Semiannual Report

April 1, 1992 - September 30, 1992

Office of Inspector General

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

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

Office of Management and Budget Circulars:

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

General Accounting Office "Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

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

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FOREWORD

We are pleased to submit this semiannual report of the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS), as required by the Inspector General Act of 1978 (Public Law 95-452), as amended. We wish to thank the Department's managers and the Members of the Congress whose continued assistance has helped us to realize our accomplishments.

The OIG works to protect the integrity of departmental programs and the health and welfare of the beneficiaries of those programs. For Fiscal Year (FY) 1992, the HHS budget reached $545 billion, an increase of $60 billion over FY 1991, and the FY 1993 budget is estimated at $585 billion. At the same time, the OIG budget has remained essentially level since FY 1990. While we are proud of our accomplishments under these conditions, we cannot continue the same high level of activity with a declining level of resources.

In recognition of the Department's responsibility to meet the important social goals and pressing health needs of the American public, the Secretary has set specific objectives and established program directions for the operating divisions designed to achieve those objectives. The OIG's activities support those goals by promoting high quality, cost-effective health care and human services, improved access to health care for all Americans, and the integrity of the Social Security and Medicare trust funds. In addition, OIG is focusing particular attention on improving financial systems within the Department, and accelerating the development and auditing of financial statements pursuant to the Chief Financial Officers Act. The OIG will expand its financial statement audit activity in FY 1993 by initiating the audit work that will allow us by FY 1995 to complete a full audit of the Health Care Financing Administration's (HCFA's) Financial Statement.

The OIG's work covers all the operating divisions of the Department. Each operating division is covered in a separate chapter in this report:

- The HCFA administers the Medicare and Medicaid programs.
- The Social Security Administration manages the Nation's Retirement, Survivors and Disability Insurance program, the Supplemental Security Income program and Part B of the Special Benefits to Disabled Coal Miners (Black Lung) program.
- The Public Health Service promotes biomedical research, disease cure and prevention, and the safety and efficacy of marketed food, drugs and medical devices; measures the impact of toxic waste sites on health; and conducts other activities designed to ensure the general health and safety of American citizens.

- The Administration on Children and Families (ACF) provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families and administers a variety of programs that provide social services to American children, families, older Americans, Native Americans and the Nation's developmentally disabled. Included in the chapter on ACF is the Administration on Aging, which serves as an advocate for older persons within the Department and with other agencies at the national level.

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

Bryan B. Mitchell
Principal Deputy Inspector General

HIGHLIGHTS

High Risk Areas and Material Weaknesses - The Federal Managers' Financial Integrity Act (FMFIA) requires Federal agency heads to establish a continuous process for the evaluation and improvement of the internal administrative, accounting and financial control systems for which they are responsible, and to report annually to the President and the Congress on the status of their internal control and accounting systems. Chapter I describes the Office of Inspector General's (OIG's) role in the Department's FMFIA program. In addition, Chapter I discusses the high risk areas identified by the Department and the Office of Management and Budget, as well as the material weaknesses identified by OIG in the 6-month period ending September 30, 1992. (See pages 1, 6 and 8)

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

- The OIG's review of Medicare credit balances at hospitals serviced by nine fiscal intermediaries (FIs) projects an estimated $266 million in overpayments due the Medicare program by hospitals nationwide. About $66 million of this amount had been recovered as of March 1992. The OIG recommended recovery of the overpayments and procedural improvements to ensure that the hospitals and the FIs perform more timely reviews. (See page 25)

- The OIG conducted a national inspection to determine the dollar amount of Medicare and Medicaid credit balances that exist at skilled nursing facilities (SNFs), and the time between SNFs' reporting and Medicare and Medicaid agencies' adjusting credit balances. The OIG found that, nationwide, there could exist $12.7 million in overdue Medicare credit balances and $32 million in overdue Medicaid credit balances. (See pages 25 and 45)

- Estimated annual Medicare and beneficiary savings of approximately $170 million could result from the Health Care Financing Administration's (HCFA's) implementation of several actions. These include the addition of a high-volume criterion to the definition of services performed in physicians' offices and the use of the revised definition of physician services subject to payment limitation. (See page 28)

- The HCFA recently implemented regulations to pay hospital capital costs prospectively, which should help curb the rise in capital costs. However,

OIG noted that historical costs, the basis for the prospective payment system rates, are inflated because of excess hospital capacity and the inclusion of inappropriate elements. The OIG recommended that HCFA submit a legislative proposal to continue mandated reductions in hospital capital payments beyond Fiscal Year (FY) 1995. (See page 25)

- The OIG found indications that the losses to the Government from bad debts arising from overpayments to bankrupt providers may be substantial. The OIG recommended that HCFA prepare periodic reports on Medicare and Medicaid receivables written off as bad debts, and propose a legislative change to the Federal bankruptcy law that would give the programs priority in provider bankruptcy proceedings. (See page 44)

- The OIG determined that significant annual savings would result if the Social Security Administration (SSA), in cooperation with HCFA, would develop and issue regulations requiring nursing homes to promptly report admission of Supplemental Security Income recipients. (See page 67)

- The OIG recommended that the Administration for Children and Families (ACF) continue to pursue the adoption of a legislative proposal to implement mandatory application and user fees in child support enforcement cases involving families not receiving public assistance. In the absence of congressional sponsorship for the proposal, OIG suggested that ACF study acceptable revenue-raising alternatives, such as making application fees contingent upon recovery of support payments. (See page 88)

Successful Judicial Prosecutions - As a result of investigations by OIG, numerous individuals and entities have been successfully prosecuted for engaging in crimes against programs of the Department of Health and Human Services. The following items highlight some of the more significant achievements during this reporting period:

- A Georgia chiropractor, his wife and 15 former patients were ordered to pay $3.2 million in fines and restitutions in a kickback scheme which defrauded Medicare and private insurers. (See page 36)

- The former executive director of a neighborhood youth agency was sentenced to 5 years in jail for embezzlement. (See page 93)

- A Maryland physician was sentenced to 10 months in prison and $100,000 in restitution for billing Medicare and Medicaid for services to nursing home patients he did not treat. (See page 34)

- A former senior vice president of the California Medicare peer review organization was sentenced for falsely reporting completion of thousands of medical reviews. (See page 34)

- Five persons were sentenced in New Jersey for embezzling more than $2 million from a major medical center. (See page 35)

- In Ohio, a man was sentenced to 20 months in jail for charging elderly persons more than $1,600 each for seat lift chairs on the promise Medicare would reimburse them for most of it, but never billing Medicare. (See page 41)

- Six employees of a New Jersey county social services agency and six local store owners or other private citizens were sentenced for defrauding the Low Income Home Energy Assistance program of approximately $150,000. (See page 94)

- A South Carolina man was sentenced to 21 months incarceration for using the benefit money he received for two children he had put in an orphanage. (See page 62)

- A man in Louisiana was sentenced to 10 months in prison for forging the signature of his deceased father-in-law on 74 benefits checks. (See page 63)

- Four former officials of a major generic drug company were given jail sentences for fraudulent activity in connection with the Food and Drug Administration's (FDA's) review and approval of the company's drugs. (See page 72)

- Six persons were sentenced in Virginia for a benefits fraud scheme in which two of them worked at a convenience store under false names and Social Security numbers in order to continue receiving disability insurance benefits. (See page 65)

- Thirteen union employees in New York were convicted for using false names and Social Security numbers to avoid paying income taxes. (See page 60)

Administrative Sanctions - Over the years, numerous health care providers and suppliers or their employees have been administratively sanctioned with program exclusions or civil

monetary penalties (CMPs) for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries, or for controlled substance abuse or loss of licenses.

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

- A California physician was excluded indefinitely after his license was revoked for inadequate patient care resulting in the patient's death. (See page 29)

- A New York physician was excluded indefinitely because the State suspended his license upon evidence of abusive medical practice. (See page 29)

- A Florida ophthalmologic service agreed to pay $2.85 million in settlement of CMP liabilities for allowing a billing service to double-bill for surgical procedures. (See page 32)

- An Arkansas doctor of osteopathy was excluded indefinitely because of failure to repay his Health Education Assistance Loan. (See page 29)

- An Ohio durable medical equipment supplier agreed to pay $1 million for charging Medicare for new seat lift chairs when it had furnished used and rebuilt ones. (See page 41)

- A Virginia psychiatrist was excluded for 15 years for charging Medicare and Medicaid for services he did not provide. (See page 30)

- An ophthalmologist agreed to pay $1 million for submitting claims to the New York City Medicare carrier for patients he treated in New Jersey. (See page 32)

- A Louisiana doctor was excluded for 10 years because of controlled substance violations. (See page 30)

- A Massachusetts medical testing service agreed to a $499,000 settlement for billing Medicare for services that were not performed by its employees. (See page 33)

Significant Recommendations for Program and Management Improvement - The following items pertaining to quality of care, the welfare of beneficiaries, and program and

management effectiveness highlight OIG findings, recommendations and activities during the second 6 months of the fiscal year:

- The OIG conducted a study to estimate the extent to which physicians are offered gifts and payments from pharmaceutical companies. The OIG found that in the year prior to the fall of 1991, pharmaceutical companies offered gifts or payments on at least one occasion to 82 percent of physicians. These gifts or payments are specifically defined by the current American Medical Association and the Pharmaceutical Manufacturers Association guidelines as being inappropriate. (See page 71)

- The OIG identified a number of weaknesses involving foster home care provided by relatives of those children in the legal custody of State child welfare agencies. The OIG recommended that ACF encourage States to extend existing foster home standards to relative foster homes and develop consistent payment policies. (See page 89)

- The OIG issued four reports dealing with the satisfaction of Social Security clients. In the annual survey, 79 percent of clients rated service as good or very good. Seventy-five percent of clients visiting local offices reported waiting less than 30 minutes. Ninety-three percent of clients calling the national 800 number reported getting through within 24 hours. (See page 55)

- The OIG conducted a series of studies dealing with manufacturers' drug pricing policies since passage of the Medicaid drug rebate legislation. The OIG recommended that HCFA establish the necessary systems edits and program controls to help provide assurance that pricing data supplied to the States is accurate and timely, and require States to develop procedures to monitor the accuracy of pharmacies' reporting of drugs dispensed. (See page 47)

- The OIG issued a report presenting an overall commentary on and summary of the results of its review of SSA's FY 1991 financial statements. It represents the capstone report prepared by OIG covering audit activities under the Chief Financial Officers (CFO) Act of 1990. Observations and comments were made to assist SSA management in meeting their reporting responsibilities under the CFO Act, with the recognition that SSA's Overview represents its first year reporting under the CFO Act. (See page 54)

- The OIG reviewed the Public Health Service's (PHS's) Service and Supply Fund and FDA's Fund for Certification and Other Services as part of financial statement audits required by the CFO Act. The OIG recommended that PHS require the fund management to develop specific guidance for implementing departmental requirements for reconciling general ledger accounts and document how it has assured that the accounts have been reconciled as required. The OIG made recommendations for FDA to improve the fund's internal controls and compliance with laws and regulations. (See pages 73 and 81)

- The OIG found that ACF has not assured that Native American Head Start grantees are complying with State and local licensing requirements and with program performance standards concerning health and safety. It recommended that ACF: notify grantees that the health and safety of Head Start children and staff must be adequately protected by complying with the applicable performance standards; work closely with the Indian Health Service to provide better, more specific training to health inspectors; improve and standardize inspections; follow-up on reported deficiencies; obtain overall assurances that facilities meet reasonable health and safety standards; and along with PHS, give priority to dissemination and tracking of inspection reports. (See page 91)

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Chapter I

GENERAL OVERSIGHT

Introduction

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

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

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

High Risk Areas

The Department of Health and Human Services (HHS), in consultation with OMB, identified a total of four high risk areas. Following is a description of those areas and a brief discussion of their present status:

A. Medicare Program Data

In 1990, OMB and the Department identified, as a high risk area, the need for more accurate and timely programmatic and financial data to better manage the national Medicare program budget. To achieve this will require the development and implementation of integrated financial and program data systems which can record and report actual program costs on a timely basis. Data must be reflected for each major benefit category and major

administrative function of Medicare. This requires utilization of the Common Working File (CWF) and its reporting capabilities, and appropriate interfaces with the accounting system of the Health Care Financing Administration (HCFA).

The targeted correction date is 1993. The HCFA's strategy for providing program and financial data from the CWF is to develop a data base management system for use as a data collection repository. Data will be derived both from the data base management system and from existing systems, and new payment reports will be generated that tabulate the monthly payments charged to the major benefit and administrative functions of Medicare. The HCFA reports that it has completed three of four critical milestones and the fourth is planned for completion in FY 1993.

In OIG's opinion, the following reports issued during the 6-month period ending September 30, 1992 relate to this high risk area:

- Carrier Assignment of Medicare Provider Numbers - This study reviews the assignment of Medicare provider numbers which are used to gather programmatic and financial data on the Medicare program. (OEI-06-89-00871) (See page 39)

- Project to Redesign Information Systems Management - This report addresses HCFA's efforts to ensure that its automated data processing and data communications requirements are met. (CIN: A-14-91-02533) (See page 43)

- Common Working File System: Opportunities for Short and Long Term Improvements - These two audits review the Common Working File system, a data base of Medicare Part A and Part B claims histories which is integrated with other HCFA data and information management systems. (CIN: A-14-91-02531; CIN: A-14-91-02532) (See pages 43 and 44)

Reviews which are currently in progress that pertain to this high risk area are:

- Preliminary Assessment of HCFA's Financial Systems for Accounts Receivable

- Review of HCFA's Internal Controls and Financial Systems for Accounts Payable: Part A

- Review of HCFA's Internal Controls and Financial Systems for Accounts Payable: Part B

B. Medicare Program Secondary Payer

The OIG has estimated that the Medicare program may be paying out as much as $1 billion a year unnecessarily because Medicare fiscal intermediaries and carriers do not always identify the primary payers, and because insurers, underwriters and third party administrators often do not pay as primary payers when they are required to do so. This problem, which was first identified as a high risk area in 1989, has been addressed through several initiatives, including proposals for legislative remedies and legal actions against noncomplying insurers. The HCFA claimed savings of $2.6 billion in FY 1991 as a result of its initiatives.

While HCFA reported that it had completed most of the milestones in its 1991 corrective action plan, it recognizes that full achievement of additional possible savings under the Medicare secondary payer (MSP) program will require continued efforts over a number of years. The HCFA's strategy is to attack the problem in several ways: perform a data match between the Internal Revenue Service, the Social Security Administration (SSA) and Medicare files; obtain primary insurance information from beneficiaries on a prepayment basis and insert data gathered from these sources into the CWF to prevent future mistaken payments; and take actions to improve the MSP recovery activities of the Medicare contractors. In addition, the Department is considering legislative proposals to improve the operation of the MSP program.

Reports issued by OIG during the 6-month period ending September 30, 1992 that, in OIG's opinion, pertain to the high risk area of MSP are as follows:

- Blue Shield of Florida - This report concerns the identification and recovery of improper payments made by Medicare as secondary payer. (CIN: A-04-91-02004) (See page 38)

- Follow-up on General Accounting Office Report - This is a follow-up report on HCFA's implementation of the General Accounting Office's (GAO's) recommendations to improve identification of primary insurance coverage which should pay claims before Medicare pays as secondary payer. (CIN: A-14-92-00375) (See page 38)

- Nationwide Employer Project - This report assesses whether Medicare, as secondary payer, inappropriately paid for services on behalf of working beneficiaries who had primary insurance coverage under their employer group health plans. (CIN: A-09-89-00162) (See page 38)

- Data Match Project - This report concerns use of the Data Match Project to identify and recover improper payments made by Medicare as secondary payer. (CIN: A-09-91-00103) (See page 39)

Reviews which are currently in progress that pertain to the high risk area of MSP are as follows:

- Survey of MSP Part A Retroactive Recovery Backlog at Empire Blue Cross
- Nationwide Review of MSP Backlog Claims for FY 1992
- Review of Empire Blue Cross Blue Shield's Compliance with the MSP Legislation
- Review of Travelers Insurance Company's Compliance with the MSP Legislation
- Review of Blue Cross Blue Shield of Michigan's Compliance with the MSP Legislation
- Review of Blue Cross Blue Shield of Florida's Compliance with the MSP Legislation
- Review of Provident Insurance Company's and Its Third Party Administrator Customers' Compliance with the MSP Legislation
- Second Review of Monitoring of HCFA's Implementation of the MSP Provisions Contained in the Omnibus Budget Reconciliation Acts of 1989 and 1990

C. Medicaid Program Data

The need for better Medicaid program data was reported as a high risk area in 1991. An OMB/HHS SWAT team identified a serious need for accurate and timely programmatic and financial data to aid in managing the national Medicaid budget. This requires the development and implementation of properly integrated financial and program data systems to record actual program costs on a timely basis.

The HCFA's strategy was to establish a special HHS/OMB Management Review Task Force to analyze why Medicaid estimates have been so inaccurate; examine the deficiencies and seek corrective measures in the current Federal/State estimating process that allows discrepancies to occur; identify ways to better understand the unique policy dynamics of the program in each State; develop methods of improving Federal Medicaid tracking efforts; and evaluate the fiscal impact of future Medicaid policy changes.

The HCFA reported that most of the actions of its corrective strategy were completed during FY 1992. Cooperation between HCFA and the National Governors' Association led to legislation to resolve funding problems with voluntary contributions and provider-specific taxes. The HCFA also reported that it has completed a number of its other planned corrective actions, including the revision of State data collection instruments, the development of data systems and report tables for OMB, and the collection and processing of necessary baseline data for the profile system. These are discussed in its June draft report "Medicaid State Profile Data System: Program Characteristics of Medicaid State Plans."

Reports issued by OIG during the 6-month period ending September 30, 1992 that, in OIG's opinion, relate to this high risk area are as follows:

- Medicaid Drug Rebates: Accuracy of Pricing Information - This report relates to the gathering and dissemination of financial and programmatic data for the Medicaid program. (CIN: A-06-91-00102) (See page 47)

- Medicaid Drug Rebates: Reporting of Drug Data by Pharmacists - This review concerns the accurate gathering and reporting of two critical data elements needed to properly determine and record actual Medicaid program costs on a timely basis. (CIN: A-06-91-00056) (See page 48)

The following reviews currently in progress pertain to this high risk area:

- Medicaid Financial Management Surveys

D. Management of Indian Health Service

The management of the Indian Health Service (IHS) was declared a high risk area in 1990. The IHS had not devoted sufficient resources and attention to the development of critical management structures and practices. Quality management is essential to providing quality health care. More responsive and efficient management had to be developed to assure quality health care to Native Americans in a time of growing demand and constrained resources. As a result, it was apparent that the development of an effective management culture needed to become a major priority.

The management of IHS was identified as a material weakness as a result of reviews of management control policies and procedures conducted pursuant to the Department's Federal Managers' Financial Integrity Act (FMFIA) program. The development of an effective management infrastructure at IHS will require a substantial commitment of effort on the part of top management. The IHS strategy has been to improve IHS performance and responsiveness by correcting material weaknesses and problem systems while developing a management culture of professionalism and continuous improvement throughout the agency.

The IHS has developed a 5-year Management Control Plan as the basis for directing the process of reviewing risk, and identifying and correcting potential material weaknesses in administrative and IHS-specific programmatic management control systems. The IHS has reported that it has completed critical milestones for several management improvement initiatives, such as revising policies and procedures for its automated billing system, for billing and managing third party collections, collection of rents and administration of travel. Also, a directive has been issued to IHS managers, including performance standards, holding them accountable for improvements in management control systems. In addition to the actions completed and underway by IHS, it has identified 11 planned actions to be carried out during FY 1993.

During the 6-month period ending September 30, 1992, OIG issued the following report which pertains to the high risk area of management of IHS:

- IHS Advance Payment System for Contractors and Grantees - This OIG report identifies a material weakness in the IHS advance payment system for contractors and grantees which has resulted in IHS management's inability to ensure that IHS cash is used only to fund IHS activities and programs. (CIN: A-06-90-00001) (See page 77)

Reviews currently in progress that relate to this high risk area are as follows:

- IHS Construction of Housing
- Review of Use of IHS Youth Alcoholism Funds
- FMFIA Segmentation Process throughout the Public Health Service
- Survey of IHS Collections from Third-Party Payers
- Survey of IHS Procurement Practices Related to Small Purchases
- Indian Alcohol and Drug Abuse
- Community Health Representatives: Management Issues

Material Weaknesses

In the 6-month period ending September 30, 1992, OIG recommended that the following deficiencies be reported as material weaknesses:

- Superfund Financial Activities of Agency for Toxic Substances and Disease Registry: FY 1990 - As part of its review of the Superfund financial activities of the Agency for Toxic Substances and Disease Registry (ATSDR), OIG analyzed conditions that were cited in an August 1991 GAO report relating to ATSDR's health assessment program. The OIG determined that the deficiencies were of such magnitude that HHS should report them as a material internal control weakness. The Public Health Service (PHS) disagreed that there are material internal control weaknesses in ATSDR's health assessment program. (CIN: A-15-91-00002) (See page 81)

- National Institutes of Health's Management and Service and Supply Funds - This audit, which was required by the Chief Financial Officers (CFO) Act, included a review of the adequacy of the Fund's system of internal accounting controls. The OIG reported significant internal control weaknesses in three areas: inventory management, accounts payable and electronic data processing security controls. The OIG believes that these three internal control weaknesses should be reported as material weaknesses in the Department's FMFIA report. The National Institutes of Health (NIH) officials generally agreed with OIG's recommendations, but raised concerns about whether the discrepancies noted in the report should be disclosed as material weaknesses. (CIN: A-15-91-00044) (See page 75)

- IHS Advance Payment System for Contractors and Grantees - The advance payment system used by IHS to advance cash to its contractors and grantees did not ensure that cash advances were limited to immediate needs, and that the cash was used only to fund IHS activities and programs. The PHS agrees that the management control weakness noted by OIG is material and plans to report it in the Department's FMFIA report for 1992. (CIN: A-06-90-00001) (See page 77)

- Health Resources and Services Administration Grant Awards to National Association of Community Health Centers - The OIG reported that grants awarded by the Bureau of Health Care Delivery and Assistance to the National Association of Community Health Centers contained tasks that were not clearly related to technical and other nonfinancial assistance. The OIG believes that this internal control weakness should be reported as a material weakness in the Department's FMFIA report. The PHS is still reviewing OIG's recommendation to designate this finding as a material weakness. (CIN: A-04-91-04067) (See page 80)

Financial Management

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

A. Federal Managers' Financial Integrity Act

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

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

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

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

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

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

- advising top management on management control issues; and

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

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

The OIG, as well as the Department, tracks the correction of material weaknesses to ensure their satisfactory resolution. Management has the responsibility to ensure that all corrective

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

During the 6-month period ending September 30, 1992, OIG issued the following reports which included reviews of management's implementation of FMFIA:

- SSA Compliance with FMFIA: FY 1991 (CIN: A-13-91-00202) (See page 54)

- Food and Drug Administration's Revolving Fund for Certification and Other Services (CIN: A-15-91-00053) (See page 73)

- Superfund Financial Activities of ATSDR: FY 1990 (CIN: A-15-91-00002) (See page 81)

- PHS's Service and Supply Fund (CIN: A-15-91-00048) (See page 81)

- HCFA's Implementation of FMFIA: FY 1991 (CIN: A-14-91-03413) (See page 24)

B. Implementation of Chief Financial Officers Act

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

- establish more effective general and financial management practices;

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

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

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

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

During the 6-month period ending September 30, 1992, OIG issued the following reports as a result of financial management audits performed under the CFO Act:

- Management and Financial Audit of Working Capital Fund: FY 1991 (CIN: A-17-92-00007) (See page 18)

- Management and Financial Audit at SSA: FY 1991 (CIN: A-13-92-00221) (See page 54)

- Food and Drug Administration's Revolving Fund for Certification and Other Services (CIN: A-15-91-00053) (See page 73)

- PHS's Service and Supply Fund (CIN: A-15-91-00048) (See page 81)

- NIH's Management and Service and Supply Funds (CIN: A-15-91-00044) (See page 75)

During this semiannual period, the HHS Inspector General (IG), who served as Chairman of the PCIE Task Force on Improved Financial Management and Implementation of Chief Financial Officers Act, issued a draft report on guidelines for implementation of the CFO Act by the PCIE community. The draft consisted of reports by the seven task force teams as follows:

- Financial Statement Audit Methodology and Policy

- Use of IG Staff Versus Independent Public Accountants

- Auditors' Assistance to Management on CFO Implementation

- Audit Reporting on Financial Management Audits

- Auditor Training for CFO Implementation

- PCIE Comments on Proposed Accounting and Auditing Standards and Reporting on the Costs and Benefits of the CFO Act to the IG Community

- Management's Overview of the Reporting Entity

C. Reporting Performance Measurement

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

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

During the 6-month period ending September 30, 1992, the HHS IG, who served as team leader of the PCIE CFO Task Force Team on Management's Overview of the Reporting Entity, issued draft guidelines for OIG's role in management's overview, including performance measurement. The draft report provides guidance to the PCIE community on auditors' assistance to management; audit work required and recommended on management's overview, including performance measurement, under the CFO Act; and audit reporting on management's overview, including performance measurement. In addition, at the request of OMB, the team issued proposed standards for the development and reporting of management's financial and program performance measures and indicators.

In order to identify OIG work in the area of performance measurement, we have tagged some items throughout the body of this semiannual report as "performance measures" with the symbol [Performance Measure]. In OIG's opinion, these audits, inspections and investigations offer information as to whether the programs or activities reviewed are achieving their missions and goals.

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]	401	$276,877	$30,103
B. Which were issued during the reporting period[2]	340	$435,283	$18,947
Subtotals (A + B)	741	$712,160	$49,050
Less:			
C. For which a management decision was made during the reporting period:[3]	373	$105,938	$25,291
(i) dollar value of disallowed costs		$69,122	$5,311
(ii) dollar value of costs not disallowed		$36,816	$19,980
D. For which no management decision had been made by the end of the reporting period	368	$606,222	$23,759
E. Reports for which no management decision was made within 6 months of issuance[4]	49	$177,063	$9,460

See Appendix E 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]	72	$1,634,326
B. Which were issued during the reporting period	62	$1,098,364
Subtotals (A + B)	134	$2,732,690
Less:		
C. For which a management decision was made during the reporting period:[2]		
(i) dollar value of recommendations that were agreed to by management		
(a) based on proposed management action[3,4]	51	$184,036
(b) based on proposed legislative action	0	$0
Subtotals (a+b)	51	$184,036
(ii) dollar value of recommendations that were not agreed to by management	8	$6,671
Subtotals (i + ii)	59	$190,707
D. For which no management decision had been made by the end of the reporting period[5]	75	$2,541,983
E. Prior decisions implemented in the period (See Appendix A)[6]		
(i) based on management action	7	$82,900
(ii) based on legislative action	10	$3,689,200

See Appendix E for footnotes.

Legislative and Regulatory Review and Regulatory Development

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. In carrying out its responsibilities under Section 4(a), OIG reviewed 100 of the Department's regulations under development and 178 legislative proposals during this reporting period.

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

The OIG also continues to develop a number of its own regulations for civil monetary penalty (CMP) and exclusion authorities which the Inspector General administers.

Governmental Accounting

Each year, State and local government entities receive over $100 billion in Federal grant funds. It is estimated that Federal agencies pay at least $6 billion and possibly as much as $12 billion for administrative costs of State and local governments. As part of its Governmentwide cognizance responsibilities as defined in OMB Circular A-87 to ensure that administrative costs are being charged in accordance with the appropriate statewide cost allocation plan, OIG has continued its efforts to identify cost containment areas and/or areas where costs are being inappropriately charged.

A. Self-Insurance Funds: Mississippi

The State of Mississippi Unemployment Insurance Fund is a self-insurance fund established to provide coverage for unemployment claims arising from former employees of State agencies. An OIG audit showed that the accumulated reserve balance in excess of $8 million occurred from charging State agencies premiums that were in excess of claims and operating expenses.

The OIG recommended that the State make a financial adjustment of over $1.6 million for the Federal share of the fund balance accumulated in excess of the amount allowed by Federal cost principles. The OIG also proposed that the State ensure that charges to Federal programs are in accordance with OMB Circular A-87 and the Statewide Cost Allocation Plan agreement. The Division of Cost Allocation concurred with the OIG findings and recommendations. The State plans to monitor the billing rates more closely and to make appropriate adjustments to prevent the accumulation of excess funds in the future. (CIN: A-04-91-00024)

B. Self-Insurance Funds: Tennessee

Self-insurance funds provide reserve type insurance for activities and real properties administered by State, county and municipal governments. Excess reserves result from premiums collected and interest earned in excess of claims and operating expenses. The OMB Circular A-87 precludes profit or the charging of such reserves (excess costs) to Federal programs.

The OIG identified a significant excess reserve balance of $27.5 million in one of Tennessee's self-insurance funds. The OIG recommended that the State make a financial adjustment of nearly $5.5 million for the Federal share of the excess reserve balance. Also, OIG recommended that the State ensure that charges to Federal programs are in accordance with OMB Circular A-87 and the statewide Cost Allocation Plan agreement with the Division of Cost Allocation. The State generally agreed with the findings and recommendations. (CIN: A-04-91-00023)

C. Capital Leases: Ohio

The OIG identified significant unallowable costs associated with equipment acquisitions included in claims by the State of Ohio for Federal reimbursement. The OMB Circular A-87 provides that interest on borrowing (however represented) is unallowable, and that compensation for use of equipment should be through use allowances or depreciation, computed on the basis of acquisition cost.

The OIG recommended that the Ohio Department of Administrative Services work with the other user agencies in establishing procedures to identify and properly account for the cost of equipment acquired through financing agreements. These procedures should preclude unallowable interest expenses being charged to Federal programs. Further, OIG recommended that Ohio refund the Federal share of excess cost and interest expenses and the Federal share of any additional interest expenses charged up to the time that corrective actions are taken. The State negotiated a settlement of $4.8 million with the Department's Division of Cost Allocation. (CIN: A-05-91-00066)

D. Training Costs: New York State

During the period April 1, 1987 through March 31, 1988 (FY 1988), New York State claimed $23.6 million in training contract costs (Federal share $15.4 million) and $3.6 million in administrative costs (Federal share $2 million). The OIG found that the State did not maintain adequate documentation to support the basis used to allocate, among benefitting programs, the training contract and related administrative costs claimed in FY 1988. The State has not modified its system of allocating training contract costs from the estimated to the actual number of attendees, even though this was addressed by the Departmental Appeals Board in 1984 and reported as a finding each year in the State's single audit report since 1988.

The OIG recommended that over $4.2 million in training costs claimed and more than $450,000 in administrative costs claimed be refunded to the Federal Government. The Department's Division of Cost Allocation concurred with all the findings. (CIN: A-02-91-02002)

E. Statewide Cost Allocation Plan: Maryland

In response to the increase in Maryland's submitted statewide cost allocation plan (SWCAP) proposal for FY 1990, the Division of Cost Allocation requested that OIG perform a review. The State's proposal showed an increase of over 200 percent in costs over the prior year. The review disclosed total questionable costs in excess of $54 million, representing 70 percent of the State's proposed total costs of $76.7 million. The OIG found that the questioned costs resulted primarily from: including cost centers that do not appear to benefit Federal programs; treating costs inconsistently; allocating costs to functions or user departments based on estimates rather than actual accounting records; and including unallowable costs such as capital assets and advertising expenses. In addition, the State's proposed SWCAP generally did not meet the Department's requirement that it include narratives describing the types of services provided by each cost center and their relevance to Federal programs.

The OIG recommended that the State resubmit the SWCAP proposal with the questionable costs excluded and with expanded descriptions of cost center services. In addition, certain sections of the SWCAP should be expanded to assure that the resubmission is supported by the required documentation. (CIN: A-03-92-00451)

Nonfederal Audits

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

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

A. 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:

- To more efficiently accomplish its nonfederal responsibility, OIG has consolidated the nonfederal function in Kansas City, Missouri.

- Through evaluation and summarization of report data, OIG is able to provide both basic audit coverage and analysis of trends that could indicate systemic problems within HHS' programs. These systemic problems are brought to the attention of departmental management to improve program administration.

- To ensure audit quality, OIG not only maintains a quality control program (discussed below) but has taken steps to ensure that adequate guidance is available to the nonfederal auditor.

- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number and through training. During the past 6 months, training was provided to HHS Head Start, community health center and Indian health center grantees, State certified public accountant societies, the American Institute of Certified Public Accountants (AICPA), and the Association of College and University Accountants.

- The OIG also has been heavily involved in the development of PCIE questions and answers on OMB Circular A-133 and the AICPA audit and accounting guide for audits of nonprofits receiving Federal awards.

B. Quality Control

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

To ensure that all audits meet Government auditing standards and Federal audit requirements, uniform procedures are used to review nonfederal audit reports. During this reporting period, OIG reviewed and processed 1,728 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,134
Reports issued with major changes	586
Reports with significant inadequacies	8
Total audit reports processed	1,728

During the review period, 10 audits were referred to State officials and professional organizations for appropriate action. Several other referrals are pending. The OIG referrals of inadequate audit work can result in significant disciplinary action against the accounting firms involved.

The 1,728 audit reports discussed above included recommendations for HHS cost recoveries totaling $10.6 million as well as many for improving management operations. In addition, areas were identified for follow-up by OIG auditors.

Management and Financial Audit of Working Capital Fund: Fiscal Year 1991

Performance Measure

This report summarizes OIG's audit of the Principal Statements of the Working Capital Fund as of September 30, 1991. In the Commentary and Summary of Audit Results, OIG discussed the fund's performance in achieving its mission and goals, and noted that improvements are needed in establishing additional performance measures to effectively evaluate and report on the achievement of the fund's stated goals to ensure effective oversight of the fund's activities. In the Report on Internal Controls, OIG discussed internal control deficiencies in the areas of reconciliation of general ledger accounts with subsidiary records and external reports, physical inventories, and separation of accounting and financial reporting duties. Though not considered material weaknesses for departmental reporting under FMFIA, these matters were considered to be reportable conditions for the operation of the fund. In the Report on Compliance with Laws and Regulations, OIG noted that the fund did not fully comply with OMB requirements for the presentation of the fund's Overview of the Reporting Entity. (CIN: A-17-92-00007)

Medical Liability Insurance Costs Charged to Federal Research at Colleges and Universities with Medical Schools

The OIG reviewed $81.1 million of medical liability insurance costs at 28 colleges and universities and found that the colleges and universities were inconsistent in charging these costs to federally sponsored research. Medical liability insurance costs charged as an

indirect cost are normally allocated to all sponsored research projects, including those not involving human test subjects. The OIG believes these costs have been handled in an inconsistent manner because colleges and universities have used varying interpretations of OMB Circular A-21 concerning medical liability insurance costs.

To make the treatment of medical liability insurance costs more consistent and equitable, OIG recommended that the Assistant Secretary for Management and Budget (ASMB) work with OMB to revise Circular A-21 to provide more specific guidance in this area. Such guidance would allow medical liability insurance to be allocated to research only to the extent that the research involved human test subjects. The ASMB agreed with OIG's findings and recommendations. (CIN: A-04-91-04048)

Appointed Consultants and Experts

An OIG review disclosed that the internal controls over the hiring and managing of consultants and experts are insufficient to ensure that: they are free from financial conflicts of interest; they are not improperly detailed and recertified; their time and attendance are properly reported; the quality of their work is evaluated; and hiring approvals are obtained in compliance with prevailing policies and procedures. The OIG found many instances of noncompliance with prescribed policies, procedures and regulations.

The OIG made a number of proposals to address the problems noted in its review, including a recommendation that the Department strengthen its controls to ensure that each operating and staff division comply with departmental requirements as well as those prescribed by OMB and the Office of Personnel Management (OPM). The Department concurred with some of the recommendations. (CIN: A-15-91-00011)

Health Benefits Program

In an audit of the Department's health benefits program, OIG identified four problem areas: the Department did not always pay OPM the correct amount for the number of enrolled employees in a timely manner; the Department resolved about two-thirds of the discrepancies identified by the carriers through the reconciliation process; some servicing personnel offices lacked documentation to confirm that carriers received enrollment changes and terminations timely; and internal control reviews of personnel operations were not adequate to identify and correct the weaknesses identified. As a result, carriers were not receiving premiums for some insured employees in a timely manner and might deny coverage to some employees because of unresolved discrepancies. Further, a lack of documented, timely notification to carriers unnecessarily exposes the Department to potential liability for premiums and health care costs after employees have separated or changed plans. The Assistant Secretary for Personnel Administration concurred with OIG's recommendations and indicated that steps are underway to implement them. (CIN: A-12-91-00008)

Regional Administrative Support Center's Procedures for Sustained Audit Disallowances

An OIG review of the operations of Region IV's regional administrative support center (RASC) relating to the recording, maintaining and collecting of sustained audit disallowances showed several areas where improvements in procedures were needed. The OIG found that cognizant RASC staff were not knowledgeable of policies and procedures for handling audit disallowances, and that, unless improvements are made, over $2 million in Federal funds could be lost.

The OIG recommended that the RASC adjust its accounting records to accurately reflect accounts receivable, interest, and administrative and penalty charges. Also, reconciliations should be made monthly and training should be provided to personnel involved in the debt management system. The ASMB generally agreed with the findings and recommendations, and ASMB staff will conduct a review of Region IV's debt management activities. (CIN: A-04-91-00001)

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 SSA claims representative in California was sentenced to 2 years probation and required to perform 150 hours of community service for accepting a gratuity. The claims representative told a benefits applicant that for $200 he would process a claim for her children within 30 days rather than the 3 months it would otherwise take. As part of his sentence he was also required to receive counseling.

- A former clerk at the Austin, Texas SSA office was sentenced for obtaining a Social Security number (SSN) for her husband under a false name. Armed with the new identity and SSN, the husband purchased, on credit, a diamond ring valued at $2,000, and the two attempted to purchase a new car, appliances and furniture. The husband, who had a previous theft conviction, also obtained employment under the new name and number. The former clerk was sentenced to 1 month incarceration and 1 year of supervised release, fined $1,000 and ordered to pay restitution of $1,792 to the jewelry company and a $25 assessment. The husband was sentenced to 10 months incarceration and 3 years of supervised release.

- A development clerk employed at the Paterson, New Jersey SSA office was sentenced for accepting gratuities in exchange for obtaining SSNs. The clerk received biographical data from a security guard and from a former SSA employee, which she entered into the computer and caused SSNs to be issued. She received $50 to $100 for each information entry. She was sentenced to 6 months home detention and 4 years probation, and ordered to pay a $50 assessment. The security guard was sentenced to 3 years probation and 500 hours of community service, and ordered to pay a $50 assessment and undergo drug treatment. The former SSA employee was sentenced to 3 years probation and ordered to seek psychiatric assistance.

- A former temporary Food and Drug Administration (FDA) employee was sentenced to 17 months in jail and 3 years probation for the theft of Government funds. During her FDA employment, and for months afterwards, the woman presented fraudulent travel documents to the FDA imprest fund (petty cash) cashier, obtaining a total of over $24,700 in cash. Beginning in September 1991 and continuing until her arrest in late January 1992, the woman prepared travel advance documents in the names of fictitious employees and forged the names of fictitious approving officials. A review of FDA's imprest fund operations was initiated.

- A former legal processing clerk employed by FDA was sentenced in Ohio for using stolen FDA identification cards bearing her photograph, false names and SSNs, and altered FDA payroll documents to obtain credit cards and defraud creditors. The clerk was responsible for maintaining and issuing FDA identification cards for the district. When creditors called trying unsuccessfully to reach an employee under one of the names she used, some of the cards were found missing and one turned up with her photograph and a false name and SSN. She was sentenced to 3 years of supervised probation and ordered to make restitution to her creditors.

- A former supervisor at a New York SSA district office was sentenced for obtaining an SSN for a nonexistent child and for claiming two nonexistent children on his Federal tax returns. He was sentenced to 6 months home detention and 3 years supervised probation, required to file amended tax returns, and ordered to pay all resulting taxes, fines and penalties. He must also submit to drug testing. He was not fined because of financial hardship.

- A former SSA development clerk was sentenced in Massachusetts for selling Social Security cards. She was ordered to serve 2 months home confinement and 5 years probation, to take part in a drug counseling program and to pay a $3,900 special assessment. While working for SSA,

the clerk offered cards for sale, generally to illegal aliens. She entered false information on card applications and had the cards sent to drop addresses.

Investigative Prosecutions

During this semiannual reporting period, OIG investigations resulted in 1,074 convictions. Also during this period, 1,156 cases were presented for prosecution to the Department of Justice and, in some instances, to nonfederal prosecutors. New criminal charges were brought by prosecutors in 997 cases.

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 civil monetary penalty law for the Medicare and Medicaid programs, which OIG is responsible for enforcing. Under PFCRA, any person who makes a claim or statement to the Department knowing, or having reason to know, that it is false, fictitious or fraudulent may be held liable in an administrative proceeding for a penalty of up to $5,000 per claim or statement. In addition, that person may be subject to an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims or statements, and for reporting at the end of each fiscal year investigations completed under PFCRA and referred for administrative action.

During this reporting period, OIG obtained a default judgment against an individual who was employed as a chief deputy in the Sheriff's department of a large metropolitan city. The suit was based on the deputy's negotiation of Social Security benefit checks in the name of his deceased father. The amount of the default judgment was $34,884 (the maximum total sought by OIG), and included penalties and an assessment. The Department has filed two other PFCRA complaints and the Department of Justice has authorized action on four others.

Cooperation with Other Law Enforcement Agencies

Many Federal, State, and local law enforcement and regulatory agencies depend on OIG expertise for assistance in identifying, locating, investigating and prosecuting individuals who have improperly used Social Security numbers in a broad range of illegal activities, including bank and credit card fraud, licensing and income tax fraud, welfare fraud, drug trafficking and racketeering, as well as fraud in programs such as student loans, food stamps and unemployment compensation. Other agencies also benefit from OIG investigations, such as private health insurers, State Medicaid programs and drug regulatory entities. Many of these cases in which OIG participates result in monetary fines, recoveries, restitutions or savings for the other agencies. During this period, the monies accruing from these cases amounted to approximately $33.8 million for other public or private entities.

Health Care Financing Administration

Chapter II

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

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

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

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

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

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

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

Fraud and abuse of the Medicare and Medicaid programs or their beneficiaries may result in criminal, civil and/or administrative actions against the perpetrators. During this fiscal year, OIG was responsible for a total of 1,907 successful actions against wrongdoers.

Implementation of Federal Managers' Financial Integrity Act: Fiscal Year 1991

The OIG performed a review of HCFA's implementation of the Federal Managers' Financial Integrity Act (FMFIA) for FY 1991. The OIG found that, despite significant efforts by HCFA in developing its FMFIA program, several areas warrant management's attention. The HCFA should: review all financial management systems that provide data to the accounting system in accordance with Section 4 of the Act; consider reclassifying the risk assessments of internal control areas that are pending material weaknesses and high risk areas; and enhance the testing used to evaluate the Medicare contractors' internal control activities.

Two of these areas are of primary concern. Under the Chief Financial Officers Act of 1990, annual preparation and audit of financial statements have begun in FY 1992. To ensure the accuracy of the financial data included on its statements, HCFA needs to provide reasonable assurance that information processed by its financial management systems is reliable and properly safeguarded. This can only be accomplished if detailed Section 4 systems control reviews of HCFA's financial management structure are performed. In addition, HCFA needs to have reasonable assurance that all major internal control systems at the Medicare contractors are adequate, especially the claims processing activities that control

approximately $110 billion in benefit payments. In its response to OIG's draft report, HCFA generally agreed with the recommendations. (CIN: A-14-91-03413)

Medicare Credit Balances at Hospitals

The OIG conducted a nationwide review of Medicare credit balances at hospitals serviced by nine fiscal intermediaries (FIs). Final reports have been issued for the individual hospitals and four FIs. The OIG determined that Medicare accounts receivable credit balances included unidentified overpayments totaling an estimated $10.8 million for the hospitals serviced by the four FIs for which reports have been finalized. Draft reports have been issued for the other five FIs. In all cases, the intermediaries reviewed credit balances or processed adjustments timely. The OIG recommended recovery of the overpayments and procedural improvements to ensure that the hospitals and the intermediaries perform more timely reviews.

Based on the preliminary results of all nine FI audits, OIG estimated that hospitals nationwide owed the Medicare program approximately $266 million, of which about $66 million has been recovered to date. A summary report will be issued at a later date. (CIN: A-04-91-02015; CIN: A-05-91-00072; CIN: A-05-91-00128; CIN: A-01-91-00515)

Medicare Credit Balances at Skilled Nursing Facilities

The OIG conducted a national inspection to determine the dollar amount of Medicare credit balances that exist at skilled nursing facilities (SNFs), and the time lapse between SNFs' reporting and Medicare intermediaries' adjusting credit balances. The OIG found that $12.7 million could exist nationwide in overdue credit balances due the Medicare program and that nearly one-fifth of the amounts identified by the SNFs had not been reported after 1 year had elapsed. Also, in more than half the cases, intermediaries did not adjust the balances within 60 days of being notified of them.

The OIG recommended specific steps that HCFA can take to correct these problems: by directing Medicare intermediaries to identify and adjust SNF credit balance accounts currently and on a continuing basis; by seeking authority to penalize providers that do not report credit balances timely; and by working with intermediaries to increase the awareness of program providers to identify and report credit balances timely. (OEI-07-90-00910)

Hospital Capital Costs

In an analysis of hospital capital costs during the first 5 years of Medicare's prospective payment system (PPS), OIG found that capital costs increased much faster than other leading economic indexes even though the hospital industry had significant excess capacity. Hospitals' ability to pass capital costs through to third party payers, such as Medicare, on a

cost reimbursement basis was an important factor in the increase of capital expenditures, despite relatively low hospital utilization.

The HCFA has recently implemented regulations to pay capital costs prospectively, which should help curb the rise in capital costs. However, OIG noted that historical costs, the basis for the PPS rates, are inflated because of excess hospital capacity and the inclusion of inappropriate elements. Accordingly, OIG recommended that HCFA submit a legislative proposal to continue mandated reductions in capital payments beyond FY 1995. The HCFA did not concur with OIG's recommendation, preferring to wait until the effect of the payment system on new capital spending is known. (CIN: A-09-91-00070)

Improper Handling of Proposed Cost Adjustments

The OIG investigated allegations made by a former FI auditor regarding 14 proposed adjustments totaling $18.4 million at two Medicare providers. The OIG agreed with the FI's action on proposed adjustments of $4.6 million and determined that the FI should take further action on adjustments of $13.8 million. The OIG recommended that HCFA require the FI to resolve the outstanding issues related to adjustments of $13.8 million. (CIN: A-04-91-02028)

National Diagnosis-Related Group Validation Study Update

The OIG conducted three related studies on coding accuracy of PPS bills. The first two studies, "National DRG Validation Study Update: Summary Report" and its technical companion, discuss the overall accuracy of diagnosis-related group (DRG) coding. The OIG found that DRG billing accuracy has significantly improved since an earlier study and that DRG errors no longer systematically overreimburse the hospitals. These studies recommended continued peer review organization (PRO) surveillance for coding accuracy. The third study, "DRG 14 Validation Update: Specific Cerebrovascular Disorders Except Transient Ischemic Attacks," is the first of a series of DRG-specific reports which discuss coding accuracy for particular DRGs. (OEI-12-89-00190; OEI-12-89-00191; OEI-12-89-00192)

Specialty Coverage in Hospital Emergency Departments

The OIG found that a majority of the hospitals reviewed in a random sample encountered difficulty in ensuring emergency specialty coverage. This problem is likely to continue because specialty physicians reported concerns about increased malpractice liability and inadequate reimbursement. The Federal patient transfer law adds to specialty physician concerns about liability and reimbursement for services provided in emergency departments. Moreover, current hospital strategies that address these concerns appear to be inadequate. Even among hospitals that offer incentives to specialty physicians to provide emergency care, the effectiveness of those incentives is uncertain. The OIG concluded that the

resolution of the problems identified will require joint action by providers, payers and consumers. (OEI-01-91-00771)

Oversight of Surgery in Outpatient Settings

An increasing number of surgical procedures are now being performed in outpatient facilities, raising concerns about the appropriateness of the setting and the quality of care rendered. Based on a congressional request, OIG conducted a study to determine the forms and extent of oversight for freestanding outpatient facilities in which surgery is performed. The OIG found that many facilities are not subject to licensure and that the licensure standards that do exist vary from State to State. Accreditation associations apply a set of separate standards which are usually more stringent than the licensure agencies require, but accreditation is usually voluntary on the part of the facility. Only certain types of facilities are certified and not all the facilities in a particular category are certified. Moreover, there is little or no oversight for physicians' offices, where much outpatient surgery is performed. (OEI-07-91-00690)

In a companion study, OIG determined the types of surgical procedures which are commonly performed in outpatient settings in four States and the extent to which such outpatient settings are subject to licensure or accreditation. The OIG determined that 13 percent of the facilities surveyed conduct procedures classifiable as "high risk." Over three-fourths of the surveyed facilities are neither licensed nor accredited, and a third of the facilities performing "high risk" procedures are neither licensed nor accredited. In addition, OIG found that medical emergency equipment and procedures are not uniformly available, and some facilities inaccurately advertise surgery or emergency services as being available on site. The OIG recommended that States examine their licensure rules to ensure the quality of surgery performed in outpatient settings, particularly "high risk" procedures. (OEI-07-91-01470)

Preprocedure Review Criteria for Carotid Endarterectomy

Performance Measure

Surgeons perform carotid endarterectomy to remove accumulated plaque when the carotid arteries leading to the brain are blocked and blood flow becomes restricted. The HCFA required preprocedure review for all carotid endarterectomies covered by Medicare until October 1, 1991, when all required preprocedure reviews were eliminated. However, a PRO may request to continue preprocedure review if it can prove that it is cost-effective and would improve quality of care.

The OIG conducted an inspection to compare PROs' preprocedure review criteria for carotid endarterectomy and to examine how these criteria affected denial rates. The OIG found that two-thirds of PROs used three primary medical criteria for evaluating carotid endarterectomy and that PROs' criteria selection did not have a clear effect on denial rates.

Eight States accounted for 79 percent of all denials. Except for patients with one specific criterion, the benefits of carotid endarterectomy are unknown. This conclusion provides further support for HCFA's decision to eliminate the preprocedure review requirement for carotid endarterectomies. (OEI-03-91-00150)

Fee Schedule Payments Based on Site of Service Differentials

The Tax Equity and Fiscal Responsibility Act of 1982 authorized a payment limit for a service routinely performed in a physician's office if the service was furnished in an outpatient setting. The HCFA determined that a service would be considered routinely performed in a physician's office if over half of the volume of the service was furnished in an office setting. The OBRA 1989 required that, as of January 1, 1992, payment for all physician services be made under the Medicare Physicians' Fee Schedule (MPFS). The fee schedule includes national uniform relative values for all physician services. The relative value of each service is the sum of the relative value units representing physician work, practice expenses and malpractice costs. The payment limitation extends to payments under MPFS and is applied to the practice expense relative value unit of the fee schedule. Since payment under the fee schedule is intended to reflect resource costs, payment should vary by site of service if practice expenses differ between office and nonoffice sites.

The OIG recommended that HCFA add a high-volume criterion to the existing definition of services routinely performed in physicians' offices and use the revised definition to identify physician services subject to the payment limitation. In addition, OIG proposed that the payment limitation be expanded to include the inpatient hospital and skilled nursing facility settings. The OIG estimated that implementation of these recommendations could result in annual program and beneficiary savings of approximately $170 million. (CIN: A-05-92-00007)

Health Maintenance Organization Payments

The General Accounting Office (GAO) had audited the process by which health maintenance organizations (HMOs) are paid the costs of providing services to Medicare beneficiaries. In a follow-up review, OIG concluded that HCFA had either implemented or was in the process of implementing the six GAO recommendations with which the Department had concurred. (CIN: A-14-92-00371)

Medicare Contractors' Administrative Costs

During this 6-month period, OIG assessed the allowability of administrative costs incurred by Medicare intermediaries and carriers and recommended disallowances of $1.8 million in costs considered unallowable for reimbursement. Unallowable costs included amounts improperly allocated to Medicare, costs in excess of the HCFA approved budget and occupancy costs. (CIN: A-03-90-00053; CIN: A-08-92-00582; CIN: A-06-92-00071)

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 831 sanctions, in the form of exclusions or monetary penalties, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. The majority of the exclusions were based on loss of license to practice, conviction of program-related crimes, or conviction of controlled substance manufacture or distribution, or patient abuse.

A. Patient and Program Protection Sanctions

The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health, and Block Grants to States for Social Services programs. Exclusions can now be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, and controlled substance abuse, as well as for revocation or surrender of a health care license. Exclusion is mandatory for those convicted of program-related crimes or patient abuse.

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 sanctions were among those imposed during this reporting period:

- A New York physician was excluded indefinitely because the State suspended him from its health care programs. The State took the action because of several instances of an abusive pattern of medical practice.

- A California medical supply company was excluded for an indefinite period after being suspended from the State's health care programs. The suspension was based on the owner's conviction.

- An Arkansas doctor of osteopathy was excluded indefinitely because of failure to repay his Health Education Assistance Loan.

- A California physician was excluded for an indefinite period of time after his medical license was revoked. The physician failed to administer adequate patient care, which resulted in a patient's death.

- A Massachusetts physician was excluded indefinitely after his medical license was revoked by the State. The physician was convicted on several sex offense charges, and assault and battery with a dangerous weapon.

- A New York podiatrist was excluded for 15 years after being convicted of providing Medicaid patients with cheaper prefabricated devices instead of the orthopedic footwear they required. His scheme, which operated over a 3-year period, resulted in damages to the Medicaid program in excess of $900,000.

- A Virginia psychiatrist was excluded for 15 years for billing both the Medicare and Medicaid programs for psychiatric services not provided to the patients. He also had operated his scheme over a 3-year period, causing a loss to the programs of more than $100,000.

- A New York dentist was excluded from the programs for 10 years for sexually abusing patients while they were under general anesthesia.

- A New Mexico psychiatrist convicted on 2 counts of fraud and conspiracy to commit fraud against an insurance company was excluded for 3 years.

- A Texas pharmacist convicted of submitting bills to third parties for prescriptions that were never filled was excluded for 5 years.

- A Wisconsin dentist was excluded for 15 years after being convicted of manufacturing and distributing a controlled substance.

- A Pennsylvania dental corporation was excluded for 3 years because of a civil judgment against the owner for filing false Medicare claims in the corporation's name.

- A Louisiana medical doctor, convicted on 2 counts of a controlled substance violation, was excluded for 10 years.

- A 10-year exclusion from the Medicare and State health care programs was imposed against a Pennsylvania registered nurse. She was convicted on 11 counts of nursing home patient abuse or neglect over a period of years. Her license to practice was revoked by the State board.

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. Several decisions on exclusions undergoing this process were rendered during this reporting period, among which the following were particularly significant:

- An ALJ upheld an 8-year exclusion of an Ohio osteopathic physician who was convicted of billing Medicare and private insurers for medical and laboratory tests which were never performed or which were not medically necessary. He had also submitted diagnoses which were false and for which he did not render treatment, to induce Medicare to pay for the tests. Sometimes he used the name of another physician who had amnesia on billings, stamp-endorsed the checks in this doctor's name and deposited the checks in his own account. His scheme resulted in an estimated $100,000 loss by Medicare and private insurance companies. In affirming the 8-year exclusion, the ALJ noted that while the doctor was engaged in his scheme he was attending law school, and that he appeared to have used his legal training to impede investigation of his criminal activities, and to conceal the scope and extent of the scheme.

- An ALJ also upheld a 3-year permissive exclusion of an Ohio physician who had been convicted of submitting false claims to private insurance companies. Asserting he was the physician in charge, the doctor submitted claims for spirometry tests and respiratory flow volume loops when they were actually part of health screenings advertised as free and performed at health fairs. The ALJ found that the case established a pattern of serious offenses as reflected in suspended terms of incarceration and significant probation, service and fines. The ALJ also found that the physician was motivated by unlawful personal gain.

- The Departmental Appeals Board affirmed the decision of an ALJ that a licensed practical nurse in New York should be excluded for 5 years. The nurse had pled guilty to willfully neglecting a patient at a health care center. The Board found that the ALJ's findings and conclusions were correct, including the fact that 5 years was the minimum required by statute and that the exclusion did not violate the double jeopardy clause.

- The District Court for the District of Columbia denied the request of a physician for a temporary restraining order to enjoin exclusion until after a hearing before an ALJ. The physician was excluded after surrendering his Maryland license while awaiting a formal disciplinary proceeding involving his professional competence or performance. The court found that he had failed to file for an ALJ hearing, that it had no jurisdiction because the exclusion was not in effect when the request was filed and that even if it had jurisdiction the request would be denied. The denial would have been based on the physician's failure to demonstrate likely success in the case and irreparable harm, and the fact that protecting beneficiaries from the risks underlying his license surrender was in the public interest.

- A Court of Appeals upheld the exclusion of a Wisconsin physician. On the basis of a determination by the Wisconsin PRO that the physician violated his obligations in the care of two patients, he was excluded from Medicare and Medicaid for 2 years. When his exclusion period expired and reasonable assurance was given that the problem would not recur, he was reinstated. He then filed an appeal asking that his exclusion be reversed, partially on the basis that his reinstatement notification was new evidence. The court upheld the exclusion as proper and held that the reinstatement was not material for the time the violations occurred.

B. Civil Monetary 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 claims to the Medicare and State health care programs. The CMP law, therefore, allows recoupment of some of the monies lost through illegitimate claims, but it also protects health care providers by affording them due process rights similar to those available in the administrative sanction process. Many providers, however, elect to settle their cases prior to litigation. The OIG recouped approximately $17.4 million through CMP settlements and hearing decisions during this period, of which the following are examples:

- A Medicare provider of ophthalmology services in Florida signed a $2.85 million CMP settlement related to fraudulent Medicare billings. The clinic's settlement is the third by a provider which used a particular billing service. The billing service fragmented and submitted as separate claims surgical procedures which Medicare had already reimbursed to the provider as part of global payments. The service was convicted in 1989 for Medicare fraud. Since then, CMP settlements of $3.1 million and $630,000 have been made with providers in Massachusetts and Texas, respectively.

- A New Jersey ophthalmologist agreed to pay $1 million to settle allegations of Medicare fraud. From 1985 through 1988, the ophthalmologist, who had previously practiced in New York, submitted about 2,500 claims to the city's Medicare carrier for patients he treated in New Jersey. He thereby obtained approximately $550,000 more than he was entitled to receive.

- The owner of two New York portable x-ray companies and his companies entered an agreement to pay $543,000 in settlement of civil and criminal liabilities for claims against Medicare. The claims in question were related to x-rays performed on patients in some 56 nursing homes serviced by the companies.

- A civil settlement was reached between the Government and a New Jersey medical center and three of its principals concerning false reimbursement requests submitted to Medicare. Between 1985 and 1989, the center improperly billed patients in over 1,000 instances for anesthesiologist supervision of the heart-lung machine operator during cardiac surgery. These charges were not legitimate because they were billed to a Medicare code which improperly described the procedure, and because the anesthesiologist was employed by the hospital and already being paid for 100 percent of his time during surgery. Around 500 Medicare patients will be entitled to refunds from a $100,000 fund established with the Department as a result of the agreement.

- A Pennsylvania hospital was found to be submitting claims to the Medicaid program for a variety of laboratory tests which either were not provided as claimed, were misrepresented or were duplicate claims. To resolve its liability under CMP and the False Claims Act, the hospital agreed to pay $234,880 in penalties and restitution, and to implement a 3-year instructional program for its employees on the subject of proper Medicaid billing techniques.

- Another Pennsylvania hospital was engaging in various schemes to defraud the Medicare and Medicaid programs, including hiring unlicensed physicians to staff its satellite clinics and billing Medicaid for their services. The hospital agreed to pay a penalty of $400,000 to resolve its civil liability.

- A settlement in the amount of $65,000 was reached with the estate of an Illinois pharmacist who billed the State's Medicaid program for items not dispensed, for items in greater amounts than actually dispensed and for items dispensed to persons without prescriptions.

- In Massachusetts, a medical testing service agreed to pay the Department $499,000 in settlement of civil and administrative claims for improperly billing the Medicare program. The service submitted global claims for holter monitoring services, which included both the actual testing and the physician interpretation of test results. The Department said that the service improperly submitted global bills since the interpretations were done by the patients' attending physicians rather than by service employees.

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:

- An attorney and an accountant in Washington State were sentenced for a scheme which cost Medicare and Medicaid more than $570,000. The two served as trustees for a $26 million estate, but claimed they owned a nursing home that was actually part of the estate. They also operated the home as trustees, but claimed that the home operator and owner were unrelated. They raised the rent (to themselves), then made a gift of the home to a charitable foundation of which they were also trustees and took tax deductions. The attorney was sentenced to 30 months in prison and 3 years probation, and ordered to pay $239,690 to Medicare and Medicaid, $88,245 to the Internal Revenue Service, a $6,000 fine and a special assessment of $2,200. The accountant, who cooperated with the Government, was sentenced to 90 days in jail.

- A Minnesota psychiatrist was sentenced to 1 year in jail and 10 years probation for defrauding Medicare, Medicaid and the Department of Veterans Affairs. He was ordered to make restitution of $17,000 and almost $8,200 in investigative and prosecutive costs. The court took under advisement a motion requesting additional restitution and may order him to pay close to $50,000. He billed for extensive psychotherapy and visits with individual patients in nursing and board and care homes when he either did not see them or saw them in groups at meals or snacks. His medical license was suspended in December 1991 for sexual improprieties with patients and for overprescribing medications.

- A Maryland physician visited nursing homes, annotated charts of patients he did not treat, and billed Medicare or Medicaid, sometimes for as many as 60 to 90 services a day. He was sentenced to 10 months incarceration, part to be served concurrently with a 2-year State sentence for neglecting patients and part in house arrest. He also agreed to repay $100,000 to the Medicare and Medicaid programs.

- The former senior vice president of the California Medicare PRO was sentenced for making a false statement to HCFA. He directed a plan in which the PRO falsely reported it had conducted thousands of medical reviews for the Government. He was put on probation, required to enter a detoxification program and fined $2,500. Earlier in a civil settlement, the

PRO agreed to pay $2 million to the Government and those who initiated a qui tam lawsuit for its false reporting.

- A Maryland physician was sentenced for conspiracy and false statements in attempting to circumvent his physician father's exclusion from Medicare and Medicaid by submitting claims for services the father performed. Both father and son were convicted, but the father fled and is being sought for sentencing for these crimes as well as for failing to appear at his trial. The son was sentenced to 6 months in jail, plus 12 months suspended and 30 months probation. He was fined $200,000 and ordered to perform 240 hours of community service.

- In Hawaii, an osteopath was sentenced for Medicaid fraud to 5 years in State prison, fined $5,000 and ordered to make restitution of $2,900. His license to practice medicine was also revoked. The false Medicaid claims he filed included services that were unnecessary and others that were not rendered.

- A co-owner of two Pennsylvania ambulance companies was sentenced to 21 months incarceration and 3 years supervised release for conspiracy, false Medicare claims and obstruction. His wife and the other co-owner were given probation terms. The other co-owner was also ordered to pay $30,000 in restitution, and the two companies were excluded from the Medicare and Medicaid programs for 7 years. The three had submitted false claims, then forged and altered company records to obstruct the investigation into the crime.

- In a series of embezzlement schemes uncovered in New Jersey, five persons were sentenced for schemes in which a medical center was defrauded of more than $2 million over a 5-year period. The former chief financial officer of the medical center was sentenced to 50 months in prison and 3 years probation, and ordered to pay restitution of $110,250 and a special assessment of $1,350. He was convicted in Federal court of involvement with a network of conspirators who diverted checks made in payment by patients and private and Government insurers; overbilled the center for collection letters sent on overdue accounts; accepted payments from a vendor to process invoices for goods never sent; and filed false income tax returns, failing to claim money from the fraud. Four other hospital employees who pled guilty and cooperated with the Government were given prison sentences ranging from 15 to 28 months, and ordered to pay restitution ranging from $150,000 to $200,000 each. Total restitution ordered amounted to $687,000, plus special assessments totaling $450.

Four officers of two vending companies were also indicted for selling supplies to the medical center which were never delivered but were diverted from one vendor to the other.

Kickbacks

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

Over the years, some 500 convictions, judgments and settlements have been obtained as a result of OIG investigations of violations of the anti-kickback statute. The following convictions for kickbacks were reported during this period:

- A Georgia chiropractor, his wife and 15 former patients were ordered to pay a total of $3.2 million in fines and restitution after being convicted of Medicare and private insurer fraud. The chiropractor and his wife were held responsible for $2.2 million of that amount. In addition, the chiropractor was sentenced to 12 years and 7 months in prison, and his wife to 5 years. The pair recruited patients for their clinic by promising kickbacks of up to one third the amount which Medicare or the insurance companies reimbursed. Bills were submitted for patients and their families regardless of whether they had been treated. In one instance, bills were submitted for 169 patients supposedly treated in a single day. The chiropractor was convicted of Medicare fraud in 1977, and at the time of the latest sentencing was serving a prison term for possession of illegal weapons.

- Three individuals associated with a telemarketing firm were sentenced in New York for their part in a kickback scheme. The case was based on a complaint by a Wisconsin hospital official that the firm was pressuring him to purchase computer cleaning supplies, offering "premiums" such as television sets and video cassette recorders in return. One of the firm's owners was sentenced to 5 years probation and ordered to pay a $125,000 fine. His son, who acquired and shipped the kickback items, was also sentenced to 5 years probation and fined $10,000. A company salesman was sentenced to 3 years probation. All three cooperated in the investigation.

- A Florida physician was convicted of conspiring to violate the Medicare anti-kickback statute. He signed certificates of medical necessity for various durable medical equipment supply companies for patients he neither examined nor treated. He was sentenced to 15 months incarceration, ordered to pay $65,000 restitution and fined $10,050.

- The Departmental Appeals Board rendered a significant decision on the first case in which OIG used its authority to exclude persons or entities under the anti-kickback statute from Medicare and State health programs. A major national laboratory chain was excluded because it established three joint venture partnerships in California that were essentially shell organizations to funnel laboratory business from investor physicians to the chain. An ALJ concluded that all the subjects in the case had violated the anti-kickback statue, but that permissive exclusions should be imposed on only some of them. Upon appeal, the Appeals Board upheld OIG, agreeing that all should be held responsible and that their exclusion periods were commensurate with the degree of their culpability.

Medicare Payment Safeguards

Medicare payment safeguards had been identified as a material weakness and a high risk area. The OIG found that although HCFA had maintained relatively stable payment safeguard funding levels as specified in its corrective action plan, these funding levels were inadequate to maintain consistent staffing and workload activity in the areas of Medicare secondary payer (MSP) and medical and utilization review. The OIG is concerned that the payment safeguard objectives are not being met, which could adversely impact the integrity of the Medicare program and result in significant program weaknesses. The OIG found that the payment safeguards preventing, detecting and recovering overpayments may have been compromised. Further, considering the $1.1 billion MSP backlog, OIG determined that the safeguard weaknesses disclosed in this review could continue to hamper the Medicare program.

The OIG proposed that HCFA review and modify its corrective action plan to assure that the objectives of the payment safeguards program are met. In addition, OIG recommended that HCFA instruct contractors to recover the improper primary payments identified in the MSP backlog report; notify other insurance companies of improper payments within the time frames of the recovery regulations; and evaluate its internal controls to assure that contractors have adequate payment safeguard programs that control against fraud, waste and abuse. The HCFA generally agreed with all but one of the above recommendations. The HCFA did not agree that its internal controls be evaluated, stating that it would not be appropriate to evaluate contractor performance of an activity that had been abated. (CIN: A-04-92-02037)

Medicare Secondary Payer Activities

A. Blue Shield of Florida

In reviewing the effect of HCFA's funding cut in FY 1990 for MSP activities at Blue Shield of Florida (BSF), OIG found that it had contributed to improper primary payments for Medicare claims totaling about $24.3 million. These improper payments were caused by a combination of factors: a HCFA directive to increase prepayment development thresholds, a BSF systems limitation and the failure by BSF to retroactively recover payments subsequent to the identification of other insurance for a Medicare beneficiary. The OIG also found that, due to the funding limitations, the carrier was not performing MSP postpayment activities. Specifically, OIG identified an estimated $2.6 million in improper primary payments which represent undeveloped postpayment correspondence cases. These correspondence cases represent notification to Medicare by insurers, providers and beneficiaries that improper payments were made.

The OIG recommended that HCFA: instruct BSF to develop and recover the improper primary payments identified in the review; ensure that BSF notifies other insurers of improper payments within the time frames of the recovery regulation; and require BSF to provide assurance that the MSP claims processing system is operational in accordance with program requirements. In lieu of additional funding, OIG suggested that HCFA consider alternative funding strategies. (CIN: A-04-91-02004)

B. Follow-Up on General Accounting Office Report

In a report entitled "More Hospital Costs Should Be Paid by Other Insurers," GAO had made six recommendations to improve identification of other forms of insurance that should pay for Medicare beneficiaries' medical services before Medicare. The OIG conducted a follow-up review and determined that HCFA had taken appropriate action on all five of the recommendations with which the Department had concurred. (CIN: A-14-92-00375)

C. Nationwide Employer Project

The OIG conducted an audit to determine if Medicare inappropriately paid for services on behalf of working beneficiaries who also had coverage under their employer group health plans (EGHPs) and to obtain information useful to HCFA in effectively implementing the MSP provisions of OBRA 1989. These provisions required HCFA to perform data matches and to contact employers to identify beneficiaries covered by EGHPs. For the 12 participating employers, OIG found that Medicare paid for services provided to 1,236 beneficiaries who were enrolled in EGHPs, with potential overpayments totaling over $2 million.

The OIG recommended that HCFA require intermediaries and carriers to examine the claims with the $2 million in potentially mistaken Medicare payments and initiate recovery actions where appropriate. The OIG also recommended that HCFA seek legislative authority to

require the use of statistical sampling to identify MSP situations and determine the amount of mistaken payments made by Medicare contractors. In addition, OIG recommended improvements to enhance implementation of the OBRA 1989 MSP provisions. (CIN: A-09-89-00162)

D. Data Match Project

In a review conducted to evaluate HCFA's efforts to implement the Data Match Project, OIG found that HCFA was providing supervision and direction to the project. However, OIG concluded that HCFA should: establish detailed procedures for implementation of the CMP process; include certain end stage renal disease beneficiaries who were excluded from the project; increase the MSP savings goals as a result of new beneficiaries identified; perform the necessary follow-up with employers who certified that they did not offer EGHPs; reevaluate and adjust as necessary the funding for the recovery of overpayments identified by the project; and monitor closely the recovery efforts of intermediaries and carriers. (CIN: A-09-91-00103)

Carrier Assignment of Medicare Provider Numbers

A study of Medicare provider numbers concluded that HCFA's direction and oversight of carriers' provider number assignment procedures are inadequate. Medicare carriers assign provider numbers to qualified providers of Part B services who furnish services or supplies to Medicare beneficiaries. The numbers are used in processing claims and establishing Medicare pricing and utilization profiles.

The OIG found that many carriers do not adequately document number assignment procedures; carriers obtain or maintain too little provider information; carriers fail to verify provider qualifications prior to assignment of provider numbers; and these weaknesses contribute to program vulnerabilities. The HCFA has agreed to issue new Medicare carrier instructions which specify more stringent requirements for the maintenance and assignment of Medicare provider numbers. These changes are in addition to the HCFA-initiated unique physician identification number program and DME/POS (durable medical equipment, prosthetics, orthotics and supplies) regionalization of carriers. (OEI-06-89-00871)

Carrier Health Care Fraud Task Force

By law, contractors who review, process and issue payments for Medicare and Medicaid services are required to have fraud detection units. The fraud detection staffs must be separate and apart from the carriers' medical review units, to assure their independence from day-to-day processing requirements. They are expected to work closely with other private insurers to identify individuals and patterns involved in fraudulent activities. Since their preliminary development of fraud cases is vital to State Medicaid Fraud Control Units and OIG investigations, their Federal funding has been tripled over that for last year.

During this reporting period, OIG and HCFA, which oversees carrier and intermediary activities, launched a coordinated program to form a nationwide health care task force of these units. In addition to training conferences to be convened annually, HCFA and OIG are designing 2-week training courses to be held periodically on various aspects of detecting and developing fraud cases. The OIG is actively assisting the units in preliminary case development, with OIG agents accompanying unit agents on occasion. The closer, skilled, and coordinated scrutiny of claims submitted will afford the best protection, in both detection and deterrence, against fraud in the Department's health care programs.

Multiple Copy Prescription Programs

The diversion of prescription drugs from legitimate distribution channels for illicit use is a serious national drug abuse and law enforcement problem. The weakest link in the distribution chain is at the retail level. One initiative to combat this problem is State-based multiple copy prescription programs (MCPPs). The MCPPs have three major elements: multiple (usually three) copies of the prescription are produced which are maintained by the physician, the pharmacist and the State agency; prescription forms are numbered sequentially and tinted so that they are hard to reproduce, forge or erase; and a retrospective data analysis is conducted to identify suspicious prescribing, dispensing or patterns of use. Nine States have MCPPs in place.

The OIG found that MCPPs reduce vulnerability to theft and forgery. Their effect on overall prescribing of controlled drugs, such as narcotics, is difficult to assess from existing studies. They appear to have had some effect on abuse of controlled drugs, as measured by emergency room visits. Program officials associate MCPPs with better targeting of investigator resources and more successful prosecutions of offenders involved in drug diversion. Opponents express concerns about the program's effect on medical decision-making as well as confidentiality. (OEI-12-91-00490)

Fraud Involving Durable Medical Equipment

Fraud in the DME industry has been a continuing major concern to OIG. Seat lift mechanisms, transcutaneous electrical nerve stimulators, oxygen equipment, home dialysis systems and similar equipment are reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers throughout the country circumvent this requirement through aggressive sales practices such as telemarketing, pressuring physicians into signing authorizations and even forging their signatures. Some suppliers simply bill for items never delivered; others bill carriers in States which pay high Medicare reimbursement, regardless of where the sale took place ("carrier shopping"). The following actions are some of the results of OIG efforts to uncover fraudulent DME sales practices:

- In an ongoing project in Pennsylvania aimed at investigating direct marketing practices of DME companies, a salesman for a DME company was sentenced for forging physician signatures on certificates of medical necessity forms. He was sentenced to 3 years imprisonment and 100 hours of community service, and ordered to make restitution of $54,555 in conjunction with another salesman who had been convicted earlier. The two men visited personal care homes and made up orders for DME that was not medically necessary. They then forged physicians' signatures on the forms stating the DME was necessary and billed Medicare.

- In Connecticut, a DME company was sentenced to pay a $62,200 special assessment and a $1,000 fine after conviction on 623 counts related to Medicare fraud. The company's owner was sentenced to 2 years in jail, given 3 years probation, and ordered to pay $300,000 in restitution and a $31,150 special assessment fee for buying lists of nursing home patients, items supplied them and dates they were supplied, from an Alabama consultant. The items were then rebilled to Medicare by the DME company. Total fines and restitution ordered for the two men and their respective corporations amounted to more than $474,000. The consultant was sentenced earlier to 26 months in prison for his part in the scheme.

- An Ohio DME company and its owner agreed to pay $1 million in a CMP settlement for having overcharged Medicare. From 1985 till 1989, the company engaged in a nationwide telemarketing scheme to sell seat lift chairs to Medicare beneficiaries, charging the program for new chairs but furnishing used and rebuilt chairs. The company should have charged Medicare $180 less per chair.

- Another Pennsylvania DME company had to pay a fine of $100,000 and its owner serve 45 days of home detention for Medicare fraud. They submitted claims of $400 each for stationary whirlpools when they supplied only portable whirlpools costing less than $100 each on the open market.

- A man convicted of operating a seat lift chair scam in Ohio was sentenced to 20 months incarceration and 3 years supervised release. He was ordered to forfeit $30,000 in cash and negotiable bonds from the Cayman Islands as partial restitution to the 37 people he defrauded. The man sold seat lift chairs to elderly Medicare recipients for more than $1,600, telling them his "company" would bill Medicare, which would pay 80 percent of the cost. He and his salesman, who was convicted and sentenced earlier, never submitted any claims - his "company" did not even have a Medicare provider number.

As a result of OIG investigations and recommendations over the years, as well as testimony at several congressional hearings, HCFA has proposed regulatory changes to address DME reimbursement problems, especially carrier shopping and telemarketing. The problem of carrier shopping and telemarketing arose largely because the carrier which served the point at which an order was placed had jurisdiction over the claim. The wide variation in coverage and allowable reimbursement rates among carriers created an incentive to make it appear that the order was placed where the supplier could receive maximum reimbursement, no matter how remote or illogical that location might be from the point the DME was to be used.

Thus, telemarketers would set up toll-free telephone lines in States that offered high reimbursement for certain types of equipment. These lines would be staffed by a single clerk who simply wrote the order down and sent it to a warehouse in another State. The toll-free number became the "point of sale," allowing the supplier to bill in the State with the higher reimbursement.

The HCFA's new regulations specify that jurisdiction for claims processing is determined by the residence of the beneficiary, which should resolve most aspects of this problem. In addition, the regulations create four regional claims processing centers for DME claims. The result should be virtually a national coverage policy on DME and closer coordination among carriers on this part of Medicare reimbursement.

Medicare Contractor's Pension Costs

A. Segmented Pension Costs

An OIG audit examined Blue Cross and Blue Shield of Michigan, Inc.'s implementation of the Medicare contract clause on pension plan segmentation. The clause required the contractor to identify, allocate and report pension assets and costs separately for Medicare segments. The OIG found that the contractor had understated Medicare's pension assets as of 1986 by approximately $580,000. Those assets were understated by another $4.4 million in the updating of Medicare segment assets from 1986 through 1990.

The OIG recommended that pension assets of the Medicare segment be increased by $580,000 as of 1986 and that the increase be carried forward as an increase to the pension assets as of 1990. Also, OIG recommended that the contractor increase the Medicare segment pension assets by an additional $4.4 million as of January 1, 1990. Both the contractor and HCFA agreed with the recommendations. (CIN: A-07-91-00471)

B. Special Early Retirement Program Pension Costs

The OIG conducted an audit of Blue Cross and Blue Shield of Michigan, Inc.'s pension costs for a special early retirement program claimed for Medicare reimbursement. The OIG

determined that the contractor received over $2.1 million in unallowable reimbursement for pension expenses claimed on the 1988 final administrative cost proposal. The OIG recommended that the contractor refund the $2.1 million to Medicare and compute future Medicare pension costs in accordance with applicable regulations. The contractor and HCFA generally agreed with the findings and recommendations. (CIN: A-07-92-00525)

Project to Redesign Information Systems Management

The Project to Redesign Information Systems Management (PRISM) is HCFA's multi-year systems modernization effort to ensure that the automatic data processing (ADP) and data communications requirements of its major mission areas and new initiatives are met over the decade of the 1990s and beyond. The OIG determined that, as of September 1989, the originally planned PRISM completion date, HCFA had achieved the short term objective of increasing ADP capabilities and capacity to meet current agency needs. However, OIG found that HCFA did not meet the long term objectives and goals.

The OIG recommended that HCFA: widen the scope of its information resources management (IRM) program to address comprehensively all Medicare claims processing systems and Federal Medicaid data collection initiatives; ensure that open technical issues in PRISM are resolved and that needed general systems controls are implemented; avoid overlapping and duplicative systems; and assign duties of sufficient scope to and maintain the independence of its principal IRM official. The OIG also recommended that the Assistant Secretary for Management and Budget continue close monitoring of HCFA on PRISM progress and related IRM issues. (CIN: A-14-91-02533)

Common Working File System

The Common Working File (CWF) system is essentially a data base of Medicare Part A and Part B claims histories used to validate Medicare claims before, rather than after, payment. The CWF integrates with other significant information resources management initiatives, including HCFA's PRISM.

A. Opportunities for Short Term Improvements

Performance Measure

In general, OIG found CWF to be an excellent cornerstone on which to build a more integrated and standardized Medicare claims processing system. Specifically, the OIG study identified the potential for short term improvements in three areas. The HCFA should: develop a procurement strategy for the acquisition of CWF host services that will provide the full benefits of competition in a timely manner, while ensuring that a high level of support for day to day Medicare operations is maintained; address the Federal telecommunication mandates; and consider internal systems improvements. The OIG believes that the alternatives described in its report will enhance the economy, efficiency and control over the data communications network for the processing of Medicare claims. (CIN: A-14-91-02531)

B. Opportunities for Long Term Improvements

Performance Measure

The OIG also found that there are significant opportunities to reduce Medicare claims processing costs, while at the same time improving the internal control environment, the utility of data collected for Medicare financial management and the degree of compliance with Federal information resources management requirements. The review focused on two key areas: opportunities for improvements which might be achieved by streamlining Medicare processing through further standardization, consolidation and integration, and ways by which the up-front costs of making the improvements might be minimized by taking advantage of CWF and other investments already made in existing systems at the Medicare contractors and at HCFA. The OIG recommended alternatives to improve the processing of Medicare claims, including the promotion of electronic billing, the consolidation of Medicare operations and the implementation of an integrated system built around CWF. (CIN: A-14-91-02532)

Electronic Media Claims

Both HCFA and OIG have become aware of allegations that certain contractors refuse to cooperate with some billing services that wish to submit electronic media claims (EMCs). This refusal would violate HCFA's instructions to provide the formats and edits needed to bill. These contractors, among others, are also alleged to require use of their subsidiaries' software to submit EMC, a practice which some complainants have alleged violates antitrust law. The OIG examined the current practices of four Medicare contractors regarding EMC submission.

The OIG found that those reviewed are following HCFA guidelines for Medicare claims submission. However, three of the four reviewed require that submissions to their private-side business use their for-profit subsidiary's software. This has the effect of requiring providers to use the contractor's system or have two separate systems operating if they wish to use any other billing service. The OIG recommended that HCFA remain aware of these subsidiaries and the contractors' general business practices, and consider creating or joining a claims clearinghouse. (OEI-12-91-01410)

Recovery of Overpayments from Bankrupt Providers

The OIG found indications that the losses to the Government from bad debts arising from overpayments to bankrupt providers may be substantial. The OIG believes that, for decision making purposes, health care policymakers should be informed about Medicare and Medicaid losses from bankrupt providers. Further, OIG believes that, as involuntary creditors, the Medicare and Medicaid programs are more vulnerable than most creditors in financial dealings with medical providers and should be given priority in bankruptcy proceedings. Accordingly, OIG recommended that HCFA prepare periodic management information reports on Medicare and Medicaid receivables written off as bad debts, and propose a legislative change to the Federal bankruptcy law that would give the programs

priority in provider bankruptcy proceedings. The HCFA partially agreed with the first recommendation and agreed to consider the second. (CIN: A-09-90-00141)

Medicaid Credit Balances in Skilled Nursing Facilities

The OIG conducted a national inspection to determine the dollar amount of Medicaid credit balances that exist at Medicaid-participating nursing facilities, and the time used by nursing facilities and State Medicaid agencies in reporting and adjusting credit balances. The OIG found that as much as $32 million ($18 million, Federal share) could exist nationwide in overdue Medicaid credit balances and that one-third of the amounts identified by the facilities had not been reported after 1 year had elapsed. Also, in more than half the cases, State Medicaid agencies did not adjust balances within 60 days after being notified of them.

The OIG recommended specific steps that HCFA could take to correct these problems: direct State Medicaid agencies to identify and adjust nursing facility credit balance accounts currently and on a continuing basis; seek legislation to penalize providers that do not timely report credit balances; and require State Medicaid agencies to adjust any outstanding Medicaid credit balances within 60 days from the point of identification, as outlined in Section 9512 of the 1985 Consolidated Omnibus Budget Reconciliation Act. (OEI-07-90-00911)

Early and Periodic Screening, Diagnosis and Treatment

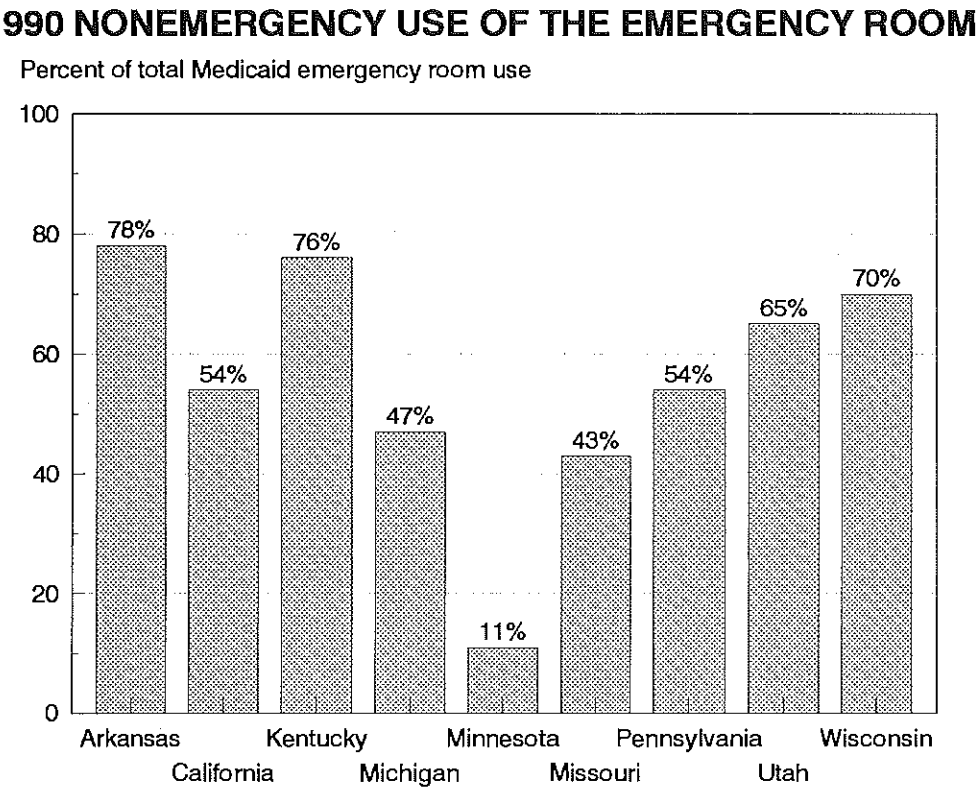
Performance Measure

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive child health program that provides for initial and periodic examinations and medically necessary follow-up care. The program objective is to find and treat the problems discovered by the screening services early, before they become more complex and costly to treat. When HCFA undertook implementation of OBRA 1989, which expanded EPSDT coverage, the existing system was inadequate to provide comprehensive data on screening. Thus HCFA began a major initiative to improve the measurement system.

The OIG conducted an inspection to assess the accuracy of States' reporting of EPSDT services to Medicaid-eligible children. The OIG found that the screening and participant ratios used to measure States' performance in the EPSDT program are essentially inaccurate. Furthermore, some States' EPSDT reporting is inconsistent with current HCFA instructions. The OIG recommended that HCFA modify the methods by which it measures screening and participation rates so that they correctly reflect States' progress in meeting statutory goals. The OIG also recommended that HCFA enhance monitoring procedures to assure the accuracy of States' reporting. (OEI-07-90-00130)

Use of Emergency Rooms by Medicaid Recipients

The OIG examined the programs and procedures developed by nine States to control nonemergency use of emergency rooms by Medicaid recipients. Based on data on the nine States displayed in the following chart, OIG found that the mean of nonemergency use as a percent of total Medicaid emergency room visits reported in 1990 for the nine States was 55 percent.



The OIG determined that substantial Medicaid savings could be realized by redirecting nonemergency visits to more appropriate and less costly care sites in the community. The States in the study developed controls to improve access to and continuity of care, as well as to reduce costs. The majority of successful programs and procedures addressed access to care through managed care and prepaid health plans.

The OIG recommended that each State develop a comprehensive initiative to reduce costly nonemergency use of hospital emergency rooms, addressing: increased use of managed care or prepaid options to improve overall care access and quality; community based access to after hours care; increased reimbursement to physicians and clinics who see Medicaid recipients after hours; definition of different levels of emergency room care and provision of corresponding tiered pricing and reimbursement levels; and triage payments to providers for

screening patients not treated in the emergency room. The OIG proposed that HCFA encourage and assist States to develop such initiatives. (OEI-06-90-00180; OEI-06-90-00181)

Medicaid Hassle: State Responses to Physician Complaints

Performance Measure

Physicians contend that administrative red tape discourages many doctors from treating patients who are covered by Medicaid. Cited were such problems as: slow payments; rejection of claims because the billing forms were completed incorrectly; difficulties in correcting claims that contain errors; inability to verify recipients' Medicaid eligibility, leading to Medicaid denials; frequent changes in policies, covered procedures and required documentation; and obtuse provider manuals.

The OIG identified nine approaches that States have found to be responsive to physician complaints about Medicaid's administrative burden. In weighing the potential impact of these approaches and their applicability elsewhere, OIG noted three considerations to be taken into account: State and Federal requirements for financial accountability make some of what providers view as hassle unavoidable; other policy initiatives, such as higher fees and development of managed care systems, often accompany efforts to reduce Medicaid's administrative burden; and fiscal constraints facing State governments limit the extent to which Medicaid programs can implement strategies to reduce the administrative burden. (OEI-01-92-00100)

Medicaid Drug Rebates

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

A. Accuracy of Pricing Information

The HCFA receives pricing information from manufacturers that includes the average manufacturer's price (AMP) and best price. From this information, a unit rebate amount (URA) for each drug is computed and furnished to the States for their use in calculating the rebate due from a particular drug manufacturer. An OIG review identified 200 different drug codes in 3 States involving 22 different drug manufacturers where errors in the AMP, base AMP and best price resulted in the URAs being overstated. At least nine States found that the rebate amounts were dramatically overstated compared to the actual drugs dispensed. Although 33 States expressed concern about the accuracy of the URAs furnished by HCFA, they still billed the drug manufacturers.

The OIG recommended that HCFA establish the necessary systems edits and program controls to help provide assurance that pricing data supplied to the States is accurate and

timely. Further, OIG proposed that HCFA consider imposing CMPs on those manufacturers that continue to provide inaccurate pricing information. The HCFA agreed with the first recommendation and agreed to consider the second. (CIN: A-06-91-00102)

B. Reporting of Drug Data by Pharmacists

Two critical data elements to be supplied by the States for each drug product are the national drug code for the drug dispensed and the total number of dosage units dispensed. In a review of Medicaid drug data submitted by pharmacists to the States, OIG found that 22 of the 46 States responding were having problems with the accuracy of their drug utilization data. These States had no procedures to monitor the accuracy of either the drug product or the number of dosage units. The inaccurate reporting of dosage units may significantly distort a manufacturer's rebate payment amount. The OIG believes that manufacturers will dispute rebate billings if there are problems with the accuracy of the utilization data and that this could result in significant delays in the receipt of rebate payments.

The OIG recommended that HCFA require the States to develop procedures to monitor the accuracy of pharmacies' reporting of drugs dispensed. Further, OIG proposed that HCFA instruct the States to test a sample of paid Medicaid prescriptions to determine the accuracy of the dosage units reported as dispensed. If this discloses significant errors, HCFA should require the States to design computer edits to detect and correct obvious reporting errors. The former recommendation has been addressed by interim regulations prepared by HCFA. However, OIG believes that additional corrective actions are still required. (CIN: A-06-91-00056)

C. Unit Rebate Amount Calculation

An OIG review disclosed that HCFA supplied inaccurate unit rebate data to the States for all new drugs that entered the market during the first quarter of Calendar Year (CY) 1991, resulting in overstated rebate billings to the manufacturers. The HCFA initiated corrective action starting with the second quarter of CY 1991, but initially made no adjustments for the first quarter rebate amounts. Subsequent to the audit field work, OIG found that HCFA did correct the URAs for the first quarter of CY 1991. Since OIG's recommendations have been implemented, no further action is necessary. (CIN: A-06-91-00100)

D. Ulcer Treatment Drugs

The OBRA 1990 requires State Medicaid agencies to operate drug use review programs on an ongoing basis. These programs are intended to assess actual patient drug use against predetermined standards. One of the standards recognized by OBRA 1990 is manufacturers' recommended dosages. The manufacturers of certain ulcer treatment drugs provide guidelines for prescribing their products in the treatment of gastric and duodenal ulcers.

An OIG review in Pennsylvania showed that drug use review programs were either not in place or not effective in limiting payment for ulcer treatment drugs to the manufacturers'

recommended dosages. The OIG determined that about $6.5 million (Federal share $3.7 million) in cost savings could have been realized for Calendar Year 1990 had the State limited payment for its drugs to the amount needed to pay for the manufacturers' recommended dosages. The OIG made recommendations to the State for procedural improvements to address the problem and the State generally concurred with the recommendations. (CIN: A-06-92-00010)

The OIG reported that Virginia did not have any restrictions pertaining to drug manufacturers' recommended dosages for ulcer treatment drugs. About $1.05 million (Federal share) in cost savings could have been realized for Calendar Year 1990 had the State only paid the amount that was in line with the manufacturers' recommended dosages. The State advised that it was considering development of an online point of sale capability that could restrict this inappropriate prescribing. (CIN: A-06-92-00009)

Point-of-Service Claims Management Systems for Medicaid

Point-of-service (POS) claims management systems use computers and telecommunications networks to perform one or more of four claims management functions: eligibility verification, claims submission, claims adjudication and utilization review. The POS systems allow all of these functions to be performed in a matter of seconds, while or before services are dispensed. The OIG found that POS systems had saved money and enhanced program administration in the only two States using them. However, few States planned to acquire POS systems, and several barriers had limited States' implementation of POS systems. In addition, many States had received inadequate or confusing information about POS systems from HCFA.

The OIG recommended that HCFA collect information on POS technology and regularly distribute it to States, illustrating alternative methods of using POS technology, offering strategies for procuring cost-effective systems, and facilitating communication among States planning to procure or already using POS systems. In addition, HCFA should clarify the operational requirements for enhanced Federal funding of POS systems, and promote the development of standard electronic claims formats and their use by State Medicaid agencies. After OIG's draft report was issued, work progressed on POS systems in a few additional States. In addition, all major Medicaid management information system suppliers are now developing POS technology, meaning that POS systems will likely find increasing use in the Medicaid program. (OEI-01-91-00820)

Electronic Funds Transfer for Medicaid Providers

The HCFA has recently expressed interest in paying providers via electronic funds transfer (EFT). The HCFA sees EFT as another step towards reducing administrative costs and improving provider relations in the Medicare and Medicaid programs. The OIG found that only eight States are using EFT to reimburse Medicaid providers. Many States see

advantages to using EFT. Several States are considering EFT, but few have definite plans to adopt it. Three commonly cited obstacles to EFT -- loss of cash flow, potential fraud and initial cost -- seem easily surmountable, while others are more difficult.

The OIG recommended that HCFA: work with the State Medicaid Directors' Association to identify additional problems with EFT facing States and to share other States' solutions to those problems; work with the National Automated Clearing House Association both to explore how the clearing house can be used for Medicaid EFT and to provide information to States; assist States in developing billing agreements for providers who use electronic claims, remittance advisories and funds transfers; and develop guidelines for provider participation in EFT. (OEI-01-91-00821)

Medicaid Mandatory Second Surgical Opinion Programs

Performance Measure

The Social Security Act requires that Medicaid State plans contain safeguards against unnecessary utilization of services, and assure that payments are consistent with efficiency, economy and quality care. States currently use second surgical opinion programs (SSOPs) as a utilization safeguard because these programs require clients to obtain independent medical opinions prior to elective surgery. An OIG report provides information on recent State evaluations of Medicaid mandatory SSOPs and their implications for HCFA's proposed regulation requiring such programs.

The OIG found that current evaluative data regarding second surgical opinion programs is limited and inconclusive, and all but two States have a review program other than a mandatory second surgical opinion program. The OIG supported HCFA's intention to withdraw the current proposal and recommended that HCFA determine the effectiveness of States' utilization review programs. (OEI-03-89-01530)

Improper State Claims for Federal Medicaid Funds

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

A. Institutions for Mental Diseases

The Social Security Act generally precludes Federal financial participation (FFP) in the cost of care and treatment provided to individuals in institutions for mental diseases who are between 22 and 64 years of age. Reviews conducted by OIG in several States identified unallowable Medicaid payments totaling over $33 million (Federal share). Partially as a result of these audits, HCFA identified and recovered an additional $40 million from the States. The OIG estimates that the Federal Government will realize annual cost savings under the Medicaid program of $35 million.

The OIG determined that internal control weaknesses at the State level permitted payments to ineligible institutions and payments for services provided to ineligible patients. The OIG recommended that HCFA direct the States to establish tighter controls and monitor State efforts to ensure that controls are implemented. The HCFA concurred, but expressed some reservations regarding resources available for monitoring activities. (CIN: A-05-92-00024)

B. Third Party Liability Collections

Federal regulations require States to pay the Federal Government a portion of third party liability (TPL) collections, determined by applying the Federal Medicaid matching percentage to total TPL collections. The OIG determined that, for amounts claimed during the period March 1, 1986 through March 31, 1991, Indiana attempted to credit the applicable portion of TPL collections to the Federal Government on quarterly expenditure reports but, through clerical errors, the effect of the credits was negated by offsetting entries on the same reports. The OIG recommended that the State refund $15 million, the aggregate Federal share of TPL credits due, and improve internal controls over TPL collections. The HCFA did not concur with the findings and recommendations. (CIN: A-05-91-00052)

C. Medical Assistance Payments to Inpatient Alcoholism Providers

The OIG found that New York State overcharged the Federal Government in excess of $2 million in Medicaid funds during the period April 1, 1987 to October 31, 1990. The Medicaid claims from eight free-standing inpatient alcoholism providers enrolled in New York's Medicaid program were intended to be funded with State funds only. However, the State did not establish appropriate edits or mechanisms within the Medicaid management information system to prevent FFP from being claimed. The OIG recommended that New York State refund the $2 million, discontinue claiming FFP for inpatient alcoholism services in free-standing alcoholism facilities, and identify unallowable claims made subsequent to the audit and return the Federal share of these claims. The State and HCFA concurred. (CIN: A-02-91-01033)

D. State-Operated Alcoholism Treatment Centers

In another review, OIG found that 11 State-operated alcoholism treatment centers (ATCs) located on the grounds of State-operated psychiatric centers (PCs) erroneously claimed $3.4 million in Medicaid funds during the period July 1, 1985 through October 31, 1990. The 11 ATCs claimed reimbursement by using Medicaid management information system (MMIS) provider identification numbers assigned to State-operated PCs. The OIG determined that: the 11 State-operated ATCs were free-standing facilities that were separate and distinct from the State-operated PCs; the ATCs were not certified to participate in the Medicare and Medicaid programs; and the ATCs were never enrolled as distinct providers under New York's Medicaid program. The OIG recommended that New York State: refund the $3.4 million; discontinue its practice of using MMIS provider identification numbers assigned to various State-operated PCs to claim Medicaid reimbursement for inpatient services provided in State-operated ATCs; establish edits or mechanisms within its MMIS to prevent the

improper claims from occurring in the future; and identify and return the Federal share of the improper claims made subsequent to the audit. Although the State did not agree, HCFA concurred with the report's findings and recommendations. (CIN: A-02-91-01048)

E. Medicaid Management Information System Costs

The Social Security Act provides for 75 percent FFP in the costs of operating an approved MMIS. The 75 percent is an enhancement in relation to the 50 percent FFP rate available for other administrative expenditures necessary for the proper and efficient administration of Medicaid State plans.

For the period October 1, 1988 through September 30, 1991, the State of Nebraska claimed MMIS costs of $14.3 million at the enhanced FFP rate. The OIG determined that claims of $4.9 million were ineligible for the enhanced rate. The corresponding reduction in FFP was $1.2 million. All of the overclaims occurred because the State considered only whole cost centers in determining costs to be claimed for enhanced FFP and did not consider that some activities, positions or costs within a cost center might be ineligible for the enhanced rate. The OIG recommended that Nebraska: refund the $1.2 million; identify and refund similar overclaims that may have occurred subsequent to the audit; and implement changes to ensure that only eligible costs are claimed at the enhanced rate of 75 percent. The HCFA agreed with the findings and recommendations. (CIN: A-07-92-00526)

State Medicaid Fraud Control Units

Medicaid health care provider payments currently exceed $72 billion dollars annually, representing a 400 percent increase over the $18 billion dollars expended in 1978. Medicaid fraud control units (MFCUs) are currently responsible for investigating fraud in more than 91 percent of all Medicaid health care provider payments.

Forty-one 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 1992, OIG administered $63 million in grants to the MFCUs. The MFCUs reported 684 convictions and $31.5 million in fines, restitutions and overpayments collected for the period July 1, 1991 through June 30, 1992.

Social Security Administration

Chapter III

SOCIAL SECURITY ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

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

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

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

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

Management and Financial Audit: Fiscal Year 1991

Performance Measure

The OIG issued a report presenting an overall commentary and summary on the results of its review of SSA's FY 1991 financial statements. It represents the capstone report prepared by OIG covering audit activities under the Chief Financial Officers (CFO) Act of 1990. Observations and comments were made to assist SSA management in meeting their reporting responsibilities under the CFO Act, with the recognition that SSA's Overview represents its first year reporting under the CFO Act.

The OIG believed that refinements and improvements to SSA's Overview were possible: it was lengthy and not always clear; it could have been more objective in reporting management problems such as the weakened status of the Disability Insurance Trust Fund; and it should focus more on identifying conditions or uncertainties that may affect future funding of the trust funds. The OIG report also summarized previously issued separate reports on audits of the principal financial statements and the Federal Managers' Financial Integrity Act program. (CIN: A-13-92-00221)

Compliance with Federal Managers' Financial Integrity Act: Fiscal Year 1991

The OIG reviewed SSA's activities to satisfy the requirements of the Federal Managers' Financial Integrity Act (FMFIA). Although SSA was found to be in overall compliance, OIG believed that certain areas required improvement. The SSA should ensure that the process for selecting sample Social Security applications for review is not skewed and that all cases have an equal chance of being selected. The OIG found that the release of personal data from the NUMIDENT record under the Privacy Act exposes the information to misuse. Also, SSA should improve its analysis of reported weaknesses, ensure the completion of accounting system reviews and submit corrective action reviews on time. The SSA generally concurred with all issues except for seeking exemption of the NUMIDENT record from the Privacy Act provisions. Instead, SSA has convened a work group to explore other ways to dispense personal information that will meet the intent of the Privacy Act without jeopardizing the integrity of federally maintained data. (CIN: A-13-91-00202)

Debt Management System

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

The OIG issued the third in a series of periodic reports. This report presented the results of its review of objectives scheduled within the period October 1, 1991 to March 31, 1992.

Generally, most of the scheduled objectives were successfully completed in new releases which included nationwide implementation of data entry screens for all Retirement, Survivors and Disability Insurance (RSDI) debt management activities and some SSI activities, and offset of tax refunds issued in 1992 to collect RSDI overpayments. However, two scheduled objectives were deferred and a correction to software did not entirely remedy the problem which it addressed. (CIN: A-13-92-00224)

Cost Recovery Operations for Services Provided to Others

The SSA provides information and related services to other Federal and State agencies, private organizations and individuals. Under the Social Security Act, the Secretary is authorized to charge requesters the full cost of services provided by SSA. The OIG found that some of the services being provided by SSA were not identified for cost recovery. In addition, existing fees and reimbursable agreements for other services were not always evaluated and updated. The OIG identified about $74.2 million in administrative costs that were not recovered by SSA in FY 1990. Under SSA's cost allocation system, most of those costs were charged to the RSDI trust funds. However, RSDI programs either did not require or did not benefit from those activities.

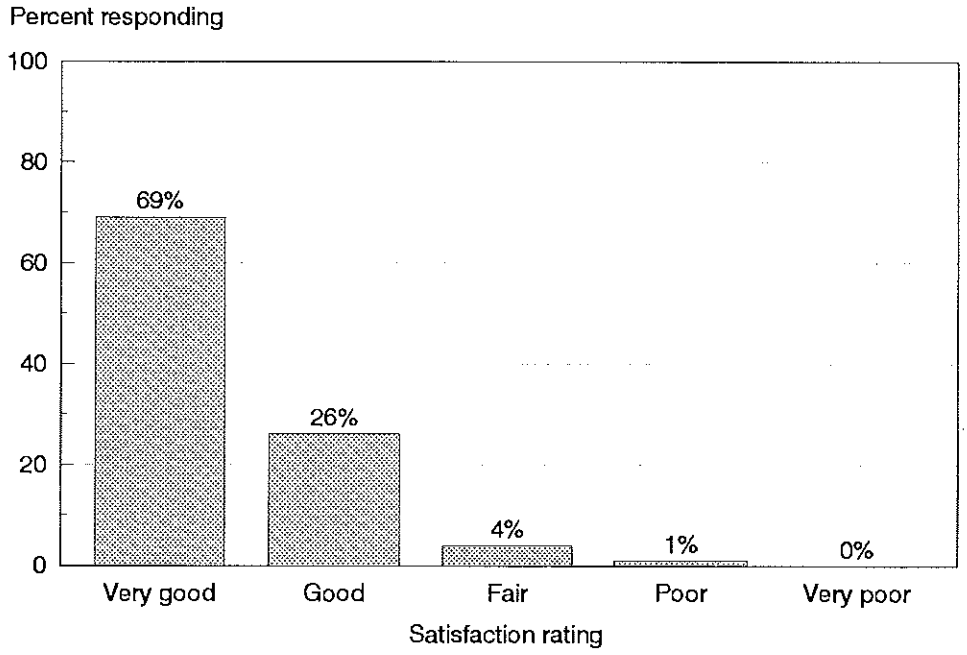
The OIG recommended that SSA clarify cost recovery policies, establish central management controls and implement comprehensive operating procedures; document its decisions to provide free services to other organizations and report the respective amounts annually to the Board of Trustees; and evaluate the specific cost recovery opportunities discussed in this report. The SSA is initiating various actions to ensure compliance with its policies. The SSA did not agree that costs for services provided at no charge that either benefit SSA programs or are in the best interest of the public needed to be reported to the Board of Trustees. Although not required by law or regulation, OIG believes that such reporting would enable responsible management of the RSDI trust funds. The SSA stated that it plans to evaluate cost recovery opportunities and, where necessary, establish appropriate fees. (CIN: A-09-91-00096)

Social Security Client Satisfaction

Performance Measure

The OIG issued four reports dealing with the satisfaction of SSA clients. One was the 1992 annual client satisfaction survey, the eighth such survey. This year, it was complemented by a separate exit interview survey conducted at SSA field offices. Both these surveys showed relatively high client satisfaction levels. In the annual survey, 79 percent of clients rated service as good or very good. In the exit interview survey, 95 percent of clients rated the service they received during their visit as either very good or good, as illustrated in the following chart.

SATISFACTION WITH SSA FIELD OFFICE SERVICE



Based on data from these two surveys, OIG prepared a separate analysis of disabled clients' satisfaction. The OIG found that only 67 percent of disabled clients were satisfied, compared to 89 percent of the nondisabled. Disabled clients receiving benefits under the RSDI program and the Supplemental Security Income program gave overall satisfaction ratings of 79 and 71 percent, respectively. Applicants under those programs not receiving benefits, including those awaiting decisions and those whose benefits had been stopped, gave satisfaction ratings of only 49 and 57 percent, respectively.

A fourth client satisfaction report provided more detailed information regarding subgroup populations and SSA's success in meeting its strategic planning goals. Seventy-five percent of clients visiting local offices reported waiting less than 30 minutes. Both urban clients and non-English speaking clients waited longer and were somewhat less satisfied with service. Ninety-three percent of clients calling the national 800 number reported getting through within 24 hours.

In a fifth study, OIG sought to evaluate the effect of nonrespondents on the client satisfaction surveys it conducts. Based on an analysis of the replies of a sample of nonrespondents to the FY 1991 Social Security Client Satisfaction Survey, OIG determined that, with continued high response rates, nonrespondents do not materially affect satisfaction

ratings. (OEI-02-90-00671; OEI-02-91-00900; OEI-02-91-01440; OEI-02-91-01441; OEI-02-91-01442)

Clarity of Social Security Notices

In July 1989, SSA published a revised "Notice Standards" handbook covering format and type style, reading level, wording, sentence length and paragraph length. While these standards have improved overall notice quality, annual studies conducted by OIG between 1987 and 1991 have shown that additional improvement is needed. In a current inspection examining several high volume notices used in SSA's Retirement, Survivors and Disability Insurance programs, OIG determined that the SSA notice standards work when used, but they are not uniformly applied to all automated notices. Particular problems were found in notices generated under the Recovery of Overpayment Accounting and Reporting (ROAR) program and the Terminations, Attainments, Transfer and Terminations (TATTER) program. Further, OIG concluded that SSA has no ongoing process for reviewing notices.

To reduce client misunderstanding and to minimize follow-up calls by confused clients, OIG recommended that SSA apply the 1989 "Notice Standards" in all automated notices, revise ROAR and TATTER system notices and establish quality assurance processes to periodically monitor the readability of notices. The SSA generally agreed with the findings and recommendations. (OEI-07-90-02410; OEI-07-90-02411)

Telecommunications Management

In a review of SSA's telecommunications management, OIG considered various issues related to the transition to and use of Federal Telecommunications System (FTS) 2000 services in the coming years. The OIG concluded that SSA has made considerable progress in the transition from existing long-distance telecommunications to the FTS 2000 system, but that it should continue to focus attention on cost control, technical issues, communications standards and service integration. The FTS 2000 transition thus far has been a conversion of the existing services and specialized networks to a new vendor without changes to existing communications practices. The SSA needs to direct more management attention to integrating telecommunications operations and procurements. The OIG identified several specific areas for improvement. The SSA generally concurred with the recommendations, but disagreed that it had acquired too much telecommunications capacity for the Office of Hearings and Appeals. (CIN: A-09-91-00105)

Nonusers of Social Security Administration's 800 Number

A 1990 OIG survey of Social Security clients disclosed that 30 percent of the respondents had not used the 800 telephone number within the prior 12 months. The OIG contacted the nonusers to learn whether they knew about the Social Security 800 number service and their reasons for not using it.

The OIG found that half of the nonusers were unaware of SSA's 800 number; the other half chose not to use it. Nearly half of all nonusers used other 800 numbers for other organizations. Even after being informed of the 800 number, most nonusers still said they preferred visiting or calling the local office. The OIG recommended that SSA target its public service awareness efforts to insure that the public is fully informed of the 800 number and emphasize the attractiveness of the 800 number in developing new promotional techniques to persuade reluctant users that it is a viable alternative to traditional face-to-face service. (OEI-02-91-00220)

Social Security Number Cards Issued from Office of Central Records

Almost all Social Security number (SSN) cards are printed electronically by a computerized system. During printing, some of the cards are accidently mutilated. Clerical staff type new SSN cards to replace mutilated cards for which name, SSN and mailing address information are legible, and the mutilated cards are destroyed. The OIG found that SSA employees were correctly following the procedures to process the manually prepared SSN cards. However, these procedures did not provide sufficient assurance that SSN cards were protected against theft, loss and misuse. The OIG recommended more management involvement and control over the processing of manually prepared SSN cards. The SSA was in general agreement with the recommendations. (CIN: A-13-91-00204)

Printing and Mailing of Social Security Number Cards

The OIG determined that SSA needs to improve security and control over the printing and mailing of SSN cards. Specifically, SSA should improve the security of SSN cards in the loading dock area, better account for each SSN card printed or spoiled, and take actions to reduce the number of SSN cards destroyed because they are undeliverable. In addition, SSA should require the mailing contractor to improve security and control over SSN cards. The SSA agreed with all recommendations except one, which required that the contractor account for all unmailable SSN cards. The SSA believed this recommendation would delay the return of mail to SSA and draw undue attention to the cards, adversely impacting security. (CIN: A-13-90-00047)

Fraudulent Social Security Numbers

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

- A self-professed California street beggar, who used assumed names to obtain several SSNs with which he made multiple applications for SSI, was sentenced to 24 months incarceration. He was also ordered to pay a total of

$88,532 in restitution and $50,000 in fines. He was convicted on nine counts of conversion of public monies, nine counts of filing false claims and two counts of money laundering. To date, approximately $1.2 million has been seized under various accounts. A civil case is pending.

- In California, a man who invented three children in order to receive welfare benefits was sentenced to 16 months in State prison. The man used counterfeit birth certificates supposedly from the State of Mississippi to apply for SSNs for three nonexistent children. With the SSNs he applied for benefits from the AFDC program and for food stamps, receiving $34,445 to which he was not entitled.

In addition to their misuse in abusing departmental programs, SSN cards are basic documents used along with birth certificates and driver's licenses to create false identities. Persons involved in a wide range of crimes, from con men operating credit card scams to murderers trying to conceal their identity, almost invariably use fraudulent SSNs for concealment. During this period, convictions in cases worked by OIG in which use of false SSNs was a major factor involved more than $41 million in court-ordered fines, restitutions and recoveries. The actual cost of the use of false SSNs is certain to amount to billions of dollars, most of it being borne by taxpayers in higher prices in the marketplace. Over the past few years, the proportion of OIG's investigative caseload involving SSN misuse has steadily increased.

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

- In California, a man was sentenced to 33 months in prison, followed by 3 years probation, for misusing SSNs to obtain tax refunds and credit. He also was ordered to pay over $268,460 in restitution to the Internal Revenue Service, almost $34,900 to California and additional restitution as determined by the probation department to the various creditors from whom he fraudulently obtained approximately $287,000. Another $377,800 in Federal tax refund checks were either not issued to him or recovered before they were negotiated.

- A Maryland attorney, her husband and her legal assistant were sentenced for misuse and sale of false SSNs and earnings statements. The attorney was sentenced to 6 years in jail and 3 years supervised probation, and ordered to pay $9,400 in fines and special assessments. The husband was sentenced to 4 years and 9 months in jail and 3 years probation, plus fines and special assessments of $11,250. The legal assistant was sentenced to 2 years in jail, 2 years probation and a $150 special assessment. The three manufactured

employment documents, verifications and earnings statements to help illegal aliens get work and resident papers, charging them about $3,000 each. Some 20 aliens pled guilty to using their service. The case grew out of an investigation of a Virginia lawyer who was convicted last year of similar crimes.

- Two men were imprisoned in Texas for attempting to murder and rob a man, then trying to use his name and SSN in buying merchandise. One was sentenced to life in prison, fined $10,000 and ordered to pay court costs of $9,695. The other was sentenced to 12 years in State prison and ordered to pay $4,157 in court costs.

- Thirteen union members were sentenced in New York for using false SSNs to report wages earned at the Jacob Javits Convention Center. All were sentenced to 1 year conditional discharge (probation) and ordered to pay fines ranging from $250 to $750. By using the false names and SSNs, they were able to avoid reporting income for tax purposes. They were, however, getting credit for union pension time. Multiple other prosecutions are pending.

- The last remaining defendant in an Ohio ring involved in check counterfeiting and using false SSNs was sentenced to two years in prison. He was also ordered to pay $3,700 in fines and restitution, and to perform 50 hours of community service. Earlier, his brother was sentenced to a year in a halfway house and the ringleader to 71 months in jail. Two other ring members were sentenced to 2 years in jail and another to 6 months. The ring used false identification documents (IDs) and counterfeit checks to obtain cash, automobiles from private owners, computers, photographic equipment, travelers checks, airplane tickets and fraudulent bank accounts. The six were ordered to pay a total of $243,000 in fines and restitution. Ten Federal and local agencies coordinated efforts to halt the ring's activities.

Indeed, in the last few years Ohio has become a favorite place for passing stolen checks from all over the country because of the ease of obtaining false IDs, which include fraudulent SSNs. State deputy registrars issue Ohio drivers' licenses and other ID items. In an investigative project targeting buyers and sellers of bogus IDs, about half of the persons indicted turned out to be employees of deputy registrars. The employees received sentences of prison time, community service and drug treatment, but they also advised investigators on ways to stop the flow of illegal IDs. Also convicted was an expert counterfeiter who must now serve the full sentence for which he was on probation, plus 2 years for his counterfeiting of Ohio drivers' licenses and IDs.

Fraud involving SSNs is proliferating, but OIG investigative resources are finite. In most cases, the use of a false SSN involves the commission of additional crimes for which other law enforcement agencies often have primary investigative responsibility. The growth of this caseload has forced OIG to develop criteria for limiting its involvement in SSN cases, in order to focus its limited budget resources more directly on the protection of the programs and trust funds of the Department of Health and Human Services.

Retirement and Survivors Insurance Benefits Fraud

One of the largest categories in OIG convictions for SSA fraud during this period was RSI benefits, of which the following are examples:

- In California, a man was sentenced after aiding and abetting his wife in stealing over $600,000 in life insurance proceeds and Federal benefits, including Social Security survivors benefits for his "widow" and children. After deserting the military service and faking his death, the man established a new identity in Michigan with the full knowledge of his wife. He was sentenced to 30 months in prison and ordered to make full restitution.

- A Wisconsin man was sentenced to 14 months in prison for concealing the skeletal remains of his half brother so he could continue to receive and spend his RSI benefits checks. The scheme was uncovered when a carpenter was boarding up a house and found the half brother's remains in a sleeping bag. The man also was ordered to make restitution of $11,800.

- In New Jersey, a 69-year-old woman was sentenced to 4 months incarceration, 4 months home detention and 2 years supervised release for using $85,000 in RSI and Veterans Affairs (VA) benefits to which she was not entitled. The woman admitted that she continued to cash her husband's checks after his death in 1968. She also admitted falsifying documents to the VA by not reporting the RSI income, thereby receiving excess VA benefits. She was ordered to make full restitution.

- A woman in Missouri was sentenced to 3 years probation for RSI benefits fraud, during which she is to repay SSA $100 each month. She had been receiving benefits as the mother of a disabled adult child. In 1990, it was discovered that she had placed her child in a nursing home in 1982 and had never told SSA.

- For 2 years, a Louisiana woman concealed from SSA the fact that she had remarried. As a result, she was overpaid $17,230 in RSI benefits. She was

put on probation for 3 years and ordered to make restitution of $4,300. The SSA recovered the remaining overpayment by withholding other benefits.

- A man was sentenced in South Carolina for stealing two children's RSI benefits. After his wife's death, he applied for the benefits for her children, whom he had adopted. He then placed them in an orphanage and for over 8 years collected $77,000, none of which he gave to them or the orphanage. When the oldest child applied for education loans and gave the orphanage as his address, the man's perfidy was discovered. He was sentenced to 21 months incarceration and 3 years probation, and ordered to perform 400 hours of community service. No restitution was ordered because he had no money, but the judge left open the opportunity for suing him later.

Optional Methods of Computing Self-Employment Income

The Social Security Act allows self-employed individuals who meet certain criteria to report net earnings under optional methods. These methods were authorized by the Congress to ease the documentation burden on low-income self-employed individuals and to enable them to maintain Social Security coverage for years during which they had low net earnings or a net loss. The OIG determined that the $1,600 per annum maximum net earnings amount under the optional method, authorized in 1965 and in effect today, is not in keeping with congressional intent. In recent years, the number of self-employed individuals electing use of the optional methods has sharply decreased. The OIG theorized that this was due mainly to the limit being less attractive as inflation caused it to lose parity with the rest of the program. Additional factors contributing to decreased utilization were the 5-year limitation on the use of the optional method by the nonfarm self-employed and the limited effort to publicize the optional methods and their benefits.

The OIG recommended that SSA consider proposing legislation to raise the cap on the maximum net earnings with periodic adjustments and to eliminate the 5-year limitation. In addition, OIG proposed that SSA increase efforts to publicize the benefits of the optional methods. The SSA disagreed with the recommendations. (CIN: A-02-90-00012)

Representative Payee Fraud

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

- In Oklahoma, a woman was sentenced to 8 months in prison and ordered to repay $11,760 she received as representative payee for an individual whose incarceration she failed to report. She will begin to serve her sentence upon

discharge from the Oklahoma Department of Corrections, where she is serving a 2-year sentence for defrauding the State welfare program by concealing the Social Security benefits she obtained illegally.

- An attorney in California was sentenced to 180 days in custody, 5 years probation and 250 hours community service for defrauding an SSI beneficiary. After SSI disability payments were approved for the recipient, the attorney applied for and was approved as the recipient's representative payee. He received two retroactive checks, but did not use the funds for the beneficiary. He was ordered to pay restitution of $10,000.

- A Texas woman was given a suspended jail sentence and ordered to make a repayment of SSA benefits she received on behalf of her son from 1977 to 1989. Her son had been in and out of jail and married, and had not lived with her since at least 1985.

Fraud Involving Deceased Beneficiaries

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

As a result of a computer match of Louisiana death records for 1 year against payments made to SSA beneficiaries, 11 individuals were indicted, 10 have been successfully prosecuted and sentenced for fraud, and 1 is awaiting trial. The following actions are representative of some of these cases:

- A man was sentenced to 10 months in prison in Louisiana for forging the signature of his deceased father-in-law on 74 SSA benefits checks. He was also ordered to pay full restitution of $41,000, with each monthly payment to be no less than the Social Security checks he will receive when he is released from prison.

- Another man was sentenced to 6 years in prison, 5 years probation and restitution of $16,598 for cashing his mother's checks from her death in 1985 until April 1991.

- A woman received 4 months in prison, 3 years probation and 200 hours of community service, and was ordered to pay restitution of $17,800. After SSA could not contact her mother, the woman was found to have negotiated her mother's checks from her death in 1973 until December 1990.

- A man who used a third party to negotiate checks sent to a brother who died in 1989 was sentenced to 4 months imprisonment, 5 years probation and 200 hours of community service, and ordered to pay $2,476 in restitution.

- A woman was sentenced to 3 months imprisonment and 5 years probation, plus restitution of $12,272. The woman continued to negotiate her mother's SSA and Civil Service annuity checks after her death in 1981.

The following cases are examples of other convictions during this period for using benefits intended for a person deceased:

- In Texas, a woman was fined $1,000, charged court costs of $260 and ordered to make restitution of $341 she obtained by forging the Social Security benefit check of a deceased person. She endorsed a man's check with his and her own signatures after he was murdered.

- Unable to find a Massachusetts woman through its Centenarian Project, SSA finally reached her grandson, a civilian clerk at an Air Force base. He claimed his grandmother died the preceding month, but investigation showed she died in 1960. He then claimed his deceased aunt had cashed the woman's SSA checks until 1986. The grandson was convicted of cashing the remainder and was sentenced to 1 year probation with 1 month home detention. He was ordered to make restitution of $12,745 and fined $5,000.

- Also in Massachusetts, a man who had a local cable television variety show known as "Mr. Wonderful and Friends" was sentenced for cashing the benefits checks of his girlfriend's deceased mother. He was put in a pretrial diversion program and ordered to repay $42,550 over a 10-year period.

Disability Insurance Benefits Fraud

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

- Six persons in a small town in Virginia were sentenced for a scheme in which two of them worked at a convenience store under their wives' names and SSNs. The two men, along with their wives, the store owner and the store manager pled guilty after being charged with conspiracy, false claims and statements, embezzlement and misuse of SSNs. The store's former owner was allowed to enter a pre-trial diversion program. The two men used their wives' SSNs, with full knowledge of all the others, to conceal their work so they could continue to receive railroad retirement disability benefits. A total of $7,600 in fines and $71,000 in restitution was ordered, and time to be served ranged from 9 years probation to 6 months house arrest.

- An SSA computer match uncovered the fact that a California woman who was receiving both disability and SSI benefits had earnings credited to her SSA record. Investigation showed that she was working as an elementary school teacher. She was sentenced to 5 years probation and ordered to make full restitution of $18,830 she had been overpaid.

- Also in California, a woman who disappeared in 1988, after indictment for using disability benefits sent to a deceased payee, was finally convicted and sentenced. A certified nurse's aide who cared for the payee and lived in his residence, the woman continued to deposit his benefits checks after his death in 1985. With a power of attorney which authorized her to sign and endorse checks on the payee's account, she deposited his checks and wrote checks to pay her personal expenses. In January 1992, she was arrested and kept incarcerated until her sentencing in late May. She was sentenced to 3 years supervised probation and ordered to pay restitution to the bank from which the Treasury Department had reclaimed the Government funds.

- In New York, a man was placed on 5 years probation and 6 months home detention for disability benefits fraud. He had applied for benefits in 1979 because of a back problem, but had been doing gardening and lawn work since 1980. He was ordered to pay $46,660 to SSA in restitution.

Windfall Offset

Prior to July 1, 1981, a beneficiary concurrently eligible for RSDI and SSI benefits whose RSDI benefits were delayed, resulting in payment of retroactive benefits, could, in some cases, receive full payment under both programs for the same months. In order to prevent this windfall, the Congress amended the Social Security Act to require SSA to offset retroactive RSDI benefits if a beneficiary received SSI benefits for the same period.

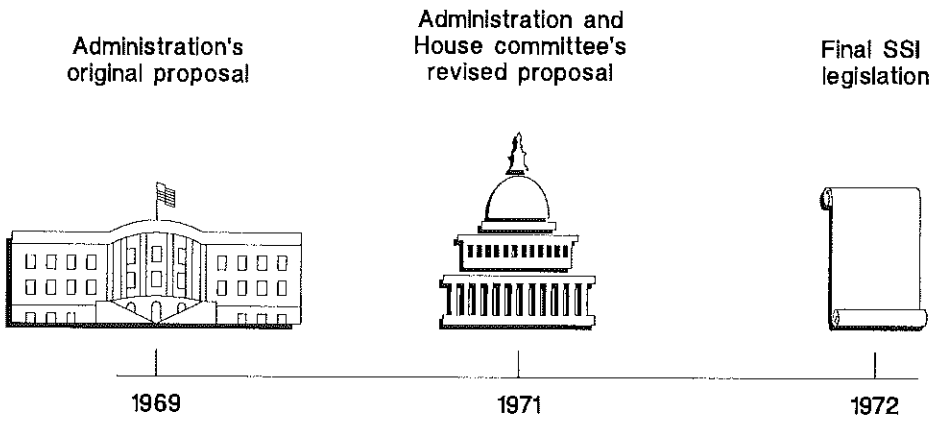
An OIG audit of a sample of concurrent RSDI and SSI cases and a sample of cases where the offset was applied disclosed no situations where inappropriate action was taken. The OIG determined that SSA was identifying windfall offset for concurrent entitlement cases and was offsetting benefits to ensure that beneficiaries were not overpaid. (CIN: A-04-90-03015)

Supplemental Security Income Overview

Performance Measure

To complement the work of SSA's SSI Modernization Project, OIG issued two reports on the SSI program, one describing SSI's legislative history and original objectives, and the other summarizing research on the program. The OIG found that the Administration and the Congress originally did not intend to create a new Federal program. The decision to create the SSI program emerged from debate over family welfare reform.

SSI EVOLVED FROM AN EARLIER WELFARE REFORM PROPOSAL



The program's primary objective was to assure more equitable and adequate income assistance for needy aged, blind or disabled individuals. While SSI has improved income assistance for millions of aged, blind and disabled individuals, many issues confront the program. Some of the major issues identified are: insufficient participation rates; inadequate benefit amounts; the program's complexity; the lack of information and referral services; the lack of coordination with the Food Stamps and Medicaid programs; and inadequate disability determination standards and procedures. (OEI-09-91-01330; OEI-09-91-01331)

Supplemental Security Income Overpayments to Recipients in Nursing Homes

Benefits under the SSI program consist of a Federal and, in some cases, a State benefit component. In 1992, the maximum Federal benefit rate (FBR) for eligible individuals is $422 per month. However, the FBR is limited to a maximum of $30 per month in cases where recipients are admitted to nursing homes, are expected to be there more than 3 months and have more than 50 percent of their medical care costs paid for by Medicaid.

An OIG audit estimated that about 60,000 SSI recipients received overpayments totaling approximately $42 million while in nursing homes in 1989. As of December 31, 1990, about $22 million remained outstanding with little chance of recovery. The OIG believes that most of the overpayments could be avoided if nursing homes were required to report to SSA on the admission of SSI recipients within 1 day of admission. Presently, admission reporting by nursing homes is voluntary and not fully successful. Consequently, OIG recommended that SSA, in cooperation with the Health Care Financing Administration (HCFA), develop and issue regulations requiring admission reporting by nursing homes. The SSA generally concurred with the recommendation, except that it believed that HCFA should develop and issue appropriate regulations. The HCFA did not concur. The OIG estimates that the recommended reporting requirement could save $22 million annually. (CIN: A-07-91-00376)

Supplemental Security Income Benefits Fraud

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

- A California woman was sentenced for defrauding SSI of more than $69,700. Shortly after becoming entitled to SSI benefits in 1975, the woman returned to work under her own SSN. Over the years, she signed some 20 statements that she did not work. Questioned several times about her earnings, she continued to insist someone else was using her SSN. She was sentenced to 5 years probation and full restitution. The judge said he ordered no community service because he would rather she worked to pay the money back.

- Another woman was sentenced in California for converting to her own use her deceased son's SSI benefits. She was representative payee for her son, who was born in late June 1987 and died in November 1987 without leaving the hospital. She continued to claim that the son was in the hospital until July 1990, when SSA notified her that she had been overpaid $19,000. Although she was given the opportunity to make repayment, she failed to do

so. She was given a suspended 5-year sentence and ordered to make full restitution.

- A man was sentenced in New York for converting an SSI recipient's benefits to his own use. His friend was representative payee for a mentally retarded cousin. When she and the cousin died within a few months of each other, the man called SSA and reported a change of address to his residence in Brooklyn. For almost a year he received the SSI checks, forged the friend's signature and cashed them. He was sentenced to 5 years probation and 2 months community confinement, and ordered to pay $6,524 restitution.

- An Iowa pawnshop owner was sentenced for concealing financial assets, including bank accounts and a $30,000 recreational vehicle, to obtain SSI and Medicaid assistance for his disabled child. The man was ordered to serve 30 days confinement, 3 years probation and 100 hours of community service. He also had to repay $19,300 to the two programs.

Public Health Service

Chapter IV

PUBLIC HEALTH SERVICE

Overview of Program Area and Office of Inspector General Activities

The activities conducted and supported by the Public Health Service (PHS) represent this country's primary defense against acute and chronic diseases and disabilities. The PHS's programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. The PHS encompasses: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed food, drugs, cosmetics and medical devices; Centers for Disease Control (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support through financial assistance the development of our future generation of health care providers; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Health Care Policy and Research, to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services; and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), to conduct biomedical and behavioral research on mental and addictive disorders and assist States in refining and expanding treatment and prevention services through ADAMHA's science-based leadership. (Recently enacted legislation dismantles ADAMHA and shifts its research functions to NIH. The change, set for October 1, 1992, adds three research institutes to NIH and boosts its budget to over $10 billion. Remaining substance abuse and mental health service programs will be placed in a new agency, named the Substance Abuse and Mental Health Services Administration.) The PHS will spend nearly $17.7 billion in Fiscal Year (FY) 1992.

The Office of Inspector General (OIG) continues to increase oversight of PHS programs and activities. The OIG concentrates on such issues as biomedical research, substance abuse, acquired immune deficiency syndrome and medical effectiveness. In addition, OIG conducts audits of colleges and universities which are awarded contract and grant funding by the Department of Health and Human Services (HHS). Recent congressional hearings and audits have raised questions concerning the propriety of charges made to research grants and contracts by colleges and universities, particularly in the area of indirect costs. The OIG will continue to examine the systems in place to ensure that research funds are monitored

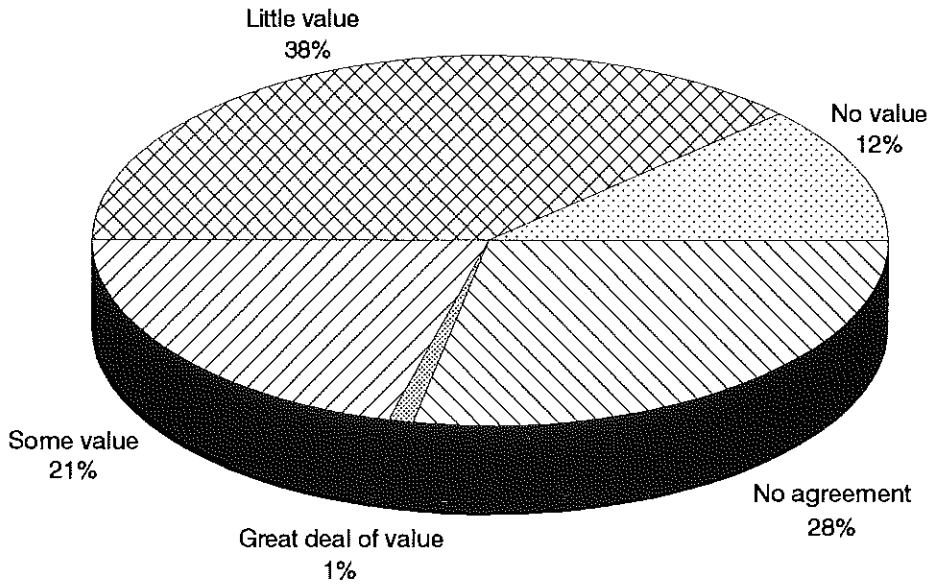
properly. Other areas of review will include grants management in general, information resource management, food and drug programs, migrant health care, community health centers, perinatal health care, community mental health programs, infant mortality programs, IHS health-related programs, student loans, departmental research programs and IHS financial management.

Prescription Drug Advertisements in Medical Journals

Performance Measure

The OIG conducted a study to assess the accuracy, truthfulness, educational value and quality of prescription drug advertisements in medical journals. Data for the study were gathered by physicians and pharmacists recruited by the University of California at Los Angeles. The reviewers noted major deficiencies in many of the advertisements reviewed: they lacked needed references and information on efficacy, appropriate populations, safety, and side effects or contraindications. The reviewers rated half of the advertisements as having little or no educational value, as illustrated in the following chart.

EDUCATIONAL VALUE OF PRESCRIPTION DRUG ADVERTISEMENTS



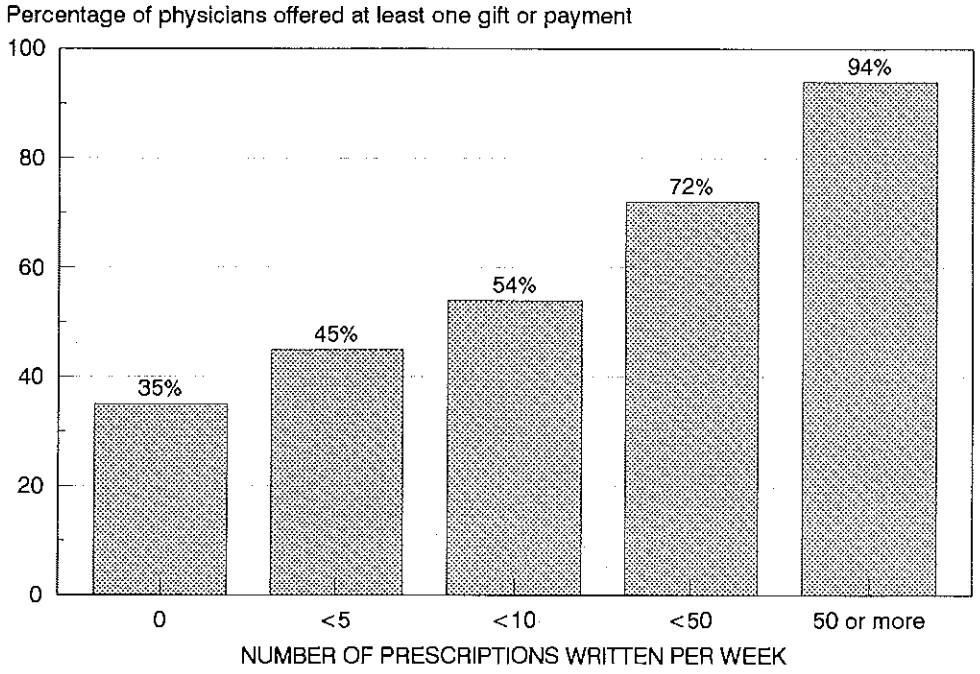
On average, the reviewers cited 4.3 examples of inadequate, misleading or inappropriate information per advertisement, indicating potential violations of FDA regulations.

The OIG offered several options for improving pharmaceutical advertising: FDA could conduct periodic review of a sample of prescription drug advertisements in medical journals; PHS could seek legislative authority to strengthen FDA's authority to deal with violators of prescription drug advertising regulations; the Pharmaceutical Manufacturers Association could emphasize to its members the importance of accuracy and truthfulness in advertising and assist them in improving procedures for reviewing advertisements prior to publication; and medical journals could identify specific ways to assure the truthfulness and accuracy of the pharmaceutical advertisements they publish. (OEI-01-90-00482)

Promotion of Prescription Drugs

The OIG surveyed physicians who bill the Medicare program to obtain information regarding promotional offers and items of value offered by pharmaceutical companies. Over 80 percent of the physicians reported that pharmaceutical companies offered them gifts or payments on at least one occasion in the year prior to fall 1991. Frequent prescribers were more likely to receive offers, as illustrated in the following chart.

FREQUENT PