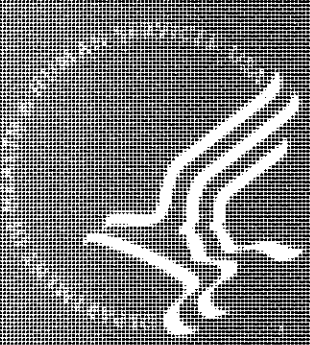


# Semiannual Report

April 1, 1994 - September 30, 1994

## Office of Inspector General

June Gibbs Brown
Inspector General

## STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

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

Office of Management and Budget Circulars:

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

General Accounting Office "Government Auditing Standards"

### CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

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

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

# A MESSAGE FROM THE SECRETARY

I would like to acknowledge the excellent collaborative working relationship which the Department of Health and Human Services (HHS) and the Office of Inspector General (OIG) have enjoyed throughout this fiscal year. While the OIG mission requires that it act as an independent fact-finder, we must ultimately work in partnership to achieve meaningful improvements in HHS programs and operations.

Two of the most striking measures of OIG's accomplishments have been the sizeable savings to the Federal Government which result from its activities and recommendations, and the notable return on the dollars invested in OIG. Moreover, through its reviews in such areas as quality of care, the welfare of beneficiaries and program and management effectiveness, OIG has worked to ensure the integrity of departmental systems and the achievement of program goals.

By employing a strategy of early intervention, OIG has enabled the Department to identify potential problems and take timely action to avert them. In a review of Medicare's onsite inspection program for screening mammography facilities, for example, OIG highlighted issues that the Food and Drug Administration recently used in implementing the Mammography Quality Standards Act.

Accepting the challenge to reinvent the way it does business, OIG has worked to meet its objectives in creative ways. To maximize effectiveness, OIG joined with the Department of Justice and other Federal agencies in an unprecedented cooperative effort to combat fraud in the health care area. Recently, OIG tested a new methodology for conducting contract preaward audits, which saved both staff days and dollars. The OIG has also initiated a partnership in which State and OIG auditors work together to identify cost savings in the growing Medicaid program — results that will benefit both Federal and State Governments.

Through efforts such as these, I am confident that OIG will continue to assist us in identifying ways to improve departmental efficiency and effectiveness, and to put our customers first.

Donna E. Shalala

# FOREWORD

I am pleased to present this semiannual report of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) describing our accomplishments during the 6-month period ending September 30, 1994.

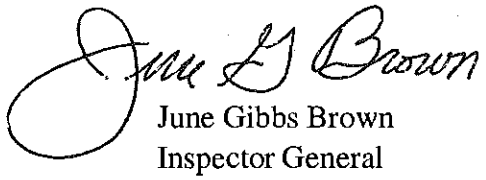
Since becoming HHS Inspector General almost 1 year ago, I have been impressed with the breadth of OIG's mission and immensely proud of its achievements. The HHS is one of the few Government agencies that touches all Americans, whether they are Medicare beneficiaries, patients benefitting from HHS-sponsored biomedical research, consumers of food or drugs, Head Start children or recipients of social services. Even with the imminent establishment of the Social Security Administration (SSA) as an independent agency, HHS and its programs will still impact the lives of most Americans.

Fiscal Year (FY) 1994 has been a time of great challenges. Our continuing resource constraints demand that we direct our activities with great care while streamlining our work force and expenditures. This is a challenge all Government agencies are facing, and we take it very seriously.

At the same time, FY 1994 has been a year of noteworthy successes. Our total savings surpassed $8 billion, which represents $80 in savings for each dollar invested in OIG and $6.4 million in savings per OIG employee. Our accomplishments included a record $379 million settlement of criminal fines, civil damages and penalties for fraud and kickbacks by a health care corporation; reviews of the National Institutes of Health's oversight of inventions arising from extramural research; audits of administrative costs charged to the Medicare program; and a series of studies of the SSA representative payee process.

To leverage our limited resources, we continue to coordinate our activities with a number of outside entities, especially in the health care area. Working with the Department of Justice, the Federal Bureau of Investigation and the HHS Office of General Counsel, we are developing a "voluntary disclosure" program to offer certain federally-funded health care providers incentives to disclose any fraud and abuse they discover within their companies. We are also embarking on a Federal/State partnership with State auditors to provide broader audit coverage of significant Medicaid issues.

In this period of streamlining and fiscal austerity, HHS requires full use of its resources to successfully carry out its mission. The OIG is firmly committed to helping the Department develop the tools and safeguards to meet its goals efficiently and effectively. With the continued dedication of OIG staff, and the cooperation and support of departmental managers and the Congress, we look forward to meeting the challenges that lay ahead.



June Gibbs Brown
Inspector General

# HIGHLIGHTS

In this second half of Fiscal Year 1994, the Office of Inspector General (OIG) has undertaken several major initiatives to protect the integrity of departmental operations and programs and the health and well-being of the beneficiaries served by those programs. Some of OIG's most significant accomplishments during this period are identified below.

**Reducing Unnecessary Spending:**

- The OIG determined that Medicare paid an estimated $85 million or more for medical services that should have been paid by a Medicare contractor's private line of business. (See page 4)

- The OIG estimated that Medicaid could save as much as $46 million if therapeutically equivalent generic drugs were used in place of 37 high volume dispensed brand name drugs. (See page 27)

- In a study of 300 cases of beneficiaries who received physical therapy services in physicians' offices, OIG found that nearly 4 out of 5 cases did not represent true physical therapy services. The OIG concluded that $47 million was inappropriately paid in 1991. (See page 20)

- The OIG determined that 95 percent of claims for orthotic body jackets in 1991, $7 million worth, were not legitimate and should not have been paid to suppliers. (See page 22)

- The OIG found that the Federal Government has not received credit from Puerto Rico for its share of $55.2 million in escheated warrants (uncashed, canceled checks). (See page 75)

- The OIG determined that California did not credit Federal programs with their proportionate share, estimated at $111 million, when excess pension funds were used to pay for State operations. (See page 75)

**Preventing and Detecting Fraud and Abuse:**

- As a result of a nationwide project involving OIG investigators, auditors and attorneys, a major health care firm agreed to a $379 million settlement for paying physicians for referrals to the firm's psychiatric hospitals. (See page 18)

- Sixteen persons were sentenced in New York for their part in an $8 million Medicaid fraud scheme involving medical clinics, bringing the final number sentenced to 33. (See page 13)

- An Ohio woman posing as a "Medicare representative" was sentenced to 8 to 15 years for burglary. (See page 13)

- A Texas physician was excluded indefinitely from the Medicare and State health programs after his license was revoked for abusing two male patients. (See page 14)

- A California pharmacist was excluded for 10 years for unlawful distribution of controlled substances. (See page 15)

- A heart valve manufacturer agreed to pay $10.75 million for concealing information during the approval process that the valves were inclined to fracture. (See page 16)

- The final 9 of 88 persons involved in accepting kickbacks from a Georgia chiropractor entered pretrial diversion agreements. (See page 19)

- A judgment of $21 million was entered against a major durable medical equipment supplier in Pennsylvania who pled guilty to mail fraud in a telemarketing scheme. (See page 24)

- A Louisiana ambulance company agreed to pay $1.86 million to settle false Medicare claims for transporting patients for dialysis. (See page 17)

**Identifying Systemic Management Problems:**

- The Health Care Financing Administration (HCFA) is promptly acting on OIG's recommendations to implement needed payment edits at Medicare contractors nationwide. (See page 21)

- The OIG found that accounts payable to the Medicare trust funds were inconsistently calculated and reported because HCFA's financial reporting instructions were inadequate. (See page 2)

- The OIG's recommended use of automated peripheral vision testing devices for assessing disability should not only save Social Security money, but also

eliminate current claimant inconvenience and reduce assessment delays. (See page 36)

- The OIG found that, as a result of inadequate oversight, many extramural research inventions created with National Institutes of Health money were not being patented in a way that ensured protection of Federal financial interests. (See page 46)

- In a report on the Ryan White Comprehensive Acquired Immune Deficiency Syndrome Resources Emergency Act, OIG presented four options to the Public Health Service for funding formulas that could be used to address a number of inequities found in the program and to target funds to the greatest need. (See page 51)

**Promoting Improved Service Delivery:**

- In its annual series of reports on Social Security client satisfaction, OIG found that overall satisfaction had leveled off after a few years of decline, that clients were generally satisfied with service, but that no progress had been made on eight important service objectives since 1992. (See page 32)

- The OIG, working with the Administration for Children and Families (ACF), analyzed shortcomings in both the overall approach to and the conduct of Federal oversight of State child welfare programs, and offered several options to improve oversight. (See page 61)

- The OIG provided options for ACF to consider in improving foster care eligibility determinations. (See page 59)

- The OIG suggested opportunities for improvement in the health and safety practices of child care providers. (See page 60)

**Developing and Assessing Performance Measures:**

- The OIG determined that HCFA's financial management systems need improvement to support the preparation of financial statements. (See page 3)

- A study of the Refugee Matching Grant program found that, while it allows voluntary agencies and their affiliates to provide a valuable range of integrated services, its effectiveness measures are inadequate. The OIG recommended that the Office of Refugee Resettlement develop performance indicators to improve the program. (See page 64)

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

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## Chapter V GENERAL OVERSIGHT

# Health Care Financing Administration

## Chapter I

# HEALTH CARE FINANCING ADMINISTRATION

## Overview of Program Area and Office of Inspector General Activities

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare and Medicaid programs. Medicare Part A provides hospital and other institutional insurance for persons age 65 or older and for certain disabled persons. Financed by the Federal Hospital Insurance (HI) Trust Fund, Fiscal Year (FY) 1994 expenditures for Medicare Part A are expected to exceed $101 billion. Medicare Part B (Supplementary Medical Insurance, or SMI) is an optional program which covers most of the costs of medically necessary physician and other services. Financed by participants and general revenues, FY 1994 expenditures for Medicare Part B are estimated at $57 billion.

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

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

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

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

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

Fraud and abuse of the Medicare and Medicaid programs or their beneficiaries may result in criminal, civil and/or administrative actions against the perpetrators. During the second half of the fiscal year, OIG was responsible for a total of 812 successful actions against wrongdoers in these programs.

## Hospital Insurance and Supplementary Medical Insurance Trust Funds' Accounts Payable Balance

The OIG identified problems with the design and implementation of HCFA's internal control structure and accounting policy used to report HI and SMI accounts payable balances. Specifically, OIG found that HCFA's financial reporting instructions to fiscal intermediaries (FIs) were too general, causing accounts payable amounts to be calculated and reported inconsistently and supporting documentation not to be retained. Accounting policy issues also need to be addressed because peer review organization (PRO) adjustments were not included in the accounts payable amount, and certain benefit payment checks and contracted services were improperly included in the accounts payable balance. The OIG also is concerned that adjustments made to an actuarial estimate were not reasonable to report the accounts payable amount for services incurred by Medicare beneficiaries but not billed at the year-end close by the providers. The HCFA generally concurred with OIG's recommendations. (CIN: A-05-92-00106; CIN: A-04-92-02054)

## Implementation of the Federal Managers' Financial Integrity Act: Fiscal Year 1993

In a review of HCFA's implementation of the FMFIA program for FY 1993, OIG found that HCFA continues to make progress in improving the FMFIA process and establishing effective controls. However, improvements are needed. The OIG recommended that HCFA modify its plan that covers the Medicare contractors' management controls and financial management systems to ensure that it has adequate coverage of the contractors under FMFIA. Further, OIG proposed that HCFA: review the functions of the Office of the

Actuary; reclassify all management control areas with pending material weaknesses or Office of Management and Budget (OMB) high-risk designation as a high risk; expand financial management system reviews; reestablish the cost allocation system material weakness until all components have properly implemented the system; perform corrective action reviews on all corrected material weaknesses; and reevaluate the corrective action plan for the Medicare secondary payer high-risk area. The FMFIA area is being revisited by OMB. These recommendations may be subject to reconsideration based on revisions to OMB Circular A-123. (CIN: A-14-93-03026)

## Financial Management Systems

The OIG conducted a review to determine whether information processed through HCFA's financial management systems supported the amounts contained in Medicare financial reports. While HCFA has made improvements to its financial reporting by incorporating accrued financial data into its general ledger system, OIG believes that HCFA's financial management systems need improvement to support the preparation of financial statements and meet OMB requirements.

The OIG recommended that HCFA take action to ensure that: actual disbursement information is recorded timely by the Medicare contractors and HCFA; all accounts payable are adequately recorded and reported; all Medicare liabilities are recorded in the general ledger at fiscal year end; capitalized HCFA equipment in the possession of contractors is included in the general ledger; assets paid from the trust funds and liabilities owed from the trust funds are properly distributed to the Medicare trust funds; the value of automated data processing hardware and software is properly reported; all transactions from the entire life cycle of a transaction are promptly recorded and properly classified; and all of the subsidiary financial management systems that process, control and account for Medicare financial transactions and resources are designed to be an integral part of HCFA's overall financial management system. The HCFA agreed with most of the recommendations. (CIN: A-14-92-03015)

## Electronic Data Interchange and Paperless Processing

This OIG report identifies emerging issues in the expansion of HCFA's use of electronic data interchange and related technology to achieve paperless processing. Some significant issues affecting implementation of this initiative are: the development of systems to process electronically submitted claims and manage data more efficiently; the establishment of standards to facilitate the electronic flow of data among providers, payers and quality of care reviewers; the identification of incentives and barriers, to encourage providers to submit claims and patient data electronically; and the use of companion technologies.

The report also discusses concerns involving the trustworthiness and reliability of data as it moves from one partner in electronic commerce to another and from one process to another.

These include: confidentiality and privacy; management controls over operations; audits and systems certifications; Medicare contractor conflicts of interest; validity of contracts; and integrity of information. In addition to having a significant impact on the Department's and HCFA's ability to manage the Medicare and Medicaid programs, these issues are critical to the detection of fraud and abuse. The OIG will further analyze these various concerns in planning its future work in this area. (OEI-12-93-00080)

## Medicare Secondary Payer: Empire Blue Cross Blue Shield

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

While HCFA reported that it had completed most of the milestones in its 1993 corrective action plan, HCFA, the Department and OMB have determined that it would be inadvisable to close this material weakness/high risk area prior to the establishment of more effective systems for preventing inappropriate primary payments by Medicare, managing the backlog of recoveries and strengthening HCFA's accounts receivable system.

During this 6-month period, at HCFA's request, OIG reviewed Empire Blue Cross Blue Shield's compliance with the Medicare secondary payer (MSP) provisions. The OIG determined that substantial improper Medicare primary payments were made by HCFA contractors when Empire private lines of business should have been primary payer for these medical services. The OIG estimated that approximately $85 million in improper payments were made during the period January 1, 1983 through November 20, 1989 for beneficiaries subject to the working-aged criteria of the MSP statute. In addition, OIG was unable to render an opinion on another $118 million in potentially improper payments since Empire customers did not cooperate or OIG was unable to contact the customers based on information provided by Empire. Most improper payments identified were the result of the inappropriate sale by Empire of secondary coverage rather than primary coverage to its customers.

The OIG recommended that HCFA negotiate a reasonable settlement with Empire to recover sums improperly paid by HCFA contractors, including the $85 million and the $118 million cited above. The matter has also been reviewed by OIG's Office of Investigations and is being referred to the Department of Justice for its review. In its response to the draft report, HCFA concurred with the findings and recommendation. (CIN: A-02-93-01006)

## Unallowable Hospital Costs

This audit was requested by the House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce. The OIG's review of 21 providers' Medicare cost reports identified unallowable general and administrative (G&A) costs and fringe benefits (FBs) of $50.7 million. Another $3.5 million of costs were identified as "costs for concern" because of their tenuous relationship to patient care. Some of the unallowable costs were explicitly unallowable and resulted primarily from the providers' lack of internal controls over costs included in Medicare cost reports. Other costs as well as "costs for concern" appear to have resulted from differing interpretations of HCFA's guidelines.

Separate reports were issued to the 21 providers with recommendations to resolve the local issues identified. The HCFA agreed with OIG's recommendations that it provide additional clarification on the allowability of specific types of G&A and FB costs. (CIN: A-03-92-00017)

## Medicare Administrative Costs

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

### A. Empire Blue Cross Blue Shield

The OIG found that from October 1, 1987 through September 30, 1992, Empire Blue Cross Blue Shield claimed $139 million for administering the Medicare Part A program, and from October 1, 1989 through September 30, 1992, it claimed $182 million for administering the Medicare Part B program. The OIG recommended that Empire make procedural improvements and refund nearly $1 million each to the Medicare Parts A and B programs. Empire stated that the recommended procedural improvements would be made and substantially agreed with the recommended monetary adjustments of almost $2 million. The HCFA generally agreed with OIG's findings and recommendations. (CIN: A-02-93-01003; CIN: A-02-93-01005)

### B. Blue Cross and Blue Shield of South Carolina

The OIG contracted for an audit of Medicare administrative costs claimed by Blue Cross and Blue Shield of South Carolina for FYs 1988 through 1992. Amounts audited were approximately $50 million for Part A and $61 million for Part B. The OIG recommended that the contractor adjust its final administrative cost proposal for this period by approximately $1.2 million for Parts A and B to eliminate unallowable and unallocable costs charged to the Medicare programs. The contractor concurred with some findings and disagreed on others. The HCFA has not made a final management decision on the recommendations. (CIN: A-04-93-01069; CIN: A-04-93-01078)

## Unfunded Pension Costs

For Medicare reimbursement, pension costs must be measured, assigned and allocated in accordance with Cost Accounting Standards (CAS) and funded as specified in the Federal Acquisition Regulations. Pension cost assigned to an accounting period, but not funded by tax filing deadlines, may not be reassigned to or claimed in subsequent accounting periods. Also, interest on any unfunded costs is an unallowable component of pension costs of future cost accounting periods.

### A. Aetna Life Insurance Company

The OIG determined that, as of January 1, 1991, Aetna Life Insurance Company accumulated $4.5 million in pension costs that are unallowable for Medicare reimbursement. The OIG recommended that Aetna: separately identify $4.5 million as an unallowable component of pension costs as of January 1, 1991; continue a yearly update of unallowable pension cost components related to the unfunded CAS costs for 1986 through 1990; and identify and track unallowable pension costs occurring in later years. Aetna disagreed and planned to seek a waiver of the CAS requirements from HCFA. The HCFA agreed with the finding and recommendations. (CIN: A-07-93-00679)

### B. Pennsylvania Blue Shield

The OIG found that, as of January 1, 1992, Pennsylvania Blue Shield (PBS) accumulated $5.5 million in pension costs that are unallowable for Medicare reimbursement. The OIG recommended that PBS: separately identify $5.5 million as an unallowable component of pension costs as of January 1, 1992; continue a yearly update of unallowable pension cost components related to the unfunded CAS costs for 1986 through 1991; and identify and update unallowable pension costs occurring in later years. The PBS disagreed with the calculated amount for the unfunded pension cost because it disagreed with the computation of the Medicare segment assets (as noted in CIN: A-07-93-00712, discussed in the following section). (CIN: A-07-93-00713)

### C. Health Care Service Corporation

The OIG determined that as of January 1, 1992, the Health Care Service Corporation (HCSC) had accumulated $1.2 million in pension costs that are unallowable for Medicare reimbursement. The OIG found that HCSC only partially funded its pension costs for Plan Years 1986 through 1991. For each of those years, OIG considered the unfunded portion of the pension costs to be unallowable. The accumulated unallowable costs must be separately identified and excluded in future calculations of Medicare pension costs. The OIG recommended that HCSC make the proper accounting adjustments to repay Medicare for the unallowable unfunded pension costs. The HCFA has not made a final management decision on the recommendations. (CIN: A-07-94-00762)

## Medicare Contractors' Pension Segmentation

Medicare contracts require treatment of Medicare as a separate segment for calculating and charging pension costs. Contractors must identify, allocate and report pension assets and costs separately for the Medicare segment.

### A. Pennsylvania Blue Shield

The OIG determined that Pennsylvania Blue Shield (PBS) omitted Medicare cost centers and misidentified Medicare participants in its calculation of the 1981 asset fraction. Use of the asset fraction as calculated by OIG increased the pension assets of the Medicare segment by over $600,000 as of January 1, 1986. The PBS' update of the Medicare segment assets to January 1, 1992 understated the assets of the Medicare segment by an additional $400,000. The OIG recommended that PBS increase the January 1, 1992 assets of the Medicare segment by $1 million. The PBS disagreed with OIG's calculation of the asset fraction, but otherwise agreed with the report. (CIN: A-07-93-00712)

### B. IASD Health Services Corporation

The OIG found that IASD omitted eight cost centers from its Medicare segment in computing the actuarial liability of the segment for 1981. The OIG recommended that pension assets of the Medicare segment be increased by more than $1.4 million as of 1986, and that the increase be carried forward as an increase to the pension assets as of 1992. Medicare's pension assets were understated by another $180,000 in the updating of the Medicare segment assets from 1986 through 1992. The OIG recommended that IASD increase the Medicare segment pension assets by that amount as of January 1, 1992. The contractor responded that it would review the report's calculations. The HCFA has not made a final management decision on the recommendations. (CIN: A-07-94-00744)

### C. Health Care Service Corporation

The OIG found that HCSC's update to the Medicare segments' assets from January 1, 1986 to January 1, 1992 understated the Medicare segments' assets by about $1 million. This was because HCSC did not properly calculate Medicare's pension costs and consider participant transfers into and out of their Medicare lines of business. The OIG recommended that HCSC increase Medicare pension assets by approximately $1 million. The contractor did not agree with OIG's calculation. The HCFA has not made a final management decision on the recommendations. (CIN: A-07-94-00763)

## Ambulatory Surgical Services in Hospital Outpatient Departments

In a review of Medicare contractors' processing of hospitals' ambulatory surgical center (ASC) claims, which are reimbursed on a cost settlement basis, OIG determined that contractors' controls were not adequate to preclude ASC payments from being overstated. The OIG found that hospitals would split ASC services into two or more claims, causing the contractor to accumulate the ASC payment amount two or more times for the same surgery.

The OIG's finding was based on pilot reviews at seven contractors in the New England region. A computer analysis of nationwide paid claims for hospital outpatient ASC surgical services for Calendar Years 1991 and 1992 identified 10,000 claims which could potentially result in overpayments of more than $2 million.

The HCFA agreed with OIG's recommendations that it implement a computer system edit to ensure that the ASC payment amount is not accumulated subsequent to the original claim; clarify existing regulations to ensure that providers are aware of the proper submission of claims; and instruct contractors to utilize the data from OIG's computer applications to determine if adjustments to providers' cost reports are needed. (CIN: A-01-93-00502)

## Bad Debts Reported by End Stage Renal Disease Facilities

The OIG's review of home office costs reported by National Medical Care, Inc. (NMC) for Calendar Year 1991 found that NMC charged $2.7 million in unallowable home office costs to its 53 end stage renal disease facilities, claiming reimbursable bad debts. Based on the disallowed home office costs, the facilities' reimbursable bad debts were reduced by approximately $463,000. The HCFA concurred with OIG's recommendations that it instruct the FIs to make the appropriate home office cost and bad debt adjustments. The NMC officials disagreed with the majority of OIG's findings. (CIN: A-01-93-00522)

## Expansion of Diagnosis-Related Group Payment Window

Under PPS, Medicare reimburses hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis-related group (DRG). Nonphysician outpatient services rendered within 72 hours of the day of a hospital inpatient admission are considered part of the DRG; separate payments are not permitted.

The OIG's review for the period November 1990 through December 1991 identified $8.6 million in improper billings and subsequent payments for such nonphysician outpatient services and another $4.1 million in related beneficiary coinsurance and deductible charges. These improper billings were made primarily because of clerical errors and misinterpretation of the regulation. The OIG recommended recovery of the improper payments and actions to preclude similar payments in the future. Further, given that the intent of PPS is to include related services in one prospective payment, OIG also recommended that HCFA consider proposing legislation to expand the DRG payments window to at least 7 days immediately prior to the day of admission. The OIG noted that during the period covered by its review, some $83.5 million in admission-related nonphysician outpatient services were rendered 4 to 7 days immediately before an inpatient admission.

In response to the draft report, HCFA concurred with recommendations for recovering improper payments, but did not concur with recommendations for procedural changes in

new billing instructions and in claims processing. Nor did it concur with the recommendation to expand the DRG payment window, citing potentially negligible savings to the Medicare program. The OIG believes that $83.5 million in program savings are not negligible and further consideration should be given to this recommendation. (CIN: A-01-92-00521)

## Impact of Flexible Benefit Plans

Performance Measure

This review updates findings reported in a prior audit on the effects of flexible benefit plans (FBPs) on the Social Security and HI trust funds. These plans involve salary reduction agreements between an employer and employee whereby the employee elects a reduced salary so that payment can be taken in the form of fringe benefits. The fringe benefits selected in lieu of salary are exempt from Medicare, Social Security and Federal income taxes.

The OIG's current review, which focused on HI impact, found that FBPs negatively impact Medicare's HI program in several ways. First, they deprive the financially unstable HI trust fund of much needed revenue. The Department of the Treasury estimated that over the next 5 years the trust fund will lose $2.1 billion of revenue due to FBPs. While revenue declines, future expenditures will not decline since participants in FBP lower their liability for HI taxes but remain entitled to receive the full range of Medicare benefits. The tax break provided by FBPs is discriminatory because it is available to only a minority of workers. Also, these tax sheltered dollars are used to pay coinsurance and deductibles, items that were meant to discourage unnecessary health care expenditures and control rising costs.

In its response to the final report, HCFA agreed with OIG's findings but declined action on the recommendation for legislative change because the Administration's proposed health care reform legislation would have eliminated the tax exempt status of health benefits in FBP. Since health care reform legislation was not enacted, OIG encourages HCFA to initiate legislation to subject FBP to the HI portion of Federal Insurance Contributions Act tax. (CIN: A-05-93-00066)

## Peer Review Organizations

The OIG conducted a review of PROs and the related monitoring of PRO performance by HCFA. The OIG also reviewed the performance of FIs and carriers in making PRO recommended payment adjustments, and the results of medical reviews performed by the SuperPRO.

Overall, OIG found that HCFA used the PRO Monitoring Protocol and Tracking System as an effective monitoring tool; PROs had evidence to support the reviews reported to HCFA; and PROs or their subcontractors generally selected the correct sample of Medicare claims for review. However, OIG found that HCFA could improve management controls in two

areas: processing of PRO claims adjustments by FIs and carriers, and medical review decisions made by PROs.

The OIG recommended that HCFA: ensure that all PRO recommended financial adjustments are made; increase monitoring of PROs' performance to ensure that PROs identify all unnecessary inpatient admissions and ambulatory surgeries, medical code validation errors and quality of care problems; ensure that PRO reviewers are adequately trained and allocated sufficient time to complete reviews; consider not allowing PRO review coordinators the authority to override medical screen failures without a physician's review; and issue regulations to implement the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 giving PROs authority to deny payment for substandard quality of care.

The HCFA agreed to all recommendations except the fourth. In this regard, HCFA noted that PROs have instituted a program to continuously improve the ability of nonphysician reviewers to identify concerns which should be referred to physicians for review. (CIN: A-07-92-00494)

## Graduate Medical Education Costs

Medicare pays hospitals for its share of direct GME costs. Direct GME costs include payments for salaries and fringe benefits for interns and residents, teaching physicians' time spent supervising interns and residents in patient care services not billed on a reasonable charge basis or allocable as hospital indirect costs. Medicare payments for direct GME totaled about $1.1 billion during FY 1991.

