teams spoke with abused children, their parents, service providers and others in 34 local communities in 15 States.

Major findings of the study included the following:

- HHS is responsible for major accomplishments in the field of child abuse and neglect.
- While basic protective services are available, few of the children and families in need are receiving adequate help.
- Few resources are devoted towards prevention of child abuse and neglect.
- Parents generally give highest acclaim to self-help groups, and to practical services.

OHDS ADMINISTRATION ISSUES

Termination of Contract Will Save About \$1.6 Million

Our review of OHDS contracting disclosed one case where a sole source contract to study the quality of care for children in day care programs was awarded without proper justification to a contractor whose technical competence for the survey was questioned after a technical review panel rated the contractor's proposal "extremely low."

We also found that the contract objectives were highly questionable, terms were too vague and often lacked specificity as to what was required by the contractor. In our opinion the contract (with proposed expenditures of \$2.4 million over 3 years) was not justified.

The Assistant Secretary of OHDS has taken action to terminate the contract. This will save about \$1.6 million.

Major Problem Found in Determining the Disposition of Millions in Cash Advances

Auditors found that in two programs, OHDS did not know the disposition of \$701.9 million in program funds:

- Head Start Program--OHDS did not adequately monitor cash advances to its grantees. Expenditure reports were not received from grantees or in some cases although received, were not recorded in the accounting system. There was little, if any, follow-up on cases where grantees did not submit required expenditure reports. As a result, on September 30, 1981, OHDS did not know the disposition of some \$700 million in grant funds. Without accountability, excess cash cannot be identified for recovery.
- Native American Program--Similar problems were found to those mentioned above. OHDS did not know the disposition of \$1.9 million in grant funds.

Audit work is continuing and we will make specific recommendations to correct these problems.

Use and Dissemination of OHDS Research, Evaluation and Demonstration Projects Studied

The Office of Human Development Services provides an estimated \$60 million annually to fund research, demonstration and evaluation projects through both grant and contract mechanisms.

We conducted a review of the dissemination and utilization of findings from research, demonstration and evaluation projects. The review focused on both the pre- and post-award stages. We examined policies and related practices in the pre- and post-award stage to determine whether potential use and dissemination of findings was adequately taken into account. We then selected a sample of completed grants and contracts to determine if they had been disseminated and used.

The final report has not yet been issued. However, through our review we found that policy guidance related to dissemination and utilization was generally unclear, and did not tend to affect the actual project outcome (i.e., dissemination and use). A truly successful research effort was more the result of a strong project officer and a supportive interest group and luck, than the result of careful planning and detailed policies.

Our recommendations will focus on ways in which dissemination and utilization can be improved, particularly in the areas of general management of projects, oversight, and planning. We plan to use this review as a model to look at this area in other Departmental Operating Divisions.

CRIMINAL INVESTIGATIONS

Seven individuals were convicted in six OHDS cases investigated by the Office of Inspector General. In addition, OIG special agents assisted the FBI in another case that netted eight convictions.

An audit conducted by a private audit firm in South Carolina revealed that a bookkeeper for a Head Start grantee embezzled six Government checks, totaling approximately \$1,150. The subject admitted to OI special agents that she had received these checks. The subject was convicted, sentenced to three years probation, and was fined \$500.

- In another Head Start case, the last of eight subjects was convicted on charges of embezzlement of funds from a program in Kentucky. The Memphis office of the FBI initially received information from an anonymous telephone caller that there was alleged misappropriation of funds. The Office of Inspector General assisted the FBI in the investigation of this matter.
- An audit by the Tennessee Department of Human Services revealed a shortage of Title XX funds in the financial records of a Government contractor. OIG investigation revealed that a senior account clerk, who was employed by the contractor, had altered bank statements and received \$12,000 in Government funds. The subject was convicted, sentenced to four years probation, and was ordered to repay \$12,960.
- An anonymous complaint received by the GAO Hotline resulted in the conviction of two doctors working on a grant awarded to a university in Wisconsin. The doctors misappropriated funds, and converted airline tickets purchased with

Federal funds to their personal use. Both doctors were convicted and sentenced to serve three years in prison, followed by three years probation. Each was also ordered to repay \$82,987.

- A joint OIG/State of Tennessee investigation of a State employee revealed that he had sold Government property for personal gain. The employee was convicted and ordered to pay court costs and restitution fees. Confinement was suspended, and the subject was placed on two years probation.
- A referral from OHDS, indicated that a former planner with a North Dakota Native American Association misappropriated grant funds. The ensuing investigation was conducted jointly by OIG and the North Dakota Bureau of Criminal Justice. The subject, by writing unauthorized checks, converted over \$20,000 of Federal funds to his personal use. He was sentenced to serve four years in prison on these charges. His parole on other charges was revoked, and he was sentenced to an additional four years imprisonment.
- A former consultant to a Native American grantee in California embezzled over \$20,000 in HHS and Department of Labor funds. The subject was convicted and sentenced to serve 10 years in prison.

DEPARTMENT ADMINISTRATION

HHS Grantees Earn Millions in Interest on Excess Federal Funds

For some time now, we have reported that Department grantees drawdown Federal funds in excess of their immediate needs. This practice enables grantees to invest such funds and earn interest in the millions with a corresponding loss of interest on the part of the Federal Government.

Although the Department has taken several steps to crackdown on this problem, the practice continues. For example, audits at two universities identified about \$1.4 million in interest earned on excess Federal funds. Although \$500,000 has already been recovered from one of the universities, we estimate that the Treasury could have incurred borrowing expense of about \$1.6 million on the excess funds.

Audits of several States have also found this same problem. However, in these cases the interest does not have to be returned. Prior to October 1968, States were required to return interest to the Federal Government. Subsequently, the Intergovernmental Cooperation Act (P.L. 90-577) changed this requirement allowing States to keep all interest earned on grant-in-aid funds.

To strengthen controls at the Federal level, we are recommending that Departmental officials responsible for awarding Federal funds to Department grantees, coordinate monitoring of grantee cash management. Approaches to consider include: working more closely with Operating Divisions to assure that accurate and timely information is obtained as a basis for judging cash needs and testing cash balances and using audits performed by non-Federal auditors more extensively to ascertain actual cash balances at grantees.

We believe that the ultimate solution to these Government-wide problems requires OMB to seek legislation requiring that interest earned on Federal funds by any grantee be returned to the Government. Consideration also needs to be given to assessing a penalty charge equal to the going Treasury rate on Federal funds drawn-down in excess of cash needs.

Controls Over Payment of Overtime Still Need Improvement

Auditors reviewed the Department's progress in upgrading controls over payments to employees for overtime work. In 1980, the OIG issued a report pointing out deficiencies in requesting, approving and documenting overtime.

In 1981 our follow-up review disclosed that while improvements have been made, certain deficiencies persisted but to a lesser degree. These included (1) no written requests and approvals of overtime, (2) unsigned authorization forms, (3) inadequate or no documentation for overtime, and (4) overtime performed at the employee's residence. Inadequate separation of timekeeper duties continues to be a prevalent weakness--supervisors return Time and Attendance cards to timekeepers after certification, and timekeepers maintain their own cards and distribute pay checks. These weaknesses in internal controls increase the opportunity for unauthorized or improper actions.

Our recommendations called for the Assistant Secretary for Personnel Administration to develop an overall strategy to minimize overtime errors and periodically test the effectiveness of OPDIVs' performance regarding overtime reporting. Procedures now in place require periodic reports to the Secretary on progress made in reducing or eliminating cited deficiencies.

