Semiannual Report

October 1, 1991 - March 31, 1992

Office of Inspector General

Richard P. Kusserow
Inspector General

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

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

Office of Management and Budget Circulars:

A- 21	Cost Principles for Educational Institutions
A- 25	User Charges
A- 50	Audit Follow-up
A- 70	Policies and Guidelines for Federal Credit Programs
A- 73	Audit of Federal Operations and Programs
A- 76	Performance of Commercial Activities
A- 87	Cost Principles for State and Local Governments
A- 88	Indirect Cost Rates, Audit, and Audit Follow-up at Educational Institutions
A-102	Uniform Administrative Requirements for Assistance to State and Local Governments
A-110	Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations
A-120	Advisory and Assistance Services
A-122	Cost Principles for Nonprofit Organizations
A-123	Internal Controls
A-127	Financial Management Systems
A-128	Audits of State and Local Governments
A-129	Managing Federal Credit Programs
A-133	Audits of Institutions of Higher Education and Other Nonprofit Institutions

General Accounting Office "Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

Title 5,	United States Code, section 552a(i)
Title 18,	United States Code, sections on crime and criminal procedures as they pertain to OIG's oversight of departmental programs and employee misconduct
Title 26,	United States Code, section 7213
Title 42,	United States Code, sections 261, 263a(l), 274e, 290dd-3, 300w-8, 300x-8, 406, 408, 707, 1320a-7b, 1320b-10 and 1383(d), the Social Security and Public Health Service Acts

Civil and administrative investigative authorities include over 75 civil monetary penalty and exclusion authorities such as those at:

Title 31,	United States Code, section 3801, et seq., the Program Fraud Civil Remedies Act
Title 42,	United States Code, sections 1320a-7, 1320c-5, 1395l, 1395m, 1395u, 1395dd and 1396b, the Social Security Act

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

The Honorable Louis W. Sullivan, M.D.
Secretary of Health and Human Services
Washington, D.C. 20201

Dear Mr. Secretary:

I respectfully submit this semiannual report, issued in accordance with the provisions of the Inspector General Act of 1978 (Public Law 95-452), as amended, which summarizes the activities of the Office of Inspector General (OIG) for the 6-month period ending March 31, 1992.

The OIG has statutory authority and responsibility to protect the integrity of departmental programs and the health and welfare of the beneficiaries of those programs; promote economy, efficiency and effectiveness in the Department's programs and operations; and prevent and detect fraud, waste and abuse. Our mission is accomplished through a comprehensive program of audits, investigations, evaluations and inspections. Our oversight activities reach all organizational levels of every operating division, including the Health Care Financing Administration, the Social Security Administration, the Public Health Service, the Administration on Children and Families, and the Administration on Aging. The Department's programs impact the well-being and the quality of life of virtually every U.S. citizen. The OIG's activities support the Department's goals by promoting high quality, cost-effective health care and human services, improved access to health care for all Americans, and the integrity of the Social Security and Medicare trust funds. We have delineated some of our most noteworthy accomplishments during this reporting period in the Highlights section of this semiannual report.

The Fiscal Year (FY) 1992 budget for the Department of Health and Human Services (HHS) of $544 billion accounts for over one-third of the budget of the United States. Many of the Department's budget increases in recent years have been in the areas of Social Security and Medicare where, historically, OIG has uncovered significant instances of fraud, waste and abuse. Although our funds have increased in the last 5 years, the increases have not kept pace with the growth in departmental outlays. Consequently, we must carefully prioritize our planned work to provide optimal coverage of the Department's programs with scarce resources.

Moreover, in recognition of the fact that vast amounts of dollars are lost each year through fraud, waste, abuse and mismanagement, the Congress has mandated fundamental reforms in the area of financial management. The OIG plays an integral part in the improvement of

systems of accounting, financial management and internal controls. The financial statement audit provisions of the Chief Financial Officers (CFO) Act of 1990 place a greater resource demand on the HHS OIG than on any other agency covered by the Act due to the size of the Department's budget and the number, scope and complexity of departmental program and activity accounts included in the HHS financial statement preparation and audit plan. Because of FY 1992 resource limitations, however, we only reallocated staff to audit and report on the FY 1991 financial statements that were not waived from audit by the Office of Management and Budget. Lack of funding for CFO in FY 1992 has severely limited our plans for implementation of the CFO Act and will not allow us to realize many of its most meaningful benefits.

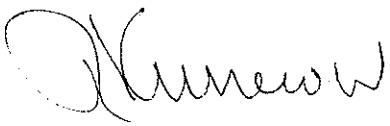
For FY 1993, we have requested the resources needed for audits of financial management issues. We intend to use some of these resources to audit FY 1992 financial statements. To the extent that we are authorized fewer full-time equivalents, we will be compelled to limit proportionately the scope of our work and delay the timing of our products. This may limit the usefulness of these reports to the Congress and other users. By not doing these financial statement audits, we will also not be reviewing the financial management systems that underlie the entities' financial reports, nor the performance measurement data included in the entities' financial statement overviews. In addition, we will not have financial audit coverage for several high risk areas: Medicare secondary payer, Medicare payment safeguards, Medicare program data and management of the Indian Health Service.

We have aggressively pursued initiatives designed to ensure that our own cost of operations is minimized and resources are used efficiently and effectively. Mandatory increases, such as salary increases, rent and communications, have been absorbed by instituting a hiring freeze, reducing advisory and assistance services, suspending payment of administratively uncontrollable overtime to our investigative staff and reducing spending in all other areas including travel and training. These measures may serve as temporary stop gaps in FY 1992. However, OIG is a labor intensive organization. We find that our basic operations have been disrupted at a time when our responsibilities are increasing.

We anticipate that future funding will provide the resources necessary to enable us to restore our base; allow us to commit adequate resources in financial management and program areas; permit us to continue to address the issues facing the Department; and ensure the integrity of HHS programs and quality of care for the beneficiaries of those programs.

We are pleased to have the opportunity to work with you in meeting the goals you have set for the Department. Moreover, we are grateful to the Department's managers and the Members of the Congress who have helped make our past successes possible, and we count on their continued cooperation and assistance in these difficult times.

Sincerely yours,



Richard P. Kusserow
Inspector General

HIGHLIGHTS

In this first half of Fiscal Year (FY) 1992, the Office of Inspector General (OIG) has undertaken several major initiatives to promote quality financial management at the Department of Health and Human Services (HHS), and to protect the integrity of HHS programs and the health and welfare of the beneficiaries served by those programs. Some of OIG's most significant accomplishments during this period are described below.

Financial Management

Financial management is the process of maintaining accountability over the resources provided to an agency or program. This process includes establishing and maintaining a system of management controls designed to enforce management's policies and to facilitate the achievement of management's goals, including guarding against undesired actions and providing a full accountability for the resources provided.

The Federal Managers' Financial Integrity Act

The Federal Managers' Financial Integrity Act (FMFIA) gives the agency head the responsibility for evaluating the agency's management controls to prevent fraud, waste and abuse. In reviewing management's implementation of the FMFIA, OIG provides technical assistance to management in its efforts to evaluate and improve management control and financial management systems. In addition, OIG corroborates the effectiveness of the FMFIA process through audits, inspections and investigations to detect fraud, waste and abuse. During 1991, OIG reviewed various aspects of the Department's FMFIA process. The OIG's overall report on the Department's FMFIA program was included with the Secretary's FMFIA report. This was the first time an Inspector General (IG) issued a report on a departmental FMFIA program that was included as an integral part of a Secretary's FMFIA report to the President and the Congress. (See page 3)

Implementation of the Chief Financial Officers Act

The Chief Financial Officers (CFO) Act of 1990 was enacted to improve the general and financial management of the Federal Government. Implementation of the CFO Act at HHS requires the preparation and audit of financial statements for 11 reporting entities.

For years OIG has recommended many of the changes mandated by the Act: improving management controls; working towards more uniform departmental accounting systems; establishing systems to produce information needed by financial managers; and interrelating FMFIA activities with financial statements preparation and audits. This IG has assumed a leadership role in promoting the goals of the Act in his capacity as chairman of the

President's Council on Integrity and Efficiency (PCIE) Task Force on Improved Financial Management and Implementation of the CFO Act. (See page 11)

Audit of Social Security's FY 1991 Financial Statements

FY 1991 marks the fifth year that OIG has audited and expressed an opinion on the Social Security Administration's (SSA's) financial statements and reported on SSA's system of internal controls and compliance with laws and regulations. The OIG will issue a complete report on its audit of SSA in April 1992, which will address the requirements of the CFO Act, including an assessment of SSA's overview, which includes its measurement of program and financial performance. (See page 50)

Reporting Performance Measurement

Throughout the Federal Government, there is a renewed emphasis on financial management and accountability for scarce resources. There is an increasing awareness that accountability includes not only safeguarding of resources from waste, fraud, and abuse, but, ultimately, the use of resources to accomplish program goals and objectives. Thus, there is an increasing focus on performance measurement as an integral part of accountability reporting. Under the CFO Act, there is a requirement to develop and maintain financial management systems which include the systematic measurement of program performance.

The IG is serving as team leader of the PCIE Task Force on Improved Financial Management and Implementation of the CFO Act team on Management's Overview of the Reporting Entity. This team is preparing guidelines for the PCIE community on auditor assistance to management on performance measurement, auditing and reporting on management's overview, and standards for assessing management's process of performance measurement. Moreover, the IG is providing training throughout the Government under the auspices of the Association of Government Accountants. The IG is also actively involved in assisting management at HHS identify appropriate indicators and measures through the Department's task force on performance measurement. In addition, the Secretary's Program Directions Plan includes requirements that each operating division report quarterly on specific performance measures. In some cases, reports by OIG are used as performance measures within this system. (See page 14)

A performance indicator may be defined as an index or pointer that assesses the level of achievement of a program goal, objective, or target. Throughout the body of this semiannual report, we have tagged some items as "performance indicators" by marking them with the symbol [Performance Indicator].

Audit Activity at Colleges and Universities

The OIG performed or reviewed 898 audits in the college and university area during Calendar Year 1991. The primary focus of the audit work was a continuing effort to ensure that the Federal Government pays only its fair share of total research costs, both direct and

indirect costs. Through these audits and special initiatives, OIG disclosed a total of $38.4 million in unallowable costs in the indirect cost pools of universities under HHS cognizance. About 15 percent of this amount, approximately $5.8 million, was allocated to research programs, primarily those sponsored by the Federal Government. The OIG also provided valuable audit assistance to the Department's Division of Cost Allocation, resulting in millions of dollars of reductions for future reimbursement of indirect costs due to negotiations of reduced indirect cost rates ($9.8 million at three schools where negotiations were recently completed).

In addition, OIG determined that it is a common practice for universities to enter into sponsored agreements with private industry and foreign governments at reduced indirect cost rates. The 10 universities in OIG's review were forgoing about $46 million in revenues per year because of reduced indirect cost rates. The OIG audits also found that some university recharge centers, such as those providing telecommunication and computer services, were billing users too much. The OIG is in the process of recommending reimbursement (approximately $1.8 million to date) to the Federal Government for overcharges to Federal research. Work continues in other aspects of schools' charges to Federal research, such as those related to property management and charges for medical liability insurance. (See page 62)

Youth and Alcohol Studies

In response to public health concerns on youth alcohol consumption and the adverse health consequences of alcohol abuse, OIG issued a series of reports on youth and alcohol at the request of the Surgeon General. These concerns mirror one of the Secretary's goals, which is to reduce the prevalence of alcohol problems among children and youth.

Because controversy surrounds alcoholic beverage advertising, its effects on youth, and the extent to which it should be regulated, OIG reviewed and described the research that has been conducted on the effects of alcohol advertising and youth. Further, OIG provided information about advertising practices and the current system governing them. These reports also included studies of current State laws and regulations governing youth access to alcohol and enforcement of these laws. In addition, OIG identified and described national, State and local programs that educate youth. (See page 67)

Durable Medical Equipment

The area of durable medical equipment (DME) continues to be a major concern to OIG. In order to more closely coordinate and focus on its various DME investigative activities, OIG established a project devoted to these cases. (See page 38)

In an inspection report issued during this period, OIG concluded that current Medicare policy for processing DME claims compromises Medicare program safeguards and may

have resulted in program losses of at least $22 million for medical supplies alone. (See page 38)

To remedy some of the systemic problems uncovered by OIG, the Health Care Financing Administration published proposed regulations which reduce the number of carriers processing DME claims, limit payment for DME to the place it is used, and require suppliers to report ownership and other information before being issued a provider number. (See page 38)

TABLE OF CONTENTS

General Oversight

Chapter I

GENERAL OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities. The Department will spend $121 million in Fiscal Year (FY) 1992 to provide overall direction for departmental activities and to provide common services such as personnel, accounting and payroll to departmental operating divisions.

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

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

Financial Management

One of the most difficult challenges in managing Government operations today is that of allocating increasingly scarce resources to competing programs. Management is responsible for using available resources to carry out the mission of its agency or program. To do so effectively, it must understand its mission and set clear goals, objectives and policy to achieve it. Management science has focused on a new concept called Total Quality Management (TQM) to help bring this about. Under TQM, management sets policy with clear goals, lines of responsibility, and involvement of every employee in the process of carrying out these goals. As part of Department management, financial managers are responsible for gathering and reporting the financial and budgetary data needed by program managers to carry out their responsibilities and achieve their program goals.

Financial management is the process of maintaining control and accountability for the resources provided to the agency or program. This process includes establishing and maintaining a system of management controls designed to enforce management's policies and facilitate the achievement of management's goals, including guarding against undesired actions and providing a full accountability for the resources provided.

Management controls, or internal controls, are defined by the Comptroller General's standards as "The plan of organization and methods and procedures adopted by management to ensure that resource use is consistent with laws, regulations, and policies; that resources are safeguarded against waste, loss, and misuse; and that reliable data are obtained, maintained and fairly disclosed in reports."

Just as every employee contributes to achievement of the mission and goals of the organization, every employee is responsible for the effective operation of management controls.

A. History

Financial management and management controls have a long history in the Federal Government. Under the Accounting and Auditing Act of 1950, the head of each agency has been given the responsibility for establishing and maintaining management controls, providing management with financial information necessary to carry out its missions and goals, and accountability for the resources provided.

The Federal Managers' Financial Integrity Act (FMFIA) of 1982 amended the Accounting and Auditing Act of 1950 by giving the agency head the additional responsibility of evaluating the agency's internal controls, reporting to the Congress on whether the agency's internal controls comply with the standards for internal control systems issued by the Comptroller General, and identifying material internal control weaknesses and plans for correcting those weaknesses.

The Comptroller General's standards for management control systems include the establishment of control objectives for each agency activity which requires that all operations of an agency be categorized into cycles, such as agency management, financial, program and administrative. Each cycle is then analyzed in detail to identify and develop the management control goals or targets to be achieved. Agency management cycles cover policy and planning, financial cycles cover financial information, program cycles cover agency activities that relate to the mission of the agency and administrative cycles cover those activities which provide support to carrying out the agency's mission.

B. Management Controls Defined

The OMB Circular A-123, Internal Control Systems, issued in 1986, requires that each agency establish management controls in all agency components that are designed and operating effectively to prevent fraud, waste, and abuse. This responsibility rests with managers throughout the agency, not just financial managers. According to Circular A-123, the objectives of management controls apply to all program and administrative activities and are to provide management reasonable assurance that programs are efficiently and effectively carried out in accordance with applicable law and management policy.

The OMB Circular A-127, Financial Management Systems, issued in 1984, holds management responsible for the planning, development, operation, review and reporting on the agency's financial management systems. Circular A-127 states that the objectives of financial management systems are to record and report financial data for use by both program and administrative managers in budget preparation, analysis and execution, and for external reporting to OMB, the Department of the Treasury and the Congress. The financial management data must be useful, timely, reliable, complete and consistent.

Circular A-127 states that additional details regarding these objectives are contained in an OMB document entitled Financial Management and Accounting Objectives, issued in March 1985. This OMB document states: "One purpose of the financial management system is to process financial transactions and control financial and related resources. An equally valid purpose is to provide information for evaluating and improving the conduct of Federal programs and the use of financial resources. Accordingly, the financial management system should provide performance measurement and reporting."

C. The OIG Role in FMFIA

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

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

- evaluating the adequacy of the Department's segmentation process to ensure that all significant aspects of program operations and administrative activity are included in the FMFIA reviews;

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

- testing the effectiveness of risk assessments, internal control reviews and financial management system reviews performed by management;

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

- advising top management on internal control issues; and

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

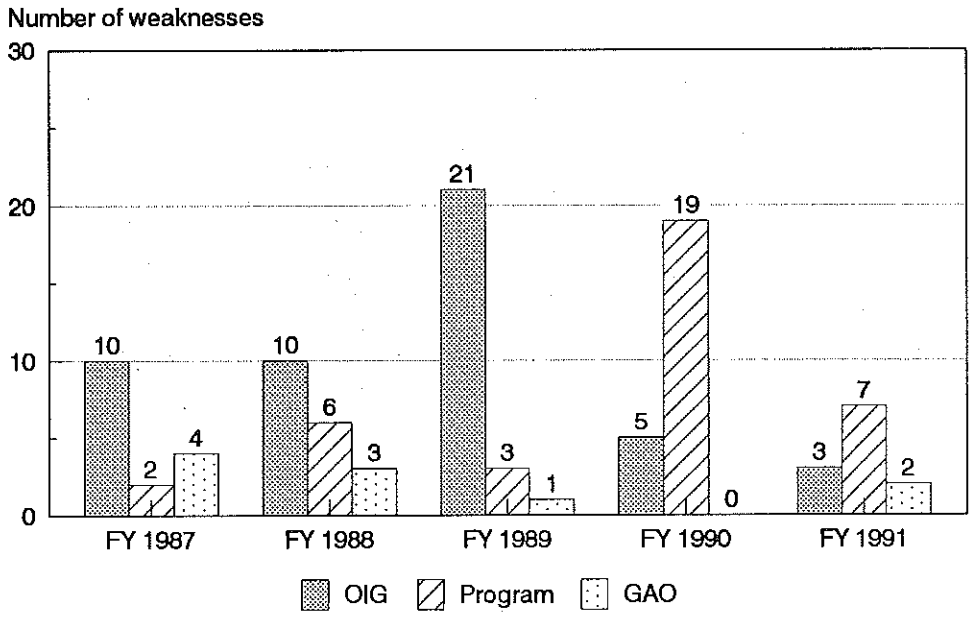
In reviewing management's implementation of FMFIA, OIG provides technical assistance to management in its efforts to evaluate and improve management control and financial management systems. In addition, OIG corroborates the effectiveness of the FMFIA process through audits, inspections and investigations to detect fraud, waste and abuse.

During 1991, as in previous years, OIG enjoyed a good working relationship with the Department of Health and Human Services (HHS) management in its implementation of FMFIA. The OIG saw a renewed emphasis by management on improving the effectiveness of its FMFIA program which resulted in an increase over prior years of management's identification of management control weaknesses. The OIG identification of weaknesses, recommended improvements and comments on the Secretary's FMFIA report were accepted by management.

As in previous years, OIG reviewed various aspects of the Department's FMFIA process. Each of OIG's audit divisions, which parallel the four major operating divisions of HHS, reviewed the Department's implementation of FMFIA, including the segmentation process, risk assessments, and reviews of management controls, financial management systems and corrective actions. The OIG conducted these reviews throughout the year and issued reports on the results. The overall report on the Department's FMFIA program was included with the Secretary's FMFIA report. This was the first time an Inspector General (IG) issued a report on a departmental FMFIA program that was included as an integral part of a Secretary's FMFIA report to the President and the Congress.

Twelve new material weaknesses or nonconformances were added to the Secretary's FMFIA report in 1991. Auditors identified five and management identified seven. There has been significant progress by management in implementing its FMFIA program over the past 5 years, as evidenced by the increased percentage of weaknesses now being identified by management. Five years ago, virtually all management control weaknesses were identified as a result of independent audits, as illustrated by the following chart.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Sources Identifying Material Weaknesses and Nonconformances
(Fiscal Years 1987-1991)



The OIG, as well as the Department, tracks the correction of material weaknesses to ensure their satisfactory resolution. Management has the responsibility to ensure that all corrective action plans for correcting material weaknesses are fully implemented and that milestones are being met. The OIG performs reviews of the corrective action plans to determine whether the planned actions will, in fact, correct the weaknesses and also monitors implementation. Any concerns are discussed with the operating manager, and unresolved issues are brought before the Management Oversight Council.

Management is also responsible for performing corrective action reviews for final resolution of material weaknesses. In 1990, management reported eight material weaknesses as corrected. Of these, management performed two corrective action reviews during 1991. The OIG reviewed the working papers prepared by Department managers for both of these corrective action reviews to ascertain the quality of the reviews, and reported the need for improvement in both cases.

For the 13 management control weaknesses reported as having been corrected during 1991, OIG will either directly review management's corrective actions or will evaluate management's corrective action review. At its discretion, the Management Oversight Council may request OIG to perform corrective action reviews on behalf of the various HHS

divisions. Any OIG concerns regarding the correction of a material weakness, if not resolved with management, will be brought before the Management Oversight Council.

The OIG has observed a clear trend of improvement in the Department's implementation of FMFIA. This has been evidenced by several positive actions by management, including encouraging managers to identify and report material weaknesses rather than relying on OIG and the General Accounting Office; aggressively resolving high risk areas and material weaknesses; encouraging closer coordination between OIG and the various HHS divisions; and creating the Management Oversight Council.

Although the Department is continuing to enhance its FMFIA program, OIG identified several areas that should be strengthened. The OIG suggested that management:

- expand segmentation of the management control structure to ensure coverage of all program and administrative functions;

- identify all financial management systems and other information systems that process financial management data and ensure that all Section 4 reviews are scheduled and performed as required by OMB Circular A-127;

- develop realistic target dates when establishing corrective action plans;

- improve the quality of documentation in FMFIA permanent files which supports management control reviews and corrective action reviews; and

- provide documentation (such as management control plans, management control review files, completed corrective action reviews and other FMFIA activity) to OIG for review in a timely manner.

In its FY 1991 report to the Secretary, OIG developed a new format to report on the Department's compliance with FMFIA. This was done as a preliminary step in structuring future reports to comply with OMB's financial reporting requirements under the CFO Act. Because OIG performed only limited testing of the FMFIA program conducted by the Department's major operating and staff divisions, the scope of the review was not sufficient for OIG to express an opinion on the Department's compliance with FMFIA. However, on the basis of the review, OIG did include recommendations for improvements in the operation of its program. The OIG plans to expand the scope of future FMFIA reviews sufficiently to express an opinion on the Department's compliance with FMFIA.

D. Recent Management Control Recommendations

As a result of its audits, investigations and inspections over the past 6 months, OIG has recommended improvements in management controls, including policies and procedures. A summary of some of the more significant ones is presented below.

- The Department should strengthen management controls and ensure that Unique Supplies, an activity of the Working Capital Fund, has an adequate inventory control system. (CIN: A-12-91-00010) (See page 22)

- The Department should strengthen controls over the custody of third party drafts to assure that all drafts are adequately safeguarded and used only for types of payments fully approved by departmental policy. (CIN: A-04-91-00009) (See page 18)

- The Department's Division of Accounting Operations (DAO) should improve controls over successor-merged appropriation ("M") account operations, review all unliquidated obligations in the accounting system and maintain documentation in support of these efforts. (CIN: A-12-91-00012) (See page 18)

- The Department should improve its management control reviews of time and attendance practices. (CIN: A-12-90-00048) (See page 19)

- The Health Care Financing Administration (HCFA) should establish management controls to prevent Medicare from mistakenly paying as primary insurer instead of as the secondary payer. (CIN: A-01-90-00509) (See page 29)

- The HCFA should correct its Medicare point of sale policy for determining carrier jurisdiction for durable medical equipment, prosthetics orthotics and medical supplies to protect the integrity of program safeguards to prevent fraud and abuse. (OEI-05-91-00043) (See page 38)

- The HCFA should improve procedures for funding carrier cost claims for administering the Medicare Part B program. (CIN: A-03-89-00046) (See page 41)

- The HCFA should report its inability to detect or prevent Federal overpayments to States for selected multiple-source drugs as a material weakness under FMFIA and improve its internal controls to detect States' noncompliance. (CIN: A-03-90-00201) (See page 45)

- The HCFA should strengthen controls to ensure compliance with Federal requirements for payments to institutions for mental diseases. (CIN: A-05-91-00021) (See page 46)

- The Social Security Administration (SSA) should implement standard management controls in two areas, the posting of Immediate Payments and security of SSA offices, on a national basis. (CIN: A-13-91-00302) (See page 51)

- The SSA should use computer programs as part of its internal controls to identify and correct situations where beneficiaries are receiving unauthorized multiple benefit payments. (CIN: A-04-91-03003) (See page 52)

- The SSA should expedite negotiations of information exchange agreements with States to eliminate overpayment of disability payments by identifying recipients of worker's compensation payments who did not report receipt of such payments. (OEI-06-89-00900) (See page 55)

- The SSA should improve management controls to ensure that its mail management plan postage containment objectives are always met. (CIN: A-13-89-00038) (See page 60)

- The Public Health Service (PHS) should take immediate corrective action on grantees that are not in compliance with the requirements of the Community Mental Health Centers Act and initiate recovery actions on 13 grants with awards totaling $6.8 million that have consistently not complied with PHS requirements. (CIN: A-05-91-00050) (See page 69)

- The National Institutes of Health (NIH) should improve its internal control policies in the area of technology transfers and royalty income to assure that all patents are fully accounted for, all revenues due the Government for transfers are received, and filing of foreign patents rights are timely and properly coordinated. (CIN: A-01-90-01502) (See page 64)

- The PHS should implement procedures immediately to offset debts arising from National Health Service Corps and Health Education Assistance Loan programs against payments to Medicare providers; and seek legislative authority to use monies collected from loan and scholarship defaulters to provide continuing program support. (OEI-02-91-00550) (See page 68)

- The NIH should review possible conflicts of interest for all members of the Institute of Medicine study of pertussis and rubella vaccines, and take corrective action, including removal if necessary; and institute procedures to follow Federal regulations on impartiality and objectivity of work performed under contract. (CIN: A-15-90-00054) (See page 64)

- The Food and Drug Administration (FDA) should establish management controls and develop policies and procedures on the type of public statements that may be made regarding all of its processes, including drugs undergoing review. (CIN: A-15-90-00046) (See page 67)

- The PHS should implement management controls to prevent the dissemination of sensitive information to third parties. (OI-HQ-92-002) (See page 66)

- The PHS should revise its procedures to improve its controls over unauthorized and unidentified access to FDA's computer network. Currently, FDA's computer security program is inadequate and exposes its network to potential tampering. (OI-HQ-92-001) (See page 65)

- The PHS should implement controls to confirm that businesses receiving contracts subject to the Buy Indian Act are 100 percent Indian-owned. Current controls do not prevent organizations acting as fronts for non-Indian owners from receiving contract funds. (EAR-OI-HQ-92-002) (See page 70)

- The PHS should improve management controls at Indian Health Service medical facilities over the release of medical information without the consent of the patient. (EAR-OI-HQ-92-001) (See page 70)

- The PHS should improve its management controls over equipment to assure that adequate reconciliation of equipment account balances are regularly performed. (CIN: A-06-91-00032) (See page 70)

- The Administration for Children and Families (ACF) should report as a material internal control weakness its program oversight of collections of overpayments by States under the Aid to Families with Dependent Children (AFDC) program. (CIN: A-12-92-00029) (See page 74)

- The ACF should improve management controls over Head Start, including accountability relating to the structure of the internal control systems, record

keeping systems and procedures and financial reporting. (CIN: A-07-91-00425) (See page 76)

- The ACF should properly plan for the analysis and use of foster care caseload data that will be reported by the States under the proposed foster care and adoption data collection system. (OEI-01-90-00490) (See page 77)

- The Administration on Aging should establish management controls and procedures designed to ensure accountability of grantees for compliance with extended service requirements for multipurpose senior centers and to recover funds if the centers are converted to other purposes. (CIN: A-12-92-00015) (See page 80)

Following are examples of recommendations made to State agencies to improve their management of Federal programs:

- Arizona should improve its procedures for claiming costs allowable under the Foster Care program and its procedures for allocating the training costs to the benefiting programs. (CIN: A-09-91-00050) (See page 78)

- Maryland should improve its management controls over Medicaid eligibility. (CIN: A-03-90-00232) (See page 47)

- Massachusetts should improve its management control procedures and documentation in accounting records to ensure that all allocations of costs for administering its homeless program are properly distributed between the AFDC and the State-funded General Relief programs. (CIN: A-01-91-02506) (See page 76)

- New York State should correct deficiencies in internal controls noted in the State's system to properly identify eligible family planning services. (CIN: A-02-90-01029) (See page 46)

- New York State should establish appropriate management controls to prevent improper Medicaid claims for free-standing alcoholism treatment facilities. (CIN: A-02-91-01030) (See page 48)

- Oklahoma should establish management controls to ensure that services are obtained using Job Opportunities and Basic Skills (JOBS) Training funds only after receiving the appropriate level of services on a nonreimbursable basis, and establish controls to ensure that the correct matching rates are

applied. (CIN: A-06-91-00006) Also, the State should establish management controls, policies and procedures to ensure compliance with regulations for procurement of contractor services under the JOBS program. (CIN: A-06-91-00008) (See pages 78 and 79)

- Pennsylvania should institute procedures to monitor compliance with Federal and State regulations regarding entitlement for maintenance payments under the Foster Care program and make financial adjustment for $6.8 million of disallowed claims. (CIN: A-03-91-00551) (See page 78)

In addition, every 6 months literally hundreds of management control weaknesses are identified in OIG reports of audits of nonfederal entities and are thereby brought to HHS management's attention.