### A. Methodology for Identifying Medicare's Share of Costs

In 1989, HCFA issued final regulations which changed the method for determining the Medicare reimbursement of GME costs pertaining to residents. In a review of this new methodology for reimbursing teaching hospitals for their GME costs, OIG identified two components which will cause Medicare to share disproportionately in GME costs. The new system allows hospital cost centers with little or no Medicare patient utilization to be given increased importance in the calculation of GME reimbursement. Moreover, the Medicare patient load percentage does not accurately represent Medicare's share of the cost of services provided to Medicare patients as it is based solely on inpatient data.

The OIG recommended that HCFA propose legislative and regulatory changes to the new payment system to more accurately identify Medicare's share of GME costs, thereby reducing Medicare's share of GME costs by an estimated $157.3 million a year. While HCFA agreed that it would be appropriate to determine Medicare's share of GME costs based on the Medicare percentage of participation, it did not believe that this was an appropriate time to propose this change. The HCFA also believed that the removal of

marginal cost centers would not result in actual savings because of offsetting factors. The OIG continues to believe that savings can be achieved if HCFA implements either one or both of OIG's recommendations. (CIN: A-06-92-00020)

### B. Analysis of Costs

To assist health care policymakers in their review of GME payment policy, OIG analyzed hospital costs for the first 5 years of Medicare's prospective payment system, which began on October 1, 1983. The OIG found that historical GME costs increased much faster than leading economic indexes and that average costs per resident varied widely among hospitals. For the hospitals reviewed, GME costs increased from $2.8 billion to $3.7 billion, or over 32 percent. If GME legislative reforms are not enacted, OIG recommends that HCFA reevaluate Medicare's policy of paying GME costs for all physician specialties, and consider submitting legislation to reduce or even possibly eliminate Medicare's investment in GME for specialties for which there is a surplus of physicians. (CIN: A-09-93-00096)

## Executive Compensation at Medicare Contractors

At the request of the Senate's Permanent Subcommittee on Investigations, Committee on Governmental Affairs, OIG reviewed executive compensation at three Medicare contractors. The OIG found that top executives at the three contractors received increases to their compensation packages that were clearly in excess of the Department of Labor's Bureau of Labor Statistics employment cost index (ECI). The ECI is a quarterly measure of the hourly compensation rate and is similar in concept to the consumer price index. The increases during the years of the review totaled nearly $3.8 million above the ECI. Using the same allocation methodologies as used by the three contractors, OIG determined that more than $1.2 million of this excess compensation was allocated to Medicare.

The HCFA, in responding to the draft report, concurred with OIG's recommendation to establish a ceiling on executive compensation increases. In doing so, HCFA stated that extensive contract negotiations would need to take place since the Medicare contracts are cost reimbursed agreements. For that purpose, OIG will share supporting documentation for this report with HCFA. (CIN: A-03-94-00004)

## Inappropriate Medicare Payments for Work-Related Disability Expenses

The OIG produced this management advisory report as a follow-up to two previous inspection reports involving Social Security and workers' compensation (WC) payments. Under the Social Security Act, the Medicare program cannot pay for medical expenses covered under a WC agreement. The OIG determined that HCFA could prevent inappropriate Medicare payments of workers' compensation medical expenses by using records from the Social Security Administration's (SSA's) disability case files. The OIG

estimates the savings to Medicare from an SSA-HCFA data exchange to range from $14 to $96 million. (OEI-06-89-00903)

## Use of Nursing Home and Medigap Guides

Performance Measure

The Assistant Secretary for Public Affairs (ASPA) requested that OIG examine departmental strategies for distributing various publications to ensure that they are received by intended users. As part of its 1993 Medicare beneficiary satisfaction survey, OIG questioned beneficiaries about their awareness of two HCFA booklets that provide guidance to Medicare beneficiaries and their families. As illustrated below, OIG determined that less than 15 percent of the beneficiaries surveyed knew about the booklets, and only two percent or fewer had ever used either of them.

### KNOWLEDGE AND USE OF HCFA GUIDES

| Guides | Aware of Guides | Have Used Guides |
|---|---|---|
| ***Guide to Choosing a Nursing Home*** | 9% | 1% |
| ***Guide to Health Insurance for People with Medicare*** | 14% | 2% |

The OIG found that beneficiaries who used the booklets found them useful, and most beneficiaries stated that they would use the guides if they needed nursing home care or Medigap insurance.

The OIG recommended that HCFA work with SSA and ASPA to develop a more effective strategy to make the guides available to beneficiaries. All three agencies agreed with the recommendation and have begun to explore ways to make the booklets more accessible to beneficiaries. (OEI-04-92-00481)

## 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 final 16 of 33 persons were sentenced in New York for mail fraud, money laundering, racketeering-influenced and corrupt organization and conspiracy charges in a scheme in which Medicaid was defrauded of more than $8 million. The scheme involved the owner of several medical clinics, several of his employees and several physicians and physician assistants. It included the rounding up of "patients" who had valid Medicaid cards, taking them to a clinic to draw blood and take blood pressure, and billing Medicaid for extensive diagnostic tests. The patients were also directed to specific pharmacists who filled prescriptions and billed Medicaid for drugs which were then sold on the street. Most of those convicted, including the clinics' owner, were given prison sentences. More than $6 million was ordered in restitution and special assessments.

- An Ohio woman was sentenced to 8 to 15 years in prison for burglary, in a scheme in which she gained entrance to victims' homes by posing as a "Medicare representative." The woman would offer to enroll elderly beneficiaries in nonexistent programs through which she claimed Medicare would pay for their utilities, rent or home cleaning services. She collected "enrollment fees" of up to $50, and often distracted the victims while she stole cash from purses or wallets. At OIG's request, the United States Attorney generated extensive publicity in the local media, and the woman was identified and arrested in days. She will not be eligible for parole for at least 8 years, and she also must repay her victims.

- The co-owner of a company that billed for about 70 nursing homes in 7 States was sentenced to 37 months imprisonment, fined $650 and ordered to pay jointly with her sister $960,166 in restitution. She pleaded guilty earlier to conspiracy and mail fraud related to Medicare claims in California and Florida. The sisters owned a company which billed for surgical dressings for nursing home patients who had had no surgery. Medicare paid a total of $7.4 million. The other sister was convicted earlier and sentenced to 5 years in prison. No restitution to Medicare was ordered because the judge expects recovery to be made directly from the nursing homes.

- A Kentucky psychiatrist was sentenced to 8 months incarceration and 3 years probation for defrauding Medicare, Medicaid, and the Civilian Health and Medical Programs of the Uniformed Services. The psychiatrist billed for psychotherapy services for which there were no hospital or office records, billed for longer sessions than those conducted and billed for psychiatric services performed by nurses. As part of his plea agreement, the psychiatrist will pay a civil settlement of $200,000 in restitution.

- A former payroll administrator for the respiratory therapy department at a Pennsylvania hospital was sentenced for embezzlement, including Medicare and Medicaid funds. The woman reactivated the accounts of employees who had worked in her department and left for other jobs. She negotiated the payroll checks of these "ghost" employees, collecting about $130,000 over a 2-year period. The salary costs were passed on in the Medicare and Medicaid cost reports, and she used the money to support a cocaine addiction. She was sentenced to 6 months home confinement and 5 years probation, ordered to make restitution to the hospital of $88,650 and made to pay a $50 special assessment.

## Fraud and Abuse Sanctions

During this reporting period, OIG imposed 709 sanctions, in the form of exclusions or monetary penalties, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. About half of the exclusions were based on conviction of program-related crimes, conviction of controlled substance manufacture or distribution, conviction related to patient abuse or loss of license to practice health care. Monetary penalties can be assessed under several civil monetary penalty authorities which have been delegated to OIG.

### A. Patient and Program Protection Exclusions

The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health Block Grant, and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, controlled substance abuse, revocation or surrender of a health care license, or failure to repay health education assistance loans (HEALs). Exclusion is mandatory for those convicted of program-related crimes or crimes relating to patient abuse. A significant number of OIG exclusions involve failure to repay HEALs, as discussed in more detail in the chapter on the Public Health Service. During this reporting period, OIG imposed exclusions on 666 individuals and entities in all.

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

- After his medical license was revoked, a Texas physician was excluded for an indefinite period. The licensing board revoked his license for

professional failure to practice medicine in an acceptable manner based on his sexual abuse of two of his male patients.

- Two Arizona nursing assistants were each convicted of aggravated assault against patients in a skilled nursing facility and were excluded for 15 years. The patients' ages ranged from 63 to 100 years.

- A 10-year exclusion was imposed on a California pharmacist. This exclusion resulted from her conviction for unlawful distribution of controlled substances.

- Seven New York physicians were excluded for periods ranging from 5 to 15 years. These exclusions were the consequence of their convictions for crimes which included mail fraud, racketeering and money laundering arising from sham medical clinics in upper Manhattan and the Bronx, and which resulted in financial damages to the Medicaid program of over $8 million. As part of this Medicaid fraud scheme, indigent individuals with no legitimate medical need for prescription drugs would enter the clinics and obtain prescriptions for expensive drugs. They, in turn, would resell the prescriptions to people on the street. In exchange for the prescriptions, the "patients" would subject themselves to unnecessary medical tests and procedures for which Medicaid could then be fraudulently billed.

- The husband-wife owners of a New York "stress reduction" clinic, the clinic itself and the clinic's medical director were excluded for a period of 5 to 15 years. The owners and their company stole in excess of $400,000 from the New York Medicaid program by submitting over 21,000 reimbursement claims for comprehensive medical examinations to Medicaid recipients that were never performed. In addition, Medicaid was billed for numerous visits on dates when patients were not even seen at the center.

- After being convicted of embezzlement of $350,000 in patient funds, the former office manager in a New York nursing home was excluded for 10 years. While employed in the nursing home, she took approximately 100 pension checks which were payable to various residents of the home.

- A Louisiana direct care worker at a rehabilitation center was excluded for 5 years. He had been convicted of two counts of battery against patients at the center.

- A Pennsylvania physician and his corporation were excluded from participation in the Medicare and State health care programs for 10 years

after being convicted of Medicare fraud and illegal drug distribution. The physician had taken blood and urine samples that he never sent to a lab but had billed Medicare as if the tests were made.

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

### B. Civil Penalties for False Claims

Under the civil monetary penalty (CMP) authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law allows recoupment of some of the monies lost through illegitimate claims, and it also protects health care providers by affording them due process rights similar to those available in the program exclusion process. Many providers elect to settle their cases prior to litigation. The Government, with the assistance of OIG, recouped approximately $374 million through both CMP and False Claims Act civil settlements and hearing decisions related to health care during this reporting period.

- A heart valve manufacturer and its parent company agreed to pay $10.75 million and reimbursement for certain medical expenses in settlement of claims of false statements to the Food and Drug Administration (FDA) about the valve the manufacturer sold. Marketed between 1979 and 1986, the valve was found on occasion to fracture after implantation: of the more than 30,000 valves estimated as having been implanted in the United States, 196 are known to have fractured. On average, two out of three fractures result in a fatality. The manufacturer made false representations to FDA in obtaining approval to market the valve in 1979, and failing to reveal all the information it had about fractures of valves during testing. According to the agreement, the company made an initial payment of $10.75 million in settlement of claims related to payments by Government agencies for the valves. It will also reimburse all Government agencies, such as the Department of Health and Human Services and the Department of Veterans Affairs, for costs incurred in connection with elective replacement or fracture of the valves. The total estimated value of the agreement could amount to as much as $20 million.

- A Louisiana ambulance company agreed to pay $1.86 million to settle charges of submitting false claims for transporting patients for dialysis who did not qualify for Medicare coverage. The company routinely represented, on thousands of Medicare claims, that patients being transported for dialysis were in either bed-confined or stretcher-bound circumstances, regardless of their condition. Over a 4-year period, the company was paid an average of more than $255 for each round trip transport.

- A Massachusetts hospital signed an agreement to pay the Government $1.6 million to resolve allegations of billing fraud. The hospital approached OIG to say that it had been overpaid for claims submitted by its billing service between 1988 and 1991. Subsequent OIG investigation confirmed that improper billings, primarily for physical therapy services provided by nurses rather than physicians, had been submitted for which the hospital was paid more than $900,000. More severe sanctions were not imposed because the hospital came forward of its own volition.

- An Ohio medical center agreed to pay the Government $472,893 in settlement for submitting false claims to the Medicare program. The medical center also agreed to take steps to ensure compliance with all Medicare and Medicaid regulations, by retaining an accounting firm to review billing practices and suggest improvements, and agreed to distribute a written policy to billing personnel advising them of the hospital's commitment to accurate billing. In 1992, the medical center billed Medicare for blood tests for dialysis patients, but they were rejected by the fiscal intermediary as needing further documentation under the code billed. Rather than supply the documentation the hospital resubmitted the claims under another code, causing Medicare to pay $198,340 for improper claims. Investigation showed that the hospital also received $10,480 for blood tests in excess of the amount properly payable for these tests.

- A Michigan osteopath paid $200,000 in settlement of allegations that he submitted fraudulent claims to Medicaid. His former employee signed an agreement to be excluded from the Medicare and Medicaid programs for 10 years without contesting the action. The employee had been excluded from the Medicare and Medicaid programs as a result of a previous conviction for Medicaid fraud. The osteopath hired him knowing this, and allowed him to perform services which were billed under the osteopath's provider number.

## Kickbacks

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

The OIG has issued four Special Fraud Alerts which are designed to give the provider community information on practices which may violate the anti-kickback statute. The most recent fraud alert, issued during this reporting period, was on prescription drug marketing schemes.

Over the years, more than 500 convictions, judgments and settlements have been obtained as a result of OIG investigations of violations of the anti-kickback statute. The following cases are examples of some of those concluded during this reporting period:

- As a result of a nationwide project in which OIG investigators, auditors and attorneys worked together with several other Federal and State agencies, a major health care firm which owned over 60 psychiatric hospitals agreed to pay the Government $379 million in criminal fines, civil damages and penalties related to Federal health care fraud and kickback charges. The settlement is the largest ever obtained in a health care case. The psychiatric hospitals agreed to plead guilty to making unlawful payments to induce doctors and other professionals to refer Medicare and Medicaid patients. The corporation agreed to pay a $33 million criminal fine, the largest ever paid in a health care fraud case, and to contribute $2 million to a Department program for the treatment of children and adolescents with emotional and mental disorders. In addition, one of the acute hospitals in Louisiana agreed to plead guilty and pay a $1 million fine for paying kickbacks.

  The corporation further agreed to pay $324.2 million in civil damages and penalties for losses to Government medical insurance programs. It agreed to divest itself of its psychiatric hospitals and substance abuse business, and to put the remaining hospitals under a "corporate integrity plan" to assure better patient care and compliance with regulations. The OIG negotiated this unprecedented plan, which reflects the Government's emphasis on corporate compliance. Part of the settlement includes at least $2.5 million and up to $5 million for the Public Health Service's Agency for Health Care Policy and Research. The corporation also paid $16.3 million to several

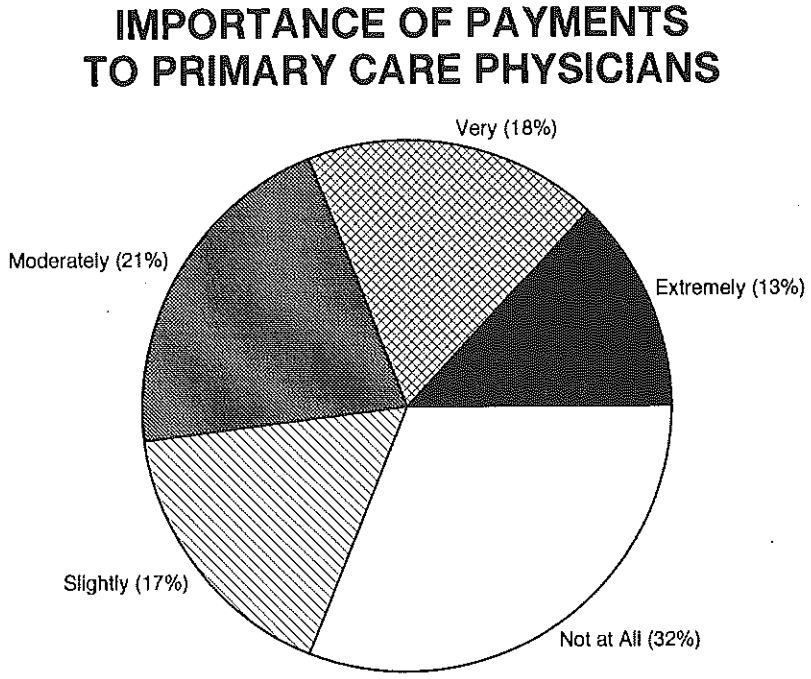
States for harm to Medicaid and other State health programs. It agreed to cooperate in investigations of individuals involved in kickbacks, some of whom are already being prosecuted.

- The last 9 of 88 convictions and pretrial diversions were obtained in a case in which a Georgia chiropractor and his wife paid "patients" kickbacks of up to one-third of the amount their insurance companies paid on fake billings. Patients receiving more than $50,000 each were prosecuted and convicted, and more than 190 others were sent demand letters. The chiropractor and his wife were sentenced earlier to 12 and 5 years in prison, respectively. More than $2 million was ordered in fines and restitutions for the defrauding of Medicare and some 30 insurance companies of millions of dollars.

## Medicare Incentive Payments in Health Professional Shortage Areas

Performance Measure

The OIG conducted a study to determine the effectiveness of Medicare's health professional shortage areas incentive payment program as part of the larger Federal effort to improve access to primary care. The OIG found that a substantial amount of the Medicare incentive money has gone to physicians who provide little or no primary care. As illustrated in the following chart, OIG determined that Medicare incentive payments rarely have a significant effect on practice location decisions among primary care physicians.



In its draft report, OIG presented three options. Since that time, congressional health care reform legislation has proposed changing the program to provide larger incentives and to eliminate incentives for specialty service in urban areas. Since that meets the objective of OIG's second option with which HCFA concurred, OIG has altered its recommendation to include only that option: that HCFA seek to modify the Medicare incentive program to target it more efficiently to primary care.

If the incentive program continues in its present or a modified form, OIG believes that the design of the program warrants review to ensure that it is a logical mechanism for accomplishing its purported goals. The HCFA will have to ensure that cost-effective measures are taken to prevent inappropriate use of incentive fund payments. (OEI-01-93-00050; OEI-01-93-00051)

## Physical Therapy in Physicians' Offices

Medicare has detailed coverage guidelines for physical therapy which apply to all outpatient settings, except physicians' offices. In the absence of HCFA national policy, local carriers may establish their own policies. In a study of 300 cases of beneficiaries who received physical therapy services in 1991, OIG found that almost four out of five cases reimbursed as physical therapy in physicians' offices did not represent true physical therapy services and that $47 million was inappropriately paid in 1991. The services were not restorative or complex, nor did they have treatment plans with goals or objective evaluations. Conversely, the great majority of independently practicing physical therapy services met all Medicare coverage guidelines. The OIG determined that carriers have paid little attention to physical therapy in physicians' offices; over two-thirds of them have no policies in this area. All the professional associations contacted, some of the carriers, physician and physical therapy respondents encouraged more stringent requirements for physical therapy in physicians' offices.

The OIG recommended that HCFA take steps to prevent inappropriate payments for these services, such as: conducting focused medical review; providing physician education activities; and applying its existing physical therapy coverage guidelines for other settings to physician's offices. The OIG estimates that this would save $235 million over 5 years. The HCFA generally agreed with the recommendations. It plans to ask carriers to focus on issues identified in OIG's report and has a work group considering alternative ways of providing physician education. (OEI-02-90-00590)

## Coding of Physician Services

The Current Procedural Terminology Codes, Fourth Edition (CPT-4) is a systematic listing of terms and identifying codes used to describe the services of health care providers. It was developed by the American Medical Association (AMA) in 1966. In a review of the CPT-4 system and HCFA's management of it as they affect Medicare expenditures, OIG found that

incorrect coding affects Medicare reimbursement and causes inequities in payment under the Medicare fee schedule. Flaws in CPT-4 codes, guidelines and index can lead to improper coding. The OIG determined that both AMA and HCFA have taken some corrective measures to address coding problems. However, OIG found that the methods by which HCFA has incorporated CPT-4 into Medicare's coding system do not ensure appropriate reimbursement to Medicare providers. The OIG believes that a proliferation of CPT-4 changes would undermine HCFA's ability to contain expenditures under the Medicare fee schedule.

The OIG made several recommendations to HCFA and AMA to improve the coding process and assure the successful implementation of the Medicare fee schedule. In response to the draft report, HCFA concurred with some recommendations and was considering others. The AMA found most of the recommendations to be fair and reasonable. (OEI-03-91-00920; OEI-03-91-00921)

## Panel and Profile Testing

The OIG initiated a series of four nationwide reviews on Medicare Part B payments for chemistry and hematology tests performed on automated equipment. Early, positive HCFA action on OIG's findings has eliminated the need for extended review.

Chemistry tests are clinical laboratory services requested by physicians to diagnose and treat patients. The physicians' CPT manual lists chemistry tests which are commonly performed on automated laboratory equipment (referred to as panel tests). The HCFA guidelines require that these panel tests be grouped together (bundled) for payment purposes. Bundling is required for three or more tests. Although HCFA guidelines limit the reimbursement of chemistry panel tests to the lesser of the fee schedule amount for the panel or the individual test(s), there is no similar requirement for reimbursement of hematology profiles. A hematology profile consists of a group of hematology tests performed on automated equipment and can include a manual differential white blood cell count.

### A. Payments to Hospitals

This review expanded on an OIG pilot study at the Massachusetts Medicare intermediary. In that pilot study, OIG identified significant overpayments to hospitals for chemistry and hematology tests performed on an outpatient basis ($2.25 million in Calendar Year [CY] 1991) that resulted from the contractor not having edits in place to detect all instances of unbundling or to detect duplicate payments. The OIG's expanded review found, through use of computer applications, that this payment edit limitation existed nationwide. Based on OIG's work, HCFA plans not only appropriate recovery action but also implementation of additional bundling and duplicate payments edits at Medicare contractors nationally. As a result of HCFA's action, OIG discontinued its national review. (CIN: A-01-93-00520)

### B. Payments to Physicians and Independent Laboratories

The OIG's second review identified similar payment edit limitations, this time by Medicare carriers to independent laboratories and physicians. The OIG's work again expanded on a pilot study in Massachusetts, which in this instance identified edit problems resulting in physicians and independent laboratories in CY 1992 being overpaid some $400,000 for chemistry and hematology testing. Again, through computer applications, OIG found that this payment edit limitation existed nationwide. Based on OIG's work, HCFA plans not only appropriate recovery action but also implementation of additional bundling and duplicate payments edits at Medicare contractors nationwide. As a result of HCFA's action, OIG discontinued its national review. (CIN: A-01-94-00513)

### C. Payment Guidelines

This review concerned Medicare payment guidelines for chemistry panel and hematology profile testing in general. The OIG determined that Medicare is paying more than necessary for claims containing fewer than three chemistry panel tests and unbundled hematology tests. The HCFA's formal comments are pending on this recently issued report. (CIN: A-01-94-00512)

### D. Automated Equipment Testing

The fourth review was on chemistry tests performed on automated equipment. Medicare Part B, through its FIs and carriers, is paying single test payment rates for chemistry tests which are commonly performed on automated laboratory equipment, resulting in increased costs to the Medicare program. An early alert on OIG's preliminary findings was issued in May. (CIN: A-01-93-00521)

## Medicare Payments for Orthotic Body Jackets

Claims for orthotic body jackets increased more than 6,400 percent from 1990 to 1992. Likewise, allowed Medicare charges increased more than 8,200 percent. In 1991, about $7 million, or 95 percent of the claims, were not for legitimate orthotic body jackets and should not have been paid. The OIG estimates that incorrect payments may have increased to $13.7 million in 1992. Suppliers marketed the devices to nursing homes as an alternative to restraints, but restraints were prohibited by the Omnibus Budget Reconciliation Act of 1990. Suppliers used loopholes in HCFA guidance and monitoring to claim nonlegitimate devices as body jackets.

The OIG recommended that HCFA closely monitor claims for body jackets. If inappropriate body jacket claims are not discontinued in FY 1994, HCFA should implement more stringent controls. Further, HCFA should inform suppliers and physicians about the abuse of body jacket codes and stress its intent to prevent such abuse. The HCFA agreed with OIG's recommendations and stated that its regionalization of claims processing and development

of medical review policies will strengthen its ability to monitor use and payment for body jackets. (OEI-04-92-01080)

## Fraud Involving Durable Medical Equipment Suppliers

The DME industry has consistently suffered from waves of fraudulent schemes in which Medicare or Medicaid is billed for equipment never delivered, higher-cost equipment than that actually delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State from that billed in order to obtain higher reimbursement. Two years ago, HCFA published new regulations addressing reimbursement problems that recurred over the years, especially those created by telemarketing and carrier shopping. It is hoped that consolidation of claims processing into four regional jurisdictions, as specified in the regulations, will resolve many of these problems. In the meantime, OIG continues to obtain settlements and convictions of unscrupulous suppliers for schemes perpetrated before the regulations were published, as shown in the following examples:

- The owner of several DME companies was sentenced in Georgia to a year and a day for defrauding Medicare and Medicaid. The owner engaged telemarketers to contact beneficiaries, ask about any physical problems and offer DME at no charge. The telemarketers were given a list of physicians ranked from 1 to 5, with a 1 indicating they would sign anything and a 5 if they refused to sign DME certifications. The telemarketers asked the beneficiaries about physicians who treated them, to identify a more compliant physician if the first one they named was rated a "5." The owner was fined $5,000 and ordered to serve 300 hours public service. Recoveries totaled $199,500.

- A Michigan DME company and its four co-owners agreed to pay $626,000 to settle allegations that the company submitted false and inflated claims for Medicare reimbursement. They convinced senior citizens that they needed DME such as transcutaneous electronic nerve stimulators, claiming they would owe no co-payment because Medicare would pay the entire cost. They never attempted to collect deductibles and co-payments, thereby inflating by 20 percent each claim submitted for Medicare-eligible customers. In addition to this settlement, the company pled guilty to mail fraud in the same manner.

- The prosthetist owner of a California orthopedic center was charged with submitting false Medicare claims for 44 orthotic bilateral contracture devices for nursing home residents that he never provided. After the investigation was underway and the carrier began withholding reimbursement, the prosthetist set up a second business under a friend's name and submitted more false claims under the friend's provider number.

The prosthetist agreed to waive indictment, pled guilty and paid restitution of $400,000.

- In New York, one of the owners of a DME company was sentenced for Medicare fraud and income tax evasion. He was sentenced to 2 years imprisonment, suspended on condition that he serve 3 months over 30 consecutive weekends. Two other persons await sentencing in the case, in which Medicare was defrauded of $2.7 million. Until they are sentenced, the owner is responsible for a repayment of $900,000 settled in a civil agreement.

- A man who operated several orthotic companies in California was sentenced to 3 years probation and fined $25,000 after pleading guilty to one count of Medicare fraud. He had been charged with billing Medicare for up to four times the number of artificial limbs actually provided, and with falsifying dates and location of service as well as physicians' orders. The loss to Medicare was estimated at more than $200,000.

- An Arizona DME supplier was excluded for 5 years for filing false Medicare claims. The man had been convicted of billing for equipment for nursing home patients as though they were living at home, and for billing both Medicare and patients for the same equipment.

- The last 5 of 16 persons prosecuted in California were sentenced for kickbacks, false Medicare and Medi-Cal claims and altering prescriptions for transcutaneous electronic nerve stimulation devices from a DME company. The 16 included the company, the 2 company owners, 6 physicians and 1 podiatrist, 2 nursing home employees and 4 other associated individual employees. The company had falsely billed Medicare $2 million and was paid $473,000. A total of $80,000 was ordered in fines and restitution. Civil cases are pending against 5 of the physicians and the podiatrist.