Tighter Controls Needed Over Travel Costs

Our review of travel costs incurred during FY 1980 by two Department components noted several administrative weaknesses which could have resulted in excessive travel costs of \$150,000. Specifically:

- Trips could have been consolidated at a savings of \$67,000.
- The most economical means of transportation was not used, resulting in about \$66,000 in additional travel costs.
- Travel advances were not being liquidated in a timely manner, nor was adequate follow-up made to collect or prevent additional advances.
- Excessive charges for meals, subsistence and taxi fares or travel to unauthorized points were not detected by voucher examination resulting in additional costs of \$16,500.

Recommendations call for improvements in forecasting, planning and coordination of applicable travel by managers, enforcement of applicable travel regulations by authorizing, approving and reviewing officials, more thorough prepayment review by voucher examiners, and closer review and follow-up on delinquent travel advances by finance officers.

Too Much Cash Maintained in Department Imprest Funds

The President's Council on Integrity and Efficiency coordinates governmentwide activities attacking fraud and waste in government programs and operations.

One of the Council's initiatives dealt with evaluating the effectiveness of the Department's safeguards over imprest funds. The Department operates over 1,500 such funds nationwide, valued at \$2.4 million. These funds are set up to pay Department employees for travel and small purchases. Our examination noted that the balances maintained in these funds exceeded need by \$663,000 nationally.

We are recommending specific reductions in imprest fund balances and improvements in internal control procedures over the funds.

Consulting Services Improvements and Remaining Problems

Section 307(b) of the Supplemental Appropriations and Recision Act of 1980 requires the Inspectors General to report annually to Congress on the Department's progress in strengthening management controls over consultant services contracts.

We reported that, during FY 1981, the Department made significant progress in improving management of certain aspects of consultant services contracting. Namely, conflict of interest regulations were published and disseminated to employees, benefits of consultant services were evaluated, the process for appointing consultants was appraised, and the information system for reporting contract data to the Federal Procurement Data System (FPDS) was being studied for possible improvements.

However, a recent follow-up review of special controls over consultant services disclosed several significant problems. We found:

- \$3.6 million in consulting service awards which were misclassified as regular procurements not subject to special safeguards required for consultant contracts. In our judgment this is the result of a misapplication of the consulting service definition and requirements. Some of these problems may have been caused by the need to apply both the OMB and Congressional definitions which do not coincide. Annual ceilings imposed on consultants services by the Congress were still not exceeded because of these errors.
- Contracting for certain advisory services was unnecessary/inappropriate. In some cases, these procurements were restricted by Federal or Departmental policy and, in other cases, the services were available or more economically produced in-house.
- Information generated by the Department's contract information system was incomplete, untimely and inaccurate.

We will recommend intensified top management oversight and increased emphasis on accountability in procurement practices.

CRIMINAL INVESTIGATIONS

Four convictions in the area of general administration occurred in 1981. Three of these involved the handling of travel related activities.

- An OIG investigation was predicated upon information by a PHS official that a supervisory voucher examiner for PHS, along with an accomplice, created three false travel vouchers totaling \$3,520, which were submitted for payment. The voucher examiner was convicted, sentenced to three years probation and ordered to repay \$2,700. Her accomplice was convicted and sentenced to four years probation. He was ordered to repay \$4,050.

- In another case involving travel, a mail clerk employed by HHS pled guilty to the theft of two checks that were refunds for unused U.S. Government Transportation Requests. The mail clerk was sentenced to two years probation, repayment to the airline, and 50 hours of public service at a tax supported facility.
- In the third travel-related case, a HHS accounting technician discovered that a former White House Conference on Families' employee had obtained \$1,855 in cash travel advances for which he was not entitled by forging several signatures. The case was investigated jointly by the OIG and the Federal Protective Service. The subject pled guilty to submitting false claims and was sentenced to two years probation. Prior to sentencing, the money was returned by the employee.
- Several U.S. Treasury checks payable to HHS employees had been stolen from the Division of Administrative Services, and were cashed by a non-payee. OIG and the U.S. Secret Service conducted the investigation which resulted in a conviction for forgery. The employee was sentenced to one to three years in prison, suspended, fined \$750, 18 months probation, and ordered to repay \$225.

ACTIONS BY THE DEPARTMENT TO IMPROVE DEBT RECOVERY

P.L. 96-304, Section 306 requires that the Department take immediate action to improve the collection of overdue debts, to charge interest on delinquent debts, and to reduce the amount of debts written off as uncollectable. The Inspector General reports quarterly on actions taken by the Department to improve debt collection activities. Beginning with the quarter ending December 31, 1980, the Inspector General has reported on actions taken to improve debt recovery or identified areas where more needs to be done.

The reviews conducted by the Inspector General have:

- Evaluated the accuracy of reported data on receivables, collections and write-offs;

- Raised the issue as to whether all debts due the Department were properly reported;
- Highlighted the need to assess interest on delinquent debts and;
- Pointed out other areas where improvements are needed in the accounting system.

Specific details concerning OPDIVs' performance are discussed in other sections of this report.

JOINT EFFORT TO EFFECTIVELY IMPLEMENT DEPARTMENT'S NEW REGULATIONS ON DEBARMENT AND SUSPENSION

The OIG undertook a preliminary examination of the extent to which information obtained about individuals or organizations who were accused of or found guilty of wrongdoing was shared throughout the Department. The National Institutes of Health and the Food and Drug Administration, each having offices set up to deal with wrongdoing, were the primary focus of these examinations.

The principal finding was that no information sharing mechanism was established between or among agencies regarding wrongdoing of individuals, organizations or firms.

The emergence in early 1981 of the Department's new regulations on Debarment and Suspension was seen as a major means of identifying and tracking individuals and organizations found guilty of wrongdoing. This was to provide a basis for appropriately sharing information across Department program lines.

Presently, the OIG is working with the Assistant Secretary for Management and Budget and the Office of General Counsel to ensure that listings are developed to provide necessary and appropriate information to the proper grant and contract-making officials. Consideration is being given to issues of privacy protection, due process, confidentiality, accuracy, timeliness and utilization.

SUBSTANTIAL PROGRESS MADE ON TRACKING OIG AND GAO RECOMMENDATIONS

With strong Secretarial support, substantial progress has been made on actions designed to enhance HHS' ability to effectively monitor the status of corrective actions being taken by the Department's Operating Divisions on OIG and GAO audit recommendations.

OIG Reports--Previously, monitoring of the implementation of OIG non-monetary (management) recommendations was accomplished by selected follow-up and routinely scheduled recurring audits. To strengthen the follow-up system for implementation of OIG recommendations, the office of the Assistant Secretary for Management and Budget (ASMB), by direction of the Secretary, now has an oversight role. Operating Divisions are required to periodically report to ASMB on the implementation of IG recommendations.

The ASMB role in monitoring implementation of IG recommendations, when fully operational, will provide further management assurances that corrective action has been taken. The OIG still has an oversight role to ensure that recommendations are fully implemented. If necessary, we will conduct follow-up audits and systems evaluations.

GAO Reports--Until recently, HHS Operating Divisions were required to submit a report of actions planned or taken on a final GAO audit report within six months after the release of HHS' comments. OIG staff reviewed reports for apparent sufficiency of actions planned/taken, and made site reviews where such close scrutiny appeared warranted. Recommendations for which appropriate corrective action was completed or underway were considered closed and the Operating Divisions were not required to submit further follow-up reports. It must be noted that corrective action on many GAO reports may take substantially longer than six months due to the lengthy process required to issue final rules and regulations.

In the latter part of 1981, the Secretary directed that additional follow-up reports be submitted on a quarterly basis until all necessary actions were properly dealt with. Complete tracking of all such actions through final resolution is now assured.

- The Assistant Secretary for Management and Budget and the OIG now share separate, but interlocking responsibilities, for monitoring the status of actions taken on GAO's recommendations.
- On a quarterly basis, OIG staff now prepare a summary report of Operating Divisions' performance in responding to and acting on GAO reports. The Operating Divisions annotate these reports with any pertinent information, such as actions taken to improve their performance, and submit these reports as part of their Operations Management System (OMS) reports to the Assistant Secretary for Management and Budget.

Essentially, OMS is a major management tracking system which receives considerable Secretarial attention. Through this new arrangement, we are assured that top level management attention is regularly focused on actions being taken on GAO audit reports.

SUBSTANTIAL PROGRESS MADE IN RESOLVING AUDIT REPORTS WITH MONETARY FINDINGS

Through the quarter ending June 30, 1981, the Office of Inspector General has repeatedly reported a problem with timely resolution of audit financial findings. Since September 30, 1981, all audits with monetary findings have been resolved within the six month period (see chart below) established by P.L. 96-304, Section 305.

This accomplishment is due to personal involvement of top Departmental management through the utilization of the HHS Audit Resolution Council. The Secretary designated the Under Secretary to lead this effort and the Under Secretary has personally chaired the Council composed of the Inspector General, the General Counsel, the Executive Secretary, and the Assistant Secretary for Management and Budget. Major monetary audits which are not likely to be resolved within six months are

scheduled for review by the Council. The head of the involved Operating Divisions must be in attendance and present (1) a case as to why the audit has not been resolved and (2) a proposed plan to resolve the audit matter. ASMB tracks the recommendation to ensure proper follow-up on the decision.

The OIG continues to provide oversight to ensure this favorable situation continues.

Unresolved Audits

<u>CY</u>	<u>Number of Audits Over Six-Months Old</u>	<u>Dollar Amounts (Millions)</u>
1978	920*	\$143.1*
1979	1,241*	135.0*
1980	666	38.5
1981 (3/30/81)	555	34.0
(6/30/81)	447	30.0
(9/30/81)	-0-	-0-
(12/30/81)	-0-	-0-

*Includes data on the former Office of Education

CHAPTER V

OPERATIONS SUMMARY

All organizations seem to go through a revolutionary stage and an evolutionary stage. Our revolution began in early 1977 when a very small criminal investigative staff and a larger audit staff were quickly combined with a new small group of systems analysts to begin operating as the Office of Inspector General. The organization was designed to begin work immediately and to meet the then mandates of Congressional and Departmental policy.

During almost five years, shifts in policy, economic conditions and staff size have required us to slowly evolve new plans to meet new challenges.

Staffing

At the end of 1979, we had a total staff of 1,240. At the close of 1980, it was 965 and at the close of 1981, it was 924. Part of this loss was due to the disproportionate amount of our staff transferred to the Department of Education, and part was due to the steady pressures of hiring freezes and overall budget reductions. Since we expect that pressures will continue to mount on the HHS budget, we cannot realistically plan for substantial short-term staff expansions. This has forced us to closely reexamine our priorities and allocation of staff to make certain that we concentrate our resources on the greatest problems and largest programs of the Department.

Workplan

Calendar year 1981 represented our first concentrated effort to put together a long range plan and a shorter range, comprehensive OIG work plan. We are confident that our organization and our priorities closely matched the needs of our revolutionary period 1976-1977. We were not certain that the needs of 1981 and beyond were as well served.

As a result of our work planning process, we believe that we must change some of our organization and work priorities to meet the demands of the future.

Challenge of Computers

More and more of the Department's programs are utilizing computers to perform some significant functions. The Social Security Administration, for example, probably has one of the world's largest computer complexes. Increasingly, these computer systems are causing (as well as solving) many problems for program administrators and for taxpayers. As a result, OIG must increase our staff's computer skills and we must be prepared for more involvement in the design, control and security of all aspects of computer systems.

Challenge of Fastest Growing Programs

In the past, we tried to provide a well balanced review of all Department programs. Furthermore, our staff was highly decentralized in major State capitals and cities where they could concentrate on aspects of State and local program administration. Because of Congressional enactments, changes in Office of Management and Budget policy and overall economic conditions, more and more concern is being expressed over the problems of Social Security Trust Fund programs, and Medicare and Medicaid. These are the fastest growing programs and the programs which experience has shown to have significant problems of fraud, abuse and waste.

As a result, we are shifting more of our resources into reviewing these major programs. Furthermore, our review of past investigations indicated that many Departmental employees or recipients of Departmental funds who were involved in crimes or serious violations of contracts or regulations, received relatively light punishment for their infractions. We also felt that substantial money recoveries were often inadvertantly lost to the taxpayer. As a result, we started a review of methods which could be employed to impose administrative sanctions against wrongdoers and methods which could be used to impose civil money restitution and of penalties where appropriate.

OFFICE OF INVESTIGATIONS

During calendar year 1981, the Office of Investigations (OI) was responsible for conducting investigations of fraud and criminal misconduct involving Departmental programs or employees and providing physical security services to Departmental Operating Divisions and the Secretary. To carry out these missions, OI was organized into four headquarter's divisions and eleven field offices.

Throughout the year, OI continued to fill the traditional role of investigating individual complaints and cases. In addition, however, OI developed and implemented a series of proactive detection projects aimed at identifying fraudulent activity in Departmental programs. Most of these projects are described elsewhere in this report.

These projects were developed by utilizing the best analytical ability of Office of Investigations, Audit, and Health Care and Systems Review (HCSR) staff. One of the most significant elements in the development of these projects was the Management Implications Report (MIR) system. MIRs are reports, written by OI investigators, that describe the program being investigated, the integrity controls in place which affected the matter under investigation, and how the controls worked or did not work. In 1980, 62 MIRs were referred for analysis. In 1981, the number increased to 150.

The MIRs are reviewed by program specialists in OI and HCSR. Where a significant weakness or potential system breakdown is identified, OIG staff discuss the problem and how to overcome it. The management reviews and audits of the Social Security Number Issuance system discussed in chapter II are examples of one of the by-products of the MIR system.

The enormous success of national projects, such as the SSA benefits projects, developed thus far has led the Inspector General to make the decision to increase the resources assigned to such projects. During calendar year 1982, a significant emphasis is being placed by OIG on the development, through a multi-discipline approach, of proactive projects in program areas of the Department not yet subject to such review. It is expected that these new projects will be very successful in detecting and prosecuting fraud and criminal misconduct in HHS programs, and will serve as a significant deterrent to future fraud.

In developing the multi-discipline approach to project development, OI began to address other areas of concern which had not, until now, been within the responsibility of OI. These areas include the subjects of civil fraud and administrative sanctions.

For calendar year 1982, OI is creating a Civil Fraud Division at headquarters. This division will be responsible for implementing the Civil Monies Penalty Bill and

Physical Security

OI's responsibility in the physical security field has expanded also. During calendar year 1981, special emphasis continued to be placed on Secretarial security. As the result of immediate need, an agreement was reached with the Department of Justice to have those OI employees directly assigned to Secretarial protection duties deputized as Special U.S. Marshals. This deputization allowed the employees to carry firearms and make arrests during such protection assignments.