E. Implementation of the CFO Act

The CFO Act of 1990 was enacted to improve the general and financial management of the Federal Government. The objectives of the CFO Act are to:

- establish more effective general and financial management practices;

- improve each agency's systems of accounting, financial management and management controls to produce reliable financial information and reduce fraud, waste and abuse of Government resources;

- produce complete, reliable, timely, consistent financial information for use by program and financial managers and the Congress in financing, management and evaluation of Federal programs;

- monitor financial execution of the budget in relation to actual expenditures including timely performance reports; and

- develop and maintain an integrated agency accounting and financial management system including financial reporting and management controls which provide for the systematic measurement of performance.

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

financial management plan required by the Act. Finally, the IG has assumed a leadership role in promoting the goals of the Act in his capacity as chairman of the PCIE Task Force on Improved Financial Management and Implementation of the CFO Act.

There is a growing emphasis on financial management, partly prompted by passage of the CFO Act. The FMFIA and the CFO Act are closely interrelated, and coordination of their implementation programs could enhance the effectiveness of each Act. On the one hand, an effective FMFIA program should reduce the cost of performing a financial statement audit because the auditor should be able to place some reliance on the FMFIA program, after appropriate testing, and thereby reduce the extent of audit procedures. On the other hand, financial statement audits should result in improvements to the underlying financial management systems which should contribute to the efficiency and effectiveness of the FMFIA program. Together, FMFIA and the CFO Act should result in a greater focus on performance measurement which should improve management and program effectiveness.

This close interrelationship between FMFIA and financial statement audits performed under the CFO Act highlights the need for a close working relationship between the Department's FMFIA managers and OIG auditors. The auditors will want to rely, to the maximum extent, on the management control reviews conducted by the FMFIA managers so as to avoid duplication of effort and reduce the cost of the financial audits. In order to rely on this work, the auditors will need to perform rigorous testing of the FMFIA processes followed by management. Also, the timing of the respective efforts will have to be very closely coordinated, so as to meet all the required reporting dates.

F. The OIG's Plan for Financial Audits

Implementation of the CFO Act at HHS requires the preparation and audit of financial statements for the following 11 reporting entities:

- the Social Security Administration (a pilot agency)
- the following Health Care Financing Administration entities:
  - the Medicare program
  - the Health Maintenance Organization program
- the following Public Health Service entities:
  - the National Institutes of Health (18 of 37 budgetary accounts)
  - the Food and Drug Administration (4 of 7 budgetary accounts)

- the Indian Health Service
- the Centers for Disease Control
- the Health Resources and Services Administration
- the Alcohol, Drug Abuse and Mental Health Administration
- the Office of the Assistant Secretary for Health (OASH)

- the Office of the Secretary Working Capital Fund

These entities represent 60 of the Department's total of 109 budgetary accounts, which amount to about $400 billion, or approximately 75 percent of its total FY 1992 outlays. This constitutes approximately one half of the Federal Government's total annual outlays required to be audited by the Act.

In the absence of additional funding to implement the CFO Act, OIG was compelled to severely restrict its financial audit plans. The OIG has continued to audit the SSA financial statements, as in the past, and is attempting to perform audits of the FY 1991 financial statements of five additional reporting entities which were not waived by OMB:

- FDA Color and Insulin Certification Fund
- NIH Management Fund
- NIH Service and Supply Fund
- OASH Service and Supply Fund
- Office of the Secretary Working Capital Fund

G. Audit of Social Security's FY 1991 Financial Statements

Fiscal Year 1991 marks the fifth year that OIG has audited and expressed an opinion on SSA's financial statements, and reported on SSA's system of internal controls and compliance with laws and regulations. The findings are discussed in chapter III, page 50. The OIG will issue a complete report on its audit of SSA in April 1992, which will address the requirements of the CFO Act, including an assessment of SSA's overview, which includes its measurement of program and financial performance. This assessment will draw from both the audit work performed directly under the requirements of the CFO Act and from the results of other relevant audits and inspections.

H. Reporting Performance Measurement

Throughout the Federal Government, there is a renewed emphasis on financial management and accountability for scarce resources. There is an increasing awareness that accountability includes not only safeguarding of resources from waste, fraud, and abuse, but, ultimately, the use of resources to accomplish program goals and objectives. Thus, there is an increasing focus on performance measurement as an integral part of accountability reporting.

Under the CFO Act, agencies are required to develop and maintain financial management systems which include the systematic measurement of program performance. Under OMB guidance, financial statements of reporting entities must include an overview containing a discussion and analysis of program performance using performance indicators and measures. A performance indicator is an index or pointer that assesses the level of achievement of a program goal, objective, or target. Performance indicators differ for each goal level and for each corresponding organizational level. Performance measures are quantitative expressions of the ratio of two performance indicators used to evaluate a program goal, such as the efficiency of an immunization program being measured by the number of inoculations provided per dollar of cost.

The HHS IG has assumed a leadership role in the area of performance measurement, heading the PCIE Task Force on Improved Financial Management and Implementation of the CFO Act team on Management's Overview of the Reporting Entity. This team is preparing guidelines for the PCIE community on auditor assistance to management on performance measurement, auditing and reporting on management's overview, and standards for assessing management's process of performance measurement. In addition, OIG has assumed a leadership role in the Federal Government in the area of performance measurement by providing training throughout the Government under the auspices of the Association of Government Accountants. Moreover, OIG is actively involved in assisting management at HHS identify appropriate indicators and measures.

Throughout the body of this semiannual report, some items have been tagged as "performance indicators" with the symbol [Performance Indicator]. These audits, inspections and investigations offer a quantifiable assessment as to whether the programs or activities reviewed are achieving their desired goals. The OIG considers this an important first step in the development and evolution of performance measurement. As OIG and others expand their work in programmatic performance measurement, the array of indicators and measures will also be enhanced.

Resolving OIG Recommendations

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

A. Questioned Costs

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

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

	Number	Dollar Value (in thousands)	
		Questioned	Unsupported
A. For which no management decision had been made by the commencement of the reporting period[1]	270	$318,571	$18,057
B. Which were issued during the reporting period[2]	369	$113,612	$22,660
Subtotals (A + B)	639	$432,183	$40,717
Less:			
C. For which a management decision was made during the reporting period:	287	$157,148	$12,682
(i) dollar value of disallowed costs[3]		$134,772	$3,891
(ii) dollar value of costs not disallowed		$22,376	$8,791
D. For which no management decision had been made by the end of the reporting period	352	$275,035	$28,035
E. Reports for which no management decision was made within 6 months of issuance[4]	44	$168,706	$5,963

[1] The opening balance was adjusted to reflect a downward revaluation of recommendations in the amount of $39.6 million.

[2] Included in the reports issued during the period are questioned costs totaling $1,973 attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

[3] A detailed listing will be included in the semiannual report covering the period April 1, 1992 through September 30, 1992.

[4] Resolution of CIN: A-07-90-00262, Review of Asset Reversions from Pension Plan Terminations Occurring after the Implementation of the Prospective Payment System ($92,000,000) and CIN: A-07-89-00034, Medicare Is Losing Millions of Dollars from Terminations of Pension Plans ($27,600,000) will be through the departmental conflict resolution process. Due to administrative delays, many of which were beyond management's control, resolution of the following audits was not completed within 6 months of issuance; however, based upon discussions with management officials responsible for those audits, resolution of these outstanding recommendations is expected before the end of the next semiannual reporting period: CIN: A-12-91-00018 ($13,200,000); CIN: A-01-90-00502 ($10,100,000); CIN: A-07-91-00391 ($6,189,163); CIN: A-03-91-14545 ($4,719,884); CIN: A-03-89-00553 ($2,850,322); CIN: A-05-90-00013 ($2,413,388); CIN: A-05-90-00090 ($1,825,677); CIN: A-03-90-00051 ($1,438,414); CIN: A-06-91-06802 ($1,165,351); CIN: A-07-91-00413 ($961,000); CIN: A-03-90-06158 ($944,811); CIN: A-09-91-00056 ($817,711); CIN: A-06-90-00098 ($781,592); CIN: A-05-91-03017 ($292,920); CIN: A-03-91-00350 ($286,477); CIN: A-03-91-14988 ($243,703); CIN: A-04-91-04050 ($169,448); CIN: A-03-91-15226 ($168,121); CIN: A-03-91-14518 ($68,205); CIN: A-06-91-15651 ($65,000); CIN: A-10-91-05517 ($63,021); CIN: A-09-91-05313 ($60,053); CIN: A-03-91-15199 ($52,325); CIN: A-04-91-05511 ($46,958); CIN: A-03-91-14830 ($35,950); CIN: A-07-91-14263 ($25,431); CIN: A-03-91-15332 ($24,138); CIN: A-09-91-03639 ($21,804); CIN: A-04-90-04009 ($21,274); CIN: A-06-91-06787 ($16,064); CIN: A-08-91-15515 ($15,238); CIN: A-09-91-05732 ($8,221); CIN: A-06-91-06790 ($4,213); CIN: A-06-91-06772 ($3,917); CIN: A-09-91-00081 ($2,272); CIN: A-03-91-15237 ($1,427); CIN: A-02-91-15679 ($1,309); CIN: A-10-91-05547 ($450); CIN: A-08-91-15691 ($429); CIN: A-12-90-00042 ($355); CIN: A-07-91-15945 ($184); CIN: A-09-91-05734 ($107).

B. Funds Put to Better Use

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

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

	Number	Dollar Value (in thousands)
A. For which no management decision had been made by the commencement of the reporting period[1]	74	$9,805,105
B. Which were issued during the reporting period	50	$227,018
Subtotals (A + B)	124	$10,032,123
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management		
(a) based on proposed management action[2,3]	43	$341,394
(b) based on proposed legislative action[4]	6	$2,889,700
Subtotals (a+b)	49	$3,231,094
(ii) dollar value of recommendations that were not agreed to by management	18	$4,522,165
Snbtotals (i + ii)	67	$7,753,259
D. For which no management decision had been made by the end of the reporting period[5]	57	$2,278,864
E. *Prior decisions implemented in the period (See Appendix A)*[6]		
(i) based on management action	6	$699,800
(ii) based on legislative action	6	$1,126,200

[1] The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of $3,124.1 million.

[2] Included are sustained management decisions totaling $321,198 attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

[3] The Health Care Financing Administration agrees with the recommendations in the following reports but does not agree with the dollar amounts of the recommendations: OEI-05-91-00043, Carrier Shopping ($22,000,000); OEI-09-88-01007, Post-Op Visits for Cataract Surgery ($5,000,000). The Public Health Service agrees with the recommendations in the following report but does not agree with the dollar amount of the recommendations: OEI-05-90-01070 ($2,500,000).

[4] The OIG has reported as "management decisions made during the period" those line items in the President's Fiscal Year 1993 budget that relate directly to OIG recommendations contained in issued reports. Management does not report these decisions in its table.

[5] Management decisions have not been made within 6 months of issuance on 16 reports. Discussions with management are ongoing and it is expected that the following reports will be resolved during the next semiannual reporting period: CIN: A-06-90-00056 ($705,000,000); OEI-07-89-00760 ($361,000,000); OEI-09-88-01006 ($54,800,000); CIN: A-12-91-00018 ($13,800,000); CIN: A-15-89-00002 ($11,986,334); CIN: A-09-89-00136 ($6,457,912); CIN: A-13-89-00018 ($4,441,000); CIN: A-03-89-00553 ($3,247,492); OEI-03-91-00470 ($2,200,000); CIN: A-04-91-00015 ($2,006,575); CIN: A-03-90-00562 ($623,156); CIN: A-04-90-04009 ($224,668); CIN: A-06-89-00001 ($180,607); CIN: A-09-91-05300 ($79,829); CIN: A-02-91-15679 ($34,050); CIN: A-09-92-06153 ($12,832).

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

Legislative and Regulatory Review

Section 4(a) of the Inspector General Act of 1978 requires the IG to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. In carrying out its responsibilities under Section 4(a), OIG reviewed 111 of the Department's regulations under development and 215 legislative proposals during this reporting period.

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

The OIG also develops regulations for civil monetary penalty (CMP) and exclusion authorities which the IG administers. During the reporting period, OIG prepared and published a major final rule (57 FR 3298) on amendments to OIG's exclusion and CMP authorities resulting from Public Law 100-93, that significantly amends the OIG chapter in the Code of Federal Regulations. Specifically, the final rule is intended to protect program beneficiaries from unfit health care practitioners, and otherwise to improve the antifraud provisions of the Department's health care programs under titles V, XVIII, XIX and XX of the Social Security Act. Among other things, the final rule sets forth: the various mandatory and permissive exclusion authorities available to OIG; revisions implementing statutory amendments and technical changes to OIG's CMP authorities; and a consolidation of the full array of hearing and appeals procedures and testimonial subpoena authority for the investigation of cases.

The OIG also is continuing to develop several regulations related to the Safe Harbor provisions under the Medicare and State health care programs' antikickback statute, and various rulemaking efforts related to expanding and revising its CMP authorities.

Governmental Accounting

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

The OIG performed a follow-up review to determine if the corrective action plan negotiated by the Department's Division of Cost Allocation (DCA) with the State of Oregon to

eliminate accumulated surpluses over a 4-year period through rate reductions had been accomplished. The OIG found that Oregon had not reduced billing rates overall to eliminate surplus balances for internal service funds. In fact, total surpluses for the State's internal service funds (excluding self-insurance and Oregon State System of Higher Education internal service funds) actually increased from the $48.5 million identified in the previous OIG audit to more than $50 million as of June 30, 1990. The OIG estimates that more than $4.7 million of these surpluses represents excess charges to the Federal Government. The OIG recommended that DCA require the State of Oregon to make financial adjustments to eliminate the accumulated surpluses, and establish written procedures to monitor and evaluate the internal service fund balances. (CIN: A-09-91-00090)

Internal Controls over the Third Party Draft System

The OIG determined that the Division of Finance's internal controls for third party drafts (TPDs) were inadequate and were not in accordance with Department of the Treasury regulations or HHS policy. The OIG found that the TPD internal control system was not documented, the separation of key duties was inadequate, access to TPDs and supporting documentation was not properly limited and accountability for blank drafts was not assigned. In addition, the internal control system failed to ensure that TPDs were not used as payments for items that should have been paid through a Treasury Financial Center or should not have been paid based on the supporting documentation. The OIG recommended that the Assistant Secretary for Management and Budget (ASMB) provide increased oversight to this system nationwide, and that the Division of Finance establish and implement internal controls that assure that TPDs are controlled in accordance with applicable laws and regulations. (CIN: A-04-91-00009)

Unliquidated Obligation Balances in Successor Merged Appropriation Accounts

Among its proposals in a prior audit (CIN: A-12-89-00130), OIG had recommended that DAO conduct and document the results of internal control reviews and the performance of annual reviews of unliquidated obligation balances. The OIG found that DAO staff had not adequately examined controls over successor-merged appropriation ("M") account operations. The OIG also noted the effects of the recently enacted Public Law 101-510, which will eliminate past "M" account problems through the phase out of these accounts. The OIG observed that DAO recorded "M" account balances in one fiscal year, only to later move them into their proper fiscal "M" account years. The new legislation requires that "M" account funds retain their fiscal year identity to effect an orderly phase out. The ASMB generally concurred with the recommendations and will continue to review all unliquidated obligations in the accounting system. Documentation in support of these efforts will be formalized to fully justify actions taken. (CIN: A-12-91-00012)

Review of Prompt Payment Reporting for FY 1990

An OIG review of DAO's compliance with the reporting requirements of the Prompt Payment Act found the Division's FY 1990 report to be generally accurate and complete. (CIN: A-12-90-00044)

Effectiveness of Internal Control Reviews of Time and Attendance Practices

This review emanated from the findings of OIG's FY 1990 time and attendance audit, Review of Controls to Prevent or Detect Unauthorized Alteration of Timecards (CIN: A-12-90-00006). The OIG was concerned as to why the Department's internal control reviews (ICRs) had not previously identified and corrected those weaknesses that the FY 1990 audit identified. The current review focused on 10 key controls in the time and attendance function. The OIG compared findings in the FY 1990 audit with the testing and weaknesses identified in related Department ICRs completed over the last 5 years. The OIG believes that the Department's ICR program has not been totally effective in identifying and correcting time and attendance weaknesses for three reasons: one-third of the components included in OIG's review had not performed the time and attendance ICRs in the offices OIG audited; the ICRs that were completed were not thorough in the testing of key controls; and when weaknesses were identified by the ICRs, corrective actions either were not timely or were not effective. (CIN: A-12-90-00048)

Nonfederal Audits

The OIG has oversight responsibility for audits of certain Government grantees conducted by nonfederal auditors, principally public accounting firms and State audit organizations. The OMB circulars assign audit oversight responsibility to OIG for about 50 percent of all Federal funds (approximately $50 billion) provided to governments, colleges, universities and nonprofit organizations. The Department has audit cognizance for 24 of 40 statewide audits as well as about 700 State agencies and local governments. The Department has been assigned cognizance for about 95 percent of all colleges and universities. The recent implementation of OMB Circular A-133 is expected to significantly increase OIG's cognizant responsibilities for nonprofit institutions.

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

A. The OIG's Proactive Role

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

- To more efficiently accomplish its nonfederal responsibility, OIG is consolidating the nonfederal function in Kansas City, Missouri. Currently, 7 of the 8 OIG regions are part of the consolidated unit, with the remaining region planned for consolidation by the end of the fiscal year.

- Through evaluation and summarization of report data, OIG is able to provide both basic audit coverage and analysis of trends that could indicate systemic problems within HHS programs. These systemic problems are brought to the attention of departmental management to improve program administration. For instance, OIG recently issued a management advisory report on findings related to the Head Start program. This unique report capitalized on the consolidation of the nonfederal audit function in Kansas City by summarizing the findings reported by nonfederal auditors nationwide. (See page 76) The summary identified areas where weaknesses were most likely, as well as the regions and types of entities in which a particular type of weakness was most frequent.

- To ensure audit quality, OIG not only maintains a quality control program (discussed below) but has taken steps to ensure that adequate guidance is available to the nonfederal auditor. For example, OIG was instrumental in the issuance of the Governmentwide OMB Compliance Supplements for Audits of Institutions of Higher Learning and Other Nonprofit Institutions in October, 1991. This guidance will improve the consistency of nonfederal audits submitted to all Federal agencies. In addition, OIG is working closely with PCIE in developing questions and answers related to OMB Circular A-133, which will assist the auditor in properly interpreting the requirements of the Circular. The OIG is also heavily involved in the PCIE task force on audit quality. To further improve quality, OIG evaluated and provided suggested improvements to draft guidance developed by the American Institute of Certified Public Accountants, OMB and PCIE during the past 6 months.

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number and through training. During the past 6 months, training was provided to State auditors, National Association of College and University business officers, State societies of certified public accountants, university administrators, community health centers, accounting students and other nonprofits.

B. Quality Control

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

To ensure that all audits meet Government auditing standards and Federal audit requirements, uniform procedures are used to review nonfederal audit reports. During this reporting period, OIG reviewed and processed 1,519 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,010
Reports issued with major changes	481
Reports with significant inadequacies	28
Total audit reports processed	1,519

During the review period, 8 audits were referred to State officials and professional organizations for appropriate action. Several other referrals are pending. The OIG referrals of inadequate audit work can result in significant disciplinary action against the accounting firms involved.

The 1,519 audit reports discussed above included recommendations for HHS cost recoveries totaling $45.7 million as well as many for improving management operations. In addition, areas were identified for follow-up by OIG auditors.

Advisory and Assistance Service Contracts

The law directs that OIG submit to the Congress each year an evaluation of the Department's progress in improving the accuracy and completeness of the information on advisory and assistance services (AAS) provided to the Federal Procurement Data System (FPDS). The OIG found that the lack of a clear definition of what constitutes an AAS obligation continues to cause the Department's operating divisions to apply varying interpretations of the OMB Circular A-120 criteria. In a review concentrating principally on HCFA, OIG determined that HCFA had failed to properly classify and report at least $2.3 million in AAS acquisitions to the Department and the FPDS.

Circular A-120 may be superseded by proposed OMB policy changes that are currently in the draft stages. However, pending such revision, OIG proposed that the Department take a

more comprehensive approach in managing, controlling and strengthening accountability over its AAS activities. The OIG recommended that the Department provide clarification and guidance to the operating divisions so that current A-120 definitions may be consistently applied. (CIN: A-14-91-02056)

Working Capital Fund: Unique Supplies

Unique Supplies, part of the Working Capital Fund (WCF), purchases, stores and distributes customized items for the Department, including letterhead, envelopes, emblems, plaques and nonstandard Government forms. The OIG found that Unique Supplies had losses of over $51,000 in FY 1989, over $205,000 in FY 1990, and nearly $95,000 through the first half of FY 1991. These losses were caused by selling the majority of products at or below cost, thereby failing to recover costs and overhead. In addition, OIG determined that inventory control was inadequate because valuation of items was not current. The OIG proposed that the Department allow Unique Supplies' management to adjust prices to cover direct costs. Further, OIG recommended that the Department strengthen internal controls and ensure that Unique Supplies has an adequate inventory control system. (CIN: A-12-91-00010)

Employees Detailed to Congressional Offices

The House Conference Report 101-906 of October 20, 1990 requires Inspectors General to submit an annual report to the House and Senate Appropriations Committees on individuals detailed to congressional committees and offices. The report is to show grade, position and office of each person detailed.

The Department had 45 employees detailed to congressional committees and offices in FY 1991. However, 31 represented employees on developmental assignments to congressional offices, not details according to the Department's personnel manual definition. For example, 13 were appointed under the Presidential Management Intern program, a 2-year internship to expose interns to various positions in the Federal Government, including congressional offices, for job development purposes. While the HHS personnel manual does not include the developmental assignments in the definition of a detail, they were included for reasons of full disclosure. (CIN: A-12-92-00015)

Employee Fraud and Misconduct

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

- A supervisory hearings assistant with the Office of Hearings and Appeals in New Jersey was sentenced for defrauding the Government. She falsely

reported five times that she did not receive her salary check, causing replacement checks to be issued in four instances. She was sentenced to 2 years probation, to include 2 months home confinement with special restrictions. She was also ordered to make restitution of $2,593. The SSA terminated her employment.

- Administrative action was taken by SSA against two employees for violating departmental standards of conduct. A lithograph foreman and a woman who worked in printing were found to have misused Government duplicating equipment to copy 2,000 church bulletins. The foreman who did the printing was suspended for 30 days, put on 2 years probation and told to make restitution of $653 to SSA. The woman was demoted from her temporary position for having asked the foreman to print the bulletins for her church. Investigation showed that neither received remuneration for their actions.

- A security officer with FDA was sentenced to 2 months home detention for embezzlement. He prepared 12 false invoices and claims for reimbursements or advances for computer equipment he did not purchase. He was also sentenced to serve 100 hours community service and to pay full restitution of $1,470 and a mandatory $25 penalty assessment. He resigned his position during a confrontation interview with an investigator.

- A voucher examiner in Colorado who embezzled Department funds lost her job and was sentenced to 4 months in prison followed by 3 years probation, part of which was to be served in a community treatment center. She was ordered to make restitution of $42,400 she embezzled by issuing travel advance and voucher reimbursement drafts in the names of two friends, who cashed them for her. The two friends were placed in 12-month pre-trial diversions programs.