- A judgment for $21 million was entered against the man who was Pennsylvania's biggest DME telemarketer in the late 1980s. Indicted earlier for mail fraud, money laundering and witness tampering in relation to the submission of false Medicare claims, he pled guilty to mail fraud, received a prison sentence, and was excluded from the Department's health care programs for 15 years. In addition, a consent judgment for more than $1 million was entered against his son for his part in the scheme.

## Federal Aggregate Upper Payment Limit Requirements for Prescription Drugs: Pennsylvania

The OIG performed a follow-up review of Pennsylvania's compliance with the Federal aggregate upper payment limit requirements for prescription drugs for the period October 29, 1988 through October 28, 1989. Federal regulations provide that States' claims for Federal financial participation (FFP) in payments for all upper limit drugs cannot exceed the aggregate of the drugs' individual upper payment limit established by HCFA plus a reasonable dispensing fee established by the State.

A prior OIG audit had determined that the State was not in compliance with the upper payment limit for the period October 28, 1987 through October 28, 1988 and, as a result, received FFP of over $3.1 million in excess payments. The follow-up audit indicated that the State remained in noncompliance during the period October 29, 1988 through October 28, 1989. As a result, the State received between $2.4 million and $6.8 million of FFP in payments in excess of HCFA's aggregate upper payment limit.

The OIG proposed procedural improvements. Also, OIG recommended that the State make a financial adjustment of $2.4 million, and either provide documentation to support its imputed dispensing fee of $4.50 or return the additional excess payment of up to $4.4 million. (CIN: A-03-92-00602)

## Ambulance Services for Medicare End Stage Renal Disease Beneficiaries: Medical Necessity

In a review of 16 carriers with 87 percent of the total Part B ambulance allowances for end stage renal disease beneficiaries, OIG found that 70 percent of dialysis-related transports did not meet Medicare Part B guidelines for medical necessity. These unnecessary claims amounted to $44 million.

The OIG recommended that HCFA ensure that claims meet coverage guidelines and offered several options for addressing this problem. The HCFA concurred with the recommendation and is implementing a number of the options. Beneficiaries, ambulance suppliers and dialysis-facility physicians will be notified of the limits on ambulance coverage. In addition, HCFA's Office of Research and Demonstrations is undertaking a study to identify the characteristics of ambulance users and to assess the reasons for, and alternatives to, ambulance transport to dialysis. (OEI-03-90-02130)

## Nonemergency Transportation for Dialysis Patients

Performance Measure

This study, part of a series, identified nonemergency transportation services and sources of financial assistance for patients going to kidney dialysis in a sample of eight cities. In most of the sampled cities, OIG found that nonemergency transportation services were generally

available to dialysis patients. A range of organizations provided financial assistance for transportation expenses for dialysis patients. However, there were problems with transportation services for some dialysis patients, including long waiting times, cost and lack of physical assistance.

It did not appear that lack of access to alternative forms of transportation was the main reason for inappropriate use of Medicaid reimbursed transportation. Most problems reported by respondents seemed to center on those dialysis patients who were not Medicaid-eligible, not elderly and not disabled. However, the study identified five cities which were successful in assuring both the availability of transportation services and financial assistance for transportation expenses for dialysis patients. More in-depth review of the these five cities might provide valuable lessons for other localities. (OEI-03-90-02132)

## Medicaid Payment of Premiums for Employer Group Health Insurance

The rate of growth in Medicaid expenditures is a major concern to both Federal and State governments. One way to curb spending in this area is to pay private health insurance premiums for Medicaid-eligible individuals so that Medicaid becomes the secondary payer for medical services. Section 1906 of the Social Security Act requires State Medicaid agencies, when cost-effective, to pay premiums for employer group health plan (EGHP) insurance for Medicaid-eligible individuals. It further requires that States use EGHP fee schedules rather than Medicaid fee schedules when paying deductibles and coinsurance.

In a survey of the 50 States and the District of Columbia, OIG determined that most have not purchased EGHP insurance for Medicaid-eligible individuals. The OIG estimated that $32 million in Federal and State Medicaid funds could be saved annually if all States were to do so. The OIG recommended that HCFA: continue to strongly support States implementing section 1906 of the Social Security Act by transferring technology from States that have developed systems and procedures for 1906 programs to States without such systems and procedures; and, if section 1906 is not superseded by broader legislative reform, propose legislation to allow States to pay EGHP deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules. The HCFA concurred with the first recommendation, but deferred comment on the second pending the outcome of proposed health reform legislation. (OEI-04-91-01050)

## Medicaid Payments for Less-Than-Effective Drugs

The Food, Drug and Cosmetic Act requires that drugs be both safe and effective for their labeled indications. The Food and Drug Administration (FDA) is responsible for identifying less-than-effective (LTE) drugs and ensuring their withdrawal from the market. Medicaid

reimbursement is prohibited for LTE drugs, as well as for drugs designated by FDA as identical, related or similar (IRS) to LTE drugs.

The OIG determined that HCFA and FDA have taken steps to strengthen the system for identifying LTE and IRS drugs, and conveying needed information to States. Despite these efforts, HCFA's list of such drugs recently supplied to Medicaid State agencies was not complete. By comparing a private database company list of LTE and IRS drugs with HCFA's, OIG identified an additional 243 drugs which should have been included on HCFA's list. However, OIG found that improvements are underway to correct the problems identified in this review. (OEI-03-94-00090)

## Therapeutically Equivalent Generic Drugs

The OIG found that 11 State Medicaid programs have policies in place that promote the use of generic drugs beyond current Federal requirements. The OIG also found that use of generic drugs was being promoted by other programs that provide health benefits. Some programs require generic substitution when available, while others use financial incentives as part of their reimbursement policies.

The OIG calculated that the annual cost savings to the Medicaid program could be as much as $46 million for 37 high volume dispensed brand name drugs if reimbursement for those drugs is limited to the amounts set by HCFA for equivalent generic drugs. Cost savings would become even greater in the future as the Federal patents on exclusive drug manufacturing of 60 important, highly-used drugs with more that $10 billion in sales will expire between now and 1995. The OIG recommended that HCFA identify and alert States to methods which would encourage the use of lower priced generic drug products in the Medicaid program.

In response to OIG's draft report, HCFA stated that the report effectively described "best practices" and agreed to share the report with all State agencies. However, HCFA expressed concerns about the recommendation that it seek legislative authority to require States to adopt policies to encourage generic drug substitution or to limit Federal financial participation to amounts based on generic drug prices rather than brand name drug prices. (CIN: A-06-93-00008)

## Island Peer Review Organization's Denials of Full Medical Assistance Claims

The OIG conducted a review to determine if full claim denials of inpatient hospital stays submitted by the Island Peer Review Organization (IPRO) for voiding were successfully processed and the affected Medicaid funds recouped. Based on its review, OIG received reasonable assurance that the automated void process was successfully processing voided transactions which resulted in recoupments from providers. Both New York State and the

Federal Government received appropriate credits for the voided transactions. However, OIG noted a significant system weakness which permitted hospitals to resubmit previously voided claims and have the claims paid. There was no control or edit in the State's Medicaid management information system (MMIS) to detect that the providers were submitting previously voided claims.

The OIG recommended that the State work with IPRO and the affected providers to determine appropriate overpayment amounts and recover these claims. Further, OIG recommended that the State develop appropriate procedures and controls within its MMIS to ensure that previously denied and voided claims are not again reimbursed by Medicaid if they are resubmitted for payment by providers. The State and HCFA generally concurred with the recommendations. (CIN: A-02-93-01023)

## 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. Personal Care Services: New York

Personal care services rendered in the home are provided to individuals who require assistance with activities of daily living, such as hygiene, dressing and feeding. This is a rapidly growing and costly component of the New York State Medicaid program. In a review of the personal care services program in Westchester County, New York, OIG identified weaknesses that raise serious questions as to the adequacy and appropriateness of care rendered to recipients. Further, OIG determined that the State had not effectively monitored the program.

Based on its sample, OIG estimated that between $3.2 million and $11.2 million may have been inappropriately charged to the Federal Government. The OIG recommended that the State: work with HCFA on development of a cost-effective plan to identify the erroneous payments made to each provider; institute appropriate recovery action; issue more specific guidance on acceptable time sheet documentation; issue additional guidance and enforce existing regulation concerning aides working 24-hour continuous care cases; and increase monitoring to ensure that providers are billing properly and maintaining adequate supporting documentation. Further, OIG recommended a number of procedural improvements to preclude recurrence of a control weakness in the area of authorization of personal care services. The HCFA concurred with the findings and recommendations and the State was in basic agreement with most of the recommendations. (CIN: A-02-91-01055)

### B. Psychiatric Hospital: Nebraska

At Nebraska's request, OIG audited claims for services provided to Medicaid recipients at Rivendell of Nebraska, a psychiatric hospital for children and adolescents. Under Nebraska's Medicaid plan, psychiatric hospitals are paid on prospective per diem rates calculated using Medicare cost reports. The OIG identified overpayments of $2.2 million (Federal share $1.3 million) that resulted because the State based its payments on Rivendell's unaudited cost reports which contained costs not allowed by HCFA regulations. Nebraska agreed with OIG's recommendations to appropriately adjust cost reports and use prospective per diem rates based on the adjusted cost reports. These actions should result in a refund of the $1.3 million overpayment and preclude future problems. The HCFA has not made a final management decision on the recommendations. (CIN: A-07-93-00635)

### C. Intermediate Care Facilities for the Mentally Retarded: Indiana

This audit resulted from a referral by the Indiana Medicaid Fraud Control Unit (MFCU) which reported the possibility of millions of dollars in duplicate payments made to intermediate care facilities for the mentally retarded while Indiana was implementing rate increases. The OIG found that, because of a miscommunication between State employees and the State's fiscal contractor, $40.6 million in duplicate payments were made. When brought to its attention, the State quickly recovered the duplicate payments. The State concurred with the second finding that its rate increases were not accurately computed, and agreed to make a financial adjustment for the $3.9 million ($2.5 million Federal share). The OIG also found inconsistencies between the 1987 and 1991 computations for the rate increases due to the different interpretations of a section of the State's plan. Indiana felt that the rate increases were not inconsistent, but was willing to work with HCFA to determine whether clarification was needed. The HCFA has not made a final management decision on the recommendations. (CIN: A-05-93-00060)

## State Medicaid Fraud Control Units

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

During FY 1994, OIG administered approximately $68.5 million in appropriated grants to the MFCUs. The MFCUs reported 297 convictions and $16.8 million in fines, restitutions and overpayments collected for the period January 1, 1994 through June 30, 1994.

# Social Security Administration

## Chapter II

# SOCIAL SECURITY ADMINISTRATION

## Overview of Program Area and Office of Inspector General Activities

Nearly 60 years ago, the Social Security Act established a national insurance system that would be financed through payroll taxes collected from workers and employers and would pay benefits to workers in their old age. The Old Age and Survivors Insurance (OASI) program, and the Disability Insurance (DI) program (collectively OASDI), added in 1956, are popularly called Social Security. In Fiscal Year (FY) 1994, the Social Security Administration (SSA) expects to pay over $314 billion in cash benefits to more than 43 million beneficiaries. The program is financed almost entirely through payroll taxes paid by employees, their employers and the self-employed. Benefits are distributed to retirees and disabled persons, their spouses and dependent children, and certain surviving family members of deceased insured workers.

The Supplemental Security Income (SSI) program is a federally administered, means-tested assistance program that provides a nationally uniform, federally funded floor of income for the aged, blind and disabled. Beginning January 1974, SSI replaced State and county run assistance programs for the aged, blind and disabled that were funded by a mix of Federal and State money. Federalization of assistance for these categories permitted the establishment of uniform eligibility criteria. In FY 1994, SSA expects to pay SSI benefits in excess of $36 billion to over 6 million recipients.

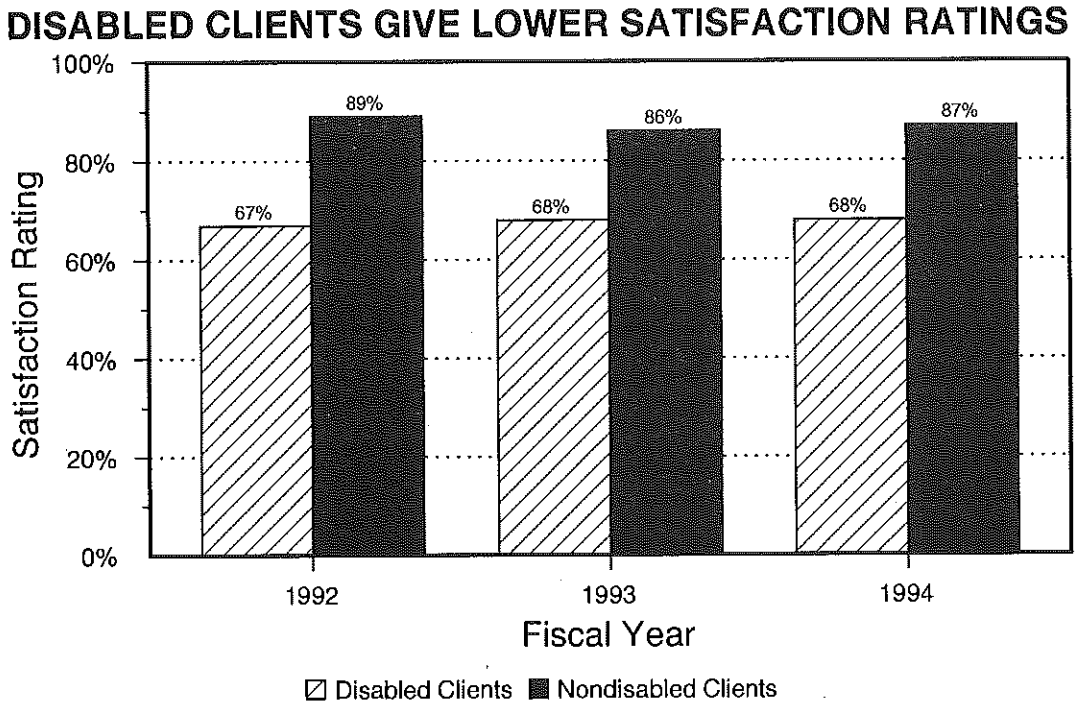
The Office of Inspector General (OIG) reviews all aspects of SSA's programs and operations, including: disability insurance benefits, information resources management, program integrity and efficiency, quality of service, representative payees and SSI benefits. The OIG is also providing oversight to SSA's financial management by auditing SSA's financial statements, examining internal controls and reporting on the status of debt management activities.

Fraud and abuse in Social Security programs have historically been based on two types of deception: concealment of a recipient's status and/or the use of false Social Security numbers (SSNs) to obtain benefits. Over the past few years, the misuse of SSNs has grown far beyond mere benefits fraud to include a wide range of "con" games and violent crime.

## Social Security Client Satisfaction: 1994 Survey

Performance Measure

The OIG has conducted annual client satisfaction surveys of Social Security beneficiaries since 1987. In the overview report of this year's survey, OIG noted that overall satisfaction had leveled off after a few years of decline. Over 77 percent of respondents rated service as good or very good. However, as illustrated in the following chart, disabled clients gave markedly lower satisfaction ratings than nondisabled clients in this and prior years. This is significant because the proportion of disabled clients in OIG's sample has increased over the last 3 years, consistent with an increase in SSA's disability workloads. Moreover, these lower ratings account for the decline in overall satisfaction since 1990.




Factors that continued to foster high satisfaction ratings were staff job performance and staff courtesy, while service delays appeared to lower satisfaction.

A report on service indicators, based on client-reported data, showed that no progress had been made on eight important service objectives since 1992. In its comments, SSA indicated its plan to establish measurable, interim objectives to better promote progress. A third report on client subgroups noted that non-English speaking clients and clients with frequent contact with SSA were less satisfied than other clients, but key indicators of service delivery in urban offices had significantly improved. (OEI-02-92-00980; OEI-02-92-00981; OEI-02-92-00982)

## Social Security Client Satisfaction: Comparing Local and 800 Number Telephone Service

Performance Measure

This inspection compared local and 800 number telephone service based on client responses to the last three Social Security client satisfaction surveys. A review of over 30 questions showed no real difference in satisfaction between clients who called the 800 number and callers to local offices. For example, both groups gave similar ratings on staff job performance, staff courtesy and the clarity of explanations given by staff. Differences were identified in only three areas: local callers' overall satisfaction ratings remained essentially unchanged for three years, while 800-number callers' ratings declined; SSI clients were more likely to call a local number than the 800 number; and access, measured by the number of call attempts required to reach SSA, appeared to have improved for urban local callers and declined for rural local callers. (OEI-02-92-00983)

## Beneficiaries with Representative Payees

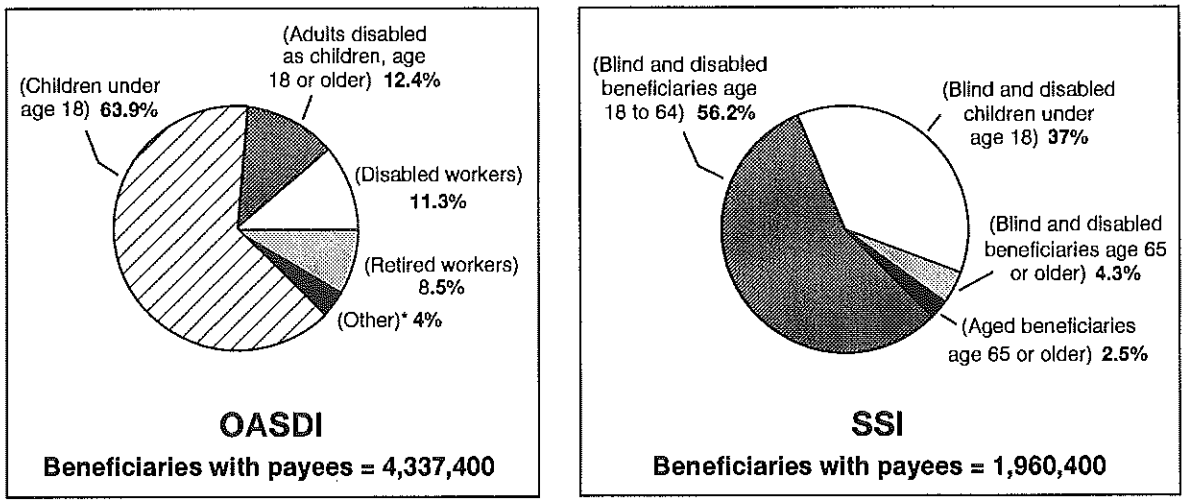
Performance Measure

To assist in its efforts to strengthen the entire representative payee process, SSA asked OIG to conduct a series of inspections to review its payee accounting system.

### A. Child Beneficiaries

In a study to provide baseline information about children with payees, OIG found that two-thirds of OASDI beneficiaries with payees and one-third of SSI beneficiaries with payees are under the age of 18, as illustrated in the following chart.

**TYPES OF BENEFICIARIES WITH PAYEES**




*Includes widows and widowers, parents, spouses and students age 18 to 19.

Parents and other relatives serve as payees for, and have custody of, almost all OASDI and SSI children. (OEI-09-92-00856)

### B. Adult Beneficiaries

In the case of adult beneficiaries, OIG observed that more than two-thirds of adults with payees are under age 65. Younger adults are more likely to require payees because their entitlement is most often based on disability rather than retirement. Adult SSI beneficiaries are six times more likely to have payees than adult OASDI beneficiaries since a greater portion of them are disabled. Beneficiaries with mental disorders are more likely to have payees than all other disabled beneficiaries combined. And while younger adults are more likely to live with relatives, OIG noted that older adults are more likely to live in institutions. (OEI-09-92-00855)

### C. Children with an Unknown Type of Payee

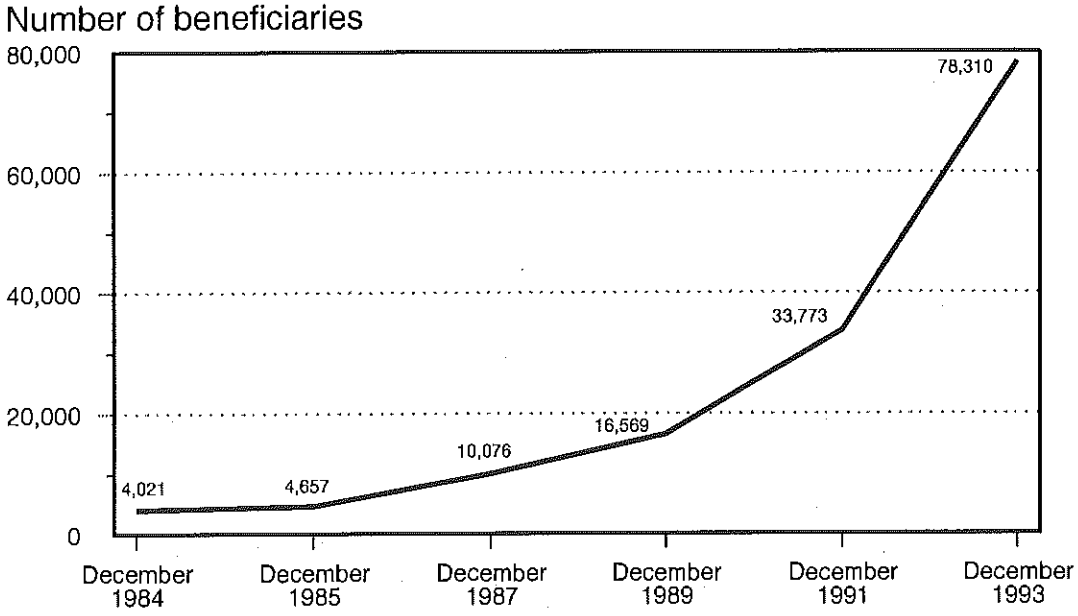
The OIG determined that the master beneficiary record (MBR) does not contain sufficient detail to determine the type of payee for one-quarter of OASDI beneficiaries with payees. The best way to correct records permanently for all payees with "unknown" coding would be to reallocate resources for the timely completion of the representative payee system and for updating the MBR. If this is not practical, OIG suggests that SSA send an attachment to the annual accounting form or undertake a study for a valid sample of "unknown" payees to provide more descriptive information about the characteristics of both the payees and the beneficiaries they represent. (OEI-09-92-00854 )

### D. Supplemental Security Income: Drug Addicts and Alcoholics

In this study, OIG analyzed the demographics of SSI drug addicts and alcoholics with representative payees. Beneficiaries who receive SSI based on drug addiction or alcoholism are required to have payees for their SSI benefits.

As illustrated in the following chart, the number of SSI drug addicts and alcoholics has increased dramatically during the past decade.

## NUMBER OF SSI DRUG ADDICTS AND ALCOHOLICS




One third of payees for SSI drug addicts and alcoholics are coded "other." This category includes, but is not limited to, friends, acquaintances and professionals such as attorneys, who may be at higher risk of misusing benefits than parents, other relatives or institutions. One fifth of SSI drug addicts and alcoholics are concurrently entitled to SSI and OASDI, and nearly one-half of them receive OASDI directly rather than through payees.

The OIG concluded that these findings present a serious challenge to SSA's representative payee program. The OIG will work with SSA to provide useful information and present various options for addressing the problems specific to the drug addict and alcoholic population. (OEI-09-92-00857)

## Representative Payee Accounting Process

In these studies, OIG found that the current accounting review process may deter, but rarely detects, misuse of SSA benefits, and that some aspects of the process are duplicative and costly. Processing centers and field offices duplicate parts of the less costly Wilkes-Barre Data Operations Center accounting review process. While some processing centers and field offices have developed creative ways to streamline the process, staff are still frustrated by large workloads and the time needed to resolve questionable accounting forms. Despite improvements, the accounting forms are still difficult to understand, cause computer exceptions and are not appropriate for some institutionalized beneficiaries.

These findings reaffirm the need to conduct planned inspections on assessment of risk, payee programs of other Federal and State agencies, and effective practices of advocacy

groups and private organizations. Before completing such studies, OIG recommends that SSA change its current procedures to allow the Wilkes-Barre Data Operations Center to manage the entire accounting review process and refer to field offices only those cases that require face-to-face contact with payees. Also, OIG recommends that SSA revise the accounting form (SSA-623) and share information with its staff on the duties and responsibilities of all components involved in the accounting review process. (OEI-09-92-00851; OEI-09-92-00858)

## Obtaining Medical Source Evidence for Disability Claims

The OIG found that the States, physicians and medical facilities sampled for this study reported mostly favorable experiences with SSA's process for obtaining medical source evidence. The OIG also noted that, while SSI and mental disability cases tend to have higher consultative exam rates than other types of cases and these exams are increasingly required for adjudication of such cases, States are generally waiting at least 21 days before ordering them. The SSA's Disability Process Reengineering Team has emphasized obtaining timely medical evidence in its redesign of the disability system. The OIG recommended that SSA remind States of their authority to order consultative exams early in the disability determination process, where it is clear that such evidence is needed to reach a timely decision. The SSA concurred with the recommendation. (OEI-02-93-00550)

## Peripheral Vision Disability Assessments

Since the 1950's, SSA has required the use of Goldmann visual testing devices for assessing whether an applicant's peripheral vision is disabling. The Goldmann device is no longer being manufactured and its availability is diminishing. The OIG found that the SSA requirement for using Goldmann testing equipment has been detrimental to the disability determination process resulting in: additional SSA costs for testing and related travel expenses; inconvenience to claimants; and delays in the disability assessment process. Experts contacted by OIG believe that newer and more readily available automated testing devices can be used to accurately quantify visual loss. The OIG recommended that SSA allow the use of currently available and widely used automated peripheral vision testing devices for disability assessment.

Subsequent to OIG's review, SSA commissioned the National Research Council (NRC) of the National Academy of Sciences to investigate whether SSA can use the results of automated perimetry for visual assessment under the statute. The NRC concluded that, with well-defined exceptions, the Goldmann and automated perimetry used under similar conditions will yield equivalent estimates of visual fields. The report recommended no general change in the current standards for visual field evaluation.

The SSA agreed to expand the use of automated perimeters, and will contact automated perimeter manufacturers to develop a set of instructions for making measurements in

accordance with the standards suggested in the NRC report. The OIG supports the SSA approach to this issue. However, if these standards cannot be developed timely, SSA should consider interim procedures allowing the use of automated testing for disability determinations until such time as standards can be developed. (CIN: A-13-93-00429)

## Disability Appeals Process

There are four administrative steps in the disability determination process: initial disability determination, reconsideration, administrative law judge (ALJ) review and Appeals Council review. The first two steps are handled by disability determination services (DDSs), which are funded and monitored by SSA. The SSA's Office of Hearings and Appeals administers the ALJ and Appeals Council review processes. The DDSs follow SSA's Program Operations Manual System in their reviews, while ALJs directly interpret statutes and regulations and apply Federal court decisions. The DDSs undergo a significant amount of review focusing on allowances. The review process for ALJ decisions is limited and focuses on denials. In FY 1993, DDSs granted benefits at the initial determination level in 39 percent of cases, while ALJs allowed benefits in 68 percent of cases appealed to them.

In surveying the 54 State DDSs and a sample of 156 ALJs, OIG found that there is almost unanimous support for the application of uniform disability standards by ALJs and DDSs. While DDS respondents supported review of decisions, ALJs strongly opposed any oversight. Both groups supported creation of a Social Security disability court, but they disagreed on the need for other structural changes to the disability appeals process. The DDSs to a greater extent than the ALJs believed that advances in technology could improve the process. The OIG presented its findings to SSA's disability process reengineering team to assist in their redesign of the disability process. (OEI-03-90-00360; OEI-03-90-00361; OEI-03-90-00362; OEI-03-90-00363)

## States' Readiness for Modernized Disability System

More than two-thirds of the States expect to be ready to implement SSA's modernized disability system (MDS) when the time comes, according to this OIG inspection. All but one of the remaining States say that it is too early to tell; they do not have enough information to form an opinion. However, States identified some problems and concerns, and offered suggestions to manage them. These included: running dual systems during the period when they are converting from the present system to MDS; resolving software and hardware problems; interfacing with each State's fiscal system; training staff on the new system; and dealing with the possible impact on personnel. States would also like to have greater involvement in MDS development and planning, and be able to give more input and receive more feedback.

The OIG recommended that SSA strengthen its communication with the States and develop individual implementation plans in collaboration with them. The SSA concurred with the recommendations which parallel its ongoing activities. (OEI-02-93-00100)

## Administrative Costs Claimed by Disability Determination Services

The OIG performs reviews to determine whether the administrative costs incurred by State agencies and reimbursed by the Federal Government are accurate and allowable.

### A. Illinois

The OIG determined that the Illinois State agency needed to revise its time and attendance system to provide for better certification of hours worked by medical consultants and nurses. The OIG found that the State agency had no assurance that the hours reported by the medical consultants and nurses were actually worked. The OIG recommended that the State agency revise its procedures to provide for a daily verification of the time worked by medical consultants and nurses. The State agency agreed, and stated that it will accurately monitor all arrival and departure times for consulting staff through the use of an electronic time clock system. (CIN: A-05-93-00059)

### B. Washington

A prior audit of administrative costs claimed by the Washington State agency had shown that final reports of obligations, accounting records and cash draw accounts were not always reconciled, and that internal control procedures were not adequate to ensure that only allowable costs were charged to the disability program. The prior audit recommended financial adjustment for excess draws and various unacceptable costs, as well as procedural improvements. An OIG follow-up review found that final reports of obligations, accounting records and cash draw accounts were reconciled, and that internal control procedures had been strengthened. Additionally, OIG found that financial adjustments totaling $510,356 were made to the SSA disability programs. Based on the actions taken by the State and SSA, OIG concluded that the findings identified in the prior report had been fully resolved. (CIN: A-10-94-00018)

## Social Security Fraud

Over 100 persons were convicted and sentenced during this reporting period for defrauding the OASI program or the DI program. The OASI convictions frequently involved relatives or representative payees converting to their own use Social Security benefits intended for others, including those mistakenly sent to deceased beneficiaries, as shown in the following examples:

- In Washington State, a mother serving as a representative payee was sentenced to 6 months confinement and 2 years probation, and ordered to repay $52,800 in Social Security benefits intended for her son. The mother had converted the checks to her own use, while the child had lived in Kentucky with his father since 1982. The only money the mother ever sent was $20 for a birthday one year. As a condition of her plea bargain, she had to make immediate restitution of $30,000.

- In Texas, a woman who served as representative payee for her disabled child was sentenced to 3 years probation and ordered to make restitution of $6,564 she had converted to her own use. Investigation showed that the child went to live with another family in 1990 and had been adopted in 1991. The woman continued to cash the checks intended for her child and used the money for her own purposes.

- A Pennsylvania man was sentenced to 2 years in prison for stealing Social Security benefits checks belonging to two deceased beneficiaries. He and a woman cashed checks sent to the woman's sister and to a senile boarder after murdering them. Fugitives for more than 2 years, the couple was captured as a result of leads generated by the television show "Unsolved Mysteries," on which their case was twice featured. The man was ordered to make restitution of $11,982 for the checks, and will be tried for murder. The woman pled guilty to theft and robbery earlier, and was ordered to repay $6,427 on the check thefts. They also are to be sentenced for robbing an elderly woman. The woman admitted that the man had killed the two beneficiaries, in part for their Social Security checks, and agreed to testify against him. She will not be charged with homicide as a result of her cooperation.

- A Virginia woman was sentenced to 10 years in prison for forging and cashing her deceased mother's SSA benefits checks from 1977 through 1993. The judge suspended all except 1 year in the county jail and advised that she was eligible for house incarceration. The woman was ordered to make full restitution to SSA of $32,000. She said that she was divorcing, should receive at least $15,000 from the sale of her house, would pay off her attorneys and would give whatever was left to SSA. The incensed judge told her the full amount would go to SSA first, and that payment of the remaining balance would be arranged through the OIG agent who worked the case. No supervised probation was ordered.

- As a result of Project Fast Track in California, a woman was sentenced to 5 years probation and ordered to make restitution of $6,020 she had obtained

by negotiating her deceased mother's Social Security benefits checks. Worked by a council of agents representing the various Federal Inspectors General, the project resulted in the earlier charging of eight persons with theft from the Government. Six of them, including the woman, were charged with Social Security trust fund theft. The project was established by the United States Attorney to batch-prosecute persons committing theft under $25,000 who would otherwise not be prosecuted.

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

- A Massachusetts man and his son were sentenced to prison for conspiracy and making false statements to SSA. The father collected disability benefits for 5 years while working as a truck driver and laborer under his son's SSN. Both claimed that it was really the son who was working. The father was sentenced to serve 21 months in prison and 3 years supervised release, and ordered to pay full restitution of $55,290 and a $200 court assessment. The son was sentenced to 3 months in prison.

- In New York, a judge sentenced a man to 3 months community confinement, 3 months home detention and 2 years probation, plus restitution of $69,145 he illegally received in disability benefits for 6 years by concealing work activity. The man had signed two false statements during that time claiming that he was not working and that SSA had mixed his son's earnings with his. The judge ruled that these statements resulted in more than "minimal planning" on the man's part, an issue raised by the defense.

- A man in Ohio had avoided criminal prosecution for collecting disability benefits while working in an automobile factory by signing an agreement with SSA to repay $29,900 at a rate of $25 per month. The civil division of the United States Attorney's office reviewed the matter, and decided that it was not reasonable for someone with his assets and it demonstrated a lack of commitment to repay — he could never possibly complete repayment. To avoid civil litigation, he promptly repaid the entire amount.

- In New York, a man was sentenced for having told SSA that he was paraplegic from the waist down because of childhood polio when he was actually fully ambulatory. Since 1976, he had received disability benefits totaling $65,000. In the meantime, he became an expert player at paintball war games, earning the nickname "Doctor Death." Witnesses saw him running and jumping without assistance while engaged in these games.

- From March 1990 through February 1992, an Indiana man forged and cashed his deceased roommate's disability checks totaling $16,000. He was sentenced to 18 months in prison and 3 years supervised release, and ordered to pay restitution. He had been charged as a result of two projects aimed at similar disability and SSI fraud in which 10 other persons were indicted, 7 of whom have been sentenced with the remainder being scheduled for an early fall sentencing.

## Supplemental Security Income Outreach by Field Offices

Performance Measure

In this inspection on SSI outreach by field offices, OIG found that outreach projects alone did not significantly increase claims for SSI benefits. Since the claims experience was nearly identical for all offices, OIG concluded that external factors, such as the declining economy, blurred the effect of outreach efforts. However, survey respondents were convinced that ongoing partnerships between local SSA offices and community-based organizations are a potentially effective means of reaching needy but unserved citizens.

The OIG recommended that SSA field offices enhance outreach efforts by better educating all community-based organizations on the SSI program and improve public information materials. In its response to the draft report, SSA generally agreed with the recommendations and described the actions underway to implement them. (OEI-07-92-00910)

## Supplemental Security Income Fraud

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

- In New York, a convict and his sister were sentenced for defrauding the SSI program. From 1985 until mid-1990, the convict received SSI benefits for speech and hearing impairments. From January 1989 until the present, however, he had been incarcerated in various prisons in New York and Pennsylvania. He enlisted his sister and her husband to represent him at an SSA office in Pennsylvania, even though he was in jail in New York. The sister's husband pretended to be the applicant to convince SSA that he was not in jail and should continue to receive benefits. The convict was sentenced to 24 months incarceration and 3 years probation, and ordered to pay $7,422 in restitution. The sister was given 3 years probation. The brother-in-law's sentencing was postponed because of his lack of cooperation with the probation office.

- A man was sentenced in the District of Columbia to 6 months confinement in a halfway house and restitution of $23,110 he fraudulently obtained in SSI benefits. From 1979 to 1992, the man received the benefits for a disability, and repeatedly told SSA, in writing and interviews, that he was unemployed. During that time he held no fewer than seven different jobs and had significant earnings. Besides the full restitution, the man must also pay any costs associated with his confinement.

- In Wisconsin, a woman was sentenced to 4 months incarceration, 4 months house arrest, and 3 years probation for defrauding the SSI program. Video surveillance of the woman at an SSA office showed that she had also presented herself under another name at another office. The woman was ordered to repay the $22,560 she received because of her deception. At the time, she was on probation for a welfare fraud conviction.

## Debt Management System

In the sixth of a series of reports, OIG evaluated SSA's progress in implementing its debt management system (DMS). This report reviewed the objectives scheduled for completion between April 1 and September 30, 1993 which were contained in Releases 9 and 10 of the DMS project plan. In addition, revisions were made during this period to Release 8 software.

The OIG found that objectives scheduled for DMS Releases 8, 9 and 10 were successfully implemented. However, OIG noted that SSA had failed to implement a related recommendation in a prior OIG report. In that report, OIG had proposed that SSA develop a plan detailing how the DMS software modernization effort would be integrated with SSA modernization initiatives for OASDI post-entitlement and SSI overpayments. While SSI overpayment issues were scheduled to be addressed as part of the modernized SSI Claims System initiative, as of the date of this report, a strategy for OASDI post-entitlement overpayments had not been developed. In its response, SSA described the efforts now underway to develop a redesign plan for the OASDI benefit payment process which will support overpayment collection and accounting. (CIN: A-13-93-00403)

## Fraudulent Social Security Numbers

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

- A woman was sentenced in Virginia to 7 months in prison, followed by 7 months house arrest and 3 years probation, for using others' names and

SSNs to obtain federally insured parent loans for undergraduate students (PLUS). An employee of a technical/vocational school, the woman used her position to obtain PLUS loans in her maiden name and the names of her ex-husband, her children and others. She was discovered when her husband received a letter about a loan he had not obtained. The woman also must make restitution of $43,260.

- A man who refused to reveal his identity was sentenced in Massachusetts to 18 months incarceration and 3 years supervised release, fined $1,000 and assessed $100. He obtained an SSN under a false name and used it to apply for a passport. Arrested and incarcerated since June 1993, he pled guilty to false application for an SSN and a passport. A fingerprint search in the United States and Canada failed to turn up a match.

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

- A Colorado man dubbed "The Love Bandit" was sentenced for cheating a woman out of more than $73,000 under a false name and SSN. After local police requested assistance, OIG identified the man, discovered that he was wanted under other aliases and SSNs for similar crimes, and found that he was on probation for one. The man disappeared, but months later was arrested in Oregon for conning another woman. He was extradited to Colorado, where he was sentenced to 16 years in prison for cheating four other women. In the sentencing on the case in which OIG was involved, he was given another 8 years to be served consecutively to the 16. He must still answer charges in Oregon.

- A man was sentenced in Texas to 57 months in prison and 36 months probation for wire fraud, money laundering and impersonating the Inspector General of the Department of Defense (DOD). A foreign national, the man had embezzled $100,000 from a Saudi Arabian company and caused them to lose an estimated $10 million in revenues and expenses in preparation for a nonexistent DOD contract. He was fined $100,900 and ordered to make restitution of $100,000. Agents from OIG were involved because the man used several false SSNs on bank accounts and credit card applications.

- A Pennsylvania man was sentenced to 3 years and 10 months incarceration for conspiracy, counterfeiting securities, misuse of SSNs and use of false

identification documents. The man used the false SSNs to obtain 13 different drivers licenses in different names, which he in turn used to open bank accounts in four east coast States. He then ordered counterfeit checks bearing the names of fictitious companies, and laundered money from the checks through the bank accounts. He was ordered to make restitution of $46,690 and pay a $1,300 special assessment. An accomplice was sentenced to 3 years supervised probation and 6 months home detention with an ankle monitor, and ordered to pay restitution and special assessments of $12,500.

# Public Health Service

## Chapter III

# PUBLIC HEALTH SERVICE

## Overview of Program Area and Office of Inspector General Activities

The activities conducted and supported by the Public Health Service (PHS) represent this country's primary defense against acute and chronic diseases and disabilities. The PHS's programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. The PHS encompasses: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed food, drugs, biological products and medical devices; Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support the development, distribution and management of health care personnel, other health resources and services; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Health Care Policy and Research (AHCPR), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), previously the Alcohol, Drug Abuse and Mental Health Administration, to assist States in refining and expanding treatment and prevention services. The PHS will spend more than $19.9 billion in Fiscal Year (FY) 1994.

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

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

## National Institutes of Health Oversight of Extramural Research Inventions

In 1980, the Congress passed the Patent and Trademark Amendments Act to allow small businesses and nonprofit organizations to acquire title to inventions produced with Federal research funding. Although the Department of Commerce was assigned responsibility for developing regulations, NIH has the primary role in ensuring that its grantees comply with Federal regulations for inventions.

An OIG study found that NIH: has limited its oversight of grantees by not requiring documentation for some Federal requirements; lacks a systematic process for ensuring that grantees submit all required invention information; and does not fully utilize its invention database to monitor grantee compliance. While OIG determined that NIH monitoring should not be so constricting as to hinder the goal of technology transfer and commercialization, it recommended that NIH have an effective monitoring role to protect the public investment in research, and promote small businesses and U.S. manufacturing. The OIG is not convinced that grantee self-monitoring would ensure that all these objectives are met. Further, OIG proposed that NIH add more detailed licensing and utilization information to its invention database and use the database to track grantees for timely compliance. In responding to the draft report, NIH stated that actions are underway to develop an electronic transfer and tracking system that will allow for the direct import of data on inventions from research institutions to NIH. The new database will include more detailed licensing and utilization information and will track grantees for timely compliance. (OEI-03-91-00930)

## Underreporting New Technologies by Scripps Research Institute

The OIG determined that NIH did not have effective procedures to detect that the Scripps Research Institute (SRI) underreported, in its patent applications, NIH's involvement in inventions resulting from NIH sponsored research. Because NIH was not aware of inventions being developed at SRI with NIH grant funds, it could not provide assurance that the objectives of the Patent and Trademark Amendments Act of 1980 were being met. Information obtained from NIH showed that only 51 (41 percent) of the 125 patents awarded to SRI were developed with help from Federal grant funds. However, after questions were raised about the accuracy of SRI's reporting, SRI, on June 30, 1993, revealed to NIH that 96 of its patents were developed with the help of Federal funds.

The OIG recommended that NIH determine if SRI properly reported all patented inventions and that NIH establish procedures to better monitor SRI's compliance with the Act. The PHS generally concurred with OIG's recommendations. As requested, OIG presented its

findings and recommendations at hearings before the House Subcommittee on Regulation, Business Opportunities and Technology, Small Business Committee. In its testimony before the Committee, NIH said that it was improving its reporting systems and working with the Patent and Trademark Office in proposing new monitoring procedures. (CIN: A-15-93-00029)

## Controls Over Technology Transfers and Royalty Income

The OIG conducted a follow-up review to determine if corrective actions were taken by PHS, through NIH, to implement controls over the transfer of technology and the maximization of royalty income. In its prior audit, OIG recommended that PHS: centralize the technology transfer function for all PHS agencies; establish priorities and milestones to complete reconciliation of patents; establish adequate procedures to ensure that valuable foreign patent rights are obtained and filed in a timely manner; and conduct a detailed internal control review of technology transfer activities. The OIG follow-up review showed that PHS has taken or is taking adequate corrective actions on all recommendations. (CIN: A-01-94-01502)

## National Institutes of Health's Controls over Advisory Committees' Potential Conflicts of Interest

The OIG found that NIH's internal control procedures were not sufficient to detect potential conflicts of interest in its 235 advisory committees. Specifically, OIG found that NIH should: comply with its own requirement regarding reviewing members' financial disclosure forms to identify perceived or actual conflicts of interest related to general matters addressed by advisory committees; require an ongoing review to identify changes in a member's financial interests and/or advisory roles which may result in a conflict of interest; revise the financial disclosure form to request information on members' involvement in nonfederal grants and contracts; provide updated guidance to responsible NIH officials for identifying conflicts of interest and determining when waivers should be sought to obtain the essential services of these members; ensure that qualified, independent officials periodically test a sample of all approved waivers to determine if the controls are followed and result in only appropriate waivers being granted; and perform a follow-up review within 1 year after completing the corrective actions and conduct future internal control reviews as required by the Federal Managers' Financial Integrity Act.

The OIG informed NIH of its findings during the audit. The NIH has taken corrective actions which, when fully implemented, should significantly strengthen internal controls. (CIN: A-15-93-00020)

## National Institutes of Health's Warren G. Magnuson Clinical Center

The OIG alerted NIH to its preliminary findings regarding controls over the provision of medical services at the NIH Clinical Center. During the review, it was noted that some patients at NIH were only receiving pharmaceutical services. A review of 61 of these patients' medical records disclosed that the care provided to 56 could not be related to any research hypothesis being tested. With regard to these, and a number of other patients, OIG found that nonresearch services were provided to patients admitted under unwritten screening protocols (diagnostic procedures) and omnibus protocols (studies that are not specific as to what research would be conducted). In response to OIG's alert, NIH quickly instituted better controls over the provision of services and issued a draft proposal on clinical protocols. The proposal stated that medical services would only be provided to patients admitted under written research protocols. The proposal also included a number of other corrective actions that should help to correct the problem. (CIN: A-15-94-00019)

## National Institutes of Health Management and Service and Supply Funds

Performance Measure

The NIH Management and Service and Supply Funds finance a variety of centralized research support and administrative activities for the operation of numerous NIH programs and facilities. They reported FY 1993 revenues of $613 million. The OIG audited the funds in accordance with the Chief Financial Officers (CFO) Act requirements, but issued a disclaimer of opinion. It was unable to satisfy itself regarding the reported account balances for inventory, property and equipment, accounts payable, leased computer equipment and the budget clearing account, as well as associated revenue and expenditures. Further, the necessary documentation supporting expenditures in both NIH funds and data supporting revenue in the management fund were not available for examination.

The OIG again found problems involving significant internal control weaknesses and noncompliance with the Department's accounting manual that had not been corrected. Underlying these weaknesses was the lack of an adequate filing system and procedures, which are needed to fully reconcile account balances and resolve suspense items. The most significant weaknesses were: inadequate reconciliations between the perpetual inventory system and the general ledger; numerous differences between physical counts and perpetual inventory records; and inadequate internal controls to ensure the accuracy of property and equipment balances. Additionally, accounts payable for both funds included a significant number of items that have been outstanding for a considerable period of time, and, as a result, may not be valid payables. (CIN: A-17-93-00037)

## Lessons from Inspections of Mammography Facilities

This report discusses OIG's examination of the onsite inspection process of Medicare screening mammography facilities. It highlights lessons learned from Medicare that FDA

should consider in the implementation of the Mammography Quality Standards Act (MQSA) of 1992.

The Health Care Financing Administration (HCFA) regulates screening mammography by requiring facilities to meet quality standards in the areas of equipment, personnel qualifications and documentation. In August 1992, HCFA began conducting onsite inspections of mammography facilities through the States' survey and certification agencies. The OIG found that States began routine onsite inspections of mammography facilities in September 1992, and that by August 1993 had inspected about 44 percent of the certified facilities. Eighty-six percent of the facilities failed at least one requirement, although less than five percent of the deficiencies were considered serious. Most facilities corrected their deficiencies. State inspectors noted that facilities' unfamiliarity with Medicare's regulations in this area was the biggest problem encountered during inspections.

The OIG found that FDA has made significant progress towards successful implementation of MQSA, including a public conference with the mammography community. Interim final regulations were published in December 1993. The OIG proposed that HCFA and FDA reach agreement on the role of HCFA's screening mammography certification program in the period before full implementation of MQSA. In addition, OIG recommended that FDA: ensure that facility personnel are aware of and thoroughly trained on MQSA's requirements; examine ways to perform the most effective and cost-efficient inspections which are adequate to enforce the regulations; and develop a management information system that allows for continuous monitoring of State inspections agency performance and facility compliance, and distinguishes between documentation noncompliance and performance noncompliance. (OEI-05-92-00300)

## Organ Procurement Organizations and Tissue Recovery

Performance Measure

Federal law requires that organ procurement organizations (OPOs) have arrangements with tissue banks for tissue procurement. How well they perform this role can have a significant bearing on recovering a sufficient supply of high quality tissue for transplantation.

In a survey of 62 OPOs, OIG found that all participated in tissue recovery to some degree, though their commitment to this process varied widely. Performance data show that they have not taken full advantage of opportunities to obtain tissue from potential donors. Further, OIG found that tensions exist between organ procurement and tissue recovery. If these tensions intensify, they could have adverse consequences for the supply of tissues and organs. Some OPOs and tissue banks have developed effective practices to improve organ and tissue donation.

The OIG recommended that PHS provide some general oversight and guidance for OPOs regarding their arrangements with tissue banks and their tissue recovery activity. While funding for new initiatives is limited, OIG believes that PHS could begin this effort without incurring extensive new expenditures and without imposing a major reporting burden on agencies or tissue banks. The OIG also proposed that HCFA include an assessment of OPOs performance in tissue recovery as part of the OPO recertification process. (OEI-01-91-00250)

## Food and Drug Administration's Revolving Fund for Certification and Other Services

Performance Measure

The OIG performed a financial audit of FDA's Revolving Fund for Certification and Other Services' FY 1993 financial statements as required by the CFO Act. The Fund accounts for receipts and expenses related to FDA's certifying the safety and effectiveness of insulin, and the safety of color additives in foods, drugs, cosmetics and medical devices. Manufacturers of insulin and color additives pay a fee to cover FDA's certification services.

The financial statements were found to present fairly, in all material respects, the financial position, operations and cash flows of the fund. However, the audit identified deficiencies in the internal control structure of the accounting system and its operation that were considered to be a reportable condition. Tests of compliance disclosed no material instances of noncompliance. (CIN: A-17-93-00036)

## Vaccines for Children Program

Performance Measure

The Vaccines for Children (VFC) program was established in 1993 by Section 13631 of the Omnibus Budget Reconciliation Act to increase immunization rates among children 2 years of age and under by providing free vaccinations to eligible individuals. The National Vaccine Program Office asked the Inspector General for assistance in implementing the VFC program prior to its effective date of October 1, 1994. The OIG's work addressed such issues as ensuring program efficiency and effectiveness, safeguarding program assets and establishing measurable performance indicators. As specifically requested, OIG also addressed permissibility and other issues related to the use of contract physicians or agents by federally qualified health centers and rural health clinics to immunize children under the VFC program. (CIN: A-15-94-00016)

## Physical Security of Data Processing Operations

The OIG found that CDC had not placed enough importance on ensuring the physical security of its data processing operations. The OIG identified significant problems in several areas, including the adequacy of facilities, access controls, plans for disaster recovery and continuity of operations, and security training. These deficiencies create unnecessary risks that could affect CDC's accomplishment of its mission.

The OIG recommended that PHS direct CDC to correct the deficiencies noted in OIG's review; develop and implement organizationwide controls over access to equipment and data; update and test disaster recovery and contingency plans; and establish a program to provide appropriate security awareness and emergency response training to employees and contractor personnel. In its comments to the draft report, PHS concurred with OIG's recommendations and reported on the status of corrective actions taken by CDC to enhance the physical security of data processing operations. (CIN: A-04-92-03501)

## Costs Incurred Under Acquired Immune Deficiency Syndrome Grants

Performance Measure

The OIG reviewed costs incurred under the acquired immune deficiency syndrome (AIDS) grants awarded to the Pennsylvania Department of Health by PHS. The OIG determined that approximately 28 percent of FY 1992 expenditures for all AIDS grants were for grant administration. The OIG proposed that PHS develop a performance measure for AIDS grants based on the extent that grants funds are used for grant administration versus provision of direct services; and establish criteria for evaluating grant applicants and administering grants using the fixed fee-for-service concept. Further, OIG recommended that PHS review AIDS grants awarded by all its components to determine the extent that such funds are used for administrative purposes.

The PHS concurred with the intent of OIG's recommendations and recognized the need to maintain a reasonable balance between cost for administration and cost to provide direct services. However, PHS believes that its current policies and procedures for evaluating budget proposals are effective for ensuring that costs are reasonable, necessary and in compliance with applicable limitations. The PHS stated that it will continue to monitor the amount of administrative costs through its grant application and negotiation process. (CIN: A-03-93-00351)

## The Ryan White Comprehensive Acquired Immune Deficiency Syndrome Resources Emergency Act

Performance Measure

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 was intended to establish services for patients with AIDS or human immunodeficiency virus who would otherwise have no access to health care, and to provide emergency assistance to communities with the highest number of reported AIDS cases. The Ryan White Act will be reauthorized in FY 1996. To provide information for the discussion surrounding reauthorization, OIG conducted a series of studies examining: grantee expenditures in FY 1992 under titles I and II of the Act; consortia use of funds in FY 1992; grantee expenditures under the Act's Special Projects of National Significance grants; and the Act's current funding formulas.

The OIG expects the funding formulas to be an important focus for discussion during reauthorization. In its study, OIG found that the number of high incidence cities increased from 16 in FY 1991 to 34 in FY 1994. The HRSA expects an increase by as many as 4 to 7 in FY 1995. The OIG determined that, as the number of high incidence cities increases, the proportion of title I funds going to the cities with the largest caseloads is likely to decrease. Moreover, OIG found that current formulas have led to inequities in funding between grantees on per-new-case basis, especially under title I. The OIG presented four basic options for formulas that could be used to address the inequities described and target funds to greatest need. (OEI-05-93-00330; OEI-05-93-00331; OEI-05-93-00332; OEI-05-93-00333; OEI-05-93-00334)

## National Hansen's Disease Program

The OIG conducted a review of the circumstances surrounding the Department's September 1993 request to reprogram $1.4 million to HRSA's National Hansen's Disease Program to determine whether program transfers were proper and necessary; why the program's operating costs were greater than expected and reimbursements through an interagency agreement were not sufficient; and what actions were taken to alleviate the shortfall. The OIG found that the program obligations were improperly transferred to other HRSA program activities. These transfers were prompted by a shortfall in program funds due to a number of factors, including HRSA's misjudging the level of resources available to provide services. Program officials took various actions to alleviate the shortfall, including the merging of two facilities, personnel actions and deferring nonemergency equipment and supply purchases. (CIN: A-15-94-00005)

## National Practitioner Data Bank: Profile of Matches Update

Performance Measure

This report is a byproduct of a study OIG is preparing at the request of the HRSA Administrator on the usefulness and impact of the data bank. The OIG found that the number of National Practitioner Data Bank matches has increased dramatically since March 1992. Physicians continue to be the type of practitioner most frequently identified in matches. While the majority of matches still results from queries by hospitals, a much higher proportion of matches now results from queries submitted by health maintenance organizations and group practices. Malpractice payment reports still account for most of the matches. The report indicates that a greater proportion of matches includes information about practitioners who crossed have State lines. (OEI-01-94-00031)

## Superfund Financial Activities: Fiscal Year 1992

The Comprehensive Environmental Response, Compensations and Liability Act of 1980, as amended, requires the Inspector General of each Federal organization with Superfund

responsibilities to conduct audits of payments, obligations, reimbursements or other uses of the Superfund.