For calendar year 1982, the staff of the Division of Security and Protection will be expanded. This will provide resources necessary to carry out the long neglected mission of conducting security surveys of the more than 1,700 HHS occupied buildings. The transfer to OI of the personnel security function for HHS will also allow OI to develop an efficient and systematic approach to the physical, documentary, and personnel security needs of the entire Department.

Investigative Operations

In developing new initiatives and programs, OI has developed additional needs and has increased already existing needs. These needs are in the areas of additional staff, law enforcement authority, and the development of implementing regulations and policies for our new initiatives.

The ultimate goal of OI is to have OI representation in each of the 97 Federal Judicial Districts in the country. Recently, OI conducted a review and identified geographical locations, based on overall population, HHS financial expenditures, and HHS employee population, which need immediate staffing. In addition, the implementation of the civil fraud investigative program is expected to strain OI's present personnel allocation.

One of the subjects OIG must give attention to is a policy relating to simultaneous parallel proceedings in our investigative cases. A policy needs to be developed as to when, and under what circumstances, administrative inquiries will be undertaken while criminal investigations and prosecutions are still pending. This situation raises many legal problems for both OIG and the Operating Divisions.

Current policy calls for U. S. Attorneys to decide whether administrative and civil action should stop and be held in

abeyance while a criminal investigation is being conducted. In two recent cases, prolonged criminal investigations have resulted in lengthy delays in administrative action which, had such action been taken earlier, may have resulted in substantial monetary savings to the Department. This entire area will be the subject of an extensive policy review by OIG during calendar year 1982.

For several years, OI has documented the need for full law enforcement authority. The development of proactive projects has increased our need for such authority. In addition, the ever increasing workload of other investigative agencies has made it more difficult to obtain their assistance on surveillance and activity monitoring assignments. An example of a case in which law enforcement authority was needed arose in Puerto Rico. After one of the subjects of the investigation was indicted, he agreed to cooperate with OIG in obtaining evidence against other investigative targets. The cooperating subject was threatened and eventually shot and wounded. This case is still under investigation.

Before the civil investigations program can become fully operational, implementing regulations need to be adopted to govern procedures for imposing civil money penalties under the new authority given the Department by Section 2105 of the Omnibus Budget Reconciliation Act. The Department is in the process of preparing regulations. Special priority needs to be given to the approval and implementation of these regulations.

OFFICE OF AUDIT

In 1981, the Office of Audit was responsible for two general functions:

- First, to assist the Inspector General to attack fraud, abuse and waste in Government programs; and
- Second, to check on what is actually happening with these monies and programs. Audit tests the controls in place to determine if they are working, and whether funds are being used properly for the purpose intended.

To carry out these responsibilities, Audit was organized into four headquarters divisions and eleven field offices.

A significant part of our audit effort is spent on retesting problem areas previously identified, while we continue to probe other areas for new problems. Because we cannot audit in a timely manner all of the thousands of entities receiving funds, it is important that we carefully select areas that may be specially vulnerable.

A summary of the contribution of Audit's efforts appears in Appendix D and includes:

- The number of reports released: During calendar year 1981 auditors released 5,483 reports on Department activities. We also released another 1,462 reports performed for other Federal agencies under the Office of Management and Budget's (OMB) system of audit cognizance for colleges and universities.
- The extent to which the audit work of others is utilized:
Of the reports processed on HHS programs, 1,250 were prepared by OIG Audit while 4,233 were done by public accountants and State auditors.
- Recommended financial adjustments: In calendar year 1981, audit reports identified some \$230.7 million in proposed adjustments; even more meaningful some \$136.2 million in audit recommended financial adjustments were concurred with by the responsible program officials.

While these recoveries are sizable and help insure adherence to the level and amount of funding established by the Congress they represent only part of the savings attributable to the auditing function. An integral part of every audit assignment involves considering the quality of Federal oversight--and making sure that Federal regulations, procedures and policies are adequate and being followed. We often find problems at an audit site are due to conditions that Federal oversight action can correct or alleviate.

On a conservative basis, we estimate additional savings of many millions annually, as well as improved program operations, can be achieved by full implementation of the recommendations we made this past year. Appendix A contains a progress report on the recommendations we made in last year's Annual Report.

We are pleased to report that the Department has made significant progress in resolving outstanding audit findings.

As we mentioned in chapter I, 1981 was a transition year for the Office of Audit. Significant changes in OMB emphasis required us to begin to devote more staff effort to reviewing internal Departmental controls and towards examining the implications of single audits on our priorities. In 1981, OMB announced their policy that recipients of Federal funds, as much as possible, should not be subjected to a multiplicity of audits for every conceivable Federal funding source. Rather, one comprehensive audit should be conducted for all Federal interests. More importantly, the audit could be conducted by any auditor, State, local or private, as long as they met generally accepted accounting standards.

OIG Working With State and Local Governments on Single Audits

OMB Circular A-102 provides for State and local governments to arrange audits of their operations to meet Federal accountability requirements. The audits are to be organization-wide rather than program-by-program in scope.

The objectives of the single, organization-wide audit are to determine whether the organization's financial statements are reliable, its control systems are free of material weaknesses, and there is no indication of extensive noncompliance with applicable laws, regulations and agreements. This information provides the Federal agencies with an indication that the organization is fulfilling its accountability responsibilities and therefore further auditing is not warranted, or an indication that there are likely to be significant questioned costs and thus additional auditing is desirable in order to determine the full extent of questionable costs.

In 1981 OIG auditors worked with OMB, Department program administrators, State and local governments, and non-Federal auditors to put the single audit concept into operation.

Our more significant achievements:

- Notification of State and local governments that HHS has been assigned audit responsibility by OMB:

- Membership in the central committee which developed the cognizant audit agency guidelines which was signed by all Inspectors General in December 1981;
- Orientation of HHS program officials, IG audit staff, CPA firms, State auditors and State and local administrators to the new concept of government auditing; and
- Preparation of compliance supplements on major HHS programs to be used by the non-Federal auditors.

OIG Helping Strengthen Department's Internal Controls

Effective systems of internal control provide strong mechanisms to prevent as well as detect fraud, abuse, and management. OMB Circular A-123, issued in 1981, prescribes Federal policy requiring effective internal administrative and accounting controls and providing guidelines to agencies in developing, maintaining, and evaluating systems of internal control. The Inspector General is formalizing and expanding somewhat the traditional role of examining agency internal controls to meet the OMB policy. Although the Secretary routinely monitors systems of internal control, the Inspector General has responsibility for advising the Secretary on internal control matters and for examining the Department's systems of internal controls.

We are reemphasizing examination of internal controls as an integral objective of all internal audits, providing advice on the Department's internal control plans and directives, and developing mechanisms to report systematically on our observations. Emphasis will be placed on those systems which appear to be most susceptible to fraud, abuse and waste. Also, we plan to test the reliability of reports submitted to top management relating to the implementation of the Department's internal control plans.

The Office of Management and Budget emphasis on internal Departmental controls and single, organization-wide audits by non-Federal auditors, together with Congressional enactment of block grant legislation and budget reductions in some Health and Human Services programs, allowed us to begin closer examination of Social Security and Health Care Financing programs. We expect this trend to continue through 1982.