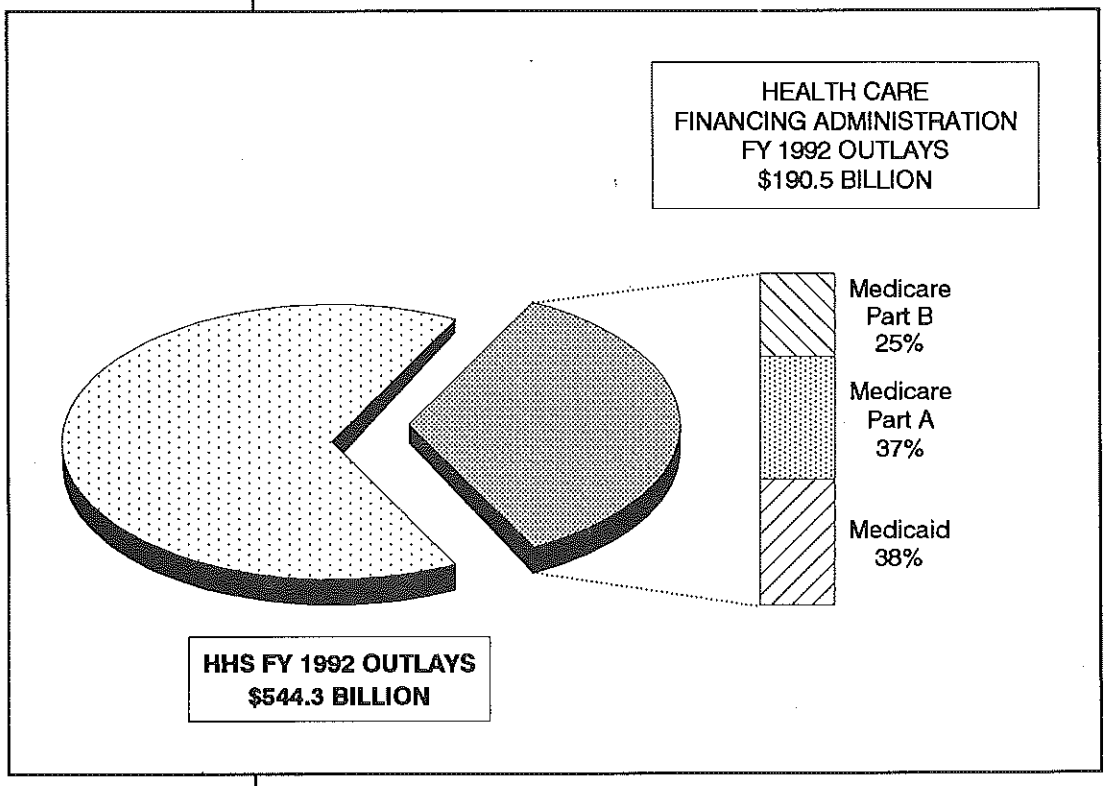
Investigative Prosecutions

During this semiannual reporting period, OIG investigations resulted in 819 convictions. Also during this period, 657 cases were presented for prosecution to the Department of Justice and, in some instances, to nonfederal prosecutors. New criminal charges were brought by prosecutors in 541 cases.

Cooperation with Other Law Enforcement Agencies

Many Federal, State, and local law enforcement and regulatory agencies depend on OIG expertise for assistance in identifying, locating, investigating and prosecuting individuals who have improperly used Social Security numbers in a broad range of illegal activities,

including bank and credit card fraud, licensing and income tax fraud, welfare fraud, drug trafficking and racketeering, as well as fraud in programs such as student loans, food stamps and unemployment compensation. Other agencies also benefit from OIG investigations, such as private health insurers, State Medicaid programs and drug regulatory entities. Many of these cases in which OIG participates result in monetary fines, recoveries, restitutions or savings for the other agencies. During this period, the monies accruing from these cases amounted to more than $15.6 million for other public or private entities.



Health Care Financing Administration

Chapter II

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

In Fiscal Year (FY) 1992, the Medicare program will provide health care coverage for an estimated 36 million individuals. Medicare Part A (hospital insurance) provides, through direct payments for specified use, hospital insurance protection for covered services to persons 65 or older and to certain disabled persons. Financed by the Federal Hospital Insurance Trust Fund, FY 1992 expenditures for Medicare Part A are expected to exceed $76 billion.

Medicare Part B (supplementary medical insurance) provides, through direct payments for specified use, insurance protection against most of the costs of health care to persons 65 and older and certain disabled persons who elect this coverage. The services covered are medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services, and certain other medical and health services. Financed by participants and general revenues, FY 1992 expenditures for Medicare Part B are expected to be over $52 billion.

The Medicaid program provides grants to States for medical care for more than 30 million low-income people. Federal grants are estimated at over $72 billion in FY 1992. Federal matching rates are determined on the basis of a formula that measures relative per capita income in each State. Eligibility for the Medicaid program is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). States may also cover certain individuals who are not eligible for SSI or AFDC. In recent years, significant changes in Medicaid have expanded eligibility and services for pregnant women and children, especially low-income women and children who, for various reasons, are ineligible for assistance under the AFDC program. The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a provision to phase in coverage of children through age 18 below 100 percent of the poverty level.

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

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

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

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

Fraud and abuse of the Medicare and Medicaid programs or their beneficiaries may result in criminal, civil and/or administrative actions against the perpetrators. During the first half of the fiscal year, OIG was responsible for a total of 952 successful actions against wrongdoers.

Financial Arrangements between Hospitals and Hospital-based Physicians

In a management advisory report, OIG alerted HCFA to potential violations of the anti-kickback statute (section 1128(B)(b) of the Social Security Act) in the financial arrangements between some hospitals and hospital-based physicians. Given the relationship between a hospital and its hospital-based physicians, contracts which require the hospital-based physicians to split portions of their income with hospitals are suspect, although not per se violations of the anti-kickback statute. The agreements identified by OIG appear to require physicians to pay far more than fair market value for services provided by the hospitals.

The OIG recommended that HCFA instruct its intermediaries to notify hospitals about potential legal liability when they enter into agreements not based on the fair market value of necessary goods and services exchanged, and refer any suspect arrangements to OIG for possible prosecution or sanctions. The HCFA issued this instruction on November 13, 1991. (OEI-09-89-00330)

Hospital Closure: 1990

Performance Indicator

This inspection, the fourth annual assessment of the extent of hospital closures and the demographics of those that closed, revealed the same patterns found previously. Fifty-six general, acute care hospitals closed, half rural, half urban. The average closed rural hospital was half the size of rural hospitals nationwide and had low occupancy rates. Urban hospitals that closed were slightly over a third the size of all urban hospitals and also had few beds occupied.

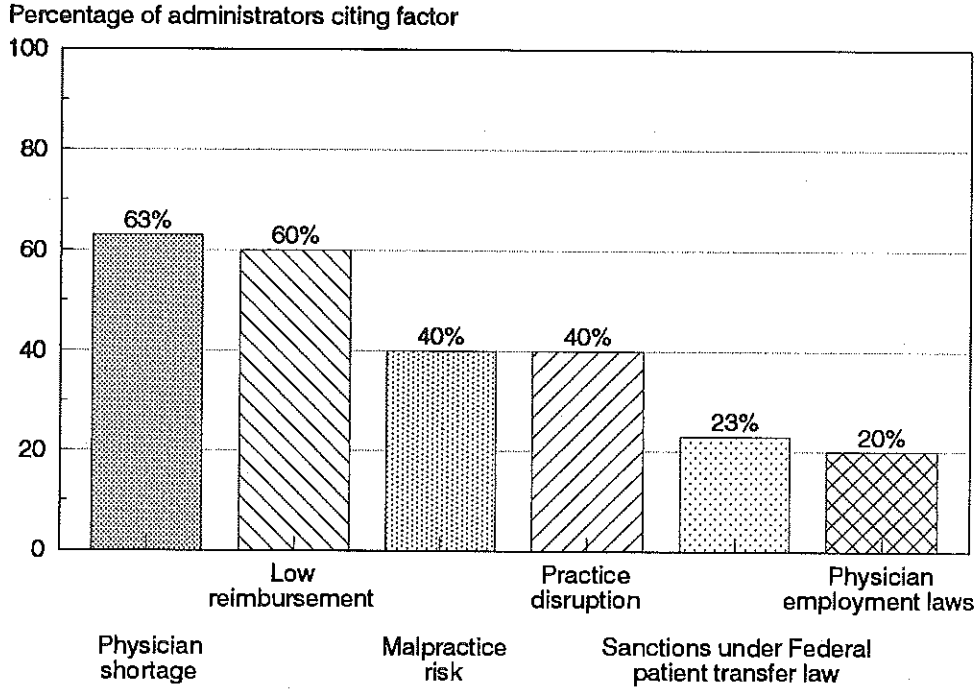
Once again, OIG found that hospitals close because of interrelated pressures from declining occupancy, lagging revenues and rising costs. Emergency and inpatient medical care are available within 20 miles of most communities where hospitals closed; however, some rural residents had to travel more than 30 miles. (OEI-04-91-00560)

State Prohibitions on Hospital Employment of Physicians

The OBRA 1990 required OIG to study State laws that prohibit hospitals from employing physicians and how these laws affect the availability of trauma and emergency care for patients. Such laws, which derive from statutes limiting the practice of medicine to licensed practitioners, necessitate that hospitals develop a contractual arrangement with a physician or group of physicians.

The OIG found that these prohibitions are not a major national problem; only five States prohibit hospitals from employing physicians, and in these States certain types of hospitals are exempt. The study, which included a survey of hospitals administrators, did note that respondents indicated some adverse impact of these laws. For example, 38 percent of hospitals administrators from the 5 States indicated that the statutes result in additional legal, recruitment and administrative costs. However, other factors were cited as more important limitations on their ability to provide specialty coverage, as illustrated in the following chart. (OEI-01-91-00770)

FACTORS AFFECTING HOSPITALS' ABILITY TO ASSURE SPECIALTY EMERGENCY COVERAGE



Reimbursement of Hospital Admissions Not Requiring an Overnight Stay

This follow-up audit found that HCFA's actions to reduce the volume of 1-day admissions on a nationwide basis have not been effective nor have they solved the problem of inappropriate admissions. The volume of 1-day admissions has increased substantially since the 1985 levels reported in the previous audit, with increases of 158 percent for 1988 and 142 percent for 1989. If the admissions with no overnight stay had been reimbursed at the lower of either the charge or the diagnosis related group payment amount, the potential savings would increase from the $118 million per year initially reported to over $200 million annually for 1988 and 1989. The OIG review indicated that nearly 37 percent of the admissions in the sample did not contain sufficient information to warrant a hospital admission.

The OIG recommended that HCFA initiate the necessary actions to implement the previous OIG recommendations. The HCFA should initiate legislation to define a hospital admission as encompassing an overnight stay, and consider payments of these hospital services without an overnight stay as an outpatient service. If HCFA decides that outpatient observation services and intensified peer review organization (PRO) reviews are the more appropriate

methods to reduce unallowable 1-day admissions, OIG recommends that HCFA submit a corrective action plan to: implement the revised instructions for outpatient observation services; provide the resources and funds to implement a program for the PROs to perform focused reviews of admissions not requiring an overnight stay; and provide for the monitoring and evaluation of the effectiveness of implemented corrective actions. (CIN: A-05-92-00006)

Medicare Secondary Payer: Effectiveness of First Claim Development

Performance Indicator

The HCFA requires carriers to send a letter to each beneficiary who is age 65 or 66 when the first Medicare claim is submitted on his or her behalf to ask for current employment and insurance information. If there is an indication of a primary insurance source, additional information is requested to establish primary liability. No claim is to be paid until complete information is received.

The OIG found that approximately 6.4 percent of the first claims developed by the carriers successfully identified primary payment sources other than Medicare, and there was a great variance in how carriers conducted the first claim development process and how HCFA's instructions were interpreted. In addition, HCFA instructions provide that all claims on behalf of disabled beneficiaries be processed and paid without delay, resulting in the need for postpayment recovery where a primary payment source is later identified.

The OIG recommended that HCFA obtain data to evaluate each carrier's reporting of first claim development activities and assure compliance with all first claim development procedures. Further, OIG recommended that HCFA collect health insurance information for disabled beneficiaries during the required 2-year waiting period before Medicare entitlement so as to establish their health insurance situation in advance. (OEI-07-90-00763)

AEtna's Compliance with Working Aged Provisions of the Medicare Secondary Payer Program

Performance Indicator

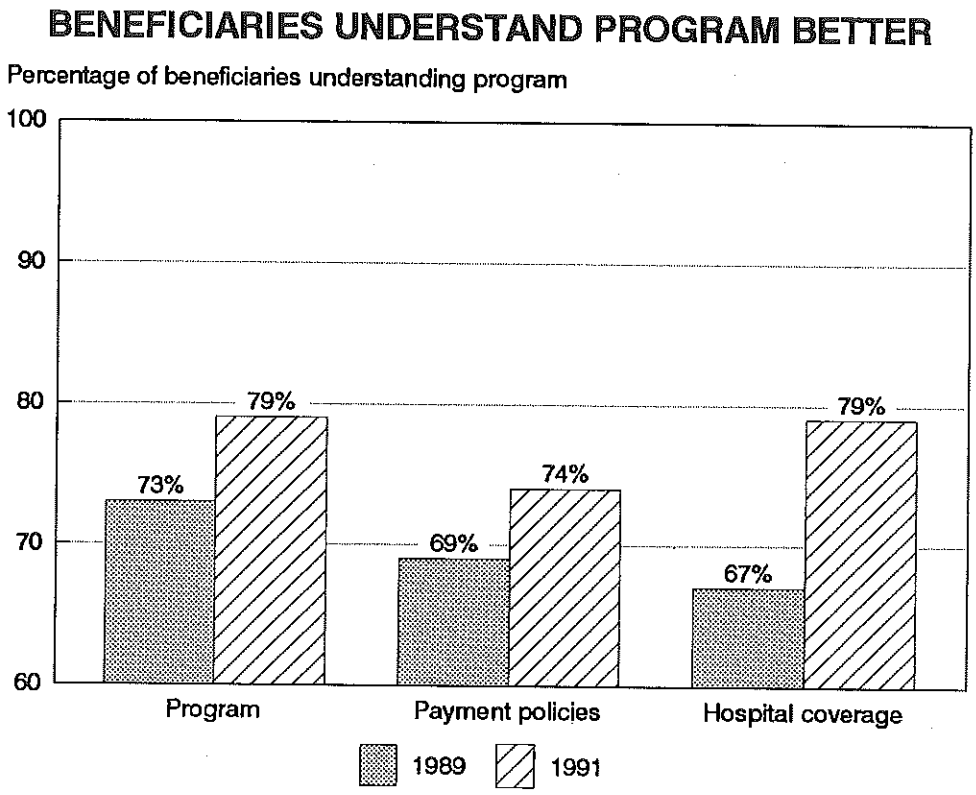
The Medicare secondary payer program requires that Medicare be the secondary payer for hospital and medical services involving beneficiaries age 65 and older who are covered under employer group health plans (EGHP) based on their own employment or that of their spouses. An OIG audit identified nearly $1.5 million in potentially erroneous Medicare payments for the sampled customers. The mistaken Medicare payments occurred primarily because beneficiaries did not always give the providers of service accurate information on their or their spouses' EGHP coverage and employment status. As a result, EGHP coverage was not always identified or billed to the appropriate payer, AEtna. To a lesser extent, OIG found instances of clerical errors in the coordination of benefit payments between AEtna and Medicare. Such internal weaknesses caused both Medicare and AEtna to pay as primary payer. This resulted in duplicate payments or inappropriate secondary payments.

The OIG proposed that AEtna continue to work with its customers to ensure that adequate and accurate information on health coverage billing is provided. In addition, OIG recommended that AEtna continue efforts to correctly reprocess the identified $1.5 million in potentially erroneous Medicare payments, and work with HCFA toward a settlement of the additional $12.1 million in potentially mistaken Medicare payments for customers not included in the sample. (CIN: A-01-90-00509)

Medicare Beneficiary Satisfaction: FY 1991

Performance Indicator

In a survey conducted to assess beneficiary experience and satisfaction with various aspects of the Medicare program, OIG found overall satisfaction very high. As compared to the findings of a similar 1989 OIG survey, and as illustrated by the following chart, a significantly greater percentage of beneficiaries indicated that they found the program, its payment policies and hospital coverage provisions to be understandable.



Ninety percent of respondents indicated that they were able to get information about Medicare when they needed it; 93 percent were satisfied with the way Medicare processed their claims; and 84 percent of those who called carriers were satisfied with the service they received.

However, 67 percent of beneficiaries cited some problem, such as difficulty in understanding what Medicare paid on their claims and why, and frequent busy signals or being put on hold for long periods when calling carriers. In addition, OIG noted that few beneficiaries were aware of, or made use of, special Medicare offerings, such as reports on hospital mortality data and nursing home inspections.

In a related survey, OIG found that nearly three-quarters of beneficiaries had not made adequate plans for nursing home care should they need it. This was identical to the result obtained in the 1989 OIG survey. (OEI-04-90-89030; OEI-04-90-89031)

South Florida Health Maintenance Organizations

Performance Indicator

At HCFA's request, OIG conducted a review to determine if any problems existed in the marketing and enrollment practices of health maintenance organizations (HMOs) in South Florida. The OIG found that the HMO market in the Miami area is unique in terms of the number of elderly and the number of Medicare-contracted HMOs. Because of this and the similar benefits offered by the various HMOs, marketing of the programs is highly competitive.

The OIG found that while the programs are basically being operated correctly, practices are not always in accordance with HCFA guidelines. Some enrollments do not represent informed choices and beneficiaries do not always understand the "lock-in" concept. The OIG recommended that HCFA: establish standards for training and monitoring of salespeople; impose a cooling off period to allow beneficiaries to reconsider enrollment decisions; limit enrollment to one open season per year; test the efficacy of having a third party handle enrollments; and implement an on-line system to identify and review cases of frequent enrollment change. The HCFA believes that only the on-line system is warranted at this time and that the problems identified are not widespread enough to merit major changes. (OEI-04-91-00630; OEI-04-91-00640)

Organ Acquisition Costs

Performance Indicator

In a follow-up to two earlier studies, OIG issued a report urging HCFA to address the increasing costs of organ acquisition. This report reiterated prior recommendations which received the support of the Public Health Service and the professional community because: the inefficiencies described in the prior reports continue to exist; fiscal oversight of organ procurement organizations is still limited and uneven; and kidney acquisition costs per transplant appear to be much higher than previously assumed.

The recommendations included: support demonstration projects incorporating kidney transplantation and acquisition under a diagnosis related group; conduct priority audits of kidney acquisition expenditures of renal transplant centers; establish uniform fiscal oversight of the organ acquisition costs of all Medicare-certified organ procurement organizations;

establish, for reimbursement purposes, a standardized nomenclature of pretransplant laboratory tests; and allow for only one Medicare-certified laboratory for pretransplant testing in each organ procurement organization service area. (OEI-01-88-01331)

Preprocedure Review Costs for Carotid Endarterectomy

Performance Indicator

Until October 1, 1991, PROs conducted preprocedure reviews for carotid endarterectomy, a surgical procedure designed to reduce blockage of one or both carotid arteries. The HCFA has now eliminated this requirement. Based on a review of preprocedure requests, reviews and denials, OIG found that PROs rarely denied preprocedure requests for carotid endarterectomies and costs to conduct the reviews significantly outstripped savings from surgery denials. During 1990, PROs spent approximately $1.4 million to save an estimated $617,000 from surgery denials. The HCFA's decision to eliminate the across the board requirement for preprocedure review for this surgery is consistent with these findings.

The OIG will continue its work on carotid endarterectomies. The low number of PRO denials, which accounts for the lack of savings from preprocedure review, could be the result of poor performance by PROs or a low incidence of unnecessary surgery. The latter could, in turn, result from the sentinel effect of PRO reviews. Future OIG reports will examine the PROs' review criteria as well as scientific studies on the need for and efficacy of carotid endarterectomy. The OIG will consider whether any kinds of special reviews, including perhaps more effective forms of PRO preprocedure review, are warranted. (OEI-03-91-00152)

Educating Physicians Responsible for Poor Medical Care: a Review of PRO Efforts

Performance Indicator

The value of educational actions that PROs direct to physicians responsible for poor medical care is uncertain, according to an OIG review of PRO efforts. The OIG also found that PROs face basic constraints that limit the effectiveness of their educational efforts. These include: insufficient information about the physicians and their problems; the conflict between the PROs' oversight and educational roles; and a lack of remedial education programs to which the physicians could be referred.

The OIG recommended that HCFA issue regulations or, if necessary, seek legislation that would require the PROs to share information regarding quality of care problems and associated educational interventions with those hospitals where the problems occurred. The OIG also recommended that HCFA mandate that the PROs take into account a physician's prior quality of care problems before developing an education plan. (OEI-01-89-00020)

Minimizing Restraints in Nursing Homes: a Guide to Action

Since October 1990, nursing homes have had to comply with a new Federal mandate stating that nursing home residents have the right to be free from physical and chemical restraints not required to treat their medical symptoms. This mandate is part of a series of reforms intended to improve the quality of care in nursing homes that was enacted by the Congress in the OBRA 1987.

In carrying out the new requirement, nursing homes have faced many operational challenges involving the dynamics of altering long standing practices. Changing policies regarding the use of restraints involves introduction of new routines and ways of thinking about the care of nursing home residents. This report is a practical reference guide for nursing homes, and contains the lessons learned by seven nursing homes engaged in reducing the use of physical and chemical restraints. Lessons are divided into three main categories: establishing a commitment to restraint reduction, reducing restraints and maintaining a restraint-free home once restraints have been reduced. (OEI-01-91-00840)

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 908 sanctions, in the form of exclusions or monetary penalties, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. The majority of the exclusions were based on loss of license to practice, conviction of program-related crimes, or conviction of controlled substance abuse or patient abuse.

A. Patient and Program Protection Sanctions

The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health, and Block Grants to States for Social Services programs. Exclusions can now be made for conviction of fraud against a private health insurer, obstruction of an investigation and controlled substance abuse, as well as for revocation or surrender of a health care license. Exclusion is mandatory for those convicted of program-related crimes or patient abuse. During this reporting period, OIG published final rules clarifying and implementing provisions of the Act. In particular, they clarify definitions and lengths of time for mandatory exclusions and various types of permissive exclusions, as well as technical and other changes to OIG's civil monetary penalty (CMP) authorities. They also consolidate the hearings and appeals procedures regarding exclusions, and clarify OIG's testimonial subpoena authority in investigations related to sanctions. The final rule should improve protection of beneficiaries from unscrupulous and incompetent health care providers.

The OIG reviews all factors involved in a case to determine whether an exclusion is appropriate and, if so, the proper length of the exclusion. Factors reviewed include

information solicited directly from the provider and information obtained from outside sources such as courts, licensing agencies or other Federal or State programs. Once a decision has been made to impose an exclusion, the provider is given notice and advised of the right to request a hearing before an administrative law judge (ALJ). If the provider is dissatisfied with the ALJ's decision, he may request a review by the Appeals Council. If he is still dissatisfied after this review, he may take his case to District Court. The following sanctions, among those imposed during this reporting period, were implemented after the providers' due process rights were honored.

- The heads of a Massachusetts HMO and a Texas systems company, and the systems company itself, were excluded for 15 years after conviction in a bribery scheme to award a $20 million contract to the systems company.

- In New York, a podiatrist was excluded for 12 years for providing Medicaid patients with cheap prefabricated devices rather than the custom-made orthopedic footwear they required. Over a 6-year period, his actions resulted in over $140,000 in damages to the Medicaid program.

- A New York pharmacist, convicted of acquiring $1 million by billing Medicaid for drugs never dispensed, was excluded for 15 years.

- A program assistant at a Texas State school for retarded persons was excluded for 20 years for physically abusing some of the residents.

- A Texas physician was excluded indefinitely after his medical license was revoked. He had been diagnosed as polydrug cross-dependent on anabolic steroids, marijuana, cocaine, amphetamines and alcohol.

- A registered nurse was also excluded indefinitely after the licensing board in Texas revoked her license. The board found that she failed to administer medications or treatments in a responsible manner because she had injected a patient with medication when the patient's medical records indicated an allergy to it.

- Another nurse was excluded indefinitely after the Texas Department of Human Services suspended her from its health care programs for stealing medications.

- A Missouri physician was excluded indefinitely because of termination from participation in the Medicaid program. She had falsified information on her application to be a Medicaid provider of services.

- A New York dentist and his corporation were excluded for 10 years after being convicted of billing Medicaid over an 8-year period for costly dental services which were not rendered to Medicaid patients.

- Two optical companies, one in New Jersey and the other in New York, were excluded for 8 years because their owner was convicted of a crime related to the Medicaid program.

- The owner of a Kentucky ambulance company was excluded for 3 years after conviction for harassing a witness.

- A secretary/bookkeeper at a Florida convalescent home was excluded for 3 years because of a conviction for taking patient funds.

- Convicted of illegal distribution of drugs in three of the four categories under The Controlled Substances Act, a Minnesota pharmacist was excluded for 3 years.

- A Virginia physician convicted of unlawful distribution of controlled substances was also excluded for 3 years.

- An Idaho nurse's aide was excluded for 20 years for raping an elderly patient with Alzheimer's disease.

B. CMPs for False Claims

Under the CMP authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false claims to the Medicare and State health care programs. The CMP law, therefore, allows recoupment of some of the monies lost through illegitimate claims, but it also protects health care providers by affording them due process rights similar to those available in the administrative sanction process. Many providers, however, elect to settle their cases prior to litigation. The OIG recouped approximately $11.2 million through CMP settlements and hearings decisions during this period, of which the following are examples:

- Two corporations signed a settlement agreement in Illinois for $3.5 million after submitting billings for supervised kidney dialysis of critically ill patients when only routine backup maintenance was provided for hospitalized beneficiaries. As a result, the corporations overcharged Medicare $1.75 million over a 2-year period. They agreed to pay that amount immediately and another $500,000 within 5 years, and to provide at

no cost $1.25 million in medical care to Medicare patients over a 5-year period.

- A settlement was reached with the Medicare PRO for the State of California. The terms of agreement included payment of over $1.6 million to the Government and another $335,000 to be paid to the two persons who initiated the qui tam lawsuit. The PRO also agreed to implement a contract integrity program to assure that any incidents which might be related to improper fulfillment of its contract obligations with the HCFA will be reported promptly to OIG. The PRO had engaged in "auto-certing" -- fraudulently certifying completion of medical reviews.

- An Iowa anesthesiologist agreed to a $500,000 settlement for routinely billing Medicare an extra hour and a half for every open heart surgery in which he participated. In addition, his nurse anesthetist brother had similarly overbilled, and the anesthesiologist had frequently failed to supervise him. He was excluded from participation in the Medicare and Medicaid programs for 2 years.

- An eye care center in Connecticut agreed to pay $425,000 in settlement of false Medicare claims. The center was overpaid $104,000 because of claims submitted on its behalf by a billing and auditing service. The billing service submitted duplicate claims, frequently by billing separately parts of a procedure which Medicare had already reimbursed as a whole.

- An Iowa physician set up a cardiac rehabilitation clinic to provide exercise therapy to cardiac patients. Services billed to Medicare were provided by physical therapists, nurses and other paraprofessionals. The OIG determined that none of these services were covered under Medicare because the clinic failed to provide physician supervision of the services as required by regulation. The physician agreed to pay $348,775 in restitution, penalties and interest in order to resolve his CMP liability.

- In Missouri, a DME company agreed to pay $250,000 for false billings to the Medicare program for diabetic monitors and supplies. In addition, the company agreed to institute certain procedures in order to prevent Medicare fraud, abuse, and false billings, such as preparing an annual audit work plan for determining the accuracy and validity of billings, and implementing a training program for employees involved in preparing or submitting bills.

- In Pennsylvania, five hospitals agreed to pay $164,500 in civil penalties and restitution for submitting improper claims to the State's Medicaid program.

The hospitals were found to be submitting claims for certain laboratory services which either were not covered by Pennsylvania Medicaid or had already been reimbursed to the hospitals under another procedure code.

Medicare Parts A and B: Administrative Costs

The OIG found that Associated Insurance Companies, Inc. charged Medicare $2.5 million in unallowable costs for its administration of Parts A and B of the program for the 2-year period ended September 30, 1986. The HCFA generally concurred with OIG's recommendations for financial adjustment and procedural improvements. (CIN: A-05-92-00026)

Criminal Fraud

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

- A Florida chiropractor was sentenced to 5 years in prison and restitution of $1,676,686 for defrauding Medicare, the Railroad Retirement Board and private insurers. The owner of several clinics, the chiropractor hired foreign-trained doctors whom he required to order x-rays, diagnostic tests and other therapies regardless of the needs of the patients. He also billed for tests never given, such as pelvic x-rays, and submitted duplicate claims for the same services.