### A. Agency for Toxic Substances and Disease Registry

The ATSDR obligated $56.2 million and disbursed about $54.8 million in Superfund resources during FY 1992. The OIG audit found that ATSDR generally administered the fund according to Superfund legislation. However, CDC and ATSDR did not have procedures in place to ensure that all Superfund grantees had obtained independent audits. The OIG recommended that PHS: direct CDC and ATSDR to establish procedures to ensure that all Superfund grantees submit audit reports; sanction grantees unwilling to have a proper audit; and require 16 grantees identified in this report to obtain the necessary audits. The PHS agreed with the spirit of these recommendations. However, PHS believes that procedures for contacting grantees should come from a central point for all Federal agencies. If a central point for all Federal agencies is not possible, PHS believes that the responsibility should be at the Office of the Secretary level. (CIN: A-04-93-04518)

### B. National Institute of Environmental Health Sciences

The National Institute of Environmental Health Sciences (NIEHS) obligated $51 million and disbursed $41 million in Superfund resources during FY 1992. The OIG audit found that NIEHS generally administered the fund according to Superfund legislation. However, OIG again recommended that PHS direct NIH, which provides administrative support to NIEHS, to establish procedures to ensure that all Superfund grantees submit audit reports and sanction grantees who are unwilling to have a proper audit conducted. The PHS agreed with spirit of the recommendation. However, PHS believes that procedures for contacting grantees should come from a central point for all Federal agencies. If a central point for all Federal agencies is not possible, PHS believes that the responsibility should be at the Office of the Secretary level. (CIN: A-04-93-04506)

## Exclusions for Health Education Assistance Loan Defaults

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

The Social Security Act permits and, in some instances, mandates exclusion from Medicare and State health care programs for nonpayment of these loans. Since mid-1992, almost 800 people have been excluded for defaulting on their HEAL debts. During this 6-month semiannual period, 384 were excluded as a result of PHS referral of their cases to OIG.

Individuals who default may enter into settlement agreements whereby the exclusion is stayed while they pay specified amounts each month to satisfy their debt. If they default on

these settlement agreements, they are then excluded until their entire debt is repaid and they have no right to appeal these exclusions. Some of these health professionals, upon being notified of their exclusion, immediately repay their HEAL debt. One example is a Mississippi physician who, shortly after being notified of his exclusion, gave the Government a check for over $96,000 to completely repay his HEAL. He was then reinstated.

At the conclusion of this reporting period, 176 individuals had taken advantage of the opportunity and entered into settlement agreements or completely repaid their HEALs. The amount of money being repaid through settlement agreements or through complete repayment totals almost $13 million.

## National Health Service Corps

After years of sharp budget reductions, the Congress and the Department have initiated a revitalization of the National Health Service Corps program, which is designed to reduce or eliminate health professional shortages in local communities. The Department requested that OIG provide information on PHS and Corps' policies and how they affect health care providers and the facilities where they serve. In addition, OIG was asked to provide information on the Corps' ability to expand in the future.

Based on its findings, OIG recommended that PHS: improve its communication with and support for providers and facilities to maintain and increase provider morale and satisfaction; consider more flexible matching and practice policies to improve retention and provide better solutions to the shortage of health care providers; develop more accurate, complete and up-to-date vacancy lists to enhance the matching process; and use direct deposit to pay providers so that loan repayers and scholars receive their checks on time and at the correct addresses.

The PHS generally concurred with the report's recommendations and described actions taken and planned in these areas. The OIG supports PHS' plans to improve communication and support, flexibility, vacancy list accuracy and monetary disbursement. (OEI-09-91-01310)

## Fraud and Abuse of Grant Funds

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

- A former lawyer who specialized in vaccine-related injury cases was sentenced in Illinois to 21 months incarceration, followed by 3 years supervised release, after being convicted for defrauding 5 disabled children

and their estates of $1.4 million. The lawyer filed claims under the 1986 Vaccine Injury Compensation Program on behalf of children who suffered crippling injuries or died after receiving a required immunization shot shortly after birth. Under this program, the Government accepts the liability for these casualties, relieving the drug companies and private practitioners, and allows the filing of administrative claims against the Government rather than individual lawsuits. The lawyer received $1.5 million in compensation checks from the Government for his clients, but he disbursed only $113,680 to them. He signed for checks himself and forged the clients' signatures, cashed them, used the money to maintain his life style and operate his law firm, and led clients to believe the checks had not been received. He was ordered to make restitution of $464,475, which is the balance of money he owed after his assets had been liquidated, to repay the petitioners. He also must perform 500 hours of community service after his release from prison.

- The founder and former executive director of Pennsylvania's largest Latino social service agency was sentenced for embezzlement involving PHS grant funds in paying her brother $25,000 as a ghost employee of the agency. The woman concocted a false letter of employment for her brother with the social service agency, which is supported by Federal, State and local funds. She then instructed her sister, who served as an aide, to initial daily work logs and cash the brother's paychecks. The sister gave the cash either to the brother, who lives in Florida, or to the woman herself. The woman was sentenced to 4 to 23 months in prison followed by 5 years probation, ordered to make full restitution and told to complete 500 hours of community service. She had been convicted earlier for misappropriating money from another organization of which she was also executive director. For that crime she was given a sentence of probation.

- In Tennessee, an administrative assistant at a dental college pled guilty and was sentenced for stealing money from PHS grant funds. The woman, who worked in the admissions office, created bogus tutoring contracts with the college's health career opportunities program, which were paid with PHS funds. She was sentenced to 5 years probation and ordered to make restitution of $9,750 to the Department.

## Public Health Service's Service and Supply Fund: Fiscal Year 1993

Performance Measure

The CFO Act requires that OIG ensure that certain funds — revolving funds, trust funds and funds with substantial commercial activity — prepare financial statements and have them audited. In accordance with the CFO Act, OIG contracted with an independent public accountant to audit PHS' Service and Supply Fund. The auditors' opinion is that the fund's

statement of financial position as of September 30 is presented fairly. However, the auditors were unable to express an opinion on the statements of operations and changes in net position, cash flows, and budget and actual expenses. Weaknesses in important internal controls were reported, and recommendations for improvement were presented. Auditors tests disclosed no material instances of noncompliance with laws and regulations. (CIN: A-17-93-00035)

# Administration for Children and Families, and Administration on Aging

## Chapter IV

# ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

## Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. Expenditures for the ACF programs are expected to total $32 billion for Fiscal Year 1994. The major programs include: Aid to Families with Dependent Children (AFDC), Child Support Enforcement (CSE), Child Care, Job Opportunities and Basic Skills (JOBS) training, Head Start, Foster Care, Adoption Assistance and Refugee Resettlement. The ACF also administers programs to improve the well-being of children through child care development and child abuse prevention and treatment, and serves special populations such as Native Americans, refugees and families in crisis.

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

Further, OIG reviews the Department's programs that serve children, and has issued several reports in this area. Overall, OIG has found that there are significant barriers to effective coordination and service delivery among these programs, including Head Start, Foster Care and Adoption Assistance, and the CSE programs. Although the Department has made changes and appears to be on the right course, improvements are needed to better target these services to the needs of children. The OIG reports have focused on ways to increase the efficient use of the program dollar, and how to better coordinate program implementation between the Federal and State and local governments.

Federal funding of the Administration on Aging (AoA), which reports directly to the Secretary, is about $900 million annually. The AoA awards grants to States for

establishment of comprehensive community-based systems that assist the elderly in maintaining their independence and in remaining in their homes as long as possible. The assistance is targeted to the socially and economically disadvantaged, especially the low-income minority elderly, and includes supportive services, nutrition services, education and training, low-cost transportation and housing, and health services.

The OIG has reported opportunities for program improvements to target the neediest for services; expand available financial resources; upgrade data collection and reporting; and enhance program oversight.

## Child Support

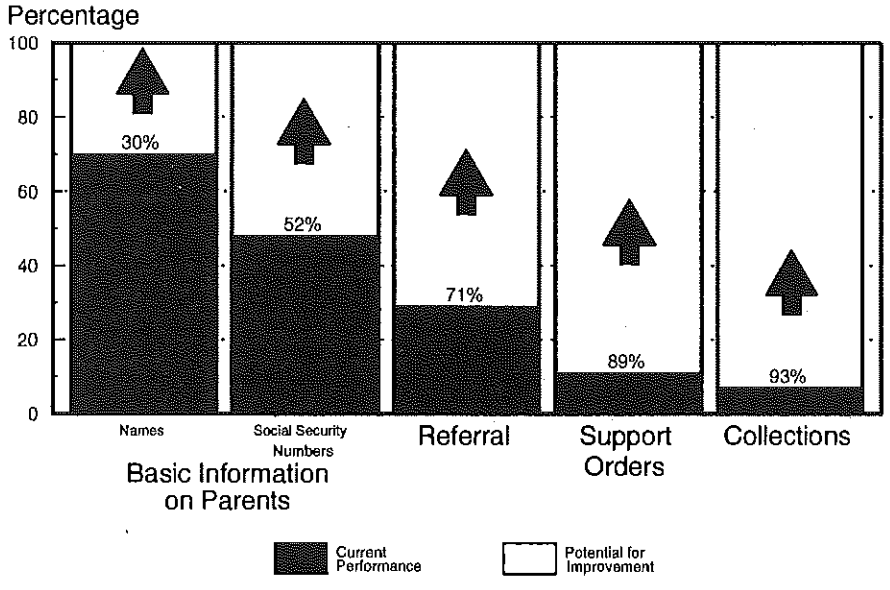
### A. Children in State Foster Care

Performance Measure

Foster care agencies are required to refer the biological parents of children in foster care to CSE agencies only if a child's care is funded by title IV-E of the Social Security Act. These children have been removed from low income families that are eligible for AFDC. Children from families whose incomes are higher or who for other reasons are not covered by title IV-E are herein referred to as "non-IV-E" children.

In a study of non-IV-E children, OIG projected that child support was collected on behalf of 9 percent of non-IV-E foster care children nationally in 1991. The OIG found that State emphasis on collecting child support is low, and that States have the potential to increase child support collections for non-IV-E foster care children. The following chart illustrates the potential for improvement in each of the four key steps for collecting child support on behalf of these children.

**OPPORTUNITY TO IMPROVE CHILD SUPPORT COLLECTIONS**



The OIG recommended that ACF encourage States to extend child support services to children in foster care, where appropriate, regardless of the funding source for the foster care, by instructing States to improve data gathering and referral systems. Further, OIG urged that other organizations interested in foster care and child support encourage States to seek child support for non-IV-E children where appropriate. (OEI-04-91-00980)

### B. Incorrect Distribution

In a study sample in nine States, OIG found that child support payments from 17 percent of the parents of non-IV-E foster care children were incorrectly distributed. In some cases, child support collected from parents was distributed to biological mothers who had lost custody of their children. In others, child support was incorrectly distributed to the AFDC program.

The OIG determined that the distribution errors were partly caused by inadequacies in the recording system. The lack of adequate tracking and reporting hinders pursuit of child support on behalf of children in non-IV-E foster care, and limits the potential for building parental responsibility. The OIG recommended that ACF develop a system to help States accurately record and distribute collections to an appropriate foster care agency. That system should include guidance to States for designating or redesignating payees. (OEI-04-91-00981)

### C. Reporting and Collecting Penalties on States

The OIG reviewed the adequacy of oversight activities and internal controls relating to the disposition of penalties imposed on States which failed Office of Child Support Enforcement audits. Federal regulations provide for imposing a penalty when a State is found not to be in substantial compliance with requirements of title IV-D of the Social Security Act.

Oversight activities were generally adequate for the small number of cases in which penalties were imposed over the last 10 years. However, OIG found some areas where improvements can be made to maintain the effectiveness of the audit penalty process. These areas included assessing penalties; recording accounts receivable; and assessing and collecting interest. The ACF concurred with the findings and recommendations, and indicated actions that have been taken in these areas. (CIN: A-12-93-00045).

## Improving Foster Care Eligibility Determinations

In this report, OIG analyzed its findings in earlier reports relating to the Federal Foster Care program. The OIG's objective was to determine if there is a need to evaluate the merits of the statutory requirements that States must meet to participate in the Federal Foster Care program.

The previous eligibility determination reviews, which covered several States, found that States were confused regarding the documentation needed to support reimbursements to States for foster care maintenance payments. This confusion resulted in States not qualifying for Federal funds based on failure to comply with the requirements of the Adoption Assistance and Child Welfare Act of 1980. Almost 42 percent of the errors noted in OIG's earlier reviews related to the lack of adequate documentation of State court actions. The OIG determined that the high error rate surrounding the judicial determination requirements may be a direct result of inflexible statutory requirements.

The OIG presented options for ACF to consider on new and better ways of doing business with the States in their administration of the Federal Foster Care program. The ACF concurred with the findings and options presented in this report. (CIN: A-12-93-00022)

## Respite Care Services for Foster Parents

An inspection on respite care for foster parents produced two related reports. The OIG found that respite care is available in most locations, mostly through other foster parents. The major source of respite care is declining because the number of foster parents is declining. Local foster care agencies were unable to show present use of respite care, but most said more formal respite care is needed. Further, OIG determined that respite care can be effectively provided in various ways.

Neither report presented recommendations, but each identified opportunities for ACF to promote and enhance respite care services for foster parents: ACF can encourage States to use Family Preservation and Family Support Services funds to enhance formal respite programs; continue providing training and technical assistance; and provide guidance to States in developing systems to track use of respite care, increase use of respite care and identify sources of providers other than foster families. (OEI-04-93-00070; OEI-04-93-00071)

## Health and Safety Practices of Child Care Providers

The OIG found that Missouri's health and safety standards were in general compliance with Federal requirements. However, OIG noted that the State's regulations allow certain child care facilities to be exempt from State licensing. Further, the exempt facilities can receive financial support from State funding, which includes Federal financial participation, by registering with the State.

The OIG also found opportunities for improvement of health and safety standards at 29 of 35 providers during its physical inspections. A number of violations were found that potentially placed children at risk. The violations also indicated that some providers did not fully understand the State health and safety standards related to child abuse screens and

tuberculin skin tests. The State concurred with OIG's recommendations and indicated that corrective action has been initiated. (CIN: A-07-93-00718)

## Criminal Background Checks of Child Care Providers

Background checks afford a State the opportunity to identify child care providers who have been arrested for a crime that could bear upon their fitness to be responsible for the safety and well-being of children. The OIG tested the usefulness and reliability of background checks of child care providers working in day care centers, foster care homes and Head Start centers. The results of the OIG review indicated that, in some instances, child care facilities employed individuals who could be a threat to the well-being of children. The OIG believed that this was due to the absence of an ACF nationwide policy requiring the screening of child care providers to identify such individuals. In December 1993, the National Child Protection Act of 1993 was passed to establish procedures for national criminal background checks for child care providers. (CIN: A-12-94-00022)

## Oversight of State Child Welfare Programs

Federal oversight of State child welfare programs has served some important purposes, particularly in establishing new directions for child welfare in the early 1980s. Despite this, there are shortcomings in both the overall approach to and the conduct of Federal oversight. This report describes options for ACF to improve its oversight of State child welfare programs by: providing States with more and better feedback on issues related to program performance; finding new ways to work with States to make improvements and address problems; improving current planning and review processes to make them more effective; making more efficient use of resources required to conduct reviews; providing States with more useful, comprehensive and expert advice on management, program and technical issues; improving and clarifying communication with States about program standards; and improving the timeliness of reporting on the results of reviews. (OEI-01-92-00770)

## Child Welfare Services and Protections for Native American Children

In this study, OIG found that most tribes have received little funding for child welfare services from ACF. In addition, while ACF has monitored the tribal provision of the child welfare protections required by the Adoption Assistance and Child Welfare Act, few tribal records have been reviewed. The OIG also found that neither ACF nor any other Federal agency has ensured State compliance with the child welfare protections required by the Indian Child Welfare Act.

The OIG identified options that ACF could pursue to facilitate tribes' access to child welfare funds and better ensure the provision of federally mandated child welfare protections to Native American children. (OEI-01-93-00110)

## Concurrent Entitlement Payments

The OIG reviewed the State of Missouri's controls for detecting and making appropriate adjustments for concurrent payments under the title IV-E Foster Care, AFDC and Supplemental Security Income (SSI) programs. Title IV-E Foster Care payments are provided for the maintenance of AFDC-eligible children in lieu of the AFDC payments to the family from which the child has been removed. Disabled children who meet the criteria for SSI may also be eligible for benefits under the title IV-E or AFDC programs. A child may meet the eligibility criteria for more than one of these programs. Concurrent payments between SSI and title IV-E are allowable when the combined payments do not exceed the monthly SSI eligibility amount.

The OIG found that Missouri had a system for detecting concurrent payments and was generally making appropriate adjustments for unallowable payments. However, OIG found instances of uncorrected errors involving concurrent title IV-E and SSI payments, and unnecessary adjustments to title IV-E payments. The OIG did not find a significant problem with concurrent payments of AFDC with either title IV-E or SSI. The OIG recommended that the State enhance controls over detecting and making adjustments under the title IV-E and SSI programs. The State generally concurred with OIG's findings and recommendations. (CIN: A-07-93-00689)

## State Income and Eligibility Verification Systems

Under their income eligibility and verification systems (IEVS), States are required to routinely match AFDC, Food Stamp and Medicaid applicant and recipient-supplied information against several data sources to identify individuals who are not eligible for public assistance or are receiving incorrect benefit payments. The OIG determined that State IEVS remain an area of controversy requiring the attention of Federal and State oversight agencies.

Although IEVS matching is mandated by Federal law and regulation, OIG found that the effectiveness, practicality and cost-effectiveness of IEVS under current regulations is uncertain. The OIG recommended that the Health Care Financing Administration and ACF use appropriate mechanisms to address IEVS issues by: examining existing IEVS requirements in each agency; addressing the need for and degree of flexibility to be afforded States; identifying areas in which coordination between oversight agencies can be improved, resources used to monitor IEVS consolidated or more effectively utilized, and procedures streamlined to minimize duplication of efforts and contradictions among Federal agencies' IEVS policies; and engaging outside, involved parties as IEVS issues and requirements are debated. (OEI-06-92-00080)

## Welfare Fraud

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

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

- A New York woman was sentenced to 15 months in jail, to be followed by 3 years supervised release, and ordered to make full restitution of more than $451,260 she received illegally in welfare benefits. Beginning in 1976, she created three fictitious families, using fraudulent North Carolina birth certificates and other fake documents. Since then she received an average of $4,230 a month in cash and food stamps for three adults and 16 children who did not exist.

- Some 30 people were sentenced during this period as a result of a project that OIG undertook with State and local welfare officials in a county in southern Ohio. All had been charged with defrauding the AFDC program. A total of over $35,000 was ordered in fines and restitutions.

- A former employee of the Louisiana AFDC program was sentenced to 6 months home detention and restitution of $15,300 for defrauding the program. Her co-conspirator was sentenced to 14 months in prison. When checks were returned because AFDC beneficiaries had moved or died, the employee gave them to her co-conspirator. He forged beneficiary signatures, signing them over to a nonexistent grocery store and cashing them through a dummy bank account set up for the store. He gave the employee half the money.

- In South Dakota, two persons were convicted, with total fines and restitution ordered of $4,322, in a project to identify and prosecute Indians who live on reservations and are suspected of AFDC fraud. The OIG participated in the project at the request of the U.S. Attorney and the State Department of Social Resources Services because agents of the latter are not allowed to conduct investigations on reservations. Thus far, seven convictions have been obtained. The project will be closed now that adequate deterrence appears to have been achieved.

## Grantee Fraud

In two instances, officials of social program organizations misused funds the Department supplied in support of their programs:

- The chairman and executive director of a counseling center were sentenced in Wisconsin for embezzling AFDC funds the center received as offset for the cost of a "learnfare" program. The program requires teenagers to attend school working toward a high school diploma. If they do not attend, the AFDC payments to their parents are reduced. The chairman laundered $30,000 of the more than $90,000 embezzled to use as down payment on a funeral home, and used $5,700 to install carpets and blinds in his residence. The executive director embezzled at least $22,000 with which she bought automobiles, furs, clothing and other personal items, and installed air conditioning in her residence. The chairman was sentenced to 14 months incarceration and 3 years probation, and ordered to repay $50,700 and forfeit $16,300. The executive director was sentenced to 4 months home detention and 3 years probation, and ordered to make restitution of $32,650.

- The president and vice president of an economic development corporation in Missouri entered a pretrial diversion program after agreeing to make restitution to the Department of $400,000. They had received two grants totaling $961,000 from the Office of Community Services to purchase and renovate a 238-room hotel. The hotel was never purchased, but the corporation reported that all the grant funds had been spent for their intended purpose. Investigation revealed that only about $304,000 was so used, while the remainder had gone to pay expenses of the corporation, which was having financial difficulties.

## Refugee Matching Grant Program: Balancing Flexibility and Accountability

The Refugee Matching Grant program examined in this study allows voluntary agencies and their affiliates to provide a valuable range of integrated services to refugees who have recently entered the United States. Program monitoring is largely the responsibility of the voluntary agencies; the Office of Refugee Resettlement's (ORR) oversight is minimal. Refugees and affiliates must overcome multiple barriers to attain self-sufficiency, and some affiliates have developed unique methods to overcome the barriers.

Affiliates praised the program guidelines, which allow them to tailor services to a diverse refugee population. However, approximately half of the affiliates believe that ORR overemphasizes early employment. In addition, the program's effectiveness measures are inadequate, and match documentation requirements limit the numbers and types of refugees

that affiliates serve. The OIG recommended that ORR develop performance indicators by revising and expanding its current measures and data collection techniques, and consider options to reduce the burden of the match requirement. (OEI-09-92-00060)

## Office of Refugee Resettlement: Miami

The OIG's review of the Miami office's contribution to the national Refugee Resettlement program goals found that functions previously performed by the Miami office are now performed by the State refugee agency. Further, the Miami office maintained obsolete refugee information and disseminated incorrect information on refugee status of individuals which caused erroneous payments to be made. Accordingly, OIG recommended that the office be closed and the resources used to further improve ACF's monitoring, oversight and technical assistance of its programs. The ACF agreed with OIG's findings and recommendations, and subsequently advised OIG that the office has been closed. (CIN: A-04-94-00075)

# General Oversight

## CHAPTER V

# GENERAL OVERSIGHT

## Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities. The Office of the Secretary (OS) will spend $137 million in Fiscal Year (FY) 1994 to provide overall direction for departmental activities as well as common services such as personnel, accounting and payroll to the individual operating divisions. Central to these activities is the development of the Department of Health and Human Services' (HHS') budget and its execution, as well as the related activities of establishing and monitoring departmental policy for debt collection, cash management, payment of HHS grants and contracts and procurements. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

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

The OIG's FY 1994 work in departmental management and Governmentwide oversight focuses principally on financial management and managers' accountability for resources entrusted, standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance.

## Nonfederal Audits

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

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

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

### A. Office of Inspector General's Proactive Role

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

- Through evaluation of reported data, OIG is able to provide basic audit coverage and analyze reports to identify entities for high-risk monitoring and trends that could indicate problems within HHS' programs. These problems are brought to the attention of departmental management to improve program administration.

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

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

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

## B. Quality Control

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

Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 2,451 nonfederal audit reports. The following table summarizes those results:

| | |
|---|---|
| Reports issued without changes or with minor changes | 1,863 |
| Reports issued with major changes | 33 |
| Reports with significant inadequacies | 555 |
| Total audit reports processed | 2,451 |

The 2,451 audit reports discussed above included recommendations for HHS program officials to take action on cost recoveries totaling $18.8 million as well as over 9,600 recommendations for improving management operations. In addition, areas were identified for follow-up by OIG auditors.

## Resolving Office of Inspector General Recommendations

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

### A. Questioned Costs

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

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

| | Number | Dollar Value (in thousands) | |
|---|---|---|---|
| | | Questioned | Unsupported |
| A. For which no management decision had been made by the commencement of the reporting period[1] | 514 | $885,367 | $35,348 |
| B. Which were issued during the reporting period[2] | 237 | $303,797 | $7,277 |
| Subtotals (A + B) | 751 | $1,189,164 | $42,625 |
| Less: | | | |
| C. For which a management decision was made during the reporting period[3]: | 399 | $810,225 | $29,513 |
| (i) dollar value of disallowed costs | | $798,200 | $28,124 |
| (ii) dollar value of costs not disallowed | | $12,025 | $1,389 |
| D. For which no management decision had been made by the end of the reporting period | 352 | $378,939 | $13,112 |
| E. Reports for which no management decision was made within 6 months of issuance[4] | 114 | $154,851 | $5,266 |

See Appendix D for footnotes.

## B. Funds Put to Better Use

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

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

| | Number | Dollar Value (in thousands) |
|---|---|---|
| A. For which no management decision had been made by the commencement of the reporting period[1] | 98 | $629,238 |
| B. Which were issued during the reporting period | 42 | $880,082 |
| Subtotals (A + B) | 140 | $1,509,320 |
| Less: | | |
| C. For which a management decision was made during the reporting period: | | |
| (i) dollar value of recommendations that were agreed to by management[2] | | |
| (a) based on proposed management action[3] | 74 | $868,920 |
| (b) based on proposed legislative action | 0 | $0 |
| Subtotals (a+b) | 74 | $868,920 |
| (ii) dollar value of recommendations that were not agreed to by management | 11 | $474 |
| Subtotals (i + ii) | 85 | $869,394 |
| D. For which no management decision had been made by the end of the reporting period[4] | 55 | $639,926 |

See Appendix D for footnotes.

# Legislative and Regulatory Review and Regulatory Development

## A. Review Functions

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. During this reporting period, OIG reviewed 97 of the Department's regulations under development and 98 departmental legislative proposals.

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

## B. Legislative and Regulatory Development Functions

The OIG also develops a variety of legislative proposals and sanction regulations for the civil monetary penalty (CMP) and program exclusion authorities which the Inspector General administers. During this reporting period, OIG developed or resubmitted a number of legislative proposals for departmental consideration. Included in these was a unique legislative proposal to create a new HHS Fraud and Abuse Control Account, designed to assist OIG and the Health Care Financing Administration in their health care fraud enforcement efforts.

The OIG continues its development of several regulatory initiatives related to the safe harbor provisions under the Medicare and State health care programs' anti-kickback statute, and various rulemaking efforts related to expanding and revising its CMP and peer review organization sanctions authorities. During this period, these efforts included the publication of a final rule establishing CMPs for hospitals and responsible physicians that fail to screen, treat and stabilize, or arrange for the proper transfer of, individuals having emergency medical conditions. Also during this period, OIG published a set of proposed regulations specifically designed to revise the initial set of safe harbor provisions and give greater clarity to the regulations' original intent.

## C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process and the preparation and provision of congressional testimony. During this 6-month period, OIG testified at several hearings. The hearing process offers OIG the opportunity to meet its statutory obligation of keeping the Congress informed of its work with regard to the effective and efficient operation of Department programs. The OIG continues to track all

relevant congressional hearings and pending legislation related to a wide range of HHS issues.

## Thrift Savings Plan: Personnel and Payroll Functions

The OIG conducted an audit to determine whether the Thrift Savings Plan (TSP) program complied with the requirements of the Federal Employees' Retirement System Act of 1986 (FERSA) and was managed in an efficient and effective manner. While OIG found no indication that the Office of the Assistant Secretary for Personnel Administration (ASPER) was out of compliance with the requirements of FERSA, it identified several areas where management of the TSP program could be improved.

The OIG recommended that ASPER: periodically reconcile the accounting reports, which show the amount of TSP contributions recorded in participants' accounts, with the initiating source documents; investigate and resolve individual cash differences between HHS and the Department of the Treasury each month; modify current lost earnings policies and procedures to allow for immediate resolution of lost earnings once they are identified; provide personal notification to all newly eligible employees as to when they may begin to participate in TSP; and conduct regularly scheduled TSP educational programs. The ASPER generally agreed with the recommendations. (CIN: A-17-92-00014)

## Working Capital Fund: Fiscal Year 1993


The OIG, in conjunction with a public accounting firm under contract with OIG, audited the Working Capital Fund in accordance with the Chief Financial Officers Act of 1990 and OMB guidance. The auditors concluded that the fund's financial statements are presented fairly in conformity with generally accepted accounting principles, except that the fund did not perform an adequate physical inventory of its property and equipment. Appropriate actions, including a physical count of all fund property, are being taken by the Department to correct this deficiency. With regard to compliance with laws and regulations, the auditors reported that their tests of compliance disclosed no material instances of noncompliance. (CIN: A-17-93-00027)

## Governmental Accounting

Each year, State and local government entities receive over $104 billion in Federal grant funds. It is estimated that Federal agencies pay at least $6 billion and possibly as much as $20 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 plans, OIG has continued its efforts to identify cost containment areas and/or areas where costs are being inappropriately charged.