OFFICE OF HEALTH CARE AND SYSTEMS REVIEW

The Office of Health Care and Systems Review (HCSR) assists the Inspector General's efforts to improve the management of programs administered or financed by the Department in order to promote efficiency and economy and to prevent fraud and abuse. The efforts of the staff tend to be directed towards cross-cutting issues, and are often accomplished in cooperation with OIG auditors and investigators as well as staff from the Office of the Secretary and Operating Divisions of the Department. The staff of the office are specialists in social science, statistics, administrative-management analysis, econometrics, medical science, computer technology, and the principle programs of the Department. Staff of the office often work directly with staff and officials of Congressional committees, and State and local governments.

The Office of Health Care and Systems Review is responsible for:

- Reviewing management of programs, paying special attention to management information systems, quality control systems and program integrity;
- Focusing reviews and other efforts on detecting and preventing systemic fraud and abuse;
- Placing emphasis on health care programs of the Department, with a special staff to carry out specific Inspector General responsibilities in certain health programs;
- Providing information to the Inspector General so that the Secretary and Congress can be kept fully informed concerning fraud and abuse, and related serious problems and deficiencies, and proposed corrective actions; and
- Developing and recommending policies to promote economy and efficiency in Department programs and operations and preventing fraud and abuse.

The Office of Health Care and Systems Review is organized in three units: Division of Health Care Financing, Division of General Systems Review and Service Delivery Assessment staff.

A new format, labeled a monograph, was devised as a means to summarize major project findings and recommendations and facilitate dissemination. Monographs were issued concerning Social Security numbers and durable medical equipment under Medicaid and Medicare.

Additionally, Health Care and Systems Review is assisting in the development of a planning system that would ensure available resources were targeted on major Departmental programs and needs. The resultant plan reflects major redirection of OIG resources. During this current year, we will refine the planning model and begin to incorporate it into our budget cycle.

We have also been assisting in tracking anti-fraud and -abuse recommendations concerning Departmental programs from all sources other than the General Accounting Office (which is handled by the OIG Office of Audit). A systematic process for collection, maintenance, review and tracking has been established. We plan to mechanize much of this process in 1982.

We have continued our responsibilities in the areas of regulations review and fraud investigation review. Proposed regulations are reviewed for potential conflict with good management practices and anti-fraud and abuse objectives. We estimate that about 108 regulations were reviewed during calendar year 1981. We also played an active role in the development of regulations for the block grant programs, again to insure they were not in conflict with anti-fraud and -abuse objectives.

Similarly, fraud investigations are reviewed for patterns which are indicative of program weaknesses. These weaknesses may include a regulation that limits the ability to prosecute or the lack of internal management controls that permit abusive activities. A system is in place to review fraud investigations, make appropriate recommendations and monitor progress in implementing recommendations.

The Service Delivery Assessment staff is responsible for conducting short-term examinations of Departmental programs and program-related issues for the Secretary. These assessments are national in scope and provide the Secretary, Under Secretary and head's of the Operating Divisions with information and recommendations for improving the effectiveness, timeliness and economy with which the Department serves its clients.

During calendar year 1981, fourteen studies were completed. A written report was prepared and the Secretary and/or Under Secretary was briefed on the findings.

Other Activities

One of the many responsibilities of the OIG is the need to respond to Congressional or private inquiries regarding fraud, abuse, or possible mismanagement of HHS programs. These responses have required everything from a few phone calls and letters to a full-blown State survey. During 1981, the OIG responded to several such inquiries, resulting in the following reviews, among others:

- An Investigation of the possibility of aliens using the services of the Maternal and Child Health and Crippled Childrens' Program--at the request of Senator Richard Lugar;
- A survey of nine States to determine the availability of transportation services for Medicaid eligibles--at the request of Senator Max Baucus; and
- A review of a particular Human Development Services' research grant, which resulted in the dissemination of materials and findings of questionable validity or value at considerable cost--responding, at the request of OMB, to the concerns of a State agency.

In some instances, the OIG reviews have resulted in formal recommendations to the Secretary or HHS OPDIVs. In other cases (e.g., the Congressional requests noted above), the purpose was fact-finding and no specific recommendations were made.

STATUS REPORT OF CORRECTIVE ACTION BY
THE DEPARTMENT ON RECOMMENDATIONS IN THE IG'S 1980 ANNUAL REPORT

FINDING	RESPONSIBLE OPDIV	STATUS OF CORRECTIVE ACTION		
		FULLY IMPLEMENTED	SUBSTANTIALLY 1/ PROGRESS	NO SUBSTANTIAL PROGRESS
Better scheduling of payments for repairs and improvements of SSA facilities could earn additional Trust Fund monies	SSA	X		
HCFA regulations covering reimbursements for housekeeping services under Medicaid need clarification	HCFA			X
Cancelled benefit checks not credited to Federal programs	SSA			X
Medicare procedures lacking for controlling the reasonableness of program changes for Hospital-based physicians	HCFA			X
Trust Fund withdrawals exceed actual Treasury disbursements to recipients	SSA		X	
Improved surveillance needed over grantee cash withdrawals	ASMB		X	
Medicare regulations covering payments for physicians' services provided by teaching physicians unclear	HCFA			X
Improved controls needed for overtime payments	ASPER		X	
More can be done to save energy in HHS occupied buildings	ASMB		X	

1/ Action substantially completed with minor recommendations yet to be implemented.

STATUS REPORT ON CORRECTIVE ACTION BY

THE DEPARTMENT ON RECOMMENDATIONS IN THE IG'S 1980 ANNUAL REPORT

Finding	Recommendation	Action Taken	Comments
Advance payments to GSA are made for non-recurring work authorizations. Refunds of advances for projects terminated were not requested by SSA. SSA Trust Funds lost interest of about \$450 million (Covers 4 fiscal years)	Waive advance payment requirement. Reimburse GSA on percentage of completion. Monitor costs of non-recurring projects. Request prompt refunds from GSA for excess payment on terminated projects	Agreement proposed by SSA and sent to GSA. Procedures were implemented to track all costs on non-recurring projects. Refunds requested on past projects.	Recommendations were implemented in April 1981. Recommendations were implemented May 1980.
HCFA Regulations covering reimbursements for house-keeping services under Medicaid need clarification. One State was charging "millions" to Medicaid for routine housekeeping services without linking these services to a physicians' medical plan of treatment.	That HCFA immediately revise its Medicaid personal care regulations to provide the specificity necessary to convey intended policy.	HCFA said that the Omnibus Reconciliation Act obviated the need for corrective action.	We disagree that the Omnibus Reconciliation Act or HCFA regulations have corrected this problem. We requested that HCFA again revise their regulations.

Finding	Recommendation	Action Taken	Comments
States retain the Federal portion of recovered overpayments and uncashed checks for unwarranted periods of time.	Six months or less be established as a uniform period for the return of the Federal portion of such funds.	SSA drafted regulations to require States to return the Federal portion of overpayments and uncashed checks within 180 days. Final regulations are expected by October 1982.	Issuance of new regulations delayed pending clearance with new Administration policies and to correspond with similar regulations published for the SSA program.
HCSR Study at request of GC and Ralph Nader. We found 98% of contracts sampled did not comply with disclosure requirements.	Change regulations to require all reports to have cover sheet with personnel and contract cost information. Train contracting officials on requirements and monitor adherence by contractors.	A final rule was published in Federal Register on September 15, 1980. A survey was conducted by Assistant Secretary for Management and Budget on December 4, 1981. The survey found substantial compliance with requirements.	
Unreasonable payments to hospital-based physicians.	Consider alternatives for resolving this issue. Select most favorable alternative, (s). Develop regulations and guidelines on limits on reimbursements and the controls to be implemented.	Option papers have been prepared and discussed with the Secretary. Revised option paper being prepared for submission to the Secretary.	Action has not been as quick and aggressive as possible.