- In Missouri, a man and his sister were sentenced for defrauding Medicare and private insurance of at least $4.5 million. Both Russian immigrants, the two operated clinics through which they advertised diagnostic testing at no cost to the patients, then billed Medicare and private insurers. The sister pled guilty to fraud, but the brother fled to the then Soviet Union. In one of its first actions as a new member of Interpol, the Soviet Union honored an extradition request and returned the man for trial. He was sentenced to 25 months in prison. The sister received a probationary sentence because she was merely a bookkeeper and had few financial resources.

- In Ohio, a man was sentenced in State court to 3 years in prison for practicing medicine without a license. For about 14 months the man posed variously as a psychoanalyst, urologist, gynecologist, surgeon and general practitioner. He worked undetected in four hospitals in the area, giving emergency room treatment, performing minor operations, administering hypodermic injections, and performing gynecological examinations on numerous patients, including Medicare beneficiaries. The court ordered

him to pay fines and restitution totaling $14,000, and to cooperate with State and Federal authorities in identifying patients he treated and the treatment he gave each. He now faces Federal charges related to his obtaining expensive automobiles and other goods under the false pretense of being a physician.

- A Pennsylvania podiatrist was sentenced to 8 to 23 months in county prison for falsely billing Medicare, Medicaid and private insurance plans. The podiatrist had pled guilty to 23 counts of Medicaid fraud and 2 counts of theft by deception, one of which included 109 instances of Medicare fraud. He was also fined $15,000 and ordered to make restitution of $40,150, which does not include Federal repayment currently being sought in civil proceedings. He billed for surgery on patients on whom he only performed routine foot care.

Carrier Shopping

This OIG report described problems with HCFA's claims processing policy on determining carrier jurisdiction for durable medical equipment, prosthetics, orthotics and medical supplies (DME/POS). Under this policy, known as point of sale, suppliers submit their claims to the carrier servicing the geographic area where the beneficiary's order for medical supplies is received. In 1989, this policy may have resulted in excess Medicare payments totaling at least $22 million for medical supplies alone. This point of sale policy compromises Medicare program safeguards and exposes the program to fraud and abuse. The OIG recommended that HCFA have bills for DME/POS submitted to the carrier having jurisdiction over the beneficiary's home rather than the point of sale. The HCFA concurred with the recommendation and has thus issued a proposed rule (56 FR 56612) which will implement this change. (OEI-05-91-00043)

Fraud Involving DME

Fraud in the DME industry is a continuing major concern to OIG. Seat lift mechanisms, transcutaneous electrical nerve stimulators, oxygen equipment, home dialysis systems and similar equipment are reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers throughout the country circumvent this requirement through aggressive sales practices, tricking physicians into signing authorizations and even forging their signature. Some suppliers simply bill for items never delivered; others bill carriers in States which pay high Medicare reimbursement, regardless of where the sale took place.

The results of OIG investigations and recommendations over the years, as well as several congressional hearings, have made it clear that reforms are needed in the Medicare payment system for DME. Recently, HCFA published a notice of proposed rulemaking (56 FR

56612) which would establish some of these reforms. The new regulations would reduce the number of carriers processing DME claims and would require that claims be submitted to the carrier serving the area where the beneficiary lives. They also would require suppliers to report ownership, sanction, conviction and other information before being issued a provider number that allows them to submit claims. These changes should eliminate the current practice of "carrier shopping" to obtain highest reimbursement. They also should allow HCFA to exercise better control over provider numbers.

In the meantime, OIG efforts to uncover fraudulent DME sales practices continue unabated. The OIG has gathered all its DME cases into a single project to assure coordination of the various DME investigative activities as well as focusing attention on this important and expensive industry. The following actions are some of the results achieved during this period:

- In Pennsylvania, a regionwide series of investigations was launched into the marketing practices of DME suppliers. Thus far, two companies, four owners and officers, and five salesmen have been charged with fabricating test results and/or forging physician signatures on certificates of medical necessity. The resulting Medicare overpayment totaled more than a million dollars. All have pled guilty and are awaiting sentencing. Others are expected to be charged.

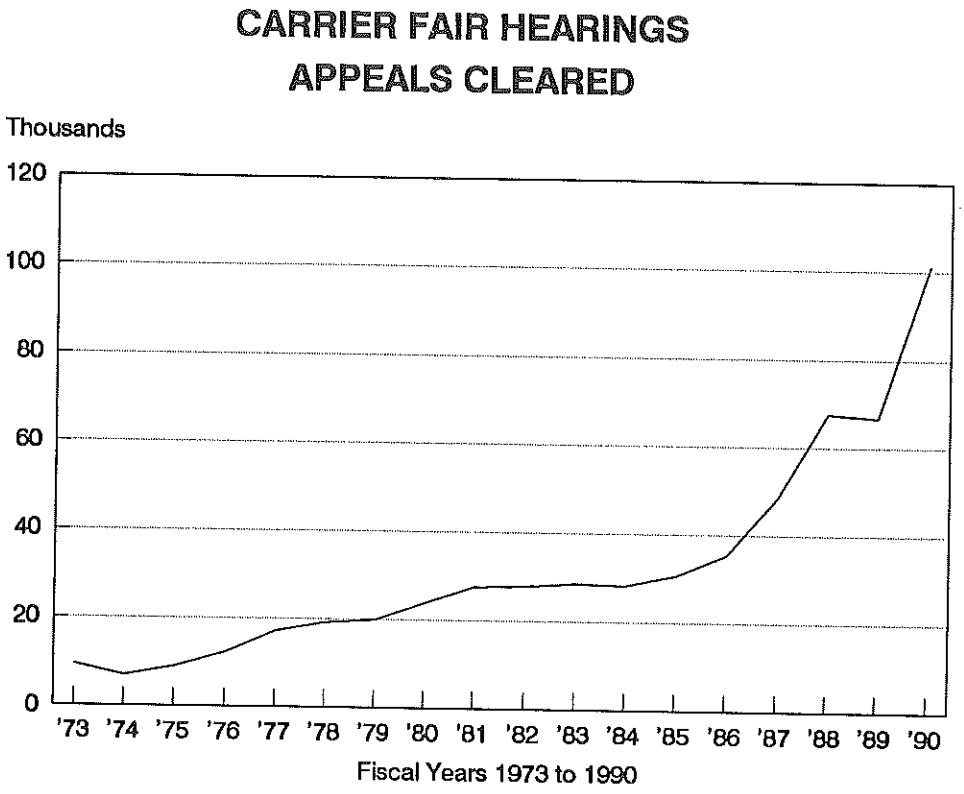
- In Florida, another series of investigations is bringing to justice physicians, middlemen and DME companies involved in selling and buying certificates of medical necessity. One physician has already been sentenced to prison for selling the certificates for patients he neither examined nor treated, knowing full well they would be used in filing Medicare claims. Other individuals and companies are under indictment, and further indictments are anticipated.

- The owner of a DME company in New York was sentenced for Medicare fraud to 5 months in jail, 5 months home detention and 2 years probation. She also was ordered to pay $100,000 in restitution, and she and the company were fined $15,500. The fraud consisted of falsifying blood tests to justify claims for oxygen equipment and inflating hours of oxygen use to obtain higher reimbursement.

Fair Hearings Process

Medicare carriers contract with HCFA to process and pay claims under the Medicare Part B program. A claimant may request a fair hearing by the carrier on a disputed claim if the amount in question is $100 or more, or if payment is not made promptly. The OIG found that, while the $100 threshold for a fair hearing has not changed in the past 18 years, there

have been substantial increases in related measures, such as medical and general costs and administrative costs. Accordingly, the threshold is no longer achieving its intended purpose of precluding hearings for negligible dollar amounts. As illustrated in the following chart, the effect has been a skyrocketing fair hearings workload.



The OIG recommended that HCFA seek legislation to increase the threshold for a fair hearing and those for subsequent levels of appeal, and require carriers to adjust reported cost savings for fair hearings reversal decisions. The HCFA agreed with the recommendations and the Department has approved a legislative proposal that would implement the OIG recommendations. (OEI-07-89-01680)

Medicare Part B: Administrative Costs

A. Nationwide Mutual Insurance Company

The OIG found that administrative costs claimed by Nationwide Mutual Insurance Company for the period October 1, 1986 through September 30, 1989 under Medicare Part B contained amounts recommended for financial adjustments of $3.3 million. The OIG recommended that Nationwide make appropriate financial adjustments in these amounts and make appropriate procedural improvements in relation to financial recommendations. The

auditee concurred with financial adjustments of approximately $710,000 and the procedural recommendations. The HCFA generally concurred with the financial and procedural recommendations. (CIN: A-05-91-00064)

B. Blue Cross and Blue Shield of Maryland

An OIG audit revealed that approximately $5.9 million of the $45.9 million costs claimed by Blue Cross and Blue Shield of Maryland (BCBSM) for administering the Medicare Part B program in the period October 1, 1984 through September 30, 1988 were unallowable. Because of BCBSM's practice of capping costs claimed, they did not actually claim all costs incurred. The OIG recommended that BCBSM make several procedural improvements. In addition, if HCFA decides to fund BCBSM based on amounts claimed rather than amounts budgeted, BCBSM should make a financial adjustment for all unallowable costs. (CIN: A-03-89-00046)

Medicare Contractor's Segmented Pension Cost

To ensure that a no profit, no loss principle is followed concerning pension plans and costs, Medicare contractors are required to treat Medicare as a separate segment for calculating and charging pension costs. An OIG review of Blue Cross and Blue Shield of Texas (BCBST) showed that the contractor identified four Medicare segments in 1981 using cost centers instead of responsible organizational units as specified in their contract. Their identification methodology understated the actuarial liability fraction of pension costs, resulting in understated assets for the Medicare segments.

The OIG recommended that Medicare's segmented assets be increased by over $550,000 for 1986. Medicare's pension assets were understated by another $880,000 in the updating of Medicare's segmented assets from 1986 to 1990. As of April 1, 1990, Medicare's pension assets should have been nearly $12.5 million rather than the $11 million that BCBST identified. Identifying the additional money as Medicare segment assets and using an acceptable actuarial cost method will result in lower Medicare pension costs in future years, and higher revisions/refunds to Medicare in the event of a pension plan termination or a termination of the Medicare contract. (CIN: A-07-91-00472)

Periodic Interim Payments Made by Blue Cross of Western Pennsylvania

The OIG found that Blue Cross of Western Pennsylvania (BCWP) erroneously made about $2.7 million in weekly payments to the 14 hospitals that were also receiving biweekly payments under the Periodic Interim Payment reimbursement method. With minor exceptions, all overpayments were made in June and July 1990. Since then, BCWP has done little to recover the overpayments and has failed to comply with Medicare recovery guidelines. As a result, less than $200,000 has been recovered, or about 6 percent of the $2.7 million owed to Medicare. Recommendations call for the recovery of outstanding

overpayments, which the U.S. Attorney's Office and OIG's Office of Investigations are in the process of collecting. (CIN: A-03-91-00033)

Medicare Part B: Radiology Services

This follow-up audit disclosed that Empire Blue Cross Blue Shield (Empire) took little action to recover $1.3 million in overpayments as previously recommended by OIG. In addition, HCFA failed to take sufficient monitoring action to ensure that the overpayments were recovered or that actions taken by Empire to preclude future overpayments were effective. The OIG recommended that HCFA institute more effective procedures to ensure the prompt recovery of overpayments and the adequacy of the corrective actions initiated by Empire. While agreeing that improvements were needed, HCFA did not agree that its monitoring was inadequate. (CIN: A-02-91-01025)

Portable X-Ray Services

Section 6134 of OBRA 1989 required that the Secretary conduct a study of the costs of, and payments for, portable x-ray services, which would include a recommendation as to whether payments for such services should be made under a separate fee schedule. The OIG study found that six of the nine carriers reviewed paid more for portable x-ray services during the fee schedule period than in the 6-month period prior to implementation of the fee schedule. However, with one exception, the additional payments were caused by errors in payments to suppliers and not the computation of the fee schedule rates. The OIG was unable to draw any conclusions regarding costs of providing portable x-ray services based on the limited data received from suppliers. The OIG concluded that if HCFA determines that a single fee schedule is warranted, either new procedure codes for portable x-ray services can be introduced or the transportation component for portable x-ray services can be adjusted to accommodate the difference in payment levels between the technical components of portable and other radiology services. (CIN: A-01-90-00517)

Medicaid Expansions for Prenatal Care: State and Local Implementation

Performance Indicator

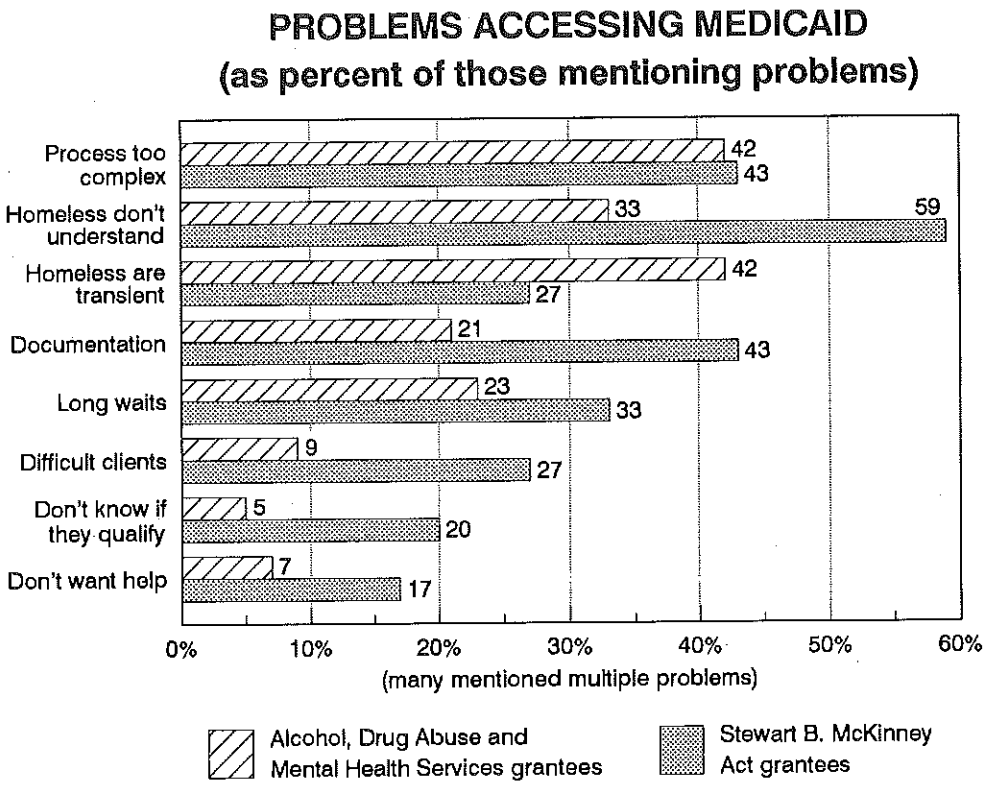
The OIG examined State and local efforts to implement eligibility expansions for Medicaid-covered prenatal care, and to overcome barriers to accessibility and availability of prenatal care. As of January 1991, many States had endorsed the optional eligibility expansions, with some States innovatively implementing the expansions. However, significant problems still prevent newly eligible women from receiving prenatal care. Some of these problems include: inadequate client outreach; cumbersome application processes; insufficient numbers of prenatal providers; difficulties with presumptive eligibility; and staffing shortages. The OIG also found inadequate data collection systems and evaluation processes to measure progress and outcomes.

The OIG recommended that HCFA develop a comprehensive outreach strategy; simplify and streamline the application process; generate incentives to increase provider participation, clarifying policy and monitoring implementation; extend data collection systems and evaluation processes to measure progress and outcomes; and establish a fully State-centralized authority to implement the expansions. (OEI-06-90-00160)

Medicaid and Homeless Individuals

Performance Indicator

The OIG examined how States use Medicaid to serve homeless individuals with alcohol, drug or mental health problems. The study found that Medicaid is important to this population because it widens access to primary care, and mental health and substance abuse services. However, the study also found that the close tie between Medicaid and SSI eligibility limits access to Medicaid for many of these homeless individuals. In addition, providers say that homeless individuals face numerous problems accessing Medicaid that they cannot overcome by themselves.



The OIG recommended that HCFA work with the Social Security Administration and the Public Health Service in various ways to address Medicaid access problems for homeless individuals. The OIG also recommended that HCFA provide technical assistance to States,

other Federal agencies and providers who serve homeless persons, and encourage them to develop special strategies to use Medicaid more effectively. (OEI-05-91-00063)

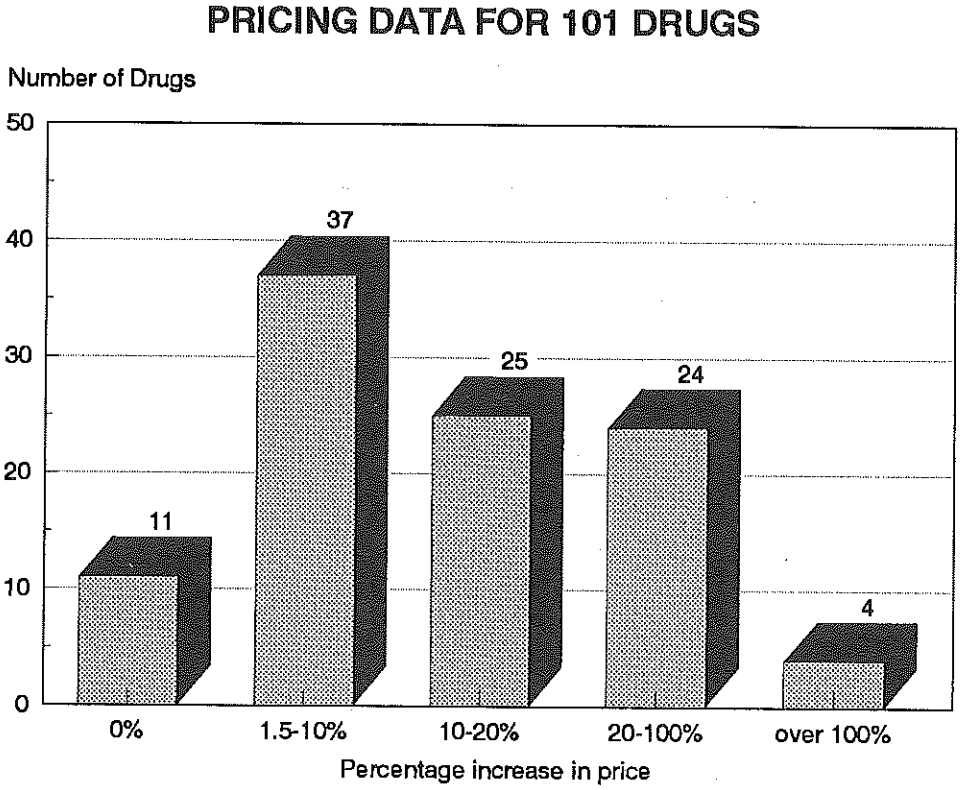
Medicaid Drug Rebates

The OBRA 1990 required that manufacturers provide rebates to States for drug purchases made by Medicaid recipients. The OIG conducted a series of studies dealing with manufacturers' drug pricing policies since passage of the Medicaid drug rebate legislation.

A. Impact of OBRA 1990: Best Price

Performance Indicator

In one study, OIG focused on the "best price" manufacturers charge customers. The best price is an integral part of the Medicaid rebate formula, and is defined to mean the lowest price available from manufacturers to any private, nonprofit or government entity. The OIG found that the drug manufacturers included in the study reacted to the legislation by increasing their drug prices, including best prices, to offset any revenue loss caused by the Medicaid drug rebate provision. Using a listing of 101 drugs commonly prescribed to Medicaid recipients, OIG determined that drug manufacturers had increased their prices for 90 of them, as illustrated in the following chart.



Using information from HCFA on best prices for 16 of the drugs on the listing, OIG found that manufacturers had increased the best price for 11 of them, with increases ranging from nearly 9 percent to over 90 percent.

The OIG recommended that a legislative proposal be made to redefine best prices on a constant basis, based on prices as they existed in October 1990 and adjusted for increases in the Consumer Price Index-Urban. In addition to eliminating the savings anticipated by the enactment of OBRA 1990, OIG believes that the price increases instituted by manufacturers may have a substantial impact on other public and private purchasers. (CIN: A-14-91-02057)

B. Need for Utilization Controls for Ulcer Treatment Drug

Performance Indicator

The OBRA 1990 requires State Medicaid agencies to provide prospective drug utilization review (DUR) programs by January 1, 1993. Such programs are intended to assess actual patient drug use against predetermined standards. In Arkansas, Medicaid DUR procedures have been used to detect misuse and abuse of prescription drugs covered under the Medicaid program. However, these procedures have generally been limited to after-the-fact analyses of drug therapy and are not as comprehensive as the OBRA 1990 requirements. The OIG found that about $1.27 million (over $940,000 Federal share) in cost savings could have been realized for Calendar Year (CY) 1989 had the State agency established DUR procedures to limit payments for certain ulcer treatment drugs to amounts paid for the manufacturers' recommended dosages. The OIG recommended that the State implement a prospective DUR program to limit the payment for all ulcer treatment drugs to the manufacturers' recommended dosages. (CIN: A-06-91-00001)

Limiting Payments for Selected Multiple-Source Drugs

The OIG issued a report on HCFA's inability to detect or prevent Federal overpayments to States for selected multiple-source drugs. States are required by Federal regulations to restrict Medicaid claims for selected multiple-source drugs to an aggregate upper limit established by HCFA. The OIG determined that in 4 of the 12 States reviewed, HCFA did not detect that the limit had been exceeded by approximately $10.8 million in the first year of the payment limit. The resulting overpayment by HCFA for FY 1988 is estimated at $6.6 million. Nationally, OIG projects that HCFA overpaid the States about $35 million in FY 1988.

The OIG recommended that HCFA report this finding as a material weakness under the Federal Managers' Financial Integrity Act; improve its internal controls by incorporating the OIG computer program designed to detect States' noncompliance and quantify overpayments into its oversight function; and consider adopting means by which States can be held accountable for violating Federal regulations. (CIN: A-03-90-00201)

Improper State Claims for Federal Medicaid Funds

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

A. Institutions for Mental Diseases

Medicaid law precludes Federal matching for patients under 65 years of age in institutions for mental diseases (IMDs). An exception is made for individuals under age 22 who are receiving inpatient psychiatric services in a psychiatric hospital. The OIG found that inappropriate Medicaid claims of over $6 million (over $3 million Federal share) were made from January 1, 1983 through April 30, 1988 for patients from 22 to 64 years of age in medical/surgical units of three IMDs operated by the State of Illinois. While the State took action to stop claiming funds for services to this group of recipients for periods after April 1988, no action was taken to identify and adjust for the unallowable claims made for earlier periods. The OIG recommended a financial adjustment of the overclaimed amounts. (CIN: A-05-91-00023)

In another review, OIG found that the State of Illinois improperly claimed $4.9 million for inpatient hospital services provided by State facilities to recipients under the youth psychiatric program. Medicaid payments were made for services during periods when the patients were no longer in the facilities or had turned 22 years of age. The OIG recommended recovery of the improper payments and a strengthening of controls to ensure compliance with Federal requirements. (CIN: A-05-91-00021)

B. Case Management Claims

The OIG found that for the period January 1, 1987 through June 30, 1990, Nebraska improperly claimed over $2.1 million in Federal financial participation (FFP) for case management services that had not been provided to the claimed individuals. This resulted from the State's use of an inappropriate methodology for claiming such services. The OIG recommended that Nebraska refund the more than $2.1 million in Medicaid FFP and make financial adjustments for any similar claims made subsequent to the audit. While Nebraska did not agree, HCFA concurred with all the recommendations. (CIN: A-07-90-00353)

C. Family Planning Services

Federal regulations provide for 90 percent payment for family planning services and the administration of such services. The OIG determined that New York State had claimed nearly $6.8 million in excess Federal reimbursement for services that were either totally or partially unrelated to the provision of family planning services. The OIG proposed that the State make a financial adjustment for the $6.8 in unallowable FFP claimed. In addition, OIG made recommendations for the correction of noted deficiencies in internal controls in the State's system to properly identify eligible services. (CIN: A-02-90-01029)

D. Ineligible Recipients

The OIG found that between February 1989 and January 1990, Maryland identified over 20,000 recipients who had been continued in the Medicaid program although they were no longer eligible. While these recipients were then removed from the Medicaid program, the State did not attempt to identify Medicaid payments for services provided to these individuals after their eligibility ceased, or to reimburse the Federal Government for the FFP associated with these payments. The OIG recommended that the State continue its efforts to improve internal controls over Medicaid eligibility; make a financial adjustment for the more than $1.2 million in FFP inappropriately claimed for CY 1988; and make additional financial adjustments for payments for services provided to these and other ineligible recipients for periods subsequent to CY 1988. (CIN: A-03-90-00232)

E. Less than Effective Drugs

Effective October 1, 1982, the Federal Government no longer pays for drugs identified by FDA as less than effective (LTE), or for drugs that are identical, related or similar (IRS) to them. The OIG determined that during the period January 1, 1986 through February 28, 1989, Texas was improperly reimbursed approximately $2.4 million in FFP for claims for LTE and IRS drugs. The OIG recommended that the State improve its drug identification procedures and make a financial adjustment of $2.4 million. (CIN: A-06-90-00101)

F. Short/Doyle Payments

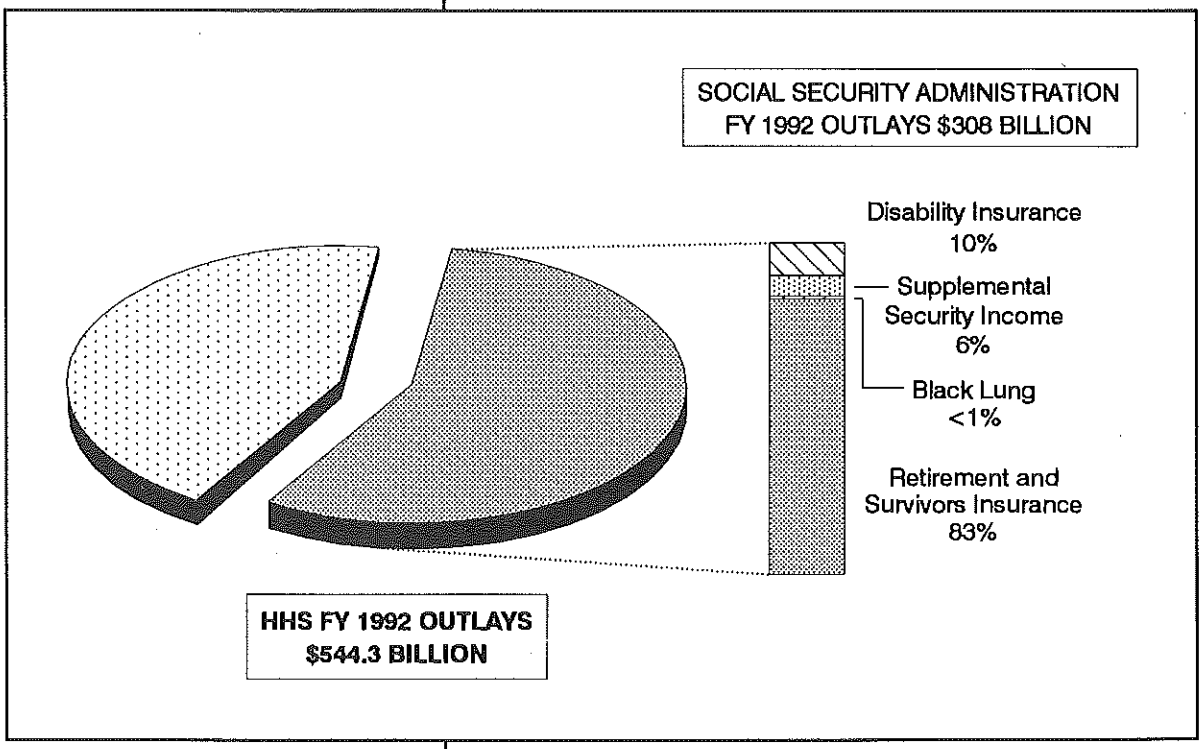
Short/Doyle is a special program serving the mentally ill in California. Prior OIG audits disclosed that California had overclaimed millions of dollars in Federal Medicaid funds due to accounting errors, and allowed a large backlog of unresolved audit exceptions to accumulate without refunding the Federal share.