### A. Capital Lease Interest Expense: Georgia

The OIG found that the State of Georgia had not fully analyzed equipment rental and purchase accounts to remove all interest expense. This resulted in Federal programs incurring unallowable capital lease interest expenses in excess of $135,000. The OMB Circular A-87 provides that interest expense, such as capital lease interest, is an unallowable expenditure under Federal programs. The State fully concurred with OIG's recommendations, and agreed to make a financial adjustment and perform annual reviews to ensure that equipment purchases are properly accounted for. (CIN: A-04-93-00056; CIN: A-04-93-00063; CIN: A-04-93-00064)

### B. Certificates of Participation Expenses: New York

New York State (NYS) entered into various arrangements for the refinancing and purchase of equipment and real property through the issuance of certificates of participation (COP). These certificates, similar to bonds, are offered for sale by a trustee to the general public.

The OIG found that NYS claimed a total of $20.7 million in COP expenses consisting of $19.4 million in principal repayments and $1.3 million in interest payments. The OMB Circular A-87 stipulates that interest payments, however represented, are unallowable costs for Federal financial participation. Therefore, OIG recommended that NYS refund the nearly $691,000 Federal share of unallowable interest costs claimed. Further, OIG found that NYS had not modified its system of allocating expenses to Federal programs to exclude the interest portion of the COP payments even though this condition was disclosed in a prior OIG report. This issue was also reported as a finding in the 1989, 1990 and 1991 NYS single audit reports and addressed by the Departmental Appeals Board in 1992. The NYS disagreed with OIG's recommendation. (CIN: A-02-93-02000)

### C. Internal Service Funds: California

Internal service funds are required to operate on a break-even basis by charging users for allowable costs as established under OMB Circular A-87. In response to OIG's prior review, California agreed to implement its recommendations and refund $14.9 million of the accumulated surpluses to the Federal Government.

However, based on three recent follow-up reviews at the Teale Data Center, the Health and Welfare Data Center and the Service Revolving Fund, OIG found that California had not implemented the previous procedural recommendations. The OIG estimated that $23.4 million represents the Federal share of accumulated surpluses. The OIG recommended that the State refund the Federal share of the surpluses and adjust billing rates to eliminate future surpluses or deficits. The State did not agree with OIG's recommendations. (CIN: A-09-92-00105; CIN: A-09-92-00119; CIN: A-09-93-00039)

### D. Pension Fund: California

The State of California did not credit Federal programs with a proportionate share when excess pension funds were used to pay for State operations. California's actions resulted from a legislative amendment which allowed the State to use $816 million of $2 billion of excess pension reserves to reduce State pension costs paid from the General Fund. As a result, the State's pension costs were reduced without a reduction of the share charged to Federal programs. This action violates basic cost principles under OMB Circular A-87 which requires that all participating Federal programs receive an equitable share of cost reductions resulting from use of reverted pension funds.

The OIG recommended that the State credit the Federal Government for a proportionate share of the pension costs. The OIG estimates that the Federal share is $111 million. The State responded that the disposition of the pension reserves was mandated by State law to provide resources for employer contributions that were paid by the General Fund. Thus, the State contends, there was no reduction of State costs nor basis for a Federal share. However, such a State enactment would be superseded by the cost principles of OMB Circular A-87, so that when the Federal Government fully participates in funding the pension system and pays its fair share of employer costs, it is entitled to an equitable share in any benefits realized. (CIN: A-09-92-00116)

### E. Puerto Rico's Escheated Warrants

Over the last 15 years, OIG has issued 11 reports dealing with Puerto Rico's failure to credit Federal programs for escheated warrants or uncashed, canceled checks. Although Puerto Rico has acknowledged the need for corrective action in response to prior audits, it has yet to implement adequate procedures whereby Federal programs receive appropriate, timely credit for their share of these checks.

This current review found that the Federal programs did not receive credit for their $15.4 million share of uncashed, canceled checks in excess of $55.2 million during the period July 1, 1986 to June 30, 1993. Puerto Rico generally agreed with the audit recommendations. However, it has yet to provide a detailed plan of action and schedule to resolve the problems. The OIG recommended that the Department, as cognizant agency, set a reasonable timetable for Puerto Rico to determine an acceptable repayment amount, make the refund, and establish the necessary controls and processing procedures to preclude recurrence of the problem. The OIG also recommended that the Department consider stronger measures should Puerto Rico fail to comply with these provisions. (CIN: A-02-94-02000)

## Employee Fraud and Misconduct

The OIG has oversight responsibility for the investigation of allegations of Department employee wrongdoing where it affects internal programs. Most of the thousands of persons

employed full time by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities as illustrated in the following cases:

- A former Social Security service representative in California was sentenced to 1 year probation and 80 hours of community service, fined $500 (or 100 additional hours of community service), and ordered to participate in a "Woman in Need" program. The woman resigned her position after being interviewed by investigators. She admitted submitting, certifying and transmitting a fraudulent Social Security number (SSN) application to create a new credit history.

- A former service representative in a New York Social Security Administration (SSA) office was sentenced to 4 months in prison, to be followed by 4 months of electronically monitored home detention, 300 hours of community service and 2 years supervised probation, for selling valid SSN cards to illegal aliens. She was also fined $300. To avoid security controls, the woman falsely indicated that the aliens were born in Puerto Rico. She sold the cards for $100 to $200 each, either in person or through middlemen she employed in parks in the Bronx and Queens. She was removed from her SSA employment.

- A teleservice representative in a New York SSA office was sentenced to 3 years probation and fined $500 for producing false identification documents. While working for SSA, the woman put false identification information on Social Security card applications, causing fraudulent cards to be created. She was terminated by SSA after her arrest by OIG agents. Her case was part of an undercover project worked by several Federal and State law enforcement agencies in which dozens of Department of Motor Vehicles employees were also arrested for trafficking in false identification documents.

## Program Fraud Civil Remedies Act

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

Two successful actions related to the PFCRA authorities were completed in FY 1994. Both occurred in the first half of the year and were described in the Semiannual Report for that period, but they are repeated here to fulfill OIG's annual reporting requirement:

- The Departmental Appeals Board affirmed an administrative law judge's decision that a Washington, D.C. woman must pay $196,800 under PFCRA. The decision was based on the fact that from October 1986 through August 1989 the woman converted her deceased mother's widows benefits checks to her own use, in the amount of $13,400. One of several aggravating circumstances was that from December 1970 until September 1986 (prior to PFCRA's enactment) she converted another 190 checks totalling $48,400. She cashed the checks undetected at the bank in which she worked. Her crime was discovered after SSA was unable to locate her mother under its Centenarian Program.

- In Massachusetts, a woman signed an agreement settling claims under PFCRA for making false statements to SSA. The woman stated twice on Supplemental Security Income redetermination forms that she owned no real property. She had, however, inherited a part ownership in two houses upon the death of her brother in 1988. She agreed to repay $1,466, including interest.

## Criminal Prosecutions

During this semiannual reporting period, OIG investigations resulted in 579 successful criminal actions. Also during this period, 800 cases were presented for prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors in 565 cases.

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

## Cooperation with Other Law Enforcement Agencies

Many Federal, State, and local law enforcement and regulatory agencies depend on OIG expertise for assistance in identifying, locating, investigating and prosecuting individuals who have improperly used SSNs in a broad range of illegal activities, including bank and credit card fraud, licensing and income tax fraud, welfare fraud, drug trafficking and racketeering, as well as fraud in programs such as student loans, food stamps and

unemployment compensation. Other agencies also benefit from OIG investigations, such as private health insurers, State Medicaid programs and drug regulatory entities. Many of these cases in which OIG participates result in monetary fines, recoveries, restitution or savings for the other agencies. During this period, the monies accruing from these cases amounted to almost $220 million for other public or private entities.

# Appendices

# APPENDIX A

## Implemented Office of Inspector General Recommendations to Put Funds to Better Use April 1994 through September 1994

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

Legislative savings are annualized amounts based on Congressional Budget Office estimates for a 5-year budget cycle. Administrative savings are calculated by OIG using departmental figures for the year in which the change is effected. Total savings for this period amount to $4,301.6 million.

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **HEALTH CARE FINANCING ADMINISTRATION** | | |
| **Use of Donations and Provider Tax Revenues:** Discontinue use of donations and provider tax revenues as a financial mechanism to fund States' share of Medicaid expenditures. (CIN: A-14-90-01009; CIN: A-14-91-01010; CIN: A-03-91-00203) | Public Law 102-234 prohibits donations made by providers, and entities related to providers, except for donations for direct costs of outstationed eligibility workers. In November 1992, the Health Care Financing Administration (HCFA) issued interim final regulations implementing the Public Law 102-234; certain sections of the law were effective January 1, 1992, without regulation. While savings began to be realized in Fiscal Year (FY) 1993, the effect of the legislation will be more marked in FY 1994. | $733 |
| **Medicare Laboratory Reimbursements:** The Medicare fee schedule allowances for clinical laboratory tests should be brought in line with the prices physicians are paying for tests purchased from independent laboratories. (OAI-02-89-01910; CIN: A-09-89-00031) | Section 4154 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 reduced the national cap to 88 percent of the median of all fee schedules and limited the annual fee schedule increase for clinical laboratory tests to 2 percent for 1991, 1992 and 1993. Section 13551 of OBRA 1993 reduced the national cap to 76 percent of the median of all fee schedules, and froze the annual update for 1994 and 1995. | 475 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Intraocular Lenses in Ambulatory Surgical Centers and Hospitals:** In a 1988 report, OIG recommended that HCFA establish a national Part B reimbursement cap of $200, with a handling fee not to exceed 10 percent, for any intraocular lens (IOL) billed to Medicare. After later studies found that IOLs were available for lesser amounts, OIG issued a report in June 1990 recommending that Medicare pay a flat $150 for all IOLs. In a March 1994 report, OIG recommended that payments for intraocular lenses (IOLs) be reduced to current acquisition rates. (OEI-07-89-01664; OAI-07-89-01662; OAI-07-89-01661; OAI-07-89-01660; OAI-09-88-00490; OAI-85-IX-046; OEI-05-92-01030) | Section 4063 of OBRA 1987 mandated a reduction in payment rates for IOL implants. On February 8, 1990, final regulations were published in the Federal Register (55 FR 4526 No. 27). Section 4151(c)(3) of OBRA 1990 maintained the $200 IOL allowance provided for in the regulations as part of the ambulatory surgical center (ASC) payment amount, through December 31, 1992. Section 13533 of OBRA 1993 reduced payments for IOLs in ASCs to $150. | $166 |
| **Preaward Audits:** The OIG reviewed contract proposals and contract extensions and provided contracting officials at HCFA with reports documenting questioned costs and unsupported costs. (Various CINs) | Contracting officials used OIG recommendations to negotiate contracts at significantly lower rates than originally proposed. | 124.5 |
| **Payment Rates for Drug Epogen:** Reimbursement for Epogen should be based on units administered rather than a flat rate. The HCFA should reduce the reimbursement rate not to exceed $10.10 per 1,000 units administered. (CIN: A-01-90-00512; CIN: A-01-92-00506) | Section 4201(c) of OBRA 1990 based the payment rate for Epogen on 1,000 units rounded to the nearest 100 units. Section 13566 of OBRA 1993 redueed the reimbursement rate for Epogen to $10 per thousand units. | 71 |
| **Anesthesia Services:** Medicare should pay only the fractional time units for anesthesiologists and certified registered nurse anesthetists rather than rounding up to the nearest whole unit. (CIN: A-07-89-00193; CIN: A-07-88-00080) | Section 6106 of OBRA 1989 specified that anesthesia time units are to be based on actual time and not rounded up. | 60 |
| **Coverage of Conventional Eyewear:** Exclude Medicare coverage of conventional eyewear following cataract surgery. (CIN: A-04-88-02039) | Section 4153 of OBRA 1990 limited Medicare coverage of eyeglasses following cataract surgery to one pair of glasses. | 50 |
| **Conversion Factors Used in the Anesthesia Payment Formula:** The HCFA should adjust the area-specific conversion factors now used to conversion factors which correlate to geographic multipliers. (CIN: A-07-90-00296) | Section 4103(a) of OBRA 1990 required the Secretary to estimate a national weighted average conversion factor and reduce it by 7 percent. | 40 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Medicaid Transfer of Assets:** Strengthen the transfer of assets rules so that people cannot give away property to qualify for Medicaid. Assets and income from special needs trusts should be counted for Medicaid qualifying purposes and be subject to third party liability recovery. (OAI-09-86-000078; CIN: A-09-93-00072) | Section 13611 provided for a delay in Medicaid eligibility for institutionalized individuals or their spouses who dispose of assets for less than fair market value on or after a specified look-back date; sets forth rules under which funds and other assets of an individual placed in trust by or on behalf of and individual or the spouse are treated, for purposes of Medicaid eligibility, as resources available to the individual, and under which payments form the trust are to be considered as assets disposed of by the individual; and specifies that, for purposes of applying transfer of assets prohibitions, the look-back period with respect to trusts is 60 months. | $25 |
| **Modifications to Medicaid Drug Rebate Program:** Establish State-specific cost reduction targets based on the comparison of individual State drug prices with national and international drug price data; set specific drug price limits for brand name drugs similar to those in place for multi-source drugs; or negotiate directly with manufacturers for prescription drug discounts and rebates. The HCFA should support legislation to retain the current procedures for computing additional rebates. (CIN: A-06-93-00070; OEI-12-90-00800) | Section 13602 of OBRA 1993 permitted States to operate prescription drug formularies meeting certain requirements; removed current law prohibition on the imposition of prior authorization controls with respect to new drugs during the first 6 months following Food and Drug Administration approval; and repealed the weighted average manufacturer price inflation formula for calculating the additional rebate under current law. | 24 |
| **Medicaid Estate Recoveries:** The HCFA should make stronger programmatic initiatives on estate recoveries and encourage statutory changes to enhance asset control and recovery activities, such as making liens (or some other form of encumbrance) a condition of eligibility. States should be required to recover Medicaid personal needs allowance funds from a deceased individual's estate to offset the cost of care. (OAI-09-86-00078; CIN: A-01-93-00002) | Section 13612 of OBRA 1993 required States to recover the costs of nursing facility and other long-term care services furnished to Medicaid beneficiaries from the estate of such beneficiaries, and establish hardship procedures for waiver of recovery in cases where undue hardship would result. | 15 |
| **Low Cost Ultrasound:** The HCFA should prohibit payment for tests conducted with pocket dopplers, and advocate revisions in procedure codes and reimbursement rates to reflect the different levels of sophistication and quality of the diagnostic information provided. (OEI-03-88-01401; OEI-03-91-00460; OEI-03-91-00461) | The HCFA issued an instruction prohibiting separate payment for tests conducted with pocket dopplers and revised the Physician's Procedural Coding handbook to revise imaging codes for hand-held ultrasound devices. | 5.7 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Medicaid Reimbursement for Heathwin Hospital:** The State of Indiana should continue to pursue with HCFA the State plan amendment that will permit an all-inclusive daily reimbursement rate for Heathwin Hospital. (CIN: A-05-92-00133) | The State incorporated the daily reimbursement data for Heathwin's prospective rate directly from OIG's findings. The HCFA approved the State plan amendment. | $1.1 |
| **SOCIAL SECURITY ADMINISTRATION** | | |
| **Social Security Coverage for State and Local Government Employees:** Require mandatory Social Security coverage for all noncovered State and local government employees who are not participating in a public employees' retirement system. (CIN: A-02-86-62604) | Section 11332 of OBRA 1990 extends Social Security coverage to most State and local employees not participating in a public employee retirement system. The effective date is July 1, 1991. | 2,500 |
| **PUBLIC HEALTH SERVICE** | | |
| **Preaward Audits:** The OIG reviewed contract proposals and contract extensions and provided contracting officials at the Public Health Service with reports documenting questioned costs and unsupported costs. (Various CINs) | Contracting officials used OIG recommendations to negotiate contracts at significantly lower rates than originally proposed. | 11.3 |

In addition to the items included in the previous listing, OIG performed significant work in the following areas in which sizeable savings were realized: reduction of Medicare hospital updates; elimination of skilled nursing facility return on equity payments; reduction of payments for transcutaneous electrical nerve stimulation devices; elimination of reimbursement for surgeons who supervise certified registered nurse anesthetists during surgery; elimination of the exception policy for reimbursement of new physicians in medical groups; and banning of physician self-referrals.

# APPENDIX B

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

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

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **HEALTH CARE FINANCING ADMINISTRATION** | | |
| **Medicare Coverage of State and Local Government Employees:** Require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1988. If this proposal is not enacted, seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (CIN: A-09-88-00072) | The President's Fiscal Year (FY) 1995 budget contains a proposal to include under Medicare all State and local government employees hired before April 1, 1988. | $1,535 |
| **Laboratory Roll-In:** Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151) | The Health Care Financing Administration (HCFA) disagreed with the recommendation. The OIG continues to believe that it should be implemented. | 1,100 |
| **Indirect Medical Education:** As an interim measure, reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether any adjustment factor is warranted for all teaching hospitals. (CIN: A-07-88-00111) | The President's FY 1995 budget contains a proposal to reduce the IME factor to 3 percent. | 1,045 |
| **Reduce Hospital Capital Costs:** Seek legislative authority to continue mandated reductions in capital payments beyond FY 1995. The HCFA should determine the extent of the capital reductions that are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070) | The President's FY 1995 budget contains a proposal to reduce inpatient capital payments to hospitals excluded from the prospective payment system (PPS) by 15 percent for FYs 1996-2000. The PPS Federal capital payments would be reduced by 7.31 percent and the hospital-specific amount by 10.41 percent. Updates to the capital rates would be reduced by 4.9 percent each year during FYs 1996-2000. | 995 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Medicare Secondary Payer - Retroactive Recoveries:** The HCFA should ensure that contractors' resources are sufficient and instruct contractors to recover improper primary payments; ensure that contractors take sufficient action to preclude the loss of backlogged Medicare secondary payer (MSP) cases (claims where contractors are more than one quarter behind in sending a demand letter) because the recovery period lapsed; implement financial management systems to ensure all overpayments are accurately recorded; and pursue alternative strategies such as contingency contracts, demonstration and incentive programs, or fund collection activities from recovery proceeds. (CIN: A-01-90-00509; CIN: A-01-91-00525; CIN: A-04-91-02004; CIN: A-04-92-02037; CIN: A-04-92-02057; CIN: A-02-93-01006; CIN: A-04-92-02049; CIN: A-14-94-00392; OEI-07-89-01683) | During FY 1992, HCFA provided the contractors an additional $20 million in administrative funding to reduce the MSP backlog, but the backlog continues. The HCFA has also developed an MSP overpayment tracking system. However, it is not considered a financial management system. In addition, the Department submitted an FY 1994 legislative proposal to establish a payment safeguards revolving fund to provide smoother and more certain funding levels which could result in more consistent and efficient contractor MSP operations. The HCFA submitted a legislative proposal that would establish a cost recovery fund for carriers. However, this proposal was never approved. | $961.6 |
| **Medicare Secondary Payer - Prospective Savings:** The HCFA should revise the justification for an FY 1990 legislative proposal, which would require insurance companies, underwriters and third-party administrators to periodically submit employer group health policy (EGHP) coverage data directly to HCFA, and resubmit it for FY 1996; require that employers report EGHP coverage on the Wage and Tax Statement (W-2); revise all Medicare claims forms to require a positive or negative response pertaining to other health insurance coverage; request that the Social Security Administration (SSA) maintain beneficiary spousal information in its master beneficiary record system for use by HCFA; establish a national data bank system containing primary insurance information; assure compliance with all carrier first claim development procedures and collect health insurance information for disabled beneficiaries during the required disability waiting period. (CIN: A-09-89-00100; CIN: A-09-91-00103; CIN: A-14-94-00392; CIN: A-14-94-00391; OEI-07-90-00760; OEI-07-90-00763) | The HCFA has taken some measures to prevent mistaken Medicare payments, such as: the initial enrollment questionnaire, the common working file and the implementation of the Internal Revenue Service (IRS)/HCFA/SSA data match project. Corrective action plans have not been implemented on some of OIG's recommendations. Even though the Omnibus Budget Reconciliation Act (OBRA) 1993 includes many MSP provisions, including extending the data match through 1998 and establishing a health claims clearinghouse for all employers who are required to file a Form W-2, OIG continues to recommend that HCFA resubmit the legislative proposal that would require employers and insurance companies to report MSP information directly to HCFA on a quarterly basis. The OIG also continues to recommend that HCFA identify and maintain spousal information. | 900 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Medicaid Payments to Institutions for Mentally Retarded:** The HCFA should take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs) by one or more of the following: take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls; seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement or national ceiling for ICF/MR reimbursements; and seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants or financial incentive programs. (OEI-04-91-01010) | The HCFA nonconcurred with OIG's recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA and OIG negotiated an agreement for HCFA to send the report to all State Medicaid directors. This action has been taken. | $683 |
| **Expand Medicare Secondary Payer Provisions:** Extend the MSP provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (CIN: A-10-86-62016) | The President's FY 1995 budget contains a proposal to permanently extend the MSP provision for individuals with ESRD to 18 months. Notwithstanding this proposal, OIG continues to advocate that Medicare should always be a secondary payer for ESRD beneficiaries. | 503 |
| **Medicare Disproportionate Share Adjustments:** Immediately terminate disproportionate share adjustment payments without redistribution of the funds to PPS hospitals. Payments under PPS adequately compensate hospitals for services provided to Medicare patients, including low-income patients. (CIN: A-04-87-00111) | The President's FY 1995 budget proposal would reduce Medicare disproportionate share payments. | 430 |
| **Clinical Laboratory Tests:** Seek legislation to set the fee schedules at amounts comparable to what physicians are paying laboratories for the same tests; develop policies and procedures to ensure that profiles are more appropriately reimbursed; and work with contractors to simplify the processing of bills from laboratories. (CIN: A-09-89-00031) | The OBRA 1993 reduced the fee schedules. However, OIG continues to recommend that HCFA seek legislative reform in FY 1996 because the reduced OBRA schedules still do not guarantee Medicare the fairest price. | 426 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Modify Payment Policy for Medicare Bad Debts:** Seek legislative authority to modify bad debt policy. The OIG presented an analysis of four options for HCFA to consider including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals which are profitable, and the inclusion of a bad debt factor in the diagnosis-related group (DRG) rates. (CIN: A-14-90-00339) | While HCFA supports OIG's recommendation to include a bad debt factor in the DRG rates, it has not sought the necessary legislation. | $400 |
| **Hospital Admissions:** Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality. (CIN: A-05-89-00055; CIN: A-05-92-00006) | The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. As a final measure, HCFA may submit a legislative proposal to remove these stays from the usual DRG payment methodology. | 210 |
| **Adjust Physician Fee Schedule Payments Based on Site of Service Differentials:** Seek legislative authority to expand the reimbursement limitation to physician services provided in additional settings and to expand the definition of services routinely performed in physicians' offices to include a high volume criterion. (CIN: A-05-92-00007) | The HCFA does not concur with OIG's high volume criterion, stating that the expense component of physician payments is statutorily defined. The HCFA is evaluating payments under the physician fee schedule to determine if adjustments should be made for services furnished in additional settings. | 176.9 |
| **Conventional Eye Wear:** Exclude conventional eye wear from Medicare coverage for beneficiaries receiving intraocular lens (IOL) implants. (CIN: A-04-88-02039) | The OIG's proposal was partially implemented with the passage of Section 4153 of OBRA 1990 which limits coverage to one pair of eyeglasses following cataract surgery with an IOL implant. However, OIG continues to recommend that HCFA seek legislation to exclude all conventional eyeglasses following certain cataract surgery. | 158 |
| **Graduate Medical Education:** Revise the regulations to remove from a hospital's allowable graduate medical education (GME) base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system. (CIN: A-06-92-00020) | The HCFA is studying various options for legislative changes and believes a total restructuring of the GME payment system may be necessary. | 157.3 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Ulcer Treatment Drugs:** The HCFA should encourage States to establish prospective limitation procedures that limit payments for the six ulcer treatment drugs (Tagamet, Zantac, Axid, Carafate and Prilose) to the dosages recommended by the manufacturers. Such limitation procedures should provide mechanisms which allow special patient treatment when deemed necessary by the physicians. (CIN: A-06-92-00003) | The HCFA has agreed to provide States with copies of OIG's report for each State's use. | $112 |
| **Outpatient Surgery - Cataract Quality of Care Costs and Unnecessary Endoscopies:** The HCFA should reduce the incidence of payments for medically unnecessary and poor quality cataract surgeries, upper gastrointestinal endoscopies and colonoscopies through a combination of efforts by peer review organizations (PROs) and carriers, including targeted review of certain providers. (OEI-09-88-01005; OEI-09-88-01006) | The HCFA has developed a new strategy for PROs which is intended to reduce poor quality and unnecessary care across the board. The HCFA is developing an evaluation plan to assess whether the revisions to the PRO programs have had the intended effect. | 106.1 |
| **Reduce Medicare Payments for Hospital Outpatient Department Services:** Establish a legislative initiative to reduce the current payments for services in outpatient departments to bring them more in line with ambulatory service center (ASC) approval payments. Pay outpatient departments the ASC-approved rate or adjust hospital payments by a uniform percentage. (CIN: A-14-89-00221; OEI-09-88-01003) | The HCFA is currently preparing a report to the Congress on developing a prospective payment system for outpatient departments. | 90 |
| **Inpatient Psychiatric Care Limits:** Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045) | A legislative proposal was not included as part of the President's FY 1995 budget. However, OIG continues to recommend that HCFA seek legislation to correct the problem. | 47.6 |
| **Monitored Anesthesia:** The HCFA should study the appropriateness of paying the same amount for monitored anesthesia care and general anesthesia in view of the fact that other insurers are more restrictive than Medicare. (OEI-02-89-00050) | The HCFA does not concur with this recommendation. | 28 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Medicaid Credit Balances:** The HCFA should perform a formal evaluation of the State agencies' oversight of hospitals' procedures regarding Medicaid credit balances and the timely refunding of overpayments. Further, it should increase its monitoring of State agencies' activities to reduce overpayments in the areas of third party liability and duplicate payments. (CIN: A-04-92-01023) | The HCFA agreed with the recommendation to perform an evaluation of State agencies' oversight activities. However, HCFA disagreed with the recommendation to increase its monitoring of State agencies' activities to reduce overpayments in the areas of third party liability and duplicate payments, but agreed to send the report to the State Medicaid directors. | $25 |
| **Further Reduce Medicare's End Stage Renal Disease Rates:** Reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215) | The HCFA agreed that ESRD facilities have become more efficient in their operations and that the composite payment rate should reflect the costs of outpatient maintenance dialysis treatment in an efficiently operated renal facility. While OBRA 1990 prohibited HCFA from changing the ESRD composite rates, it mandated a study to determine the costs and services and profits associated with various modalities of dialysis treatments. | 22* |
| **Nonemergency Advanced Life Support Ambulance Services:** The HCFA should modify its Medical Carriers Manual to allow payment for nonemergency advanced life support ambulance service only when that level of service is medically necessary; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. (CIN: A-01-91-00513) | The HCFA concurred with the recommendations, stating that it planned to promulgate a notice of proposed rulemaking to implement the changes. | 15.9 |
| **Establish Mandatory Prepayment Edit Screens for Medicare and Medicaid:** The HCFA should move swiftly with the process of establishing mandatory prepayment edit screens for the Medicare and Medicaid programs. (CIN: A-03-91-00019) | The HCFA believes that the OIG approach does not consider the carriers' responsibility to establish Medicare coverage and payment policy when there is no national HCFA policy. The OIG disagrees. Good internal control procedures would require basic edit checks to ensure that the procedure codes are not manipulated. The HCFA has, however, solicited proposals for developing a national rebundling policy for Medicare Part B carriers. | 12.9 |