Finding	Recommendation	Action Taken	Comments
Trust Fund withdrawals to cover Title II benefit payments not accurately determined with a resultant loss of \$4.5 million annually in interest income. Documentation on correcting accounting imbalances from processing Title II payment data not always maintained. About 25 manual steps were performed by SSA as part of the operation of comparing Title II payment update totals to the fiscal integrity totals.	Current daily benefit payment activity should be used to determine Trust Fund withdrawals and fund transfers with the U.S. Treasury should be made on an "as needed" basis rather than weekly. Adequately document how the imbalances were corrected and analyze the causes of the imbalances to correct the system to avoid their recurrence. Automate the procedures followed to balance the accounting information developed in preparing Title II benefit payments for issuance.	SSA agreed to use daily activity data and developed a formal agreement with the Treasury to allow for the daily transfer of funds to cover benefit disbursements effective for 1981. SSA plans to make the system redesign needed to document the imbalance corrections as soon as staff resources are available, but has begun action to have accounting and systems personnel work together to change the programs to help avoid imbalance recurrences. SSA agreed to fully automate the operation as new systems are developed but noted that the manual operations currently performed by a few employees are the residual of what formerly required the work of about 100 clerks nation-wide.	Action taken by SSA is acceptable. SSA should give a higher priority to documenting how the imbalances are corrected. Action planned by SSA is acceptable.

Finding	Recommendation	Action Taken	Comments
Improved surveillance needed over grantee cash withdrawals.	DFAFS need follow-up to recover funds from recipients identified as having excess cash through more frequent site visits. Also, the sample size for reviewing recipients was too small to adequately cover all recipients.	Recipients identified as having excess cash are now contacted by phone or letter to explain apparent excess. Implementing in conjunction with Treasury, a test Electronic fund transfer system assuring recipients of more timely receipt of funds. Developing an automated recipient dunning letter process which scans the entire DFAFS base monthly and identifies recipients who appear to have excess cash. Implementing a delay-of-drawdown or a limited checks-paid letter-of-credit technique.	Actions taken are satisfactory, however, certain procedures such as site visits are not done because of lack of personnel. Sixteen additional positions have been requested in the FY 82 budget.
As much as \$1.2 million in Federal funds may have been improperly disbursed to physicians at two hospitals because carriers did not obtain required documentation on the extent of physicians' services.	Specify whether physician bills are for services as the patient's attending physician or for personal and identifiable medical services.	Instructions drafted in June 1981. Instructions are being revised for publication in the <u>Federal Register</u> in December 1981.	Actions have not been quick or aggressive. If properly implemented, the proposed regulations should correct the problems.

Finding	Recommendation	Action Taken	Comments
Improved controls needed for overtime payments.	Emphasize to all carriers the need to comply with existing requirements. That: steps be taken to assure that overtime is requested in writing and approved in advance, hours worked be documented and verified; a program be initiated to reduce the incidence of timekeeper errors; and ASPER re-emphasize the need for segregation of functions relating to time and attendance.	Final regulations expected to be published in June 1982. The requirement for prior, written approval of overtime was reemphasized in ASPER memorandum and the new Guide for Timekeepers. Use of sign-in/sign-out sheets for overtime work was mandated. Central payroll initiated an audit of 6,000 time cards per pay period--errors are summarized and sent to OPDIVs for corrective action. The new Guide for Timekeepers requires appropriate segregation of functions. Adherence to time and attendance procedures are being monitored at the local level.	Except for the monitoring of component time and attendance practices, we believe satisfactory action has been taken. With respect to monitoring, we believe it would be preferable for some testing by ASPER staff. However, this does not appear feasible with the current level of personnel resources.

Finding	Recommendation	Action Taken	Comments
More can be done to save energy in HHS occupied buildings.	That periodic energy surveys be made to identify possible energy conservation measures; high priority be given to requesting funds for energy conservation retrofit projects; all levels of management be made aware of their roles in energy conservation; and that employee awareness of energy conservation contributions they can make be emphasized.	Energy surveys were made at 104 installations. The 1983 budget requests includes \$3.5 million for retrofit projects. Specific management responsibilities were defined and stressed at an energy amplified in Department instructions. Also, arrangements have been made with DOE to obtain posters, circulars, etc. stressing employee awareness.	Actions are deemed satisfactory.

The following is a summary of Hotline complaints:

HOTLINE CALLS

During Calendar year 1981, OIG Hotline has received:

1,157 OIG complaints (381 actionables)
(776 non-actionable)
108 GAO Hotline referrals to OIG
372 GAO Hotline referrals directly to the Social
Security Administration
1,637 Total

Of the 381 actionable complaints received, 226 are closed
and 155 pending.

TRENDS AND PATTERNS

Actionable OIG Complaints:

		<u>pending</u>	<u>Closed</u>
SSA	171	80	91
HCFA	21	8	13
OIG	27	13	14
OHDS	5	4	1
PHS	73	15	58
OS	4	1	3
OCR	3	1	2
OPSI	41	29	12
Other	22	4	18
No Merit	14	--	14
TOTALS	<u>381</u>	<u>155</u>	<u>226</u>
Program Abuse		109	
Waste/Mismanagement		91	
Grants/Contracts		20	
Time and Attendance/Travel		59	
Personnel Violations		47	
Employee Misconduct		38	
Other		17	
TOTAL		<u>381</u>	

Non-actionable OIG Complaints:

Follow-up on original complaints	109
Other agency calls	91
Congressional inquiries	20
Additional information on original complaints	59
Press inquiries	47
Non-substantive complaints	381
Disability problems	93
TOTAL	<u>776</u>

MEDICARE AND MEDICAID CASES PRESENTED TO DEPARTMENT OF JUSTICE IN 1981

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Disposition
1.	RI	MO	Double billing.	10/01/81			12/01/81	Closed-Recovery of overpayment.
2.	NH	AMB	Submitting false claims.	09/04/81			09/04/81	Open-Referred for adm. action.
3.	RI	DPM	Billing for services not rendered.	02/25/81			02/25/81	Closed-To recover overpayments.
4.	RI	MO	Representation of services.	10/20/81			10/20/81	Closed-Administrative recovery overpayment by carrier.
5.	NJ	LAB	Billing for services not rendered.	01/08/81			01/08/81	Closed.
6.	NJ	LAB	Billing for services not rendered.	01/08/81			01/08/81	Closed.
7.	NJ	SNF	Submitting false cost reports.	02/18/81			02/18/81	Closed lack of prosecution merit.
8.	W-NY	MO	Billing for services not rendered.	06/10/81			06/10/81	Closed-Referred to HCFA for adm. action.
9.	NJ	MO/EMP	Billing for services not rendered.	05/20/81			05/20/81	Referred to HCFA for adm. action.
10.	NJ	HOSP	Kickbacks/Rebates.	06/29/81	07/06/81	10/29/81		Closed-Further prosecution authorized.
11.	NJ	ANES	Billing for services not rendered.	03/01/81	06/03/81	06/03/81		Open- 6 mo. incar. 5 yr. prob., \$25,000 fine.