An audit of San Francisco County disclosed that claims were made for unnecessary hospital care; services not provided, not documented or lacking physician involvement; and duplicates. The OIG estimated that almost 23 percent of the claims (between $3.1 million and $4.9 million) for the 2 fiscal years ended June 30, 1986 was unallowable for Federal Medicaid funding. (CIN: A-09-90-00089)

In another audit, OIG concluded that Short/Doyle expenditures in San Francisco County were 21 percent higher than reasonable allowances under the Medicare program for the same or similar services. Also, expenditures were 87 percent higher than the maximum permitted under California's regular Medicaid program. Much of the high cost of the program was for administrative and overhead expenses. The OIG recommended that the Department limit future Medicaid payments for Short/Doyle services to reasonable amounts. Regional Medicaid officials agreed to do so. (CIN: A-09-91-00076)

G. Alcoholism Treatment Facilities

Services provided by free-standing alcoholism treatment facilities (ATFs) are not available for Federal funding under Medicaid. The OIG found that New York State improperly claimed Federal reimbursement for five free-standing ATFs for periods after a federally sponsored demonstration project in which they participated had ended. The OIG recommended that HCFA recover $1.9 million in Federal overcharges and that the State establish appropriate controls to prevent future improper claims. (CIN: A-02-91-01030)



Social Security Administration

Chapter III

SOCIAL SECURITY ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

Fifty-seven years ago, the Social Security Act established a national insurance system that would be financed through payroll taxes collected from workers and employers and would pay benefits to workers in their old age. The Retirement and Survivors Insurance (RSI) program, and the Disability Insurance (DI) program, popularly called Social Security, are the largest of the Social Security Administration (SSA) programs. In Fiscal Year (FY) 1992, SSA will pay over $286 billion in cash benefits to more than 40 million beneficiaries. The program is financed almost entirely through payroll taxes paid by employees, their employers and the self-employed. Benefits are distributed to retired and disabled workers, spouses, certain divorced spouses, children and disabled children of retired and disabled workers. Benefits are also provided to widows and widowers, certain surviving divorced spouses, children and dependent parents of deceased insured workers.

The Supplemental Security Income (SSI) program is a federally administered, means-tested assistance program that provides a nationally uniform, federally funded floor of income for the aged, blind and disabled. Beginning January 1974, SSI replaced State and county run assistance programs for the aged, blind and disabled that were funded by a mix of Federal and State money. Federalization of assistance for these categories permitted the establishment of uniform eligibility criteria. In FY 1992, SSA will pay SSI benefits in excess of $19 billion to over 5 million recipients.

In addition, program expenditures under the Black Lung program will exceed $800 million. These monies pay eligible miners, their dependents and survivors. The SSA continues to administer certain claims, although administration of the program was transferred to the Department of Labor in 1973.

The Office of Inspector General (OIG) is reviewing a number of areas within SSA's programs and operations, such as client satisfaction with SSA services, the quality of service provided in SSA field offices, the disability determination process, procurement activities and systems modernization. An overall assessment of performance and program management has been conducted as well as an audit of SSA's financial statements.

Audit of SSA's FY 1991 Financial Statements

Fiscal Year 1991 marks the fifth year that OIG has audited and expressed an opinion on SSA's financial statements, and reported on SSA's system of internal controls and compliance with laws and regulations. The OIG found that problems persisted with SSA's accounting for receivables and property which precluded it from expressing an opinion on the fair presentation of those accounts in the financial statements. In addition, uncertainty continued as to the final amount of employment tax revenue that should be credited to the trust funds. It was also disclosed that the actuarial projections of income and expenses of the DI trust fund would likely differ significantly from more current actuarial projections that will be reported in the 1992 Board of Trustees' Report. However, because the actuarial projections will not be available for examination until after the issuance of the Trustees' Report, the impact on the DI trust funds could not be assessed. In OIG's opinion, except for the effects of these problems on the financial statements, SSA's financial position and results of operations are fairly presented in conformity with appropriate accounting principles.

In its report on internal controls and compliance with laws and regulations, OIG discussed the systems problems that caused it to qualify its opinion on the financial statements. With regard to the receivables, OIG recommended that SSA establish controls for overpayments and document the title II and title XVI overpayment accounting systems as part of its new debt management system. For the property accounting system, OIG recommended that SSA complete its reconciliation of its accounting records with the results of its physical inventory and remove from the records all property no longer owned. Finally, OIG recommended that SSA expeditiously seek congressional guidance on the methodologies and wage bases to be used in certifying employment tax revenues to the trust funds. (CIN: A-13-91-00206)

Review of Internal Control Activities: FY 1990

The OIG reviewed SSA's FY 1990 internal control activities in accordance with the requirements of the Federal Managers' Financial Integrity Act (FMFIA). The OIG evaluated administrative internal control areas (ICAs) of SSA's field offices, program ICAs in the program service centers and data operations centers, and a central office internal control review. The OIG concluded that SSA is in overall compliance with FMFIA, but further improvements are needed. The review showed that: the internal controls for an ICA at two locations were inadequate; management needs to provide a timely analysis of internal control review results so that pervasive problem areas can be addressed as soon as possible; the description of ICAs needs to be revised and updated to ensure that all control functions are included during reviews; one central office internal control review was unacceptable; and, in order to evaluate the effectiveness of new guidelines, SSA did not perform a complete financial management systems review of the SSI record maintenance subsystem as required by Office of Management and Budget Circular A-127. The SSA agreed with OIG's findings and recommendations. (CIN: A-13-90-00029)

Internal Controls at Field Offices

The OIG issued a report summarizing the results of its internal control reviews at 48 SSA field offices. These reviews evaluated the nonprogrammatic internal control areas of each office visited. The OIG found that the internal controls at the offices reviewed generally were in place and operating efficiently. However, OIG also determined that the operation of selected internal controls over cash disbursements and remittances at two offices was inadequate. Further, OIG identified 780 individual weaknesses in the control structure at the field offices, several of which were common to many of the 48 offices. In addition, OIG noted two areas where standard controls need to be implemented on a national basis. One of them concerns procedures for verifying the posting of Immediate Payments to an individual's account and is the subject of a more detailed OIG review. The other concerns the security of SSA offices during after-hours cleaning. The SSA agreed with OIG's recommendations and advised that measures are in process to implement them. (CIN: A-13-91-00302)

Debt Management System

Since May 1988, SSA has been working to design, develop and implement the debt management system (DMS) to control, account for and facilitate timely recovery of all programmatic debts due SSA. The DMS is being implemented at SSA in a series of incremental software releases which will continue for the next several years. At the Commissioner's request, OIG has participated as part of the project team in an oversight role.

In one report discussing SSA's progress, OIG determined that while some problems have been experienced, satisfactory progress has been made toward implementation of the new DMS. Completion of the releases to date has allowed SSA to report the resolution of four material weaknesses and software development for future releases is in progress. The DMS development is now entering a critical phase which will focus on replacement of the system which accounts for and controls Retirement, Survivors and Disability Insurance (RSDI) overpayments. The OIG concluded that the current plan and approach have worked well to date. (CIN: A-13-91-00010)

In a second report, OIG concluded that a number of objectives have been successfully completed. These include pilot testing new data entry screens for all RSDI debt management activities and some SSI activities, and producing data to support agency initiatives relating to selection of representative payees. Although completion of DMS objectives to date has been successful, OIG continues to be concerned that DMS developmental efforts have focused on screen-oriented, on-line processing. While the full implementation of the screens will be completed soon, much remains to be done. The complete replacement of the back-end processes for RSDI and SSI cases has not yet been scheduled. Without a complete replacement of the software which processes RSDI

overpayments and the modernization of the SSI debt management software, implementation of DMS will not be successful. The OIG is, therefore, recommending that SSA accelerate efforts to develop a comprehensive plan for replacing the RSDI and SSI back-end processes. (CIN: A-13-92-00216)

Multiple Payments to the Same Person at the Same Address

An earlier OIG review concluded that weaknesses in SSA's internal controls related to unauthorized multiple payments which resulted in overpayments. The OIG recommended that SSA recover the overpayments identified in 23 cases, and use OIG's computer programs as part of its internal controls to identify beneficiaries receiving unauthorized benefit payments. In a follow-up review, OIG determined that SSA had resolved the identified overpayments and had incorporated a modified version of OIG's computer programs in its duplicate payment detection module. The enhanced effectiveness resulting from OIG's programs brought about the identification of additional cases, with overpayments totaling $1.4 million and anticipated annual savings of $6.9 million. (CIN: A-04-91-03003)

Fraudulent Social Security Numbers

Departmental programs are directly affected by the criminal use of false Social Security numbers (SSNs), with cases ranging from fraudulent applications for SSNs to the receipt of SSA and Aid to Families with Dependent Children (AFDC) benefits under multiple false identities.

- An Ohio man used an assumed name and SSN to obtain benefits for himself, his wife and two children under the Medicaid, AFDC, food stamps and general assistance programs. By using the false SSN, he concealed the fact that he had been employed and was receiving State worker's compensation under his real name. He and his wife, who knew about the scheme, were ordered to pay $38,230 in restitution and fines. They were also sentenced to 6 months in jail, 5 suspended, and forbidden to apply for food stamps for 6 months.

- A Washington State man used his wife's SSN when he retumed to work in 1980 in order to continue receiving disability payments. He and his wife, and his employer and his wife, who had gone along with the scheme, had to repay $29,190 and were placed in a pre-trial diversion program.

- A Minnesota woman was sentenced to 6 months in jail for using false names and SSNs to collect welfare benefits in two States. For 2 1/2 years she made trips between Duluth, Minnesota and Chicago, Illinois to collect benefits for herself and her daughter under both their own and false names and SSNs.

- An African national who had been in this country for 10 years was sentenced to 6 months in prison for bribing a Federal employee to obtain SSN cards. After a security guard in a New York SSA office reported being approached by the man, an OIG agent assumed the cover of a corrupt SSA employee. Transactions were monitored in which the man paid the agent $330 for two cards. The man also was sentenced to pay a $5,000 fine and a $100 assessment.

In addition to their misuse in abusing departmental programs, SSN cards are basic documents used along with birth certificates and driver's licenses to create false identities. Persons involved in a wide range of crimes, from con men operating credit card scams to murderers trying to conceal their identity, almost invariably use fraudulent SSNs for concealment. During this period, convictions in cases worked by OIG in which use of false SSNs was a major factor involved more than $8 million in court-ordered fines, restitutions and recoveries. The actual cost of the use of false SSNs is certain to amount to billions of dollars, most of it being borne by taxpayer in higher prices in the marketplace.

Over the past few years, the proportion of OIG's investigative caseload involving SSN misuse has steadily increased. In California, several persons were found applying for Federal disaster relief benefits using false SSNs after the Loma Prieta earthquake, when they had suffered no earthquake-related property damage, did not reside at the address where damage occurred, or reported damage to buildings which did not exist. Also in California, at least seven persons, including an SSA employee, were sentenced in a single project for using fraudulent SSNs in credit card, bank loan and other crimes. In New York City, drug smugglers and sellers used false SSNs for box drops and money laundering. In another region, investigators following up SSA employees' leads on suspicious SSN applications identified at least 15 fugitives wanted for crimes ranging from child abuse to prison escapes.

The following cases are examples of SSN-related schemes involving other Federal and private industry funds:

- A man was sentenced in Ohio to 18 months in jail for misuse of an SSN and passing counterfeit checks. In 1989, the man opened a fraudulent checking account in an Ohio bank, obtained false identification documents and passed what appeared to be payroll checks at grocery stores. He and three confederates repeated similar criminal acts across the eastern United States, defrauding different persons of a total of about $1 million over the last year. When he was arrested in South Carolina, 24 law enforcement agencies were looking for him. In Ohio, he was also sentenced to make restitution of $16,000, pay a $50 assessment for each of the 18 counts to which he pled guilty, get a job when he is out of jail and undergo drug rehabilitation. He is

under indictment in North Carolina, however, and will go there next to face charges.

- In Virginia, a man was sentenced to 26 months in prison for filing 45 income tax returns claiming refunds totaling $210,000 under other people's names and SSNs. He was also ordered to pay $15,600 in restitution and serve 3 years supervised probation. The man had received $68,600 before certain similarities among the returns tipped off Federal authorities to his scheme.

- Two men were sentenced in Texas, one to 5 years imprisonment and the other to 9 months, for using false SSNs in a worker's compensation fraud scheme. The two used false identities and SSNs to gain employment with various oil drilling companies, then staged fictitious accidents in order to claim worker's compensation. The Worker's Compensation Commission could not disprove their claims because the two had pre-existing back conditions. Charged with SSN violations, however, both men pled guilty. They were ordered to pay a total of $19,600 in restitution, but they had illegally obtained an estimated $272,000 in benefits.

- A man was sentenced in Texas to 12 months incarceration for using fraudulent SSNs to obtain credit cards. He claimed to be a plastic surgeon earning $8,000 per month when he was actually an unemployed former professional wrestler. The man was ordered to make restitution of $10,844.

Fraud involving SSN is proliferating, but OIG investigative resources are finite. The point has come that some hard choices must be made. Since in most cases the use of a false SSN involves the commission of additional crimes, other law enforcement agencies often have primary investigative responsibility. The growth of this caseload may in the future require OIG to examine whether it should defer to these other entities and focus its limited budget resources more directly on the protection of the programs and trust funds of the Department of Health and Human Services.

Birth Certificate Fraud Update

A 1988 OIG report recommended specific fraud prevention activities to be undertaken by agencies which issue birth certificates and by agencies which receive them to verify the eligibility of applicants. In a follow-up inspection conducted at SSA's request, OIG found that the nature and extent of birth certificate fraud appears to be relatively unchanged since 1988. Incremental improvements were noted among issuing agencies, such as the use of safety paper and the sharing of death certificates. However, major weaknesses in issuing agencies continue to hamper the ability of receiving agencies to rely on birth certificates as

evidence of eligibility, and efforts among Federal and State agencies to prevent birth certificate fraud lack coordination.

The OIG noted that SSA has taken steps in the last few years to prevent the use of fraudulent birth certificates by applicants in obtaining SSNs or SSA benefits. These efforts include: use of a computerized fraud detection system; implementation of a system to allow parents and legal guardians of newborns to obtain SSNs at the time of birth; and initiation of program integrity studies. (OEI-02-91-01530)

Payment Accuracy Rates

Performance Indicator

In a follow-up to a 1987 report by the General Accounting Office (GAO) entitled Payment Accuracy Rates Are Overstated, OIG reviewed the actions taken by SSA in response to the GAO recommendations. The GAO had proposed that SSA report: case accuracy rates as well as dollar accuracy rates, all errors detected during the sample period and the incidence of errors attributable to SSA. The OIG found that SSA did not report case accuracy rates for the most recent reporting period; the Department did not agree to GAO's recommendation to report errors under $5 and those barred to correction under the rules of administrative finality; and SSA did report the incidence of errors caused by SSA. The SSA advised that it did not report case accuracy rates for the most recent reporting period as a result of an administrative oversight, and that it would provide FY 1990 RSI case accuracy rates to the Congress. (CIN: A-13-90-00035)

Crediting Earnings to Individuals' Records

The OIG followed up on recommendations in a GAO report entitled Social Security: More Must Be Done to Credit Earnings to Individuals' Accounts, which found that, for tax years 1978 through 1984, $58.5 billion more in wages were reported to the Internal Revenue Service than to SSA. The OIG found that SSA, in response to GAO's recommendations, had done a great deal to reduce future employer reporting errors and eliminate existing backlogs of unreconciled differences. However, still needed is resolution of any adjustment to the Social Security trust funds which may be necessary after completing the resolution of the individual reporting differences. The OIG recommended that SSA seek congressional guidance in an expeditious manner regarding the methodology to be used to determine the wage amounts to certify to the Department of the Treasury. (CIN: A-13-90-00043)

Unreported Worker's Compensation Payments

The Social Security Act requires that, under certain conditions, Social Security disability payments must be reduced or offset based on receipt of worker's compensation (WC) payments. The SSA relies on the injured workers to report WC payments (actual or potential) when they apply for Social Security disability payments. The OIG found that a significant number of beneficiaries failed to report receipt of WC, and that failure resulted in overpayments of Social Security benefits totaling $11.7 million annually. In addition, SSA

did not detect or properly code all WC cases. The OIG concluded that SSA could reduce overpayments by establishing information exchange agreements with States to complement the current method of self-reported WC information. The OIG recommended that pilot studies be conducted and, if found to be cost-effective, that SSA then pursue data exchange agreements with the States and legislation requiring the data exchanges. (OEI-06-89-00900)

Disability Benefits Fraud

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

- In New York, a man was sentenced to 1 year in prison for concealing work to obtain disability and WC benefits. He had been receiving Social Security disability checks for himself and his family since 1982. He was also receiving Federal WC benefits for an injury sustained while working for the Post Office. Investigation showed that he was working as a real estate agent and preparing tax returns at the same time he was receiving benefits. He was ordered to repay $21,408 in Social Security benefits and $71,390 in WC.

- The husband of an SSA employee was sentenced for concealing his work while receiving disability benefits, and the employee was placed by the court on a pre-trial diversion. The man, a disability beneficiary since 1984, was sentenced to 3 years incarceration, suspended, and 5 years probation. He was also ordered to repay $19,298 to SSA. His wife and representative payee had been employed by SSA for 18 years. She was placed on 60 days suspension by SSA.

- A Wyoming man was sentenced to 1 year probation and ordered to pay a $75,000 fine for making false statements to SSA to obtain disability benefits. From 1987 through 1990 he claimed to be retired from his construction company. During that time, he was photographed and videotaped while operating cranes and working on jobs.

Death Match Operation

The OIG determined that SSA's death match operation has improved SSA's processing of death records. However, the Death Alert, Control and Update System did not provide sufficient information to help management monitor death match performance or to detect errors. To correct this, OIG recommended that SSA build an appropriate management information system into future death match enhancements. The SSA should also correct and

continue to process certain rejected death records. In addition, death verification alerts should be generated for all suspended beneficiaries so their payments can be terminated appropriately. The SSA agreed to address OIG's recommendations in planned systems modification projects. (CIN: A-13-90-00046)

Fraud Involving Deceased Beneficiaries

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

- Six persons were indicted in Louisiana and complaints were filed against three others as a result of a match of death records against payments made to beneficiaries of SSA programs. Another person entered a pre-trial diversion program, and $92,390 was recovered from five other persons not prosecuted. Total benefits paid out in these cases amounted to more than $341,800.

- A woman in Oklahoma was sentenced to 4 months in prison for writing checks against SSA benefits deposited electronically into the account of a deceased uncle. The uncle died in 1985, but the woman never reported his death to SSA. Upon release from prison, she is to enter a home incarceration program and wear an electronic monitoring device for 120 days. She also must make restitution of $28,370.

- In New York, another woman must also wear an electronic bracelet on her foot for 4 months of home detention levied because she cashed Social Security checks mailed to her father after his death. She was also given 5 years to make full restitution of the $12,000 she obtained in this illegal fashion.

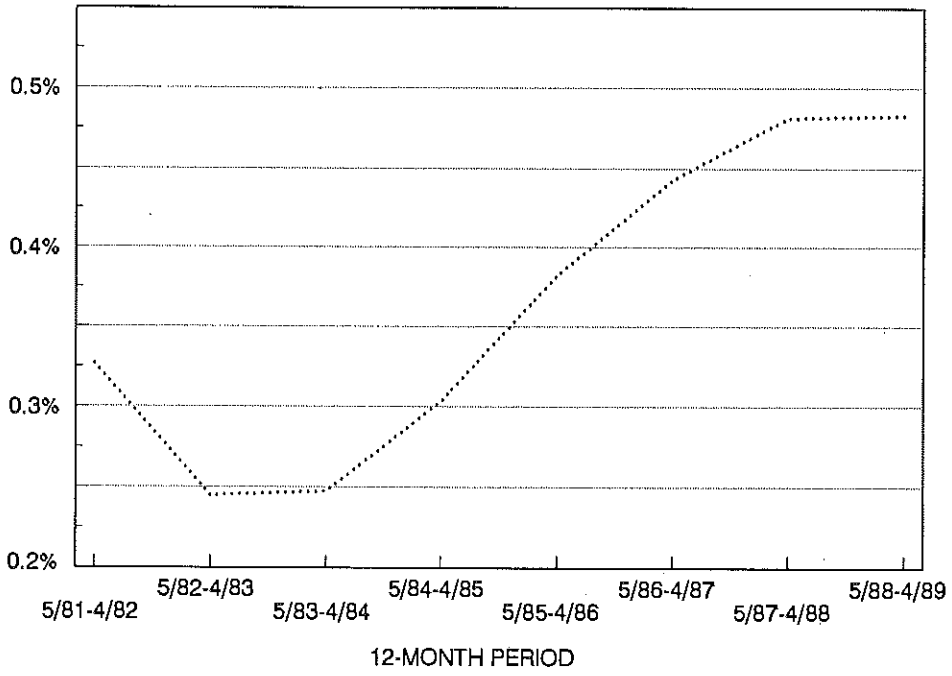
Work Incentives for Disabled SSI Recipients

Performance Indicator

During the 1980's, the Congress attempted to increase work incentives for disabled SSI recipients while containing program costs. An OIG inspection measured the change in the number of disabled SSI recipients who earned at least $300 per month by working for nine consecutive months between 1981 and 1988.

The OIG found that disabled SSI recipients entered the work force at a 48 percent higher rate in 1988 than in 1981. The number of SSI recipients who entered the work force increased from 1/3 of 1 percent of the disabled SSI population in 1981 (about 7,000 recipients out of 2.3 million) to 1/2 of 1 percent in 1988 (about 14,000 recipients out of 2.9 million).

PERCENT OF DISABLED SSI RECIPIENTS ENTERING THE WORK FORCE



The OIG also determined that improvement in the U.S. economy appears to account for this increase. The OIG recommended that SSA take the lead in organizing efforts to identify and study ways to encourage employers to hire severely disabled workers. (OEI-09-90-00020)

SSI for Homeless Individuals

Performance Indicator

The OIG examined the availability, accessibility and appropriateness of the SSI program in relation to homeless individuals who have mental health, alcohol or other drug problems. Service providers indicated that this population faces numerous problems in gaining access to SSI benefits, which they cannot solve by themselves. Moreover, SSA district office respondents indicated that they encounter a range of problems when trying to serve this population, including the transient lifestyle of this population, the inability of homeless

individuals to follow through on the application process and the difficulty in finding representative payees.

The OIG recommended that SSA increase its coordination with other agencies and providers that work with homeless individuals to help overcome problems this population faces in accessing SSI. The OIG also recommended that SSA collect data on a trial basis, and that it consult with the Interagency Council on the Homeless if the Council decides to mount a national survey of the homeless. (OEI-05-91-00060)

SSI Benefits Fraud

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

- In New York State court, a man was sentenced to 1 1/2 to 5 years in prison for defrauding the SSI and Medicaid programs of $1 million. He collected SSI for a mental disability and Medicaid for two severely disabled children, while owning extensive real estate including 13 properties in New York and three turkey farms in Nebraska. He used various names and SSNs, including his brother's, in executing his scheme. He was ordered to make full restitution.

- A man who concealed his marriage to a Social Security beneficiary was sentenced in Louisiana. He married her in 1986, but filed for Social Security benefits for her in 1987, stating that she was not married. In all, he collected close to $11,000 by concealing the marriage, about half of which was SSI benefits. He was ordered to make restitution of $8,715.

- A woman was sentenced in Wisconsin to 3 months incarceration and restitution of $5,975 she stole in SSI benefits. She directed her 12-year-old son to simulate mental retardation when she applied for SSI benefits for him. As soon as she began to receive benefits as his representative payee, she abandoned him. The boy went to live with an aunt, who was his entire support. When the aunt filed to become his foster parent, the mother's crime was discovered.

Approval of Direct Deposits without Sign-up Form

Performance Indicator

An OIG review of SSA's processing of direct deposits without the standard sign-up form disclosed no increase in errors. All deposits were directed to the correct financial institutions. Although there were a few instances in which the deposits were not directed to the correct accounts, the financial institutions were able to direct these payments to the

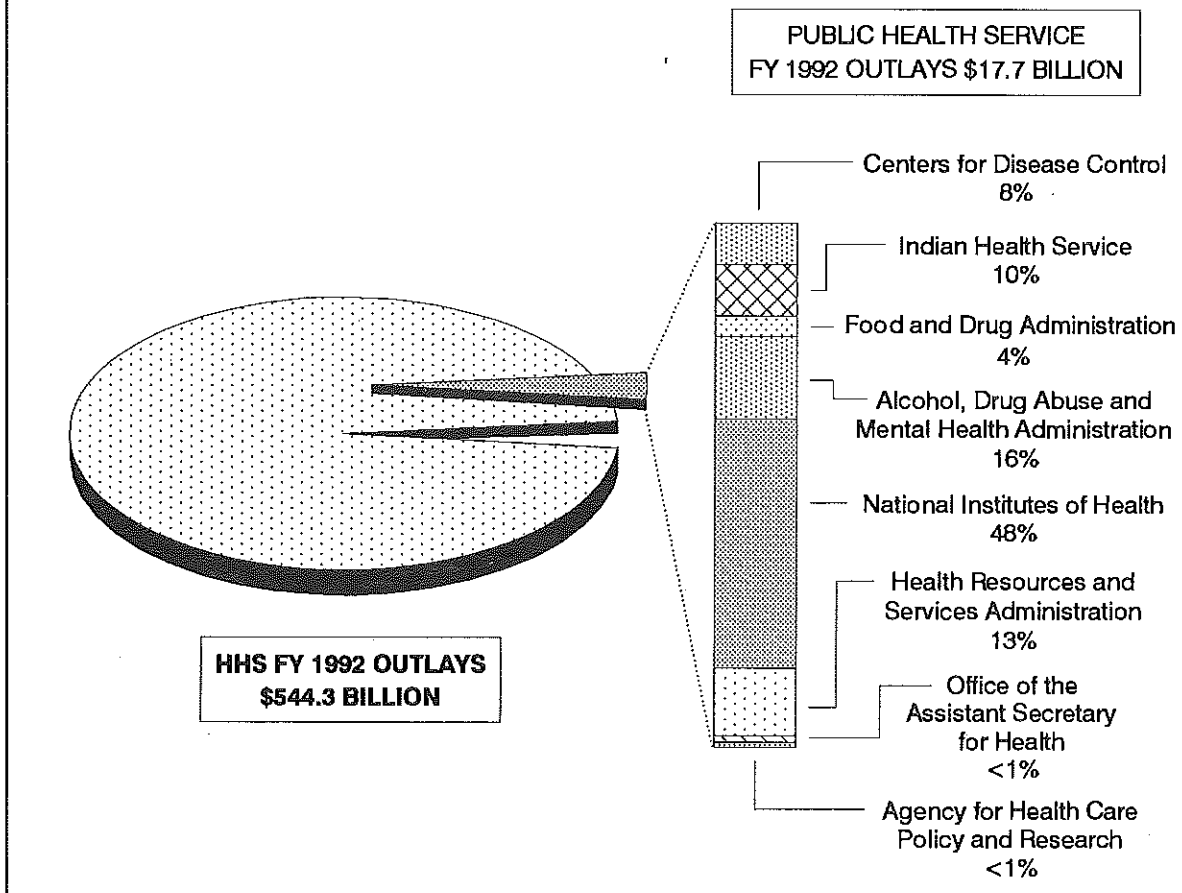
proper accounts. However, OIG did note problems in direct deposit cases, processed with and without sign-up forms, where representative payees were involved. There were instances in which payees other than parents, in addition to the beneficiaries, had ownership interest in the accounts. Also, in some cases, beneficiaries who had been determined incapable of handling their own finances had direct access to their accounts.