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

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Limit Reimbursement for Hospital Beds:** The HCFA should develop a new approach for reimbursing suppliers for hospital beds used by Medicare beneficiaries at home. A new reimbursement methodology should reflect a hospital bed's useful life and the number of times a bed can customarily be rented over that period. (CIN: A-06-91-00080) | The HCFA generally did not concur with OIG's recommendations to lower the monthly rental payments and extend the rental period to reflect the useful life of the bed. However, HCFA agreed to consider using a competitive bidding process in paying suppliers for hospital bed use. The President's FY 1995 budget contains a proposal that would authorize competitive bidding for durable medical equipment. | $9.8 |
| **Medicaid Payments for Employer Group Health Insurance:** The HCFA should continue to strongly support States implementing Section 1906 of the Social Security Act, and should propose legislation that allows States to pay employer group health plan (EGHP) deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules. (OEI-04-91-01050) | The HCFA concurred with the first recommendation and has been working in partnership with regional offices and States to promote full implementation. The HCFA deferred comment on the second recommendation because the requirements under section 1906 of the Social Security Act may change under proposed health care reform. | 6.4 |
| **Medicaid Cost Sharing:** The HCFA should promote the development of effective cost sharing programs by: allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts; and/or recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services; and allowing for higher recipient cost sharing amounts; and promoting the use of cost sharing in States that do not currently have programs. (OEI-03-91-01800) | The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs. It plans to solicit information from States implementing cost sharing and distribute it to States that do not impose it. | 4 |
| **Unbundled Laboratory Services:** The fiscal intermediary should install edits to detect and prevent overpayments for unbundled or duplicate charges for chemistry and hematology tests performed by hospitals on an outpatient basis, and initiate recovery from hospitals for identified overpayments. (CIN: A-01-92-00523) | The intermediary concurred that overpayments resulted from unbundling and duplicate charges, agreed to develop edits and to initiate recovery of overpayments. The intermediary also informed OIG that claims are processed through a system shared with 20 other contractors. The OIG is working with HCFA to identify overpayments due to systematic problems with claims processing systems at all Medicare contractors. | 2.25 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Medicare Payments for Orthotic Body Jackets:** The OIG should require the durable medical equipment regional carriers (DMERCs) to closely monitor claims for body jackets, including: analysis of payment trends, provision of an early warning of abusive practices and monitoring of suppliers who have engaged in abusive practices. (OEI-04-92-01080) | The HCFA concurred and has instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices. The statistical analysis DMERCs produce quarterly reports and monthly ad hoc reports which assist the DMERCs in identifying potential abusive practices, and monitor those suppliers that appear to engage in abusive practices. | $1.7 |
| **Medicare's Reimbursement for Hospital Emergency Room X-Rays:** The HCFA should pay for reinterpretations of x-rays only when attending physicians specifically request a second physician's interpretation in order to render appropriate medical care before the patient is discharged. (OEI-02-89-01490) | The HCFA will revise the hospital emergency room x-ray interpretation policy guidelines in the Medicare Carriers Manual 2020G. The manual revision is currently under development. | .8 |
| **SOCIAL SECURITY ADMINISTRATION** | | |
| **Close Loopholes Affecting the Federal Insurance Contributions Act Wage Base:** Require that salary reduction agreements established under Internal Revenue Code cafeteria plans be included in the definition of wages for Federal Insurance Contributions Act (FICA) purposes. (CIN: A-05-86-62602) | Actions on OIG recommendations to correct the tax inequities are beyond the authority of this Department. The authority lies with the Department of the Treasury or with the Congress. | 1,533 |
| **Lodging Compensation:** Include permanent lodging compensation for FICA coverage. (CIN: A-09-90-00050) | Actions on OIG recommendations to correct the tax inequities are beyond the authority of this Department. The authority lies with the Department of the Treasury or with the Congress. | 221 |
| **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) | Actions on OIG recommendations to correct the tax inequities are beyond the authority of this Department. The authority lies with the Department of the Treasury or with the Congress. | 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 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **State Reverse Offset Laws for Disability Benefits:**<br>The SSA should seek legislation rescinding reverse offset laws, and requiring a reduction of the Social Security disability payment because of workers' compensation and public disability benefit payments in all States. (OEI-06-89-00902) | Legislation to rescind reverse offset laws will be included in SSA's 1996 legislation proposals. | $40.5 |
| **First Month of Eligibility:**<br>The SSA should submit a legislative proposal establishing a consistent definition of eligibility for age-based retirement and survivor payments. (OEI-12-89-01260) | The SSA did not agree with the recommendation and thought that it should be supported with a stronger rationale. | 40 |
| **Overpayments to Supplemental Security Income Recipients:**<br>Nursing homes should be required to report to SSA admissions of Supplemental Security Income (SSI) recipients within 1 day after they are admitted. (CIN: A-07-91-00376) | The SSA concurred that improved reporting by nursing homes to SSA of admissions of SSI beneficiaries could prevent overpayments and that nursing homes should report this information directly to SSA. However, SSA believed that appropriate regulations should be pursued through HCFA. The HCFA did not concur since it did not believe the recommendation should be pursued via a Medicaid regulation. The SSA and HCFA reached a tentative agreement on how to implement the Medicaid regulation. In the fall of 1993, the Senate Finance Committee introduced an amendment to the Social Security Act requiring nursing homes to report admissions of Medicaid-eligible individuals within 2 weeks of such admissions. Action by SSA and HCFA is on hold pending the outcome of the proposed amendment. | 22 |
| **Develop Cost Standards for Disability Determination Services:**<br>The SSA should adopt the reimbursement method for laboratory fees used by Medicare for use by the disability determination services (DDSs). (OAI-06-88-00820) | The SSA had been considering a proposed rulemaking which would apply the Medicare laboratory fee schedule for use by DDSs, but deferred action until more experience was gained using a new consultative examination regulation. However, recent feedback on the regulation indicates that there is not enough information to implement the Medicare fee schedule. Moreover, due to budget and resource limitations, SSA plans to defer action on this recommendation until the issue is addressed under health care reform. | 15.3 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Unreported Workers' Compensation:** The SSA should expedite current negotiations and consider expansion of information exchange agreements with several States. A pilot exchange should be conducted to determine the most efficient method of obtaining workers' compensation (WC) information. If the pilot proves to be cost-effective, SSA should seek legislation to require States to identify WC recipients. (OEI-06-89-00900) | The SSA is negotiating with a State for a pilot WC information exchange agreement to determine the efficacy of legislation to require States to provide SSA with WC information. | $11.7 |
| **Collect Nonresident Alien Taxes:** Use SSA's automated systems to identify retroactive nonresident alien taxes due and develop procedures to facilitate collection by the automated system. (CIN: A-13-90-00041) | The SSA replied that it agreed with OIG's recommendation. The SSA is designing the needed automated systems. Changes and implementation are scheduled for FY 1995. The SSA indicated that these cases would not be worked until the process is automated. | 7.7 |
| **Recover Supplemental Security Income Benefits through Income Tax Refund Offset:** Take administrative action to recover certain SSI overpayments through income tax refunds. (OAI-12-86-00065) | The SSA has implemented tax refund offset to recover Retirement, Survivors and Disability Insurance overpayments. In consideration of the potential for a relatively small collection of delinquent debt and other priority demands for available resources, SSA has postponed implementation of tax refund offset for SSI debt until 1995. | 6 |
| **Revoking Penalties Under Good Cause Policy:** The SSA should increase training to ensure that employees authorized to revoke penalties for failure to file earnings reports under the good cause policy are properly interpreting and applying written requirements. In addition, SSA should provide for independent and/or supervisory review of penalty revocation decisions before final authorization of such transactions and entry of the results into the automated system. (CIN: A-13-91-00208) | A new training lesson entitled "Annual Report Penalties and Good Cause" has been distributed by SSA along with a December 1992 memorandum to management officials encouraging its use. The SSA has not agreed that a second supervisory review is necessary in lieu of the new training lesson and heightened management awareness through issued memorandums. However, SSA is planning to sample the penalty waiver process to test the effectiveness of training initiatives. Completion and analysis of this sample is expected shortly. | 5.6 |
| **New Cards for New Brides:** The SSA should actively pursue the acquisition of computerized marriage records from States having this capability. (OEI-06-90-00820) | The SSA agreed with this concept, but will study quantitative and cost issues before agreeing to implement. | 5.5 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Child Dependents' Dates of Birth:** The SSA should review the universe of child dependents with incorrect dates of birth; identify and collect overpayments; create mandatory edits to preclude processing a claim when dates differ on the payment record and Social Security number record; and modify alert verification processes to better identify date of birth discrepancies. (CIN: A-01-92-02001) | The SSA agreed with the recommendations to review the universe of child dependents with records showing different dates of birth, and to identify and collect overpayments as appropriate. The SSA is currently analyzing a sample of cases to determine the best method to resolve the cases. | $5.3 |
| **Commercial Zip Code Software:** The SSA should improve service to the public and reduce mail costs by using zip code software for zip code maintenance. (CIN: A-13-91-00207) | Master records for both Social Security and Supplemental Security Income (SSI) benefits have been encoded with zip+4 codes. Zip+4 mailing of SSI checks began in November 1990 and Social Security checks followed in March 1991. In December 1990, SSI cost of living adjustment notices secured zip+4 discounts. Zip+4 data improved the carrier qualification rate for SSA-1099s, Social Security Benefit Statements, by 2.5 percent (to 89.75 percent). The decentralized correspondence workload was encoded with zip+4 on March 10, 1993. The HCFA has not yet advised SSA of the date of completion of programming changes needed for the Medicare card. | 5 |
| **Make Work Incentives Sufficient for Low-Earning Beneficiaries:** Defer any benefit increases based on the trial work earnings of a disabled beneficiary until he or she reaches age 62 and can receive retirement benefits, or until his or her disability benefits period is up and he or she refiles for disability. (CIN: A-13-92-00223) | The SSA did not concur with the recommendation. It indicated that delaying disability payment increases based on trial work earnings would weaken the link between earnings and benefit levels, and might be considered discriminatory to disabled beneficiaries. The OIG disagreed with SSA's comments. The OIG recommendation would not cancel payment increases, only defer them until retirement or subsequent periods of disability. The intent of the recommendation would not be considered discriminatory because, according to the regulations, policies and procedures under the Social Security Act, the practice of targeting separate policies and procedures for certain populations is widespread within SSA. | 3.7 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **PUBLIC HEALTH SERVICE** | | |
| **Institute and Collect User Fees for Food and Drug Administration Regulations:** Extend user fees to various functions performed by the Food and Drug Administration (FDA), possibly including premarket review and approval for drugs and devices, inspections of additional manufacturing facilities, and inspections of food processors and establishments. (OEI-12-90-02020; OEI-05-90-01070) | The total estimated collections for all user fees for FY 1994 are $60.3 million ($4 million from insulin and color additive certification, and $56.3 million from prescription drug user fee activities). The President's FY 1994 budget request for FDA included a provision to assess user fees totaling $259 million, which was intended to cover a broader range of activities. New legislation is required to authorize additional user fees to collect the full $259 million. | $198.7 |
| **Recover Grant Funds Awarded for the Construction of Community Mental Health Centers:** The Substance Abuse and Mental Health Services Administration (SAMHSA) should initiate recovery action on grants awarded in excess of $6.8 million (Federal share for 13 grants) from 9 grantees not providing essential and below-cost or free services, and determine whether an additional $235,000 plus interest can be recovered from one grantee. (CIN: A-05-91-00050) | The SAMHSA is scheduling visits to all community mental health center grantees over the next several years to determine if grantees are complying with waiver conditions and are now providing all essential services. | 7 |
| **ADMINISTRATION FOR CHILDREN AND FAMILIES** | | |
| **Reducing Federal Financial Participation:** The Administration for Children and Families (ACF) should consult with the Congress on modifications to the Federal Medical Assistance Percentages (FMAPs) formula which would result in distributions of Federal funds that would more closely reflect per-capita-income relationships. (CIN: A-06-90-00056) | The ACF disagrees with the recommendation to consult with the Congress on options for changing the FMAP formula, saying that "while we believe such a proposal makes sense from a programmatic and budget standpoint, we are not inclined to move forward with this proposal because of our concern that opening the Aid to Families with Dependent Children statute could result in unwanted changes in the program." | 1,100 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Reduce Incentive Payments and Base Them on States' Performance:** Base incentive payments on the States' demonstrated ability to meet Federal child support enforcement (CSE) requirements and performance objectives. Also, consider OIG recommended options to reduce financial incentives realized by States that would result in a more equitable cost sharing with the Federal Government. These options are: limiting incentives to a break-even point where a State's share of Aid to Families with Dependent Children collections plus incentive equal the State's share of CSE costs; eliminating incentives to poor performing States; and reducing the Federal share of administrative costs. (CIN: A-09-91-00147; CIN: A-09-91-00034) | The ACF proposed a new incentive plan for legislative action, but has not agreed with OIG-recommended options. The ACF proposal requires the incentive funds to be reinvested in child welfare programs instead of just the CSE program, but does not provide an incentive to increase collection and/or efficiencies. This proposal is to be considered in the new welfare reform proposals. | $277 |
| **Limit Federal Participation in States' Costs for Administering the Foster Care Program:** Limit Federal participation in Foster Care administrative costs through one of the following actions: limit future increases in administrative costs to no more than 10 percent per year; fund administrative activities via a single block grant with future increases based on the consumer price index; limit administrative costs to a percentage of maintenance payments; or restrict, through legislation, the filing period for retroactive claims, namely require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. (CIN: A-07-90-00274; OEI-05-91-01080) | Substantial effort has been expended attempting to control administrative costs associated with the title IV-E program (including proposed legislation). However, the Congress did not act on ACF's legislative proposal. | 247 |
| **Limit Period of Emergency Assistance to 30 Days:** Revise current emergency assistance regulations to limit benefits to one period of 30 consecutive days or less in 12 consecutive months. (CIN: A-01-87-02301) | The 102nd Congress did not act on this legislation prior to adjournment. No additional proposals have been submitted at this time. | 22 |
| **Low Income Home Energy Assistance Program - Duplication of Benefits:** The ACF should continue its effort to seek a change in the Low Income Home Energy Assistance Program (LIHEAP) statute that will explicitly allow States to consider other home energy assistance received by applicants before LIHEAP grants are made. (CIN: A-04-90-00005) | The ACF agreed and submitted a legislative proposal. This has been overtaken by events. Public Law 103-185 was passed as an amendment to Department of Housing and Urban Development (HUD) laws, and provides that HUD and Farmers Home Administration utility allowances may be taken into account by grantees when they determine the LIHEAP benefits for which a household is eligible. | 14.4 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **GENERAL OVERSIGHT** | | |
| **Disallow Interest Charges on Unfunded Liabilities of Government Pension Plans:** The Office of Management and Budget (OMB) should revise Circular A-87 limiting Federal sharing of actuarially determined pension costs, including amortization of unfunded liabilities, to situations where the State and local governmental unit are funding such costs through an actuarially sound plan. Interest costs caused by late funding should not be allowed. (CIN: A-09-87-00031) | Because of the sensitivity and financial impact of the proposed changes on the State and local governmental entities, OMB has expended considerable effort working with State and local interest groups prior to issuance as a draft proposed rule change. The OIG continues to recommend that OMB clarify the rule relating to pensions by finalizing revisions to Circular A-87. | $1,300 |
| **Simplify Administrative/Indirect Cost Allocation Systems:** Control the growth of administrative/indirect costs charged to Federal programs through reform of the cost allocation plans. The OIG has identified a range of options, some of which require legislative actions, to reform the cost allocation system. Options for reform include: use of block grant awards; a flat percentage rate for administrative/indirect costs; and negotiation of a nonadjustable rate for a predetermined number of years. (CIN: A-12-92-00014) | The OIG's recommendations are cited in the National Performance Review (NPR) report that call for reform of the cost allocation process. The OMB, in revising Circular A-87, will address the NPR recommendations. | 400 |
| **Accelerate Federal Grantees' Deposits of Payroll Taxes:** Require recipients of Federal funds to deposit payroll taxes on the same day Federal funds are drawn down to meet payroll needs. (CIN: A-12-88-00110) | The recommendations are being considered by OMB in its initiative to develop cost containment proposals. Corrective action is pending implementation of the Cash Management Reform Act. | 103.4 |
| **Recover Federal Share of Excess Reserves in Self-Insurance Funds:** The OMB should revise Circular A-87 to tighten standards for charging of self-insurance funds to Federal programs and improve reporting by the States on fund operations, condition and funds flow. (CIN: A-04-90-00018; CIN: A-05-88-00082; CIN: A-02-88-02010; CIN: A-04-88-00061; CIN: A-03-91-01450; CIN: A-04-90-00019; CIN: A-04-91-00023; CIN: A-04-88-00060; CIN: A-04-90-00020; CIN: A-10-86-60450; CIN: A-03-91-14562; CIN: A-03-92-00603; CIN: A-04-91-00024) | The OMB has developed changes to its cost principles that will tighten the standards and improve reporting on self-insurance funds. The OMB will seek and consider public comments before finalizing revisions to Circular A-87. The OIG continues to recommend that OMB clarify all rules on self-insurance funds by finalizing revisions to Circular A-87 cost principles. | 76 |

| OIG Recommendation | Status | Savings in Millions |
|---|---|---|
| **Disallow State Sales Tax Charged to Federal Programs:** The OMB should review Circular A-87 to disallow payment of self-assessed State sales tax as charged to Federal programs. (CIN: A-04-87-00040) | The OMB has developed a change to Circular A-87 cost principles that will disallow payment of self-assessed sales and similar taxes as an allowable cost to Federal programs. The OMB will seek public comments and make changes as appropriate. The OIG continues to recommend that OMB clarify the rules relating to charging of State sales taxes by finalizing revisions to Circular A-87. | $54 |

# APPENDIX C

## Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

| OIG Recommendation | Status |
|---|---|
| **HEALTH CARE FINANCING ADMINISTRATION** | |
| **Kidney Acquisition Cost:** The Health Care Financing Administration (HCFA) should establish uniform fiscal oversight of the organ acquisition costs of all Medicare artificial organ procurement organizations. (OEI-01-88-01331) | The HCFA largely disagrees with this recommendation. |
| **Medicare Carrier Assessment of New Technologies:** The HCFA should foster greater consistency among carriers in their coverage and pricing decisions, by providing carriers with selective access to comparative information on new technologies, reviewing carrier performance and working with the Public Health Service (PHS) to disseminate information on new health care technologies. (OEI-01-88-00010) | The HCFA indicated that it recognized the problems with the carrier assessment of new technologies and had taken steps to correct the problems. The OIG plans to conduct a follow-up study to determine if effective actions have been completed. |
| **Carrier Maintenance of Provider Numbers:** The HCFA should establish adequate safeguards for detection of abusive providers. (OEI-06-89-00870) | The HCFA is taking steps to address the problems identified in the report, which OIG will monitor. The HCFA agreed to issue a modification to the Medicare Carrier Manual which will clearly state that carriers have a responsibility to ensure the integrity of provider numbers and that only those practitioners and providers with legal authority to practice are given and may retain provider numbers. The HCFA is also implementing changes to the contractor evaluation process, durable medical equipment claims processing and supplier requirements, and provider number system. |
| **Review of Medicare Bill and Claim Processing - Opportunities for Long Term Improvement:** The HCFA should initiate a strategic planning effort to determine the feasibility of further streamlining Medicare operations through standardization, consolidation and system integration. Further, HCFA should include the initiative in its information resources management (IRM) strategic plan submission to the Department. (CIN: A-14-91-02532) | The HCFA was largely in agreement with the recommendations and believes that in several instances it has already taken corrective actions. |

| OIG Recommendation | Status |
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| **Review of the Health Care Financing Administration's Implementation of the Project to Redesign Information Systems Management:**<br>The HCFA should include in its IRM plan a discussion of how it intends to assign duties of sufficient scope to, and maintain the independence of, its principal IRM official (PIO). Also, the Assistant Secretary for Management and Budget (ASMB) should review HCFA's implementation of recently issued departmental IRM policy, particularly with respect to assignment of PIO duties. (CIN: A-14-91-02533) | The HCFA disagrees because it believes that the duties of the senior IRM official in HCFA are properly assigned within HCFA's organizational structure. The ASMB has issued several IRM policies to improve the planning and management controls of departmental operating division IRM programs. |
| **Improve the Health Care Financing Administration's Federal Managers' Financial Integrity Program:**<br>The HCFA should enhance the testing used to evaluate the contractors' claims processing internal controls. Also, HCFA should consider reclassifying risk assessments of internal control areas that are pending material weakness and high risk areas to a high risk rating. (CIN: A-14-91-03413) | The HCFA agreed and has established a contractor claims processing internal control task force. The HCFA believes a moderate risk rating is appropriate for some high risk areas. |
| **Implement Proper Accountability over Billing and Collection of Medicare Drug Rebates:**<br>The HCFA should ensure that States implement accounting and internal control systems in accordance with applicable Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current and complete disclosure of drug rebate transactions and provide HCFA with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (CIN: A-06-92-00029) | The HCFA concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The HCFA expects to have regulations in place in Fiscal Year (FY) 1995. |
| **Physical Therapy in Physicians' Offices:**<br>The HCFA should take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. Some options are: conduct focused medical review; provide physician education activities; apply existing physical therapy coverage guidelines for other settings to physicians' offices. (OEI-02-90-00590) | The HCFA concurred with options one and two, and have distributed copies of the report to the carriers to determine if the issues identified are problems in their service areas. The HCFA is also forming a work group that represent physicians who provide physical therapy services in their offices to focus on the clinical appropriateness of services provided, including monitoring of these services. |
| **Lessons From Inspections of Mammography Facilities:**<br>The HCFA should reach an agreement on the role of HCFA's screening mammography certification program in the interim period before full implementation of the Mammography Quality Standards Act (MQSA). (OEI-05-92-00300) | The HCFA and the Food and Drug Administration (FDA) have agreed on an approach to surveying screening mammography facilities between now and the time MQSA becomes effective (after September 30), when FDA will assume responsibility for all certification activity. The HCFA will also issue a regulation to accept FDA's quality standards for Medicare facilities that provide mammography services. |

| OIG Recommendation | Status |
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| **Use of Nursing Homes and Medigap Guides:** The HCFA should work with the Social Security Administration (SSA) and the Assistant Secretary for Public Affairs to develop a more effective strategy to make the booklets available to all beneficiaries. (OEI-04-92-00481) | The HCFA concurred with OIG's recommendation. It is also considering other OIG suggestions, such as distributing information through physicians' offices, hospital personnel and post offices to continue to improve its communication with beneficiaries. |
| **Coding of Physician Services:** The HCFA should produce and promulgate to the American Medical Association and medical specialty societies clear coding objectives and criteria for Medicare's resource-based payment system, and encourage them to apply the objectives in the development of new or revised codes. Also, HCFA should apply coding objectives and criteria when evaluating new or revised codes to assure compliance with the needs of the Medicare Fee Schedule. (OEI-03-91-00920) | The HCFA concurred with both recommendations. Improvements were made to the evaluation and managements codes, and steps have been taken to guard against coding changes leading to the circumvention of the relative value units for new and revised codes. |
| **SOCIAL SECURITY ADMINISTRATION** | |
| **Suspended Payments Need to be Resolved Timely:** The SSA should, in direct deposit cases where the beneficiary is placed in suspense status, institute stronger controls to ensure that timely action is taken to resolve these suspensions so that SSA can either terminate or reinstate payments. (CIN: A-13-89-00027) | The SSA agreed to proceed with policy and procedural changes. Plans to implement the changes await funding. |
| **Further Improvements Necessary to 800 Number Telephone System:** The SSA should decrease the number and increase the size of telephone centers, make better use of technology and back-up agents to increase handling capacity and accuracy, and initiate a pilot to determine whether the telephone centers could become full service centers. (CIN: A-09-90-00071) | The SSA has referred the issue of the number and size of the telephone centers to a work group for evaluation. It has included evaluation of technological improvements in its service delivery plans and has expanded use of back-up units in its program service centers. The SSA did not support the concept of full service centers for the 800 number system. |
| **Project Clean Data:** The SSA should develop, maintain and widely disseminate a software package for detecting invalid Social Security numbers patterned after Project Clean Data. (OEI-12-90-02360) | The SSA agrees with the objective but believes greater use of the enumeration verification system would be more effective. The SSA is conducting a pilot test to assess employer interest and use. |
| **Drug Addicts and Alcoholics:** The SSA should work with PHS and HCFA to develop clearer definitions for drug addiction and alcoholism status, treatment and successful rehabilitation. (OEI-02-90-00950) | The SSA, working in conjunction with HCFA and the Public Health Service, developed a uniform referral and monitoring process for treatment of drug addicts and alcoholics. To date, 45 States have contracted to administer this process, and the remaining States are expected to be under contract in the near future. |

| OIG Recommendation | Status |
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| **Delayed Notices of Planned Action:** Because of the potential cost implications of field office failure to maximize opportunities for overpayment avoidance by using manual notices of planned action in the Supplemental Security Income (SSI) program, OIG recommended that SSA initiate a review to determine the extent of the problem. (OEI-04-90-02160) | The SSA is conducting a comprehensive review of the subject. The OIG will defer its actions until after the results of SSA's studies are compiled. |
| **Work Incentives for Disabled Supplemental Security Income Recipients:** The Commissioner of SSA should take the lead in organizing efforts to identify and study ways to encourage employers to hire severely disabled workers. (OEI-09-90-00020) | The SSA believes that coordination of agency efforts is a good idea, but that it should not assume the lead for such a Governmentwide effort. However, SSA has initiated several pilots to test different approaches to encourage the disabled workers to return to work. |
| **Wage Certification:** The SSA should expeditiously seek congressional guidance on the proper method for certifying wages so that proper revenue amounts are credited to the trust funds. (CIN: A-13-91-00206) | A proposal for legislation to remedy the wage certification issue has been agreed to by the Department of the Treasury and approved by the Department of Health and Human Services (HHS) for drafting of the legislation. |
| **Supplemental Security Income Accounts Payable:** The SSA needs to identify the problems in the SSI accounts payable system, document the causes and integrate the solution into a systemic plan. (CIN: A-13-91-00206) | The SSA is in the process of implementing the recommendations. |
| **Telecommunications Management:** The SSA should test new telecommunications technology after first identifying those functions where it can have the most impact on reducing costs and improving service. It also needs to monitor procurement and perform a needs assessment regarding video services. (CIN: A-09-91-00105) | The SSA concurred and is continuing to work on a sound network strategy and an evaluation of emerging technology. It will focus on optimum utilization in a cost-effective manner. |
| **Death Match Operation:** The SSA should: build an appropriate management information system into future death match enhancements to help monitor performance and detect errors; correct and continue to process certain rejected death records; and generate death verification alerts for all suspended beneficiaries so their payments can be terminated. (CIN: A-13-90-00046) | The SSA is addressing the recommendations in planned systems modification projects. Plans to implement the modifications await funding. |
| **Accelerate Efforts to Improve the Systems Providing Overpayment Accounting Data in the Debt Management System:** The SSA should accelerate efforts to develop a comprehensive plan for replacing Retirement, Survivors and Disability Insurance and Supplemental Security Income (SSI) "back-end" processes (programmatic systems providing overpayment accounting data). (CIN: A-13-92-00216) | The SSA has issued a debt management transition plan which documents "back-end" processing with the debt management system. |