MEDICARE AND MEDICAID CASES PRESENTED TO DEPARTMENT OF JUSTICE IN 1981

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Disposition
12.	E-NY	POD	Billing for services not rendered.	07/31/81			07/031/81	Open.
13.	NJ	HOSP	Embezzlement	06/01/81	06/30/81	06/30/81		Closed--\$163,000 rest., \$39,739 recovery. Open-Pending.
14.	NJ	SNF	Billing for services not rendered.	06/25/81				Open-Pending.
15.	NJ	DME	Billing for services not rendered.	09/30/1	10/26/81			Open-Pending.
16.	W-VA		Duplicate billings.	05/81				Open-Pending.
17.	E-PA	AMB	Fraudulent billing.	07/29/81			07/29/81	Closed.
18.	E-PA	LAB	Submitting false claims.	11/81			11/81	Closed.
19.	DEL	DME	Submitting false claims.	10/31/81			10/31/81	Closed-Referred to FBI.
20.	S-WV	SNF	Submitting false claims.	04/23/81	07/31/81	07/31/81		Closed-First subject 20 yrs. susp., \$57,000 rest., \$40,000 fine, \$25,000 savings, 5 yrs. public service. Second and third subjects- Pre-Trial Diversion.
21.	W-VA	DME	Kickbacks.	01/13/81			01/13/81	Closed.
22.	W-PA	DME	Kickbacks.	08/31/81			08/31/81	Closed.

MEDICARE AND MEDICAID CASES PRESENTED TO DEPARTMENT OF JUSTICE IN 1981

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Disposition
23.	S-FL	HDSP	Kickbacks/Rebates	01/06/81			01/06/81	Closed.
24.	W-TN	MD	Billing for services not rendered.	01/21/81			01/21/81	Closed.
25.	W-TN	MD	Submitting false claims.	05/08/81			05/08/81	Closed.
26.	S-FL	HHA	Fraudulent cost reports.	02/02/81			02/02/81	Closed.
27.	S-FL	SNF	Kickbacks/Rebates.	08/05/81			08/05/81	Closed.
28.	S-FL	LAB	Kickbacks.	01/23/81			04/06/81	Closed.
29.	O-ALA	DME	Misrepresenting services.	02/18/81				Open-Active.
30.	S-FL	AVES	Billing for services not rendered.	04/30/81			11/03/81	Closed-Referred for adm. action.
31.	N-AL	DIR	Fraudulent cost reports.	08/23/81				Open-Active.
32.	N-FL	CLN	Submitted false claims.	03/25/81		11/17/81		Closed-Pre-Trial Diversion.
33.	S-FL	MD	Misrepresenting services.	03/31/81				Open-fugitive, extradition to Canada.

MEDICARE AND MEDICAID CASES PRESENTED TO DEPARTMENT OF JUSTICE IN 1981

Case #	Judicial District Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Disposition
34.	N-AL SNF	Billing for services not rendered.	05/19/81				Open-Active.
35.	M-FL OP/SUP	Billing for services not rendered.	05/26/81				Open-Active.
36.	N-FL PSRO	Embezzlement.	06/23/81	09/22/81			Open-Pending.
37.	M-TN BENE	Submitting false claims.	06/30/81				Open-Pending.
38.	M-FL BENE	Forgery/Larceny.					Open-Active.
39.	S-IN ICF	Kickback/Rebates.	05/04/81				Closed until complainant is ready to cooperate.
40.	E-MI HOSP	Fraudulent cost reports.	09/09/81			09/09/81	Closed-Request HCFA to recover \$100,125 loss.
41.	E-MI SNF	Billing for services not rendered.	01/30/81			01/30/81	Closed-\$70,000 recovery.
42.	HOSP	Kickbacks.	05/16/81			08/26/81	Open.
43.	E-ILL INTER	Destruction of correspondence.	07/01/81			07/01/81	Closed.
44.	N-ILL HOSP	Kickbacks/Rebates.	03/31/81			03/31/81	Closed.
46.	C-ILL THERAP	Billing for services not rendered.	07/09/81			07/09/81	Closed.
47.	N-ILL 00	Billing for services not rendered.	09/25/81			09/25/81	Open.

MEDICARE AND MEDICAID CASES PRESENTED TO DEPARTMENT OF JUSTICE IN 1981

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Disposition
48.	N-OH	MD	Submitting false claims.					Open-Referred to FBI.
49.	N-ILL	HOSP	Submitting false reports.	09/01/81			09/01/81	Open-Referred to HCFA for adm. action.
50.	E-MI	THERAP	Billing for services not rendered.	04/23/81			04/23/81	Closed-Civil declination 9/1/81.
51.	E-MI	HOSP		04/08/81			04/08/81	Closed.
52.	N-ILL	INT-E	Forgery of checks. personal use.	04/21/81	05/29/81	Federal charges dropped.		Open-1 yr. sent., 3 mo. work release, 5 yrs. probation (State conviction).
53.	N-ILL	INT	Causing false int. checks to be issued.	04/24/81				Open-Awaiting indictment.
54.	S-IND	AMB	Submitting false claims.	09/15/81				Open-Pending.
55.	S-IND	INT	Forgery of checks.	02/01/81				Open-Pending.
56.	S-IND	HHA	Submitting false claims.	07/15/81				Open-Pending.
57.	E-ARK	SNF	Submitting false reports.	05/08/81			05/08/81	Closed.
58.	N-TX	DME	False claims.	09/02/81			09/02/81	Open-Criminal declined. Civil case in process.
59.	N-TX	HHA	False cost reports.	06/21/81	06/21/81	06/21/81		Three years to serve-civil pending. Case on appeal.

MEDICARE AND MEDICAID CASES PRESENTED TO DEPARTMENT OF JUSTICE IN 1981

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Disposition
60.	N-TX	DME	Billing for services not rendered.	02/26/81	03/12/81			Open-Fugitive 12 cnt. Indictment.
61.	S-TX	DME	Billing for services not rendered.	01/21/81	02/24/81		02/24/81	Open-Pending sentence.
62.	E-NC	RECIP	Falsifying records.	08/31/81	08/06/81	08/06/81		
63.	M-LA	DENT	Billing for services not rendered.	08/06/81			10/09/81	Closed-Contract cancelled.
64.	KAN	MD	Submitting false claims.	06/08/81			11/04/81	Open-Filled civil litigation.
65.	KAN	MD	Billing for services not rendered.	03/09/81			04/01/81	Closed.
66.	S-IO	HOSP	Submitting false claims.	08/18/81				Open-Pending.
67.	S-IO	EMP	Submitting false claims.	11/17/81				Open-Pending.
68.	S-IO	EMP	Submitting false claims.	11/17/81				Open-Pending.
69.	CO	MD	Billing for services not rendered.	03/16/81			03/16/81	Closed.
70.	MT	MD	Billing for services not rendered.	04/02/81			04/02/81	Closed.
71.	CO	THERAP	Billing for services not rendered.	09/18/81	10/09/81	10/09/81		\$25,000 rest., \$12,500 fine, 5 yrs. probation.