The OIG recommended that SSA verify account titles directly with the financial institutions whenever there is a representative payee involved. The SSA did not concur. The OIG also recommended that payees be instructed that beneficiaries should not have direct access to the accounts. The SSA agreed and is taking action. (CIN: A-06-90-00117)

Mailing Practices

The OIG performed a review to determine whether SSA could reduce postage costs associated with the mailing of forms, booklets and pamphlets to the public. The OIG expects that measures recently implemented by SSA relating to the use of commercial zip code software will result in postage savings of about $6.8 million annually. The OIG concluded that further savings of about $2.5 million annually are available if SSA elects to use third-class mail for forms, booklets and pamphlets.

The SSA's mail management plan (MMP) states that mailing activities are to achieve economy of operations and postage costs consistent with delivery requirements. The OIG believes that SSA management controls are not adequate to ensure that MMP postage containment objectives are always met. The OIG recommended that SSA coordinate all mail activity through the Mail Management Branch (MMB); include the ability to process mail at third-class rates as part of teleservice center enhancements; mail all blank forms at third-class mail rates; and expand MMB mail audit guidelines to sufficiently address issues associated with postage savings and operational efficiencies. The SSA generally agreed, but had reservations regarding the use of third-class mail. (CIN: A-13-89-00038)



Public Health Service

Chapter IV

PUBLIC HEALTH SERVICE

Overview of Program Area and Office of Inspector General Activities

The activities conducted and supported by the Public Health Service (PHS) represent this country's primary defense against acute and chronic diseases and disabilities. The PHS's programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. The PHS encompasses: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed food, drugs, cosmetics and medical devices; Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), to conduct biomedical and behavioral research on mental and addictive disorders and to assist States in refining and expanding treatment and prevention services through ADAMHA's science-based leadership; Centers for Disease Control, to combat preventable diseases and protect the public health; Health Resources and Services Administration, to support through financial assistance the development of our future generation of health care providers; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry, to address issues related to Superfund toxic waste sites; and the Agency for Health Care Policy and Research, to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services. The PHS will spend nearly $17.7 billion in Fiscal Year (FY) 1992.

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

Audit Activity at Colleges and Universities

During Calendar Year (CY) 1991, the Federal Government allocated about $10 billion to research at universities. The Department contributed $5.3 billion (or about 53 percent of the Federal total), primarily to advance biomedical research. Pursuant to the Office of Management and Budget (OMB) Circular A-88, Indirect Cost Rates, Audit and Audit Follow-Up at Educational Institutions, the vast majority of colleges and universities receiving Federal funding have been assigned to HHS for cognizance. This has meant that the HHS Division of Cost Allocation (DCA) has been charged, among other things, with establishing the indirect cost rates, and the HHS OIG with auditing those rates to insure compliance with OMB Circular A-21, Cost Principles for Educational Institutions.

Currently, there are some 2800 colleges and universities that receive Federal funding of one type or another. Of that number, only about 700 receive Federal research grants and less than half of that number have significant levels of funding. The major recipients of Federal funding are generally divided up for Federal oversight according to which agency has the largest amount of funding. About 262 major universities, the majority, receive more Federal research money from HHS than from any other agency. The cognizant or responsible auditor for all Federal funding at those schools is the HHS OIG.

A. Summary of CY 1991 Audit Activity at Colleges and Universities

In light of the high level of interest on the part of the Congress, the Administration, the Department and the public in the college and university area, OIG issued a management advisory report to recapitulate the full range of work performed over the last year. The report summarizes the results of 898 audits performed or reviewed by OIG in the college and university area during CY 1991. The primary focus of OIG's audit work was its continuing effort to ensure that the Federal Government pays only its fair share of total research costs, both direct and indirect.

Through these 898 audits and special initiatives, OIG disclosed a total of $38.4 million in unallowable costs in the indirect cost pools of universities under HHS cognizance. About 15 percent of this amount, approximately $5.8 million, was allocated to research programs, primarily those sponsored by the Federal Government. The OIG also provided valuable assistance to DCA, resulting in millions of dollars of reductions in future reimbursement of indirect costs due to negotiations of reduced indirect cost rates ($9.8 million at three schools where negotiations were recently completed). In addition, OIG determined that some university recharge center operations, such as telecommunication and computing services, were not in compliance with Federal requirements. This resulted in about $1.8 million in direct costs, indirect costs, and imputed interest on the surplus overcharges to Federal research, which OIG has recommended for reimbursement to the Federal Government. (CIN: A-01-92-04005)

B. Indirect Cost Issues Related to Research Conducted by Colleges and Universities

The OIG conducted a review in response to congressional concerns as to whether reforms to college and university cost principles proposed by OMB are having the intended effect. The study gathered certain information and statistics regarding indirect cost rates, and included an evaluation of the potential effect of returning to earlier capped rates or of making further reductions to existing rate levels. The report includes information on: estimated savings ranging from $55 million to $153 million with further reductions in the administrative costs cap; calculation of estimated savings ranging from $35 million to $120 million resulting from capping other categories of indirect costs; analysis of savings estimated to be as much as $1.8 billion resulting from returning to arbitrary caps in existence prior to 1966; possible causes of escalation of indirect cost rates; and estimated savings of overall caps. (CIN: A-15-92-00007)

C. National Audit of General and Administrative Indirect Costs at Selected Colleges and Universities

An OIG review of general and administrative indirect costs at selected colleges and universities disclosed that 14 schools included approximately $20.4 million of unallowable costs in their indirect cost proposals submitted to HHS. About 15 percent of this amount, approximately $3 million, was allocated to research programs, primarily those sponsored by the Federal Government. However, OIG's review also disclosed that some of the provisions of OMB Circular A-21, Cost Principles for Educational Institutions, did not provide clear enough guidance to adequately resolve other questions related to the allocability of certain general and administrative costs. The OIG recommended that the Assistant Secretary for Management and Budget (ASMB) work with OMB to revise Circular A-21 to: clarify the definitions of allowable and allocable costs; clarify certain costs already considered unallowable; and add additional categories of unallowable costs. The OIG also recommended that ASMB: continue to provide the schools assistance whenever possible regarding the clarification and the implementation of Circular A-21; appropriately implement the 26 percent cap on administrative costs; and, where appropriate, adjust the previously negotiated indirect cost rate for the schools audited and calculate refunds. The ASMB generally agreed with the conclusions and recommendations presented in the report. (CIN: A-01-91-04008)

D. Reduced Indirect Cost Rates at Ten Large Research Universities

In response to a congressional request, OIG examined the practice at 10 large universities of entering into sponsored research agreements with private industry and foreign governments at reduced indirect cost rates. The focus of the review was to determine whether the Federal Government was subsidizing the indirect costs for nonfederal research projects with reduced indirect cost rates. The OIG determined that all of the 10 universities entered into sponsored agreements using reduced indirect cost rates. In addition, OIG determined that the federally negotiated indirect cost rates were not overstated because of sponsored agreements with other nonfederal entities which used reduced rates.

The OIG also reported that the universities were forgoing a significant amount of revenue because of reduced indirect cost rates, about $46 million for the year reviewed, or an average of $4.6 million per university. The OIG found that universities seem to be willing to accept lower indirect cost rates because research is part of their purpose and they receive other benefits from conducting such research.

The OIG also found that under OMB Circular A-21, the institutions can fund research costs from private gift accounts which are classified as instruction and not organized research. The OIG plans to review this practice to determine the effect on Federal reimbursement and, if appropriate, to recommend ways to change OMB Circular A-21. (CIN: A-09-91-04018)

PHS Controls over Technology Transfers and Royalty Income

The OIG determined that PHS and NIH did not have adequate internal controls over technology transfer and royalty income for CY 1990. During part of that year, PHS did not have an adequate management information system to track and monitor innovations from development through patent application to licensing, commercialization and collection of royalties. Specifically, OIG found that NIH did not have adequate: accounting of the status of its patents; procedures to ensure that technology, once transferred, was developed, commercialized and receiving its proper share of royalty income; and procedures to ensure timely decisions and proper coordination for filing of foreign patent rights. Prior to and during the review, NIH started to implement corrective actions; however, OIG determined that additional corrective actions were needed. The PHS did not agree that a material internal control weakness exists in the technology transfer program because improvements and innovations made by NIH have significantly changed the management and oversight of the technology transfer program. However, OIG believes that the Department should report this matter as a material weakness in its next annual report under the Federal Managers' Financial Integrity Act (FMFIA). (CIN: A-01-90-01502)

Conflict of Interest in Institute of Medicine Study

In response to a congressional request, OIG reviewed a possible conflict of interest involving an Institute of Medicine study of pertussis and rubella vaccines. The study was funded by NIH, as required by the National Childhood Vaccine Injury Act, to determine whether significant side effects resulted from administration of these vaccines.

The OIG identified two conflict of interest situations: one committee member was employed by a nonprofit fund that was fully supported by a pertussis vaccine manufacturer, and another resigned after the Institute of Medicine discovered that he had made public statements that prejudged the committee's findings. The OIG recommended that NIH review possible conflicts of interest for all committee members and take corrective action, including removal if necessary. The NIH agreed to perform a review of all the committee members. The OIG also found that NIH did not follow Federal regulations to assure the

impartiality and objectivity of work performed under the contract. The NIH agreed to evaluate the study results, and determine if the conclusions were impartial and objective. (CIN: A-15-90-00054)

Oversight of FDA Activities: Summary Report

The OIG issued a summary report to provide information on OIG's oversight activities at FDA. Five major management challenges facing FDA, identified through OIG audits, investigations and inspections, as well as OIG recommendations for improvement are discussed. These challenges include the need to: restore integrity to FDA's product approval process; vigorously detect and investigate potential fraud and abuse; invigorate FDA's inspections of manufacturing and processing facilities; ensure that FDA can respond to individuals and businesses out of compliance with the Food, Drug and Cosmetic Act; and create and use reliable management information systems.

The OIG continues to monitor FDA's efforts to implement the recommendations found in the original reports. In general, OIG believes FDA must act to improve its product approval system to ensure equitable and fair treatment; obtain necessary enforcement authorities; conduct appropriate systems analysis to ensure that useful information systems are in place and providing FDA management with needed information; identify resource needs; and develop full-scale criminal investigative capability. (OEI-12-92-00200)

FDA Security

The OIG issued two management advisory reports alerting FDA to serious deficiencies in computer security and employee handling of privileged information.

An investigation of unauthorized access to FDA's computer network by an unidentified person revealed the following shortcomings in security measures:

- individual user passwords and systemwide privileges had not been reevaluated since installation;
- computer security was deactivated; and
- staff accountability and consistency in computer security procedures were lacking.

The OIG recommended that FDA design and implement an agencywide computer security program to ensure the integrity of its data, including a series of controls. (OI-HQ-92-001)

Other investigations revealed that FDA employees had improperly discussed privileged information with representatives of outside organizations. Interviews showed that employees had varying understandings of the concept of privileged information and that specific training in this area was lacking. The OIG recommended that FDA publish a guide describing the various types of restricted information, and employee responsibilities and methods of handling them. The OIG also recommended that this subject be emphasized in FDA's ethics awareness training, and that periodic reminders be issued or displayed. (OI-HQ-92-002)

Generic Drugs

Over the past 3 years, the generic drug industry has been rocked by a series of prosecutions resulting from OIG investigations. The prosecutions have progressed through two phases: a corruption phase, which involved the giving of illegal gratuities to FDA employees by generic drug companies, and a fraud and false statement phase, in which the companies engaged in various deceptions regarding the testing and manufacturing of their products. The FDA is conducting a comprehensive review of the drug approval process to determine the extent to which controls or improvements are warranted.

During this reporting period, the former director of research and development for a pharmaceuticals company was sentenced to 2 years incarceration for making false statements in connection with a variety of generic drug applications filed with FDA. One major generic drug company was fined $2.5 million in settlement of charges and another agreed to establish a $3.8 million fund to settle a class action suit. Thus far in the ongoing investigations into the generic drug industry, a total of 35 individuals or organizations have been charged. By the end of the reporting period, 18 had been convicted and sentenced, and another 6 were awaiting sentencing.

Drug Registration and Listing System

The Drug Listing Act of 1972 requires the drug industry to provide FDA with data on all drug firms and commercially distributed drugs. This information is maintained in the files of a computer database called the Drug Registration and Listing System (DRLS). In a study of the DRLS prescription drug file of 39,000 products as of March 1990, OIG found that the file was neither complete nor totally accurate. The OIG estimated that more than 8,000 additional products were on the market but missing from the file, and 1,400 products in the file were off the market. Drug firms did not always supply the required data, and deficiencies at FDA also caused or compounded drug file errors.

The FDA has undertaken some steps to remedy the situation. The OIG recommended that FDA clarify and strengthen its legal authority to take regulatory action against firms that do not return compliance verification reports; clarify data requirements for industry; develop internal control procedures for manual data processing; and ensure that maximum benefits

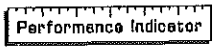
result from the new computer software system being implemented. The PHS concurred with the recommendations.

In a related report, OIG noted that FDA appears to be moving in the right direction with the overhaul of the computer system, but that the adequacy of the new system cannot be determined until the entire conversion is completed. (OEI-03-90-02300; OEI-03-90-02301)

FDA Review of Bovine Somatotropin

In response to a congressional request, OIG reviewed several issues pertaining to bovine somatotropin (bST), a new animal drug. The OIG found that research has been conducted to demonstrate both that bST is not harmful to humans and that bST levels in milk are not higher in bST-treated cows than in nontreated cows. Also, OIG determined that FDA and Monsanto have appropriately withheld animal health data on bST, but FDA has publicly disclosed the data it reviewed on human food safety. Further, OIG found no evidence indicating that FDA or Monsanto engaged in manipulation or suppression of bST test data. As to public statements made by FDA officials regarding the safety of bST and the likelihood of its approval, OIG concluded that such statements did not violate law or regulations. However, OIG believes that Government officials should not publicly comment on the outcome of the review of a new animal drug. Therefore, OIG recommended that FDA develop policies and procedures on the type of public statements that may be made regarding a new animal drug undergoing review. The PHS agreed with this recommendation and indicated that it would expand such policies to make them FDA-wide, covering all of its processes. (CIN: A-15-90-00046)

Youth and Alcohol



The OIG has completed a series of reports on youth and alcohol at the request of the Surgeon General. The OIG examined current State laws and regulations governing youth access to alcohol and how these laws are enforced. State laws were found to have many loopholes that enable underage drinking. A compendium was issued to present State alcoholic beverage control laws relating to youth for all 50 States and the District of Columbia. Moreover, OIG identified and described national, State and local programs that educate youth about the health and social effects of using alcohol, State alcohol laws and penalties for minors, and ways to resist alcohol and increase self-esteem.

Further, OIG reviewed and described the research that has been conducted on the effects of alcohol advertising on youth. Controversy surrounds alcoholic beverage advertising, its effects on youth and the extent to which it should be regulated. Research findings conclude that alcohol advertising and media portrayals of alcohol do affect youth attitudes and consumption because advertising images and themes are attractive to youth. Despite attempts by Federal and State agencies, the alcohol industry and three broadcast networks to provide standards for alcohol advertising, alcohol advertisements that appeal to youth

continue to appear on broadcast television and in the print media. (OEI-09-91-00650; OEI-09-91-00651; OEI-09-91-00654; OEI-09-91-00655; OEI-09-91-00656)

Metropolitan Atlanta Council on Alcohol and Drugs

Performance Indicator

Based on a congressional request, OIG reviewed the funding allocation and spending practices of the Metropolitan Atlanta Council on Alcohol and Drugs (MACAD). In April 1990, MACAD and 12 other organizations in Atlanta, Georgia, combined their resources and formed the City of Atlanta Community Prevention Coalition to apply for a grant under a program designed to achieve reductions in drug and alcohol abuse in local communities. The OIG determined that MACAD was not required to allocate a portion of the grant funds to other members of the coalition and did not do so. In accordance with the grant announcement, the 12 other organizations designated MACAD as the lead agency to receive an award on behalf of all members. In addition, OIG found no evidence of a misuse of funds. However, the review did disclose other issues related to the achievement of grant objectives by MACAD which OIG brought to ADAMHA's attention for corrective action. (CIN: A-04-91-04036)

National Health Service Corps and Health Education Assistance Loan Debt Collection

This study examined the use of Medicare offset agreements and exclusions on debt collection activities of the National Health Service Corps scholarship and Health Education Assistance Loan programs. The OIG found that while preliminary data suggests that a considerable number of loan and scholarship defaulters are Medicare providers, as of the time of the review PHS had not implemented any offset procedures. It had initiated the exclusion option against only one scholarship defaulter.

The OIG recommended that PHS immediately implement procedures for Medicare offset agreements and exclusions. The OIG also recommended that PHS seek legislative authority to return to the program monies collected from loan and scholarship defaulters to provide continuing support for program goals and objectives. (OEI-02-91-00550)

Analysis of Selected Data on Community and Migrant Health Centers

The Community Health Centers (CHC) and Migrant Health Centers (MHC) programs provide Federal support for the establishment and operation of systems providing access to primary health care services in areas that are medically unserved or underserved, and to migrant and seasonal farm workers and their families. In FY 1990, 546 centers were funded under the two programs, with 436 centers receiving CHC grants, 26 receiving MHC grants, and 84 receiving both CHC and MHC grants. The combined funding for both programs was approximately $508 million.

The OIG was asked by the Assistant Secretary for Management and Budget to provide information on several subjects, including: the universe of individuals served by CHC and MHC, broken down by the sex and age of users; the revenues received by CHC and MHC, particularly from non-grant sources such as the Medicare and Medicaid programs; and any disparities between the cost effectiveness of urban and rural CHCs and MHCs.

The OIG review showed that 546 CHCs and MHCs served more than 5.8 million individuals in 1990, continuing a small but steady increase in the number of users annually. Children aged 14 or below represented 34.6 percent of the individuals served. Revenues received by the centers increased significantly over the 3 years covered by the review, with the greatest increases attributable to payments from the Medicaid program and CHC grants. (CIN: A-04-91-04092)

Community Mental Health Centers Construction Grant Program

The Community Mental Health Centers (CMHC) Act authorized grants for the construction of public and other nonprofit CMHCs. Grantees are required to continue using the constructed facility to provide mental health services for a period of 20 years to all persons in need of such services in designated service areas. In addition, they must furnish a reasonable volume of services below cost or without charge to residents of the service area who are unable to pay.

In the first phase of a three part study, OIG audited CMHC construction grant reviews conducted by a contractor, Continuing Medical Education, Inc. (CME) for the National Institute of Mental Health (NIMH) and actions taken by NIMH to resolve cases of grantee noncompliance. The OIG found that CME had generally identified and reported areas of grantee noncompliance for the grantees OIG reviewed, except for the provision of a reasonable volume of below cost or free services to persons unable to pay. Also, CME reports generally contained sufficient information for NIMH to take actions to bring the grantees back into compliance, initiate recovery of Federal funds or extend the grantee's service obligation date. However, OIG determined that NIMH did not adequately monitor or resolve reported deficiencies.

The OIG recommended that PHS take immediate corrective action on grantees that are not in compliance with the requirements of the Act; initiate recovery action on 13 grants with awards totaling $6.8 million that have consistently not complied with program requirements; and include the internal control weaknesses in the CMHC construction grant program in this year's report under the Federal Managers' Financial Integrity Act. The PHS generally concurred with the recommendations and has taken or is taking action to implement them. (CIN: A-05-91-00050)

Fraud and Abuse in IHS

The OIG released two reports alerting IHS to potential material weaknesses regarding contract awards under the Buy Indian Act and on Privacy Act violations in connection with the release of medical records.

- Allegations and investigations indicate that IHS needs to require certification and verification that firms to which contracts are awarded are 100 percent Indian-owned, as mandated by the Buy Indian Act. (EAR-OI-HQ-92-002)

- Complaints were received that at least three IHS area offices released patient medical records without proper authorizations. The OIG recommended that IHS undertake an internal control review to determine whether a material weakness exists. (EAR-OI-HQ-92-001)

Several convictions obtained during this period indicate that the internal systems of tribal facilities funded by IHS have problems. In Arizona, an employee of a health center embezzled $4,655 from the imprest (petty cash) fund and falsified audit reports to conceal the cash shortage. Similarly, as a result of a series of investigations in a tribal health department in Wisconsin, two employees were found to have illegally kept and used travel advances, and a third altered the figures on a check. Others have been indicted, as the project continues.

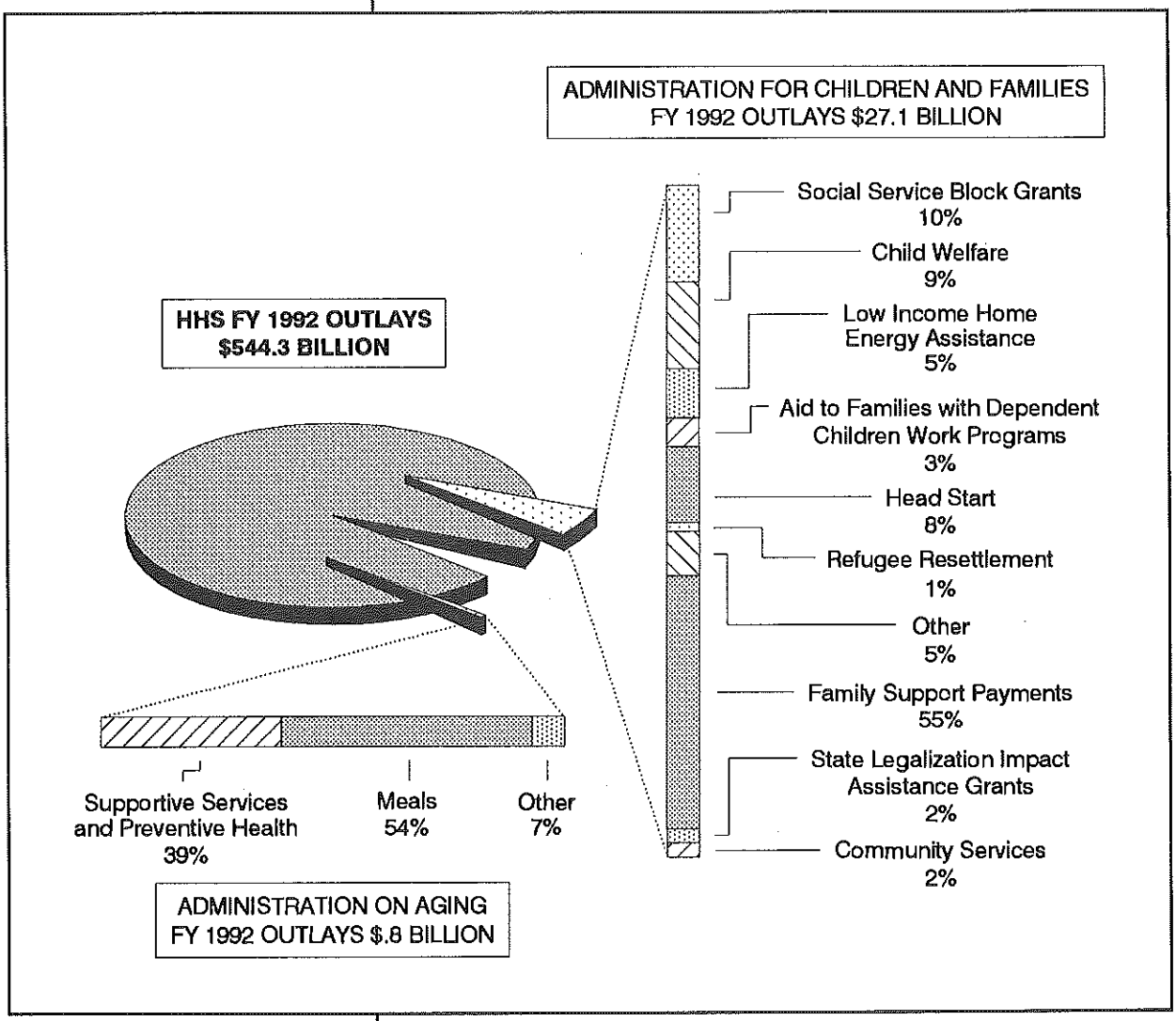
Equipment Inventory Controls at Three IHS Area Offices

The OIG found that a material internal control weakness, previously reported as corrected, continues to exist due to lack of reconciliation of IHS equipment records. The Department, in its annual FMFIA report for FY 1986, disclosed such a material weakness and, in its annual report for FY 1988, disclosed a material nonconformance in the system that provides accounting services to IHS. In its annual report for FY 1990, the Department noted that it had completed corrective action on these material internal control problems. The Department acknowledged the continuation of this problem in its annual report for FY 1991, as part of a narrative on the high risk area Management of the Indian Health Service. (CIN: A-06-91-00032)

Injury Control

At the request of the Secretary, OIG conducted a review to determine the nature and extent of possible overlap between the injury control program operated by the Division of Injury Control (DIC) at the Centers for Disease Control and other programs within and outside the Department. The OIG found that some overlap exists between DIC's legislative authority and that of other Federal agencies. Both DIC and other Federal agencies work in some general areas of injury control. However, there is no duplication of effort with regard to

specific projects. Further, DIC is playing a coordinating and leadership role that is valued in the injury control community. (OEI-02-92-00310)



Administration for Children and Families

Administration on Aging

Chapter V

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides Federal direction and funding for State, local and private organizations as well as for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. It also oversees a variety of programs that provide social services to the Nation's children, youth and families, persons with developmental disabilities and Native Americans.