| OIG Recommendation | Status |
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| **Establish Better Controls to Help Prevent or Detect Duplicate Payments to Attorneys:** The SSA should: document a procedure instructing employees to look up attorney fee payments that may have been previously recorded before making any payment; modify the automated system with a control to detect duplicate payments to attorneys; review all potential duplicates identified by OIG for Calendar Year 1991 and begin recovery procedures; and periodically identify and review cases that contain two or more identical attorney fee payments to determine if a duplicate payment was made. (CIN: A-13-92-00219) | The SSA has implemented several of the recommendations and is proceeding with actions to implement the remaining recommendations. |
| **PUBLIC HEALTH SERVICE** | |
| **Fully Implement Internal Controls in the Food and Drug Administration's Medical Device 510(k) Review Process:** The OIG recommended that the Food and Drug Administration (FDA) modify its exception report for use on a quarterly basis to detect possible manipulation of the 510(k) process; periodically sample reviewer workload to ensure compliance with the "first-in, first-reviewed" policy; require reviewers to document responses to all items on the review checklist; conduct bioresearch monitoring inspections on devices likely to result in 510(k) submissions; complete postmarket testing of the four devices it selected for review and increase the number sampled for future tests; include in its quality control reviews an independent scientific evaluation of reviewers' 510(k) decisions; and periodically monitor employee compliance with procedures for employee/industry contacts. (CIN: A-03-92-00605) | In a September 2, 1993 status report to OIG, PHS reported that FDA has made significant progress in rectifying deficiencies in this program area, and that it will continue to monitor FDA's efforts until all corrective actions are implemented. |
| **Controls over Technology Transfers and Royalty Income:** The National Institutes of Health should centralize the technology transfer function for all PHS agencies; establish priorities and milestones to complete reconciliation of patents; establish adequate procedures to ensure that valuable foreign patent rights are obtained and filed in a timely manner; and conduct detailed internal control reviews of technology transfer activities. (CIN: A-01-90-01502) | A follow-up review by OIG showed that PHS has taken or is taking adequate corrective actions on all recommendations. |
| **Tighten Controls of the Advance Payment System Used by the Indian Health Service to Advance Cash to Contractors and Grantees:** The PHS should: consider reporting the problems identified in the advance payment system used by the Indian Health Service (IHS) to advance funds to its contractors and grantees as a material internal control weakness or a material nonconformance under the Federal Managers' Financial Integrity Act; assess the propriety of funds advanced to 16 contractors who commingled IHS funds with their other funds; and evaluate alternatives for improving the current system of advancing funds to IHS contractors and grantees. (CIN: A-06-90-00001) | In its November 30, 1993 report on the status of corrective actions taken on OIG reports, PHS noted that IHS has corrected certain problems disclosed by the OIG report. Correction of all the problems will reportedly be completed when all area office tribal contracts are transferred to the departmental payment management system, expected by December 31, 1994. |

| OIG Recommendation | Status |
|---|---|
| **Properly Justify the Acquisition of Computer Equipment and Services at the Centers for Disease Control and Prevention:** The ASMB should suspend the delegation of procurement authority for the Centers for Disease Control and Prevention's (CDC) planned acquisition until CDC demonstrates the need for and cost benefit of the acquisition; direct PHS to require that CDC document its requirements analysis and the costs and benefits of the planned acquisition of microcomputers; and review the role of PHS in reviewing proposed computer acquisitions. The Assistant Secretary for Health should require CDC to document its requirement analysis and the costs and benefits, and review the role of PHS in reviewing the proposed acquisition. (CIN: A-15-92-00016) | Delegation of procurement authority was reinstated September 18, 1992 to the Assistant Secretary for Health, who subsequently reinstated this delegation to CDC. |
| **ADMINISTRATION FOR CHILDREN AND FAMILIES** | |
| **Summarization of Head Start Grantee Audit Findings:** The Administration for Children and Families (ACF) should increase training and technical assistance to grantees; strengthen procedures regarding grantee monitoring and use of interest bearing accounts, and refunding interest income; implement the new audit requirement for nonprofit organizations administering Federal programs; develop procedures to detect grantees with interfund transfers; reevaluate procedures to ensure that excess cash is not drawn; and obtain evidence that excess balances are collaterally secured when awarding grants. The ACF should also reemphasize that the nonfederal match is properly documented and met; require evidence of current licensing or compliance with all of the facility standards; and emphasize use of sales tax exemptions and timely deposits of tax refunds. (CIN: A-07-91-00425) | The ACF is in general agreement with the recommendations. |
| **Child Support Enforcement Payments - Financial and Program Implications:** Incentives should be based on the States' demonstrated capability to meet Federal child support enforcement (CSE) requirements and performance objectives. In addition, the Office of Child Support Enforcement should continue its efforts to revise the CSE incentive formula to be more equitable for both the States and the Federal Government. The OIG also has recommended various options for legislative changes to increase the effectiveness and efficiency of the CSE program. (CIN: A-09-91-00147) | The ACF agreed with the thrust of the OIG recommendations, indicating it will continue to pursue the adoption of its legislative proposal on performance-based incentives. It was submitted to Congress in February 1992. The ACF submitted a budget proposal to revise the method of calculating incentives. The ACF agreed that the restructuring of incentives would facilitate improvements. |
| **Protect Federal Interest in Real Property Acquired by Grantees:** The ACF should establish a management information system to identify, track and monitor real property purchased with grant funds. The management information system should include the date, type, location and cost of property purchased. (CIN: A-12-90-00020) | The ACF implemented the Office of Community Services grants tracking and monitoring computer system in 1990 to identify, track and monitor real property that was purchased with Federal grant funds. According to ACF's corrective action plan, this material weakness' targeted correction date is FY 1995. A corrective action review will be performed within 1 year from completion date. |

| OIG Recommendation | Status |
|---|---|
| **Improve Management of Community Services Discretionary Grants:**<br>The ACF should: develop grant policies and procedures that implement the Department's grants administration manual; provide adequate oversight of external grant application reviewers and resolve grant application reviewer comments before funding grants; prepare guidelines for selecting grantees for site visits, following up on site visit problems and documenting the visit; process expenditure reports timely to prevent draw down of unobligated balances and expedite recovery of misused grant funds; and obtain and use available audit reports to expedite the review and close-out process to eliminate the backlog of expired and terminated grants. (CIN: A-12-90-00022) | The ACF advised that corrective actions have been or are being taken. However, ACF did not agree with OIG's recommendation to resolve reviewers' comments, stating that there is no requirement to resolve the comments before funding. The ACF is moving to close out the backlog of expired grants and protect the Government's interest. |
| **Improve Cash Management of Child Support Collections:**<br>The ACF should require the State and local agencies to: specify that collection and recording procedures be in writing; maintain accurate records and proper segregation of the collection and recording processes; restrict access to the computer systems; increase controls over the receipt forms, blank checks and signature devices; perform follow-up reviews to ensure that all child support agencies are offsetting interest earned on child support collections; negotiate with investment institutions to maximize earnings on deposited child support collections; perform follow-up reviews to determine the status of undistributable child support collections; and ensure that all CSE agencies have adequate systems for establishing, recording, maintaining and reviewing account balances. (CIN: A-12-91-00018) | The ACF generally concurred with the findings and recommendations and indicated that increased efforts would be made to promote adequate internal controls and cash management practices at the State level. |
| **Ensure State Compliance with Health and Safety Regulations at Child Care Facilities:**<br>North Carolina should reevaluate their (federally-required) plan to assure timely, accurate and comprehensive inspections that will assure compliance with State regulations. The plan should assure compliance with fire codes, building codes, sanitation regulations, requirements for background checks on child care providers and day care regulations by accommodating consultant workload. In addition, North Carolina should review regulations and eliminate vagueness, provide technical assistance to providers, provide health and safety information to parents, and ask parents to report conditions that would be harmful to their children. (CIN: A-12-92-00044) | North Carolina generally concurred with the observations noted. |

| OIG Recommendation | Status |
|---|---|
| **GENERAL OVERSIGHT** | |
| **Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake:**<br>The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify HHS' disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to PHS, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040) | The OASH has taken the lead in this area and has met with headquarters operating division emergency preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved. |
| **Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake:**<br>The OASH should issue guidelines to improve disaster planning. The plans of each operating and staff division should spell out lines of communication with each other, and should specify headquarters and regional lines of communication with the Federal Emergency Management Agency. (OEI-09-90-01040) | The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department. |
| **Ensure that New York Allocates Training Costs to Federal Programs for Actual Number of Attendees:**<br>The Department should be more aggressive when approving State plans to ensure that the State (among other actions): allocates future training contracts to programs based on the actual number of participants; maintains documentation which clearly details which programs benefit from future training and, where applicable, allocates training costs to all benefitting programs; and discontinues using third party contributions provided by private contractors to meet its share of training costs. (CIN: A-02-91-02002) | The Department's Division of Cost Allocation (charged with approval of State cost allocation plans) expressed agreement with the findings and recommendations. |

# APPENDIX D

## Notes to Tables I and II

**Table I**

[1] The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of $354.3 million.

[2] Included in the reports issued during the period are management decisions to disallow $8,558 in costs attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

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

| | |
|---|---|
| CIN: A-07-89-00199 | Audit of Missouri Department of Social Services: After further review, HCFA determined that drugs previously disallowed, of $439,878, were allowable under Federal financial participation. |
| CIN: A-04-91-02001 | Audit of Blue Cross/Blue Shield of Florida: Upon further review, the carrier determined the actual overpayment is $415,741, not $1,072,004 as previously disallowed. |
| CIN: A-09-91-05179 | Audit of Northern Valley Indian Health, Inc.: The grantee provided documentation to support previously disallowed costs of $180,797. |

Not detailed are additional revisions to previously reported decisions totaling $2.6 million.

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

A. Due to administrative delays, many of which were beyond management's control, resolutiou 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-04-92-01023 | Medicaid Credit Balances, March 1993, $40,931,405 |
| CIN: A-02-93-01021 | Follow-up HCFA Resolution Two Westchester IMDS, December 1993, $20,687,621 |
| CIN: A-03-91-00552 | Independent Living Program - National, March 1993, $6,529,545 (Related recommendation of $10,161,742 outstanding on Table II.) |
| CIN: A-07-92-00578 | Blue Cross Blue Shield of Texas Inc.- Unfunded Pension Costs, October 1992, $6,244,637 |
| CIN: A-03-89-00046 | Maryland Blue Cross Blue Shield Administrative Costs, September 1991, $5,996,278 |
| CIN: A-02-93-02010 | Refugee Resettlement Program Cash Assistance Payments Claimed by New York City Fiscal Year 1991, November 1993, $4,265,430 |
| CIN: A-05-93-00054 | Illinois Associated Insurance Group - Contract Audit, October 1993, $3,355,560 |
| CIN: A-07-93-00633 | Pension Segmentation - AETNA Life Insurance Co., October 1993, $3,011,376 |
| CIN: A-07-92-00585 | Pension Segmentation Blue Cross Blue Shield of California, January 1994, $2,973,504 |
| CIN: A-03-93-03308 | GSX Services Inc. Contract Audit, February 1994, $2,806,577 |

CIN: A-07-92-00579 Blue Cross Blue Shield of Michigan Inc. Unfunded Pension Costs, October 1992, $2,535,689

CIN: A-05-92-00026 Associated Insurance Company Medicare Administration, February 1992, $2,530,409

CIN: A-02-91-01006 Blue Shield of Western New York Medicare Administration, September 1991, $2,379,239

CIN: A-09-89-00162 Medicare Secondary Payer Nationwide Employer Review, July 1992, $2,218,824

CIN: A-03-90-02003 Blue Cross Blue Shield of Western Pennsylvania Administrative Costs Fiscal Years 1986-1989, July 1993, $2,218,528

CIN: A-03-91-02000 Independence Blue Cross Blue Shield Administrative Costs, June 1993, $1,763,319

CIN: A-03-92-19733 State of Maryland, August 1992, $1,505,462

CIN: A-03-90-00051 Maryland Blue Cross Blue Shield Administrative Costs - Part A - Fiscal Years 1985-1988, August 1991, $1,438,414

CIN: A-05-93-00057 Michigan Blue Cross Blue Shield Contract Audit, July 1993, $1,409,954

CIN: A-02-92-02002 Refugee Resettlement Costs Claimed by New York City Fiscal Years 1989-1991, October 1993, $1,244,281

CIN: A-07-93-00665 Travelers Insurance Company - Unfunded Pension Cost Audit, October 1993, $1,218,963

CIN: A-03-93-03313 Biocon Inc. Contract Audit, February 1994, $1,061,376

CIN: A-07-93-00634 Pension Segmentation - Travelers Insurance Company, October 1993, $1,026,460

CIN: A-05-92-00060 Blue Cross Blue Shield Administrative Costs, February 1993, $879,609

CIN: A-03-94-03304 Biocon Inc. Contract Audit, February 1994, $747,865

CIN: A-08-94-00739 Blue Cross Blue Shield of North Dakota Pension Segmentation, January 1994, $730,875

CIN: A-05-91-00136 Community Mutual Insurance Company Administrative Costs, August 1992, $720,668

CIN: A-04-91-04029 Audit of O&M AIDS Campaign Contract, May 1992, $675,750

CIN: A-08-94-00074 Blue Cross Blue Shield of North Dakota - Unfunded Pension Cost, January 1994, $671,198

CIN: A-03-94-03303 Biocon Inc. Contract Audit, February 1994, $524,682

CIN: A-03-92-16229 State of Pennsylvania, March 1992, $496,876

CIN: A-03-93-26413 East Coast Migrant Head Start Project, September 1993, $481,130

CIN: A-06-92-00102 Job Opportunities and Basic Skills - Federal Financial Participation, October 1993, $438,996 (Related recommendation of $14,999 outstanding on Table II.)

CIN: A-06-93-00042 Blue Cross Blue Shield of Texas Administrative Costs - Medicare Parts A and B, January 1993, $434,134

CIN: A-03-91-03310 Beach Advertising Contract Closeout, March 1993, $377,424

CIN: A-05-92-00126 Wisconsin Westcap Head Start Administration for Children and Families RO Request, March 1993, $347,576

| | |
|---|---|
| CIN: A-09-93-00030 | Undistributed Child Support Collections, January 1994, $347,057 |
| CIN: A-10-93-26777 | Migrant and Indian Coalition for Coordinated Child Care, October 1993, $332,689 |
| CIN: A-01-93-00500 | Health Maintenance Organization's Reg 10 HCHP & Fallon Pilot Review, December 1993, $330,000 |
| CIN: A-05-93-25697 | West Central Wisconsin Community Action Agency Inc., August 1993, $324,759 |
| CIN: A-09-92-00063 | Blue Cross of California Administrative Costs, March 1992, $310,665 |
| CIN: A-05-93-00025 | Ohio Department of Human Services - Follow-up on State Report, July 1993, $251,013 |
| CIN: A-03-92-20033 | State of Delaware, August 1992, $247,609 |
| CIN: A-02-92-16749 | City of San Juan Puerto Rico, December 1991, $233,462 |
| CIN: A-05-91-00064 | Nationwide Administrative Costs Contract Audit, October 1991, $211,422 |
| CIN: A-05-93-00050 | Ohio - ODHS/JOBS/Work Supplementation, October 1993, $194,463 |
| CIN: A-05-93-24819 | Economic Opportunity Committee of St. Clair County, August 1993, $188,691 |
| CIN: A-10-92-00005 | WPS Administrative Cost Audit, February 1992, $179,891 |
| CIN: A-05-94-28643 | Community Action Against Poverty of Greater Indian, January 1994, $176,159 |
| CIN: A-03-94-26611 | State of Delaware, December 1993, $163,100 |
| CIN: A-09-94-24310 | State of Arizona, October 1993, $162,129 |
| CIN: A-09-92-06850 | Santa Ysabel Band of Mission Indians, September 1992, $151,081 |
| CIN: A-03-93-21104 | State of Pennsylvania, June 1993, $150,000 |
| CIN: A-09-92-00111 | Health Services Advisory Group, UCDS Costs, July 1993, $142,114 |
| CIN: A-04-94-26731 | State of Florida, December 1993, $135,226 |
| CIN: A-04-94-25773 | Central Mississippi Civic Improvement Association, February 1994, $132,487 |
| CIN: A-05-92-00048 | Wisconsin Physicians Services, Pension - Medicare versus ERISA, October 1992, $130,577 (Related recommendation of $2,068,964 outstanding on Table II.) |
| CIN: A-09-92-00093 | Blue Cross Arizona Administrative Costs, August 1992, $129,518, |
| CIN: A-04-93-20785 | State of Florida, June 1993, $103,486 |
| CIN: A-05-93-00071 | Indiana Family Social Services Administration - Foster Care Rate Agreements, January 1994, $102,256 |
| CIN: A-12-93-00042 | Survey of District of Columbia Administrative Costs CSBG Fiscal Year 1992, February 1994, $99,819 |
| CIN: A-01-92-10075 | State of Massachusetts, September 1992, $96,703 |
| CIN: A-02-93-02518 | Biederman, Kelly and Shafer Contract, February 1994, $72,883 |
| CIN: A-03-91-02002 | Delaware Blue Cross Administrative Costs, October 1991, $66,858 |
| CIN: A-03-93-21786 | District of Columbia Department of Human Services, October 1993, $64,307 |
| CIN: A-03-91-16232 | UNISYS Inc., September 1991, $61,754 |

| | |
|---|---|
| CIN: A-06-92-19887 | Central Tribes of the Shawnee Area Inc., July 1992, $57,944 |
| CIN: A-05-94-27548 | Hoosier Valley Economic Opportunity Corporation, January 1994, $55,811 |
| CIN: A-06-94-24924 | State of Louisiana, December 1994, $51,842 |
| CIN: A-03-93-03306 | Survey Research Associates Contract Award, December 1993, $48,779 |
| CIN: A-02-94-27434 | University of Puerto Rico, February 1993, $41,454 |
| CIN: A-01-93-20875 | State of Maine, May 1993, $40,540 |
| CIN: A-05-94-27622 | Lake Geauga United Head Start Inc., January 1994, $36,420 (Related recommendation of $86,988 outstanding on Table II.) |
| CIN: A-03-92-00351 | Frederick Cancer R&D Center, April 1993, $35,531 |
| CIN: A-10-93-23022 | State of Alaska, August 1993, $34,731 |
| CIN: A-04-93-20785 | Medlantic Research Institute, June 1993, $31,531 |
| CIN: A-02-94-27435 | University of Puerto Rico, February 1994, $29,574 |
| CIN: A-06-94-28862 | Pueblo of San Felipe, January 1994, $23,599 |
| CIN: A-10-93-22465 | Small Tribes Organization of Western Washington, January 1993, $23,220 |
| CIN: A-06-92-20334 | Pueblo of Jemez, September 1992, $20,156 |
| CIN: A-03-93-22091 | Pennsylvania State University, September 1993, $19,878 |
| CIN: A-02-93-24129 | Council of Jewish Federations Inc., May 1993, $19,152 |
| CIN: A-05-93-21928 | Wright State University, July 1993, $18,308 |
| CIN: A-02-93-24742 | Puerto Rico Department of Anti-Addiction Services, July 1993, $17,554 |
| CIN: A-10-93-26035 | State of Washington, September 1993, $15,915 |
| CIN: A-04-93-20961 | Commonwealth of Kentucky, January 1993, $15,000 |
| CIN: A-10-92-20781 | Tulalip Tribes of Washington, September 1992, $14,525 |
| CIN: A-04-92-19467 | Yomba Shoshone Tribe, November 1992, $12,832 |
| CIN: A-03-93-21579 | State of West Virginia, April 1993, $11,380 |
| CIN: A-09-94-27562 | Tohono Odhame Nation, October 1993, $10,817 |
| CIN: A-03-93-21785 | District of Columbia Department of Human Services, October 1993, $8,166 |
| CIN: A-09-93-23668 | Center for Education and Manpower Resources, Inc., July 1993, $8,093 |
| CIN: A-09-93-07000 | Yomba Shoshone Tribe, November 1992, $7,745 |
| CIN: A-10-93-22136 | Confederated Tribes of the Grand Ronde Community, December 1992, $7,384 |
| CIN: A-02-94-28062 | Associated Beth Rivkah Schools, Inc., November 1993, $7,051 (Related recommendation of $13,111 outstanding on Table II.) |
| CIN: A-01-93-24739 | State of New Hampshire, August 1993, $5,758 |
| CIN: A-05-93-26026 | Bad River Band of Lake Superior Tribe of Chippewa, September 1993, $5,458 |
| CIN: A-06-91-00034 | Audit of Collection and Credit Activities at TDHS, January 1992, $5,081 |

CIN: A-09-94-28318 Institute for Human and Social Development Inc., December 1993, $4,889

CIN: A-02-93-26106 Second Street Youth Center Foundation Inc., July 1993, $3,989

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

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

CIN: A-07-94-25955 State of Kansas, December 1993, $2,783

CIN: A-03-93-25970 Little Neighborhood Schools Inc., June 1993, $2,604

B. Reports in litigation:

CIN: A-04-92-02056 Administrative Cost Audit of Medicare Part B, Blue Cross Blue Shield of Florida, May 1993, $14,722,615

CIN: A-05-93-00013 Michigan Blue Cross Blue Shield Medicare Contract Audit, April 1993, $3,010,916

CIN: A-09-91-00155 Blackburn Care Home, November 1991, $1,772,944 (Related recommendation outstanding of $662,000 on Table II.)

CIN: A-10-91-00011 WPS - Keystone Computer Acquisition, October 1992, $1,346,681

CIN: A-02-91-03508 Audit of New Jersey Child Care and Supportive Services, June 1993, $506,710

CIN: A-06-92-00102 Indian Health Service Contract Closeout Report, May 1992, $468,217

CIN: A-04-93-20785 State of Florida, June 1993, $33,511

CIN: A-03-92-00033 Blue Cross Blue Shield of West Virginia Termination, November 1992, $25,200

CIN: A-09-94-27868 Inyo Mono Advocates for Community Action, November 1993, $22,875

CIN: A-03-91-02004 West Virginia Blue Cross Blue Shield Administrative Costs Fiscal Years 1985/1990 and Termination Cost, November 1992, $7,556

**Table II**

[1] The opening balance was adjusted to reflect a downward adjustment of $317.4 million.

[2] Included are sustained management decisions of funds put to better use of $4.6 million attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

[3] The Social Security Administration agreed with the recommendations but disagreed with the savings figure of $8 million for OEI-01-92-00020, Overpayments to Disability Insurance Beneficiaries Who Return to Work.

[4] Management decisions have not been made within 6 months of issuance on 13 reports:

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

CIN: A-06-91-00048 Non-AFDC Application and User Fees for Child Support Enforcement Services, July 1992, $385,000,000

CIN: A-05-92-00006 One Day Admissions Finalization, January 1992, $233,000,000

OEI-03-91-01800 Medicaid Cost Sharing, July 1993, $99,000,000

CIN: A-02-91-01052 Medicaid - Eliminate Enhanced Family Planning, December 1992, $80,000,000

CIN: A-12-91-00018 Cash Management by State Child Support Agencies, August 1991, $13,800,000

CIN: A-01-93-00509 National Medical Care, Home Offices Costs Calendar Year 1991, December 1993, $1,470,296

CIN: A-06-91-00089 Audit of Cash on Hand Indian Health Service, April 1992, $445,890

CIN: A-06-92-00081 Follow-up Hansen's Disease Center, August 1993, $164,728

CIN: A-04-93-22872 Montgomery Community Action Committee Inc., January 1993, $106,760

CIN: A-06-93-25797 Palo Pinto Community Service Corp., August 1993, $12,823

CIN: A-06-94-27237 Tom Green Co. Community Action Council, January 1994, $10,081

B. Report in litigation:

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

C. Report that has subsequently been resolved:

CIN: A-04-94-26559 Primary Health Care Center of Dade Inc., October 1993, $68,626

# APPENDIX E

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

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

| Section of the Act | Requirement | Page |
|---|---|---|
| **Section 4(a)(2)** | Review of legislation and regulations | 72 |
| **Section 5(a)(1)** | Significant problems, abuses and deficiencies | throughout |
| **Section 5(a)(2)** | Recommendations with respect to significant problems, abuses and deficiencies | throughout |
| **Section 5(a)(3)** | Prior significant recommendations on which corrective action has not been completed | appendices B and C |
| **Section 5(a)(4)** | Matters referred to prosecutive authorities | 77 |
| **Section 5(a)(5)** | Summary of instances where information was refused | none |
| **Section 5(a)(6)** | List of audit reports | under separate cover |
| **Section 5(a)(7)** | Summary of significant reports | throughout |
| **Section 5(a)(8)** | Statistical table I - reports with questioned costs | 70 |
| **Section 5(a)(9)** | Statistical table II - reports with recommendations that funds be put to better use | 71 |
| **Section 5(a)(10)** | Summary of previous audit reports without management decisions | appendix D |
| **Section 5(a)(11)** | Description and explanation of revised management decisions | appendix D |
| **Section 5(a)(12)** | Management decisions with which the Inspector General is in disagreement | none |

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# INDEX

## G



## H



## I



## J



## K



## L



## M



## N



## O



## P

# ACRONYMS

| | |
|---|---|
| ACF | Administration for Children and Families |
| AFDC | Aid to Families with Dependent Children |
| ALJ | administrative law judge |
| AoA | Administration on Aging |
| ASC | ambulatory surgical center |
| ASMB | Assistant Secretary for Management and Budget |
| CDC | Centers for Disease Control and Prevention |
| CFO | Chief Financial Officer |
| CMP | civil monetary penalty |
| CPT | current procedural terminology |
| CSE | child support enforcement |
| DDS | Disability Determination Service |
| DI | Disability Insurance |
| DME | durable medical equipment |
| DRG | diagnosis-related group |
| EGHP | employer gronp health policy |
| ESRD | end stage renal disease |
| FDA | Food and Drug Administration |
| FFP | Federal financial participation |
| FI | fiscal intermediary |
| FMFIA | Federal Managers' Financial Integrity Act |
| FY | fiscal year |
| GME | graduate medical education |
| HCFA | Health Care Financing Administration |
| HEAL | health education assistance loan |
| HHS | Department of Health and Human Services |
| HI | Hospital Insurance |
| HRSA | Health Resources and Services Administration |
| HUD | Department of Housing and Urban Development |
| ICF/MR | intermediate care facility for the mentally retarded |
| IEVS | Income and Eligibility Verification System |
| IME | indirect medical education |
| IOL | intraocular lens |
| IRM | information resources management |
| JOBS | Job Opportunity and Basic Skills |
| LIHEAP | Low Income Home Energy Assistance Program |
| MBR | master beneficiary record |
| MFCU | Medicaid fraud control unit |
| MQSA | Mammography Quality Standards Act |
| MSP | Medicare secondary payer |
| NIEHS | National Institute of Environmental Health Sciences |
| NIH | National Institutes of Health |
| NPR | National Performance Review |
| OASH | Office of the Assistant Secretary for Health |
| OASI | Old Age and Survivors Insurance |
| OBRA | Omnibus Budget Reconciliation Act |
| OMB | Office of Management and Budget |
| OPO | organ procurement organization |
| ORR | Office of Refugee Resettlement |
| PFCRA | Program Fraud Civil Remedies Act |
| PHS | Public Health Service |
| PPS | prospective payment system |
| PRO | peer review organization |
| SMI | Supplementary Medical Insurance |
| SSA | Social Security Administration |
| SSI | Snpplemental Security Income |
| SSN | Social Security number |
| WC | workers' compensation |

DEPARTMENT OF HEALTH
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