MEDICARE AND MEDICAID CASES PRESENTED TO DEPARTMENT OF JUSTICE IN 1981

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Decimation	Status Disposition
72.	UTAH	DME	Billing for services not rendered.	09/23/81			09/23/81	Closed.
73.	UTAH	MD	Billing for services not rendered.	06/01/81	10/21/81			Closed-Indictment dismissed 12/14/81.
74.	UTAH	MD	Billing for services not rendered.	12/16/81			12/16/81	Closed.
75.	C-CA	HOSP	Submitting false cost reports.	09/81			09/81	Closed.
76.	N-CA	MD	Misrepresenting services.	08/21/81			01/82	Open.
77.	C-CA	LAB	Billing for services not rendered.	01/81				Open-Pending further investigation.
78.	N-CA	HOSP	Submitting false cost reports.	04/81			12/81	
79.	NV	CLIN	Submitting false claims.	02/81				Open-Pending.
80.	AZ	DO	Submitting false claims.	03/81				Open-Pending.
81.	C-CA	DPM	Submitting false claims.	08/81			08/81	Closed.
82.	S-CA	HOSP	Submitting false claims.	07/81				Open-Pending.

MEDICARE AND MEDICAID CASES PRESENTED TO DEPARTMENT OF JUSTICE IN 1981

Case #	Judicial District	Class	Nature of Offense	Date Referred		Date of Indictment	Date of Conviction	Date of Declination	Status	
				U.S. Attorney	to				Disposition	
83.	C-CA	HOSP	Submitting false cost reports.	01/81				01/81	Closed.	
84.	C-CA	HOSP	Submitting false cost reports.	01/81				01/81	Closed.	
85.	AZ	HOSP	Submitting false cost reports.	05/81					Open-Pending.	
86.	E-CA	CLIN	Submitting false claims.	04/81					Open-Pending.	
87.	E-CA	AMB	Submitting false claims.	04/81					Open-Pending.	
88.	C-CA	DME	Kickbacks.	05/81					Referred to FBI.	
89.	NV	MD	Submitting false claims.	05/81					Open-Pending.	
90.	C-CA	HOSP	Submitting false claims.	08/81				08/81	Closed.	
91.	ID	HHA	False cost reports.	08/14/81					Open-Pending.	

AUDIT REPORTS ISSUED ON HHS PROGRAMS
CALENDAR YEAR 1981

Audit Areas	Audit Reviews		Non-Federal Reviews		Total Reviews	
	No. of Reports	Recommended Financial Adj. (Millions)	No. of Reports	Recommended Financial Adj. (Millions)	No. of Reports	Recommended Financial Adj. (Millions)
<u>Health Care Financing Administration</u>						
Medicaid	41	\$75.6	20	\$.9	61	\$76.5
1864-1902 State Certification of Health Facilities	46	4.5	31	.9	77	5.4
Professional Standards Review Organizations	11	10.1	22	2.0	33	12.1
HCFA Total	15	2.2	237	1.5	252	3.7
	113	\$92.4	310	\$ 5.3	423	\$97.7
<u>Social Security Administration</u>						
Public Assistance - Administrative Costs	20	\$45.9	3	\$.0	23	\$45.9
Public Assistance - Assistance Payments - Supplemental Security Income (SSI)	20	9.7	0	.0	20	9.7
SSA	5	1.2	1	.0	6	1.2
	46	5.5	32	.7	78	6.2
SSA Total	91	\$62.3	36	\$.7	127	\$63.0
<u>Office of Human Development Service</u>						
Head Start	14	\$.3	1632	\$15.5	1646	\$15.8
Native American	1	.0	218	.6	219	.6
Title XX	20	7.2	19	2.3	39	9.5
Administration on Aging	14	.8	173	.1	187	.9
Work Incentive (WIN)	7	1.1	0	.0	7	1.1
Other	13	22.0	102	.0	115	22.0
OHDS Total	69	\$31.4	2144	\$18.5	2213	\$49.9

AUDIT REPORTS ISSUED ON HHS PROGRAMS
CALENDAR YEAR 1981

Audit Areas	Audit Reviews		Non-Federal Reviews		Total Reviews	
	No. of Reports	Recommended Financial Adj. (Millions)	No. of Reports	Recommended Financial Adj. (Millions)	No. of Reports	Recommended Financial Adj. (Millions)
Public Health Service	530	\$ 9.8	601	\$ 1.0	1131	\$10.8
Research, Training, and Development	10	2.2	1	.0	11	2.2
Maternal and Child Health	49	1.7	502	1.0	551	2.7
Family Health Centers	21	.7	91	.1	112	.8
Family Planning Service	2	.0	66	.4	68	.4
Migrant Health	179	2.1	422	.4	601	2.5
Other	791	\$16.5	1683	\$ 2.9	2474	\$19.4
PHS Total						
Departmental Administration	114	\$.7	45	\$.0	159	\$.7
Cost Proposals	13	.0	13	.0	26	.0
Quality of Grantee Management	59	.0	2	.0	61	.0
Other	186	\$.7	60	\$.0	246	\$.7
DA Total						
Department Total	1250	\$203.3	4233	\$27.4	5483	\$230.7

ACCEPTANCE OF AUDIT ADJUSTMENTS ON HHS PROGRAMS
CALENDAR YEAR 1980

Audit Area	Office of Audit Reports		Non-Federal Reports		Total Reviews	
	No. of Reports	Concurrences (Millions)	No. of Reports	Concurrences (Millions)	No. of Reports	Concurrences (Millions)
Health Care Financing Administration						
Medicaid	38	\$23.5	5	\$ 2.9	43	\$26.4
Medicare	68	9.0	40	3.0	108	12.0
1864-1902 State Certification of Health Facilities	5	1.2	12	1.8	17	3.0
Professional Standards Review Organizations	22	2.7	35	.5	57	3.2
HCFA Total	133	\$36.4	92	\$ 8.2	225	\$44.6
Social Security Administration						
Public Assistance - Administrative Costs	2	\$10.1	0	\$.0	2	\$10.1
Public Assistance - Assistance Payments	22	12.3	0	.0	22	12.3
Supplemental Security Income (SSI)	5	1.0	2	.0	7	1.0
Other - SSA	17	4.6	7	.2	24	4.8
SSA Total	46	\$28.0	9	\$.2	55	\$28.2
Office of Human Development Service						
Head Start	5	\$.1	356	\$ 9.0	361	\$ 9.1
Native American	1	.0	90	.7	91	.7
Title XX	8	3.3	6	.3	14	3.6
Administration on Aging	15	1.1	5	.0	20	1.1
Work Incentive (WIN)	2	.9	0	.0	2	.9
Other	11	21.4	9	.0	20	21.4
OHDS Total	42	\$26.8	466	\$10.0	508	\$36.8
Public Health Service						
Research, Training and Development	304	\$10.5	31	\$.6	335	\$11.1
Maternal and Child Health	5	1.7	1	.0	6	1.7
Family Health Centers	24	.4	27	.4	51	.8
Family Planning Services	7	.5	8	.0	15	.5
Migrant Health	1	.0	12	.1	13	.1
Other	96	2.7	44	.8	140	3.5
PHS Total	437	\$15.8	123	\$ 1.9	560	\$17.7

ACCEPTANCE OF AUDIT ADJUSTMENTS ON HHS PROGRAMS
CALENDAR YEAR 1980

Audit Area	Office of Audit Reports		Non-Federal Reports		Total Reviews	
	No. of Reports	Concurrences (Millions)	No. of Reports	Concurrences (Millions)	No. of Reports	Concurrences (Millions)
Departmental Administration						
Cost Proposals	13	\$ 7.2	0	\$.0	13	\$ 7.2
Quality of Grantee Management	2	.1	2	.1	4	.2
Other	6	1.2	1	.4	7	1.6
DA Total	21	\$ 8.5	3	\$.5	24	\$ 9.0
Department Total	679	\$115.5	693	\$20.8	1372	\$136.3

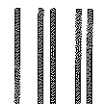


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