Family support payments to States encompass: Aid to Families with Dependent Children (AFDC), a cooperative program among Federal, State and local governments which reaches nearly 4.7 million families consisting of 13.5 million individuals each month; the Child Support Enforcement (CSE) program, which provides grants to States to enforce obligations of absent parents to support their children by locating absent parents, establishing paternity when necessary, and establishing and enforcing child support orders; and Child Care, which frees eligible adults receiving AFDC (or recently exited AFDC) for education, training and employment. In Fiscal Year (FY) 1992, the Head Start program will spend $2.2 billion to provide comprehensive health, educational, nutritional, social and other services primarily to preschool children and their families who are economically disadvantaged. The Foster Care and Adoption Assistance program provides grants to States to assist with the cost of foster care and special needs adoptions maintenance, administrative costs and training for staff; the program's goal is to strengthen families in which children are at risk, reduce inappropriate use of foster care and facilitate the placement of hard-to-place children in permanent adoptive homes when family reunification is not feasible. The Family and Youth Service Bureau is responsible for administering programs that provide services for troubled youth and their families through the Runaway and Homeless Youth Grant, the Transitional Living Program, the Drug Abuse Prevention Program for Runaway and Homeless Youth, and the Youth Gang Drug Prevention Program. The Low Income Home Energy Assistance program (LIHEAP) provides block grants to the States and Indian tribes to help offset the increased cost of fuel for low income households, including recipients of AFDC, food stamps and Supplemental Security Income. Other programs include Emergency Assistance, Refugee

and Entrant Assistance, Community Services, Job Opportunities and Basic Skills Training (JOBS), and the State Legalization Impact Assistance Grants program. Expenditures for ACF programs will total approximately $27.1 billion for FY 1992.

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

Also included in this chapter is the Administration on Aging (AoA), which reports directly to the Secretary. Established by the Older Americans Act of 1965, AoA serves as an advocate for older persons within the Department and with other agencies at the national level. In addition, AoA is charged with assisting and supporting the efforts of the other components of the national aging network: the State and area agencies on aging, and the agencies and organizations providing direct services at the community level. The AoA will spend approximately $830 million in FY 1992. Among the issues of particular interest to OIG in this area are nutrition, service provision and integration, abuse of the elderly, administrative costs and the nonmedical aspects of long-term care.

Monitoring States' AFDC Overpayments

In April 1991, OIG alerted ACF to a potential material internal control weakness surfacing in a review of collections of overpayments by States under the AFDC program. The preliminary review identified up to $3.5 billion in AFDC overpayments that were not reported by the States. The OIG determined that intensified program monitoring, including field site reviews, was necessary to protect Federal interests by assuring that States are exercising due diligence in the identification, collection, write-off and reporting of AFDC overpayments. Based on the preliminary survey work and audit of the State of Connecticut, this matter was reported as a significant management concern in the Secretary's 1991 report under the Federal Managers' Financial Integrity Act.

The OIG has now completed audit field work at five additional locations. These five reviews demonstrate that significant problems exist at State and local entities in monitoring,

reporting, identifying, collecting and writing off uncollectible overpayments. The OIG believes that the additional evidence is sufficient to elevate the classification of the area from a significant management concern to a reportable material internal control weakness. The OIG is in the process of consolidating and further analyzing the results of the reviews, and refining with ACF the methodology to more exactly determine the dollar consequences. Full corrective action for this material weakness cannot be completed until legal impediments are addressed which prevent collection of overpayments from States that are sanctioned and fail to accurately identify and report overpayments. (CIN: A-12-92-00029)

Welfare Fraud

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

Most of OIG's success in investigating welfare fraud is attributable to working on joint projects or task forces that include State and local public assistance agencies, and even local law enforcement authorities. For example, OIG investigations carried out on referral from, and with the assistance of, the Indiana Department of Public Welfare resulted in five convictions and more than $83,000 ordered in fines and restitutions. Four had concealed employment to continue to receive welfare benefits and one had concealed Social Security benefit payments. Three received suspended jail sentences, but one was ordered to spend 2 months in prison and another 6 months in home detention.

One approach to resolving welfare cases that has proved highly successful has been to group cases for mass prosecutive action. Grouping the cases, which individually may involve relatively small amounts of money, improves their appeal to busy prosecutors. Announcements of mass indictments also heighten public interest and enhance the deterrent impact. Two continuing projects in the State of Ohio, again worked with State and local agencies, illustrate the prosecutive success of this tactic:

- In southern Ohio, over 100 persons were charged in three separate mass actions as a result of OIG work with State and county agencies. The total amount received in fraudulent benefits amounted to more than $300,000.

- In the second phase of a similar project in northern Ohio, 80 persons have been indicted in several mass actions and 25 have been convicted thus far. Total unwarranted benefits paid in this project amounted to $1.5 million.

Massachusetts Homeless Program: Administrative Costs

In a follow-up to an earlier audit, OIG found that Massachusetts still needs to improve its procedures to ensure that costs of administering its homeless program are allocated between the AFDC and the State-funded General Relief programs in accordance with relative benefits received. The OIG found several deficiencies in the State's accounting records used for allocating administrative costs for the homeless unit's central office. The previous audit report had recommended a financial adjustment of nearly $1.3 million (over $531,000 Federal share), representing administrative costs that should have been charged to the State-funded General Relief program. After negotiations between the Department's Division of Cost Allocation (DCA) and the State, the basis for financial adjustment was changed and the recommended disallowance recalculated. Although OIG found that nearly $379,000 of the Federal share had been properly credited, the revised portion of the credit was not calculated in accordance with the methodology agreed upon between DCA and the State.

The OIG recommended that DCA address the State's need to improve its internal control procedures to ensure that all allocations of costs are properly documented and supported in accordance with Federal guidelines. Also, DCA should pursue the additional $36,000 in adjustments that were not accurately calculated by the State. The DCA concurred with both recommendations. (CIN: A-01-91-02506)

Head Start: Summarization of Grantee Audit Problems

The OIG reviewed nonfederal audits of the Head Start program issued between October 1, 1987 and August 30, 1990 to identify specific management control weaknesses. The OIG analyzed audit reports accounting for 751 grantees with Head Start expenditures of $1.42 billion. The OIG identified problems in three general areas: accountability, relating to the structure of the internal control systems, record keeping systems and procedures, and financial reporting; grants management, relating to compliance with Federal rules and regulations; and cash management, relating to the adequacy of the systems used to safeguard cash. In addition, OIG determined that the tracking system used to ensure that required audits of Head Start Grantees are being done should be reevaluated.

The OIG recommended that ACF review all important aspects of financial management and accountability including: technical assistance, monitoring, financial reporting, tracking of audit reports and audit resolution. In addition, ACF should require financial management capability reviews for new grantees. Moreover, OIG concluded that training, along with fiscal and program oversight, would be helpful to correct persistent deficiencies. (CIN: A-07-91-00425)

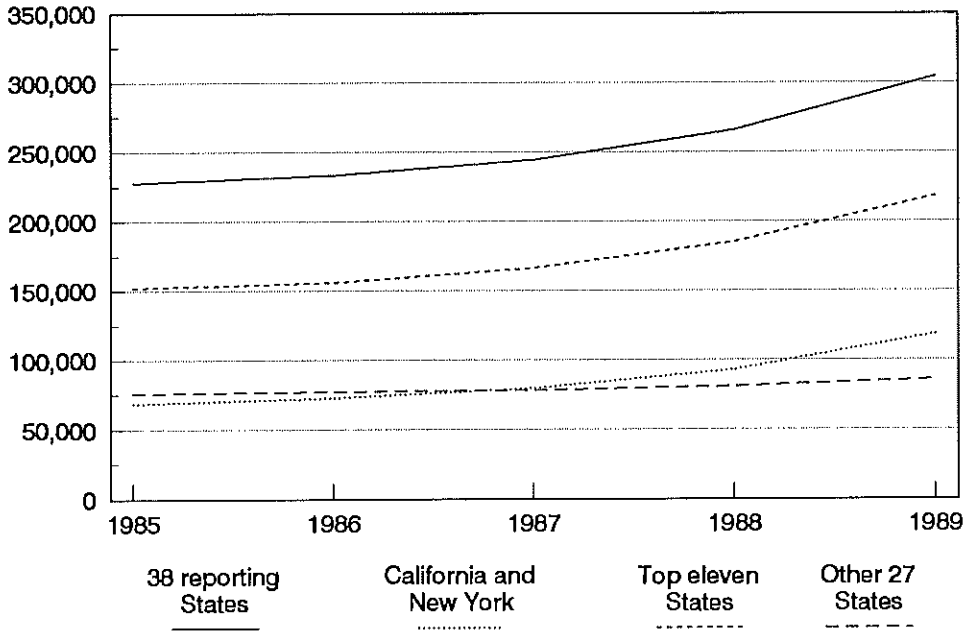
Foster Care

A. Trends in Foster Care

Performance Indicator

Because of variations in State reporting, there was no reliable information available on the number and age of children being placed in foster care group facilities. In order to perform a trend analysis of this population, OIG conducted a survey of State child welfare officials. The OIG found that, after years of apparently little or no growth, the national foster care caseload increased substantially in the last half of the 1980s, as illustrated by the following chart.

TOTAL FOSTER CARE CASELOAD 1985 - 1989
38 STATES



The OIG determined that the number of children placed in group homes has been increasing, but at a lower rate than those placed in family foster homes. From 1985 to 1989, for 33 reporting States, the number of foster children in group homes increased by 16 percent, from 44,226 to 51,189. California and New York accounted for 57 percent of this growth. The study also indicated that during the last half of the 1980's, infants and preschoolers accounted for a small but increasing proportion of group home caseloads. The OIG recommended that ACF specify plans for the analysis and use of the data that will be reported by States under the proposed foster care and adoption data collection system. (OEI-01-90-00490)

B. Maintenance Payments

The OIG found that Pennsylvania was not entitled to almost $6.8 million in Federal financial participation (FFP) for Philadelphia County for FY 1989 because numerous claims for foster care maintenance payments involved one or more violations of Federal and/or State regulations. These included claims for children who were voluntarily placed in foster care; lacked the required judicial determinations; resided in foster homes that were not documented as being evaluated and approved annually; were not eligible for the AFDC program; and/or exceeded the program's age limit.

The OIG recommended that Pennsylvania monitor compliance with Federal and State regulations regarding entitlement under the Foster Care program, and make financial adjustment for the nearly $6.9 million in FFP that was ineligible for Federal reimbursement. Pennsylvania did not agree. (CIN: A-03-91-00551)

C. Training Costs

As part of a nationwide effort to determine if State and local entities were claiming foster care training costs in accordance with Federal law and regulations, OIG performed an audit of the training costs claimed for Federal reimbursement by the State of New Jersey during the period October 1, 1986 through September 30, 1989. The OIG found that although, in most instances, training costs were charged to the Foster Care program in accordance with the State's approved training plan and were computed at the appropriate FFP rate, the State had calculated some training costs at an incorrect FFP rate, resulting in excess reimbursement of over $300,000. The OIG recommended that the State initiate a financial adjustment for the incorrect claims. The State did not concur. (CIN: A-02-90-02017)

Another OIG audit disclosed that over $170,000 (over $128,000 Federal share) claimed by Arizona for the period October 1, 1986 through September 30, 1989 was either unallowable under the Foster Care program or was not allocable to the program. The OIG recommended that Arizona make a financial adjustment for these costs. In addition, OIG proposed that the State improve its procedures for claiming costs allowable under Federal regulations, and for allocating the training costs to the benefiting programs. (CIN: A-09-91-00050)

JOBS Program: Oklahoma

The cornerstone of the Family Support Act of 1988 is the JOBS program, which provides AFDC clients education, employment and training opportunities, and related supportive services. The JOBS regulations place several requirements on States regarding maintenance of effort for JOBS expenditures. The OIG found that Oklahoma met the maintenance of effort requirement of maintaining the FY 1986 level of expenditures for JOBS related programs for FY 1990, but did not properly compute the FY 1986 JOBS baseline year expenditure amount. Further, the State was unable to ensure that JOBS funds were not used for services otherwise available on a nonreimbursable basis, and had not obtained the

required certification to that effect from the contract provider. Finally, the State claimed unallowable costs and excessive FFP totaling $445,000 (Federal share) for its JOBS program.

The OIG recommended that the State: revise the FY 1986 baseline year amount from $2,640,000 to $2,174,000; establish adequate controls to ensure that services are obtained, using JOBS funds, only after receiving the appropriate level of services on a nonreimbursable basis; obtain proper certifications prior to entering contracts for JOBS related services; refund $445,000 for excess FFP claimed and unallowable costs charged to the JOBS program; and establish controls to ensure that the correct matching rates are applied and that unallowable costs are not charged to the JOBS program. The State agreed with the findings and recommendations, and noted actions taken to resolve them. Subsequent to the audit field work, the State made a financial adjustment of $445,000. (CIN: A-06-91-00006)

Procurement of Services

The JOBS regulations state that services contracted under JOBS are subject to the requirements of the Department's uniform regulations for State grant programs. These regulations state that when procuring services under a grant, the State will follow the same policies and procedures it uses for procurement using nonfederal funds.

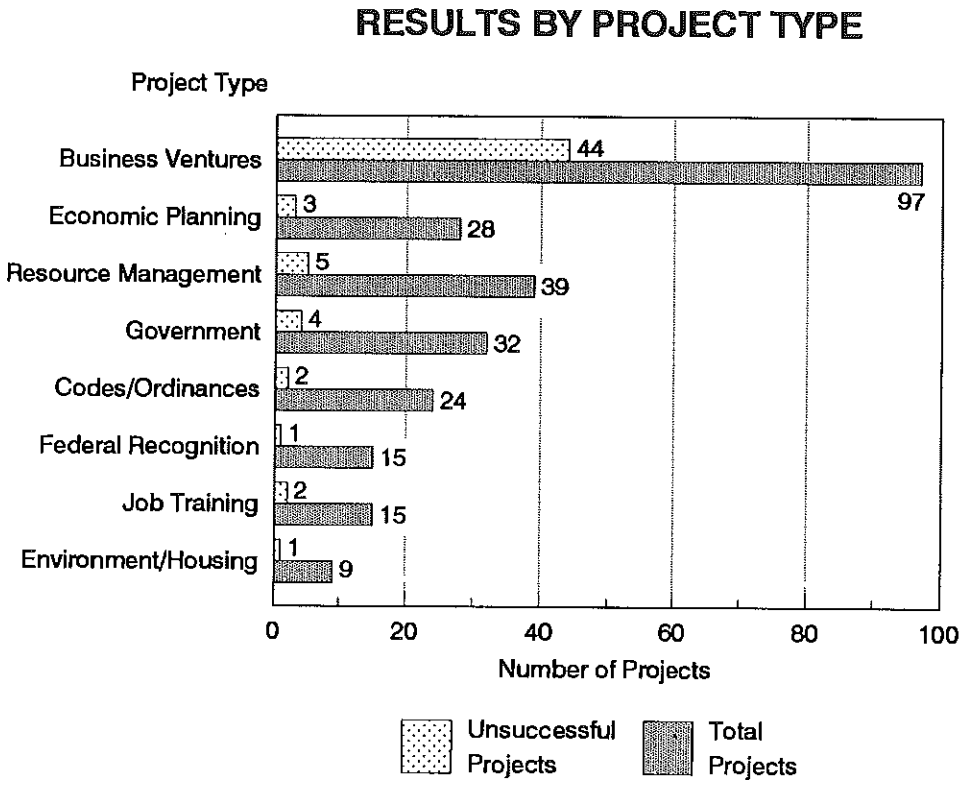
The OIG reviewed the one contract that had been awarded under the JOBS program at that time. The OIG recommended that Oklahoma: ensure that contracts specifically require contractors to identify non-JOBS participants on the class rosters when billing for educational services; strengthen monitoring procedures to ensure that payments are made only for JOBS participants and for classes that qualify for reimbursement by having the required minimum number of JOBS participants; and reimburse the Federal Government $14,000 for the overclaim made for non-JOBS participants and non-JOBS classes. The State agreed and is prepared to take corrective action. (CIN: A-06-91-00008)

Administration for Native Americans: Review of Social and Economic Development Strategies

Performance Indicator

The Native American Programs Act of 1974 (Public Law 93-644), as amended, authorized a program of financial and technical assistance to promote social and economic self-sufficiency for American Indians, Alaskan Natives, Native Hawaiians and Pacific Islanders. In 1981, the Administration for Native Americans (ANA), with the Tribes and Native American leaders, developed the definition of self-sufficiency which became the basis for the social and economic development strategies (SEDS) policy for financial assistance.

The OIG conducted an inspection to determine whether Native American organizations receiving grants from ANA achieved their project objectives and whether SEDS grants contributed to Native American progress toward self-sufficiency. The OIG found that one quarter of SEDS-funded projects did not meet their goals, as illustrated below.



Although grantees viewed ANA and the SEDS program favorably, progress toward self-sufficiency could not be determined. The OIG recommended that ANA adhere to current monitoring guidelines and develop standards which measure the extent to which SEDS grants contribute to grantee progress toward self-sufficiency. (OEI-03-90-00390)

Issues in the Aging Programs

Performance Indicator

The OIG issued a memorandum to the U.S. Commissioner on Aging, offering ideas for consideration in identifying program improvements. The ideas were based on recently completed and ongoing work, as well as discussions with program officials during AoA preparations for reauthorizing hearings at which both OIG and AoA testified.

Regarding public/private partnerships, a major national initiative to mobilize the private sector to participate in projects for senior citizens, OIG found that AoA had been unable to.

provide desired oversight to assure accountability. The OIG also determined that AoA needs to more closely monitor grantee compliance with extended service requirements for multipurpose senior centers and to recover funds if the centers are converted to other purposes. The AoA has implemented a management control program through its regional offices to ensure State compliance with AoA-issued requirements to protect Federal reversionary interest in multipurpose senior centers. A study on cost-sharing disclosed that State aging program officials and many senior citizens support the idea of charging fees for services to the elderly on an ability-to-pay basis. In another study, OIG described the characteristics of successful State ombudsman programs. The OIG commented on several other AoA issues as well, including administration of discretionary grants, State outreach efforts, management information, integration of services and nutrition services. (CIN: A-12-91-00030)

Appendices

APPENDIX A

Implemented OIG Recommendations to Put Funds to Better Use October 1991 through March 1992

The following schedule is a quantification of actions taken in response to OIG recommendations to prevent unnecessary obligations for expenditures of agency funds or to improve agency systems and operations. The amounts shown represent funds or resources that will be used more efficiently as a result of documented measures taken by the Congress or by management to implement OIG recommendations, including: actual reductions in unnecessary budget outlays; deobligations of funds; reductions in costs incurred or preaward grant reductions from agency programs or operations; and reduction and/or withdrawal of the Federal portion of interest subsidy costs on loans or loan guarantees, or insurance of bonds. Total savings during this period amounted to $1,826 million.

OIG Recommendation	Status	Savings in Millions
Division of Cost Allocation Savings: Reviews and negotiations of indirect cost rates and cost allocation plans conducted by the Department's Division of Cost Allocation (DCA) resulted in the savings shown. The OIG provides audit support to DCA in conducting some of the negotiations.	The DCA negotiations conducted in Fiscal Year (FY) 1991 resulted in the savings shown.	$526.5
Raise and Index the Medicare Part B Deductible: The Medicare Part B deductible should be raised to $100 and indexed. (ACN: 09-52043)	Section 4302 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 increased the Part B deductible to $100 beginning in 1991. However, OBRA 1990 did not subject the deductible to indexing.	545
Reimbursement for Outpatient Facility Services: The Health Care Financing Administration (HCFA) should limit outpatient department (OPD) facility fees and beneficiary charges to the applicable ambulatory surgical center (ASC) rate or reduce payments for OPD services to bring them in line with ASC payments. (OAI-85-IX-00046; CIN: A-14-89-00221)	Section 4151(b) of OBRA 1990 reduced payments for hospital outpatient services paid on a reasonable cost basis, and section 4151(c)(1)(a) modified the blending formula for payments for ambulatory surgical procedures performed in OPDs. However, the disparity between OPD and ASC payments still exists.	285
Coronary Artery Bypass Graft Surgery and Cataract Surgery: The HCFA should place special limitations on reasonable charges for the primary surgeon's fee for coronary artery bypass graft (CABG) surgery, and should consider consolidating payments for primary surgeons, assistant surgeons and anesthesiologists. The HCFA should periodically assess the changes in surgical procedures and technology, and mandate adjustments to Medicare reimbursement. (OAI-09-86-00076; OAI-85-IX-00046)	Section 6104 of OBRA 1989 required a further reduction from those imposed in OBRA 1987 in the Medicare reimbursement rates for CABG surgery and for cataract implant surgery effective April 1, 1990.	186.2

OIG Recommendation	Status	Savings in Millions
Continuous Ambulatory Peritoneal Dialysis Supplies: The HCFA should limit payment allowances to suppliers who deal directly with end stage renal disease (ESRD) patients to amounts allowable under a single composite rate to an ESRD facility. (CIN: A-09-87-00108)	Section 6230 of OBRA 1989 reduced payments for supplies to no more than the amounts paid under a single composite rate to an ESRD facility, beginning February 1, 1990.	$110
Child Support Enforcement for Non-Aid to Families with Dependent Children Clients: States should perform systematic review of all child support cases, including those from sources other than the Aid to Families with Dependent Children program, targeting those where absent parents earn more than $10,000 annually, and establish new or modify existing child support orders. (OAI-05-88-00340)	The Administration for Children and Families has encouraged the States to begin periodic review of all child support cases, and where appropriate, establish new orders or modify existing ones. Many States have taken the recommended action with positive results.	84
Hospital Patient Transfers: The HCFA should recover Medicare claims erroneously reported and paid as discharges for patients who were actually transferred to other prospective payment system hospitals and implement computer edits to prevent further overpayments. (CIN: A-06-89-00021)	The HCFA has implemented the recommended computer edits to prevent future overpayments of this nature.	36
Coordinate Third Party Liability Information: The Office of Child Support Enforcement (OCSE) should enforce current regulations regarding medical support by amending its Program Results Audit Guide and applying penalties to States found negligent in applying those regulations. (OAI-07-88-00860)	The OCSE amended its Program Results Audit Guide to reflect the medical support regulations and has penalized negligent States.	32
Optimal Cost of Medicare Claims Processing: A joint OIG/HCFA study determined the optimal cost of processing a Medicare claim. It provided detailed recommendations for use by individual contractors to achieve the optimal cost, and proposed best practice patterns applicable to all contractors. (CIN: A-14-89-00123)	The HCFA used the results of this study to effect savings in the amount of $37 million for FYs 1991 and 1992. The optimal costs were compared to contractors' actual costs, and adjustments were made to reduce individual contractors' budgeted claim costs when they fell above the optimal range.	18
Zip Code Software: The Social Security Administration (SSA) should acquire commercial zip code software to help ensure accurate address information and quicker mail delivery. (CIN: A-13-87-02656)	The SSA began using the 9 digit zip code for Supplemental Security Income benefit checks in November 1990 and for Retirement, Survivors and Disability Insurance benefit checks in March 1991.	2
Improper Cashing of Replacement Checks: The SSA should establish automated controls over double check negotiation eases. (CIN: A-13-86-62635)	The SSA has established automated controls as part of its debt management system.	1.3

APPENDIX B

Unimplemented OIG Recommendations to Put Funds to Better Use

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

OIG Recommendation	Status	Savings in Millions
Medicare Coverage of All State and Local Employees: Require Medicare coverage for all State and local employees, including those hired before April 1, 1986, or make Medicare the secondary payer for retirees of exempt agencies. (CIN: A-09-88-00072)	This proposal is included in the President's Fiscal Year (FY) 1993 budget.	$1,866
Indirect Medical Education: Modify Medicare payments to teaching hospitals by reducing the prospective payment system (PPS) adjustment factor. (ACN: 14-52018; ACN: 09-62003; CIN: A-09-87-00100; CIN: A-07-88-00101)	The President's FY 1993 Comprehensive Health Reform Program indicates that indirect medical education subsidies, for the most part, would be unnecessary under the President's reform proposal.	1,390
Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89151)	The Health Care Financing Administration (HCFA) disagreed with the recommendation. The OIG continues to believe that it should be implemented.	1,000
Identify and Recover Medicare Secondary Payer Claims: Seek legislation to facilitate the identification and recovery of Medicare secondary payer (MSP) claims. (CIN: A-09-89-00100)	Although the Congress rejected the insurance company and employer reporting proposal, HCFA and OIG support the proposal. The HCFA has implemented a number of measures to improve the identification of beneficiaries with private health plans primary insurance and is considering additional measures. The Department has reported the MSP issue as a high risk and material internal control weakness in the December 1991 Federal Managers' Financial Integrity Act report to the President and the Congress.	900

OIG Recommendation	Status	Savings in Millions
Revise Accounting for Penalties and Interest: The Social Security Administration (SSA) should support a legislative change to restore equity to the accounting process by requiring the Internal Revenue Service (IRS) to compensate the trust funds for interest and penalties collected which exceed the cost of IRS' administration of the Social Security tax. (CIN: A-13-86-62640)	Based on information from IRS, SSA does not believe that the current accounting method disadvantages the trust funds. The OIG has reqnested that the Department of the Treasury undertake a study of the current accounting method.	$844
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to various functions performed by the Food and Drug Administration (FDA), possibly including premarket review and approval for drugs and devices. (OEI-12-90-02020)	Various legislative proposals are being considered which would result in the expansion of user fees across FDA functions.	587
Extend Secondary Payer Provision: Extend the MSP provision for end stage renal disease (ESRD) beneficiaries beyond the current 1-year limit to the period of time that ESRD beneficiaries are covered by an employer group health plan (EGHP). (CIN: A-10-86-62016)	The provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1990 provisions partially implemented the OIG recommendation by extending the MSP provision for ESRD beneficiaries covered by an EGHP to 18 months. This extension would save an estimated $370 million for the 5-year budget cycle. The OIG still recommends that the MSP provision be extended to the period of time that ESRD beneficiaries are covered by an EGHP. The General Accounting Office is required to evaluate the effect of the extension. An interim report to the Congress is due in January 1993 and a final report is due in January 1995.	503
Clinical Laboratory Tests: Set the Medicare lab fee schedules at amounts comparable to what physicians are paying and ensure that profile tests are appropriately reimbursed. (CIN: A-09-89-00031)	The OBRA 1990 provisions reduced payments for laboratory tests by limiting the annual fee schedule increase to 2 percent and reducing the national cap to 88 percent. There is a proposal in the FY 1993 President's budget that would cap laboratory fee schedule amounts at 76 percent of the median national fee schedule amount and give the Secretary discretion in determining future update amounts for the fee schedule.	426
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt payment policy. (CIN: A-14-90-00339)	The HCFA is considering the option to include a bad debt factor in the diagnosis related group rates, and indicated that the OIG report should assist the Congress in understanding the rapid growth occurring in hospital bad debts.	400

OIG Recommendation	Status	Savings in Millions
Limit Participation in Foster Care Administrative Costs: To contain the rapid increase in State claims for administrative costs in foster care, controls or caps are needed. (CIN: A-07-90-00274)	The President's FY 1993 budget includes a legislative proposal to change the financing of State child welfare activities by creating and funding a new Comprehensive Child Welfare Services capped entitlement program. Under the proposal, each State will be required to maintain current efforts and previous levels of expenditures, and provide a match of 25 percent of funding, as opposed to the 50 percent match currently required for administrative costs.	$340
Reduce Payments of Medicaid Drug Expenditures: The HCFA should implement restricted drug lists. (OEI-12-90-00800)	The HCFA rejected this proposal since OBRA 1990, in its opinion, prohibits such restrictions.	226
Lodging Compensation: Include permanent lodging compensation for FICA coverage. (CIN: A-09-90-00050)	The SSA did not support the recommendation since it results in different Social Security and IRS treatment of the value of employer-supplied lodging and the IRS indicated the proposal would be difficult to administer. The SSA believes the impact of the proposal on the subject workers would be very small.	221

OIG Recommendation	Status	Savings in Millions
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services at the lower of cost or charges. (CIN: A-05-89-00055; CIN: A-05-92-00006)	The HCFA disagreed with the proposal, stating that payments for less than 1-day stays are part of the overall PPS formula which is designed to average out the payments among all Medicare cases. However, HCFA agreed that it may be appropriate to modify policy to encourage hospitals to treat cases involving observation after outpatient services as outpatient rather than inpatient cases, since it is not anticipated that these patients will require additional procedures. The HCFA intensified peer review organization (PRO) review of short-stay admissions as a first step in dealing with the problem, and has modified both the intermediary and hospital manuals in an effort to minimize the problem of inappropriate admissions. However, OIG's follow-up report indicated that problems still exist with intermediary instructions pertaining to inappropriate admissions, and that the instructions have not significantly reduced the volume of 1-day admissions on a national basis. The volume of 1-day admissions has increased approximately 150 percent over 1985 levels.	$210
Medicare Prepayment Review: MSP Carrier Procedures The HCFA should restore operations of the MSP units to a level equivalent to FY 1989, and consider demonstration projects to evaluate incentives to carriers to enhancing identification and recovery of inappropriate MSP payments. (OEI-07-89-01683)	The HCFA questions whether increased funding for the development of MSP situations is cost-effective, believing that other efforts will generate a larger return on investment. The HCFA will consider the question of demonstration projects in the A-19 process.	199
Recover Retirement, Survivors and Disability Insurance and Supplemental Security Income Benefits through Income Tax Refund Offset: Actively support legislation to allow offset of income tax refunds to recover certain Retirement, Survivors and Disability Insurance (RSDI) overpayments. Take administrative action to recover certain Supplemental Security Income (SSI) overpayments through income tax refunds. (OAI-12-88-01290; OAI-12-86-00065)	The OBRA 1990 grants the legislative authority to recover RSDI overpayments through income tax refund offset. The SSA is in the process of implementing the recommendation. The SSA continues to negotiate with IRS to administratively implement the SSI refund offset by FY 1993.	193.7

OIG Recommendation	Status	Savings in Millions
Tax Equity and Fiscal Reform Act Outpatient Limitation: Expand the list of procedures subject to the outpatient limitation and apply the limitation to physician services in additional settings. (CIN: A-07-86-62041; CIN: A-05-91-00006)	The HCFA is currently evaluating OIG's recommendations. After the 1992 implementation of physician payment reform, HCFA will evaluate payment levels for appropriate physician services furnished outside the office setting. If physician payment reform has failed to make the appropriate distinction based on site of service, the Department will consider legislative options.	$170
Reduce Payments for Intraocular Lenses: Medicare should pay a flat $150 for all intraocular lenses (IOLs). (OEI-07-89-01664)	The HCFA is currently prohibited by law from reducing the IOL reimbursement rate below the $200 cap until 1993.	169
MSP: Effectiveness of Current Procedures The HCFA should require contractors to match their private health insurance data with Medicare files to avoid inappropriate MSP payments. (OEI-07-90-00761)	The HCFA is currently prohibited from requiring Medicare contractors to match their health insurance data with Medicare files to identify MSP situations.	143.7
Expand Mandatory Tip Reporting Requirements: Expand the requirements for mandatory reporting of tip income to include other types of businesses where tipping is a common practice. (CIN: A-09-89-00072)	The Treasury is conducting an in-house study before considering whether to endorse the proposal.	134
Recover Value Lost to the Trust Funds from Past Due Debts: Institute a policy change to allow recovery for each delinquent overpayment at the higher of the interest income lost to the trust funds or the value lost to the trust funds due to inflation. (OAI-03-88-00680)	The SSA disagrees with the proposed method of recovery in the absence of a clear legislative mandate. The OIG remains convinced that the recommendation is appropriate.	112
Extracorporeal Shock Wave Lithotripsy: Apply inherent reasonableness factors to charges for extracorporeal shock wave lithotripsy (ESWL). (CIN: A-09-89-00082)	Although OBRA 1990 reduced payments for ESWL, these procedures are still overpriced.	110
Outpatient Surgery: Cataract Quality of Care Costs and Unnecessary Endoscopies The HCFA should rednce the incidence of payments for medically unnecessary and poor quality cataract surgeries, upper gastrointestinal endoscopies and colonoscopies throngh a combination of efforts by PROs and carriers, including targeted review of certain providers. (OEI-09-88-01005; OEI-09-88-01006)	Contingent upon the approval of the fourth scope of work, PROs will review a 3 percent sample of outpatient surgeries for medical necessity and quality of care.	106.1

OIG Recommendation	Status	Savings in Millions
Recover Medicare Funds From Terminated Pension Plans: Recover Medicare's share of pension asset reversions from terminated pension plans. (CIN: A-07-90-00262; CIN: A-07-88-00134)	The HCFA and OIG have mutually agreed to seek a joint HCFA/OIG Office of General Counsel opinion on the propriety of OIG's recommendations to recover Medicare funds from terminated pension plans, both retrospectively and prospectively.	$92
Conventional Eye Wear: Exclude conventional eye wear from Medicare coverage for beneficiaries receiving IOL implants. (CIN: A-04-88-02038)	The OBRA 1990 limits coverage to one pair of eyeglasses following cataract surgery with an IOL implant.	72
Use Credit Reporting Agencies to Help Collect Debts: The SSA should seek legislative authority to use credit reporting agencies to locate debtors and report certain delinquent debtors to credit reporting agencies. (CIN: A-03-89-02610)	The SSA will assess the utilization of income tax refund offset before cousidering whether to seek authority to use credit reporting agencies.	52.4
Recover Medicare Payments Made for Beneficiaries Eligible for Other Government Health Insurance: Recoup part of unauthorized Medicare payments made on behalf of the Uniformed Services Treatment Program members. (CIN: A-I4-90-00325)	The HCFA agreed to the recommendation. The OIG will verify the effectiveness of HCFA's corrective action plan.	50
Repay Mortgages Early: Use trust fund money to liquidate the remaining mortgage balances on three program service center buildings. (CIN: A-09-88-00131)	The SSA reduced the mortgages, but has not paid them off. The tight budget of the last few years has not provided ample discretionary funds to pay off the mortgages, nor will any be available in the foreseeable future.	48
Inpatient Psychiatric Care Limits: New limits should be developed to deal with the high cost and changing utilization patterns of inpatient psychiatric services. (CIN: A-06-86-62045)	There is no legislative proposal addressing this issue in the FY 1993 President's budget.	48
First Month of Eligibility: The SSA should submit a legislative proposal establishing a consistent definition of eligibility for age-based retirement and survivor payments. (OEI-12-89-01260)	The SSA did not agree with the recommendation and thought that it should be supported with a stronger rationale.	40

OIG Recommendation	Status	Savings in Millions
Improve Recovery of SSI Overpayments through Cross Program Adjustment: More aggressively pursue cross program adjustment as a means of collecting the outstanding debts owed by former SSI recipients who are current RSDI beneficiaries. Resubmit a legislative proposal authorizing the adjustment of RSDI payments to recover overpayments from former SSI recipients. (OAI-12-87-00029)	The President's FY 1993 budget includes a provision to recover SSI overpayments through reduction of Social Security benefits.	$34
Monitored Anesthesia The HCFA should study the appropriateness of paying the same amount for monitored anesthesia care and general anesthesia in view of the fact that other insurers are more restrictive than Medicare. (OEI-02-89-00050)	Further discussions are planned with HCFA regarding this recommendation.	28
Age Attainment: The SSA should define attainment of age as occurring on one's birthday instead of following the common law that age attainment occurs on the day before a person's birthday. (CIN: A-09-89-00073)	The SSA did not concur since it believed administrative costs would outweigh savings and that short term savings would be offset by long range costs.	21.4
Halt Medicaid Payments for Less than Effective Drugs: Work with FDA to provide to all States periodic lists of less than effective drugs identified by FDA. (CIN: A-03-89-00320)	The OIG has been iuformed that on March 12, 1992, HCFA and FDA entered into an intra-agency agreement (IAA) under which both agencies agreed to share, on a periodic basis, information on less than effective and identical, related and similar drugs. The HCFA anticipates that the first list resulting from the IAA will be provided to the States by July 1, 1992.	16
Develop Cost Standards for Disability Determination Services: Formulate disability determination services (DDS) cost-per-case (CPC) standards as quickly as possible and adopt the reimbursement method for laboratory fees used by Medicare for use by the DDSs. (OAI-06-88-00822; OAI-06-88-00820)	The SSA will issue a regulation outlining cost standards based on the CPC allocation process; however, one full year of experience with the CPC allocation system is necessary prior to formulation of a regulation. The revised target date is October 15, 1992. A new draft notice of proposed rulemaking has been developed which would apply Medicare laboratory fee schedules for use by DDSs. The SSA will defer action however, until gaining a year's experience using the new consultative examination regulation which was published in the Federal Register on August 1, 1991.	15.3

OIG Recommendation	Status	Savings in Millions
Improve Reclamation Procedures: Deficient Treasury procedures related to reclaiming check payments involving unauthorized endorsements caused losses to the trust funds. The SSA should negotiate with Treasury for more direct involvement in the reclaiming of checks. (CIN: A-04-87-03005)	The SSA agreed that there were problems in the reclamation process, but stated that SSA lacks the authority to correct the problem. The SSA suggested that OIG report this to an oversight body.	$10.5
Modify Earnings Enforcement Process: The SSA should modify its earnings enforcement operation to include late posted earnings reports, suspense reinstatements, and earnings adjustments and corrections. (CIN: A-13-89-00031)	The SSA's automated data processing (ADP) plan now contains initiatives to include late posted earnings, suspense reinstatements, and earnings adjustments and corrections. However, SSA estimates actual savings will be much lower than OIG's projections.	10
Eliminate a Separate Carrier for Railroad Retirement Beneficiary Claims: Discontinue the use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)	The HCFA is currently evaluating OIG's recommendation.	9.1
Revise Criteria for Waiving Overpayments: The SSA should pursue a regulatory or statutory change in waiver criteria to eliminate waivers for persons under age 59 so that it could pursue collection when and if the individual developed an ability to repay. (CIN: A-05-90-00034)	The SSA disagreed with OIG's recommendation.	9
Issue Social Security Numbers for Noncitizens: Issue original Social Security numbers for noncitizens based on electronic transfer of data collected by the Immigration and Naturalization Service (INS). (OEI-05-88-01060)	The INS has informed SSA that it cannot agree to assume an enumeration role due to resource considerations. The OIG asked SSA to give further consideration to its recommendation suggesting a small scale test that would have minimal impact on INS resources.	8.2
Collect Nonresident Alien Taxes: Use automated systems to identify and collect alien taxes involving benefit payments for retroactive periods. (CIN: A-13-90-00041)	The SSA's ADP plan now includes a project to address this issue.	7.7
Abandoned Reclamations: The SSA and Treasury need to improve policies and procedures regarding abandoned reclamations. (CIN: A-04-89-03021)	Several problem areas between SSA and Treasury are still in need of negotiation and resolution, including abandoned reclamations.	7.7
New Cards for New Brides: The SSA should actively pursue the acquisition of computerized marriage records from States having this capability. (OEI-06-90-00820)	The SSA agreed with this concept, but will study quantitative and cost issues before agreeing to implement.	5.5

OIG Recommendation	Status	Savings in Millions
User Fees for Attorneys: Determine administrative costs for processing attorney fee payments and assess user fees. (CIN: A-13-90-00026)	The SSA rejected this proposal since it believes it needs legislative authority.	$5
Zip Code Software: Acquire commercial zip code software which will verify and correct address records, attach carrier route and zip+4 codes to address field, etc. (CIN: A-13-87-02656)	The SSA began using the 9-digit zip code for benefit check mailings and further savings may be achieved.	3
Intercept Direct Deposit Transfer to Deceased Beneficiaries: The SSA should arrange for interception of erroneons direct deposit payments made to beneficiaries who died after the 23rd of the month. (CIN: A-13-89-00037)	The SSA rejected OIG's proposal.	2.9
Mail Practices: The SSA should use third-class bulk mailing where feasible. (CIN: A-13-89-00038)	The SSA did not agree to use third-class mail for some recommended mailings, but plans to conduct a study to determine its feasibility for other mailings.	2.5
Reimbursement for Multiple Source Prescription Drugs: The HCFA should review its prices on the upper limit list for possible savings. (OEI-03-91-00470)	The HCFA is considering the proposal.	2
Discontinue Payment for Broken Medical Appointments: The SSA should not pay State agencies for consultative exams that are canceled or otherwise not kept. (CIN: A-01-87-02004)	The SSA has deferred action until after a year's experience with the new consultative examination regulations has been acquired.	0.9

APPENDIX C

Unimplemented OIG Program and Management Improvement Recommendations

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

OIG Recommendation	Status
Kidney Acquisition Cost: The Health Care Financing Administration (HCFA) should support demonstration projects incorporating kidney transplantation and acquisition under a diagnosis related group. (OEI-01-88-01331)	The HCFA is considering the recommendation.
Medicare Carrier Assessment of New Technologies: The HCFA should foster greater consistency among carriers in their coverage and pricing decisions, by providing carriers with selective access to comparative information on new technologies, reviewing carrier performance and working with the Public Health Service (PHS) to disseminate information on new health care technologies. (OEI-01-88-00010)	The HCFA indicated that it recognized the problems with the carrier assessment of new technologies and had taken steps to correct the problems. The OIG plans to conduct a follow-up study to determine if effective actions have been completed.
Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake: The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify the Department of Health and Human Services (HHS) disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to PHS, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040)	The OASH has taken the lead in this area and has met with headquarters operating division emergency preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved.
Coping With Twin Disasters - HHS Response to Hurricane Hugo and the Loma Prieta Earthquake: The OASH should issue guidelines to improve disaster planning. The plans of each operating and staff division should spell out lines of communication with each other, and should specify headquarters and regional lines of communication with the Federal Emergency Management Agency. (OEI-09-90-01040)	The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department.
Integrity of Medical Evidence in Disability Determinations: The Disability Determination Services (DDS) quality assurance procedures should include a sample check of physician reimbursements against the files containing the evidence for which payment was made. (OEI-03-88-00670)	The Social Security Administration (SSA) is developing procedural guidelines which will require DDSs to conduct sample checks by its quality assurance units to compare medical evidence payment vouchers with the medical evidence in the file.

OIG Recommendation	Status
False Evidence Submitted to Obtain a Social Security Number: The SSA should systematically identify all original Social Security number (SSN) applications from U.S. born applicants over age 24 and require a second level review of such applications. (OEI unnumbered management advisory report, October 1987)	The SSA conducted a nationwide study of selected SSN applications to validate the results of an earlier regional study. A report of the study is scheduled for completion in 1992.
Recovery of Retirement, Survivors and Disability Insurance Overpayments through Income Tax Refund Offset: The SSA should determine the SSNs of the overpaid former auxiliary beneficiaries for whom SSNs are unknown. (OEI-12-91-00610)	The SSA determined and updated its Master Beneficiary Record with the SSNs of former auxiliary beneficiaries. Tax refund offset proceedings will begin in tax year 1992.
Social Security Payments for Vocational Rehabilitation: The SSA should require the States to establish a formal mechanism to screen and enroll those SSA clients who show the greatest potential for successful rehabilitation. (OAI-07-89-00950)	The SSA is reviewing the entire area of vocational rehabilitation referral, and has established a task force with the Rehabilitation Services Administration to jointly develop a framework for better screening mechanisms and a more effective referral process.
Improvements Needed in Processing Controls for Retirement, Survivors and Disability Insurance Diary Actions: The SSA should emphasize to staff the importance of completing diaried actions, incorporate standards into managers' merit pay plans and perform internal control reviews after the proposed automated diary system is completed. (CIN: A-13-88-00024)	The SSA has issued regular reminders regarding prompt processing; rejected OIG's proposal to include items in merit pay plans; and incorporated plans to evaluate the effectiveness of the new system.
Suspended Payments Need to be Resolved Timely: The SSA should, in direct deposit cases where the beneficiary is placed in suspense status, institute stronger controls to ensure that timely action is taken to resolve these suspensions so that SSA can either terminate or reinstate payments. (CIN: A-13-89-00027)	The SSA agreed to proceed with policy and procedural changes.
Modernized Claims System Needs Controls to Compensate for Lack of Separation of Duties: The SSA needs to implement controls in the modernized claims system since employees are authorized to take, develop, adjudicate and effect payment on a claim without any independent review or compensating controls. (CIN: A-13-89-00025)	The SSA generally agreed and has proposed corrective action.
Undeliverable Notices Need to be Better Controlled: The SSA needs better controls to make the undeliverable notice process an effective tool for detecting unreported deaths. (CIN: A-13-88-00035)	The SSA agreed to make improvements.
Representative Payee Procedures: The SSA should review accountability reports to identify high risk cases and verify the information reported, and should also verify a random number of reports. (CIN: A-07-90-00266)	The SSA performed a study to determine high risk representative payees and developed plans to perform other verifications as additional resources permit.

OIG Recommendation	Status
Improved Controls Necessary in Field Office Processing of Death Alerts: The SSA should ensure that field offices comply with instructions for processing death alerts and issue monthly reports to management on cases pending over 60 days for beneficiaries in current pay. (CIN: A-09-90-00044)	The SSA agreed to remind field offices of procedures and to more closely monitor compliance. A systems capability to have on-line information is under consideration.
Improved Controls Necessary in Field Office Processing of Death Alerts: The SSA should provide for a separation of duties in death alert processing at field offices since staff are also involved in other claims data. (CIN: A-09-90-00044)	The SSA generally agreed to improve controls.
Further Improvements Necessary to 800 Telephone System: The SSA shonld decrease the number and increase the size of telephone centers, make better nse of technology and back-up agents to increase handling capacity and accuracy, and initiate a pilot to determine whether the telephone centers could become full service centers. (CIN: A-09-90-00071)	The SSA agreed to consider OIG's recommendations.
Review of HCFA's Cost Allocation System for Fiscal Year 1988: The Assistant Secretary for Management and Budget (ASMB) shonld provide HCFA with guidance on how to refine its cost allocation system and periodically monitor the system to ensure that it is being properly implemented and maintained. The HCFA should establish a system to document actual central office staff activities; distribute administrative costs to the trust funds and the general fund on the basis of actual employee activity; and identify costs contained in the administrative cost pool as either direct or indirect. (CIN: A-04-89-02036)	The HCFA and ASMB agreed with the recommendation. The cost allocation system has been revised and is being tested.
Follow-up to the General Accounting Office's Audit of the Medicare Healthchoice Demonstration Project: The HCFA should establish a divisionwide policy for data release using the Data Release User Guide developed by the Bureau of Data Management and Strategy (BDMS) as a model; require Privacy Act coordinators within each component to adhere to this policy; and designate BDMS as the focal point for the continued development of data release policies and procedures. These policies and procedures should be fully coordinated with HCFA's Privacy Act officer. (CIN: A-14-90-02048)	The HCFA originally concurred with the General Accounting Office's (GAO's) recommendation and developed a Data Release User Guide. However, HCFA has not yet issued the guide as divisionwide policy.

OIG Recommendation	Status
Follow-up to GAO Audit on Use of Medicaid Data to Monitor Controlled Substance Diversion: The HCFA should work with the Department of Justice (DOJ) to identify ways in which the Medicaid management information system (MMIS) controlled substance data can be used by regulatory, licensing and law enforcement agencies. It should also make information obtained from OIG's computer program for MMIS controlled substances data available through DOJ to law enforcement, regulatory and licensing agencies outside the Medicaid program. (CIN: A-14-90-02047)	The HCFA has developed a corrective action plan and implementation is underway.
Indian Health Service Contracting Practices: The Indian Health Service should implement post-award monitoring of contract compliance and document all contract compliance evaluations; establish post-award monitoring performance standards for all project officers; establish a process to ensure that project officers are provided with evaluations and data on a contractor's performance; and establish a process for the review and approval of pnblic vouchers by the project officer. (CIN: A-06-89-00066)	The Oklahoma City Area Office concurred with all of OIG's proposals. Corrective actions were completed by PHS in all areas except for the establishment of a process to ensure that project officers are provided with evaluations and data on a contractor's performance. The PHS stated that a written policy is being developed to ensure that project officers receive this information.
Commissioned Corps Identification Cards: The OASH should immediately perform a review of internal controls over the issuance of Commissioned Corps identification cards. (CIN: A-15-91-00010)	The PHS has scheduled the internal control reviews of card issuance for Fiscal Year (FY) 1993.
New Cards for New Brides: The SSA should target its public information efforts to newlyweds. (OEI-06-90-00820)	The SSA is implementing this recommendation by developing public service advertisements, mailing posters to State Burean of Vital Statistics offices and field offices for display in the community, and rewriting an employee pamphlet.
Project Clean Data: The SSA should develop, maintain and widely disseminate a software package for detecting invalid SSNs patterned after Project Clean Data. (OEI-12-90-02360)	The SSA agrees with the objective but believes greater use of the ennmeration verification system would be more effective. The SSA will conduct a pilot test in FY 1992 to assess employer interest and use.
Availability of Representative Payees: The SSA should correct coding problems to facilitate ongoing monitoring of beneficiaries who require representative payees. (OEI-02-89-01420)	The SSA agreed and is taking corrective action.
Drug Addicts and Alcoholics: The SSA should work with PHS and HCFA to develop clearer definitions for drug addiction and alcoholism status, treatment and successful rehabilitation. (OEI-02-90-00950)	The SSA agreed that significant improvements are needed in this process and identified the cooperative efforts that are planned to make the indicated improvements.

OIG Recommendation	Status
Delayed Notices of Planned Action: Because of the potential cost implications of field office failure to maximize opportunities for overpayment avoidance by using manual notices of planned action in the Supplemental Security Income (SSI) program, OIG recommended that SSA initiate a review to determine the extent of the problem. (OEI-04-90-02160)	The SSA had already planned a comprehensive review of the same subject. The OIG will defer its actions until after the results of SSA's studies are compiled.
Carrier Maintenance of Provider Numbers: The HCFA should establish adequate safeguards for detection of abusive providers. (OEI-06-89-00870)	The HCFA is taking steps to address the problems identified in the report, which OIG will monitor.
Independent Physiological Laboratories: The HCFA should increase its monitoring of independent physiological laboratories (IPLs), including determining what testing is appropriate in IPLs, and establishing a regulatory or certification program to promote stronger quality assurance in IPLs. (OEI-03-88-01400)	Although it will not pursue the actions outlined in the recommendations, HCFA is studying data from Medicare carriers and its regional offices to determine if it is necessary to regulate or set standards for these laboratories.
Equipment Inventory: The SSA should perform an inventory of all equipment, document accountability for it and adjust the general ledger to agree with subsidiary records. (CIN: A-13-91-00210)	The SSA has completed a physical inventory of all equipment, and acquired and implemented an accountability system which should improve controls over all types of equipment. However, the accounting records have not been adjusted to reflect the results of the physical inventory.
Certified Wages: The SSA should take prompt action to certify wages for tax years after 1978 by using as a basis its own wage records or seeking legislation to change the basis. (CIN: A-13-91-00210)	The SSA sought GAO's views, which provided options for consideration. The SSA plans to resolve this issue quickly.
Illegal Work Activity and Duplicate SSN Cards Associated with Deported Aliens: The SSA should implement a systems control to identify earnings reported to deported aliens, refer this information to the INS and prevent issuance of duplicate SSN cards to deported aliens. (CIN: A-05-88-00070)	The SSA generally concurred and agreed to develop systems controls.
Improvements Needed in Processing Delayed Claims: The SSA should follow procedures and better utilize its claims control system to prevent claims from remaining in delayed status for unreasonable periods. (CIN: A-06-88-00037)	The SSA generally agreed and stated that changes have been made or are in the process of being made.
Better Controls Would Help Post More Earnings to Wage-Earners' Accounts: The OIG made 29 recommendations which, if implemented, should substantially improve SSA's capability for correcting name and SSN errors for reported earnings. (CIN: A-13-89-00040)	The SSA agreed with most of the recommendations. It has started to implement some of these as well as other recommendations made by its own work group convened to explore wage reporting problems.
Financial Management: The SSA needs to improve controls relating to financial management in the SSI program. (CIN: A-13-90-00036)	The SSA did not concur.

OIG Recommendation	Status
Debt Management: The SSA should expedite the development and implementation of its new debt management system. (CIN: A-13-91-00210)	The SSA agreed. It has made considerable progress with phased implementation.
Payments to Vocational Rehabilitation Agencies: To prevent making reimbursements without adequate supporting documentation, SSA should continue to review minimum documentation criteria, identify overpayments and pursue collection. (CIN: A-13-91-00210)	The SSA has implemented a process to evaluate the adequacy of documentation and to identify overpayments with individual claims.

ACRONYMS

ACF	Administration for Children and Families
ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
ADP	automated data processing
AFDC	Aid to Families with Dependent Children
AoA	Administration on Aging
ASC	ambulatory surgical center
ASMB	Assistant Secretary for Management and Budget
ATF	alcoholism treatment facility
bST	bovine somatotropin
CABG	coronary artery bypass graft
CFO	Chief Financial Officer
CHC	community health center
CMHC	community mental health center
CMP	civil monetary penalty
CPC	cost per case
CSE	child support enforcement
CY	calendar year
DCA	Division of Cost Allocation
DDS	disability determination service
DME	durable medical equipment
DMS	debt management system
DOJ	Department of Justice
DRLS	drug registration and listing system
DUR	drug utilization review
EGHP	employer group health plan
ESRD	end stage renal disease
FDA	Food and Drug Administration
FFP	Federal financial participation
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
ICA	internal control area
ICR	internal control review
IHS	Indian Health Service
IMD	institution for mental diseases
INS	Immigration and Naturalization Service
IOL	intraocular lens
IRS	Internal Revenue Service
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance Program
LTE	less than effective
MHC	migrant health center
MMIS	Medicaid management information system
MMP	mail management plan
MSP	Medicare secondary payer
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
OASH	Office of the Assistant Secretary for Health
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
OPD	outpatient department
OS	Office of the Secretary
PCIE	President's Council on Integrity and Efficiency
PHS	Public Health Service
PPS	prospective payment system
PRO	peer review organization
RSDI	Retirement, Survivors and Disability Insurance
SEDS	social and economic development strategies
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
WC	workers' compensation
WCF	Working Capital Fund

DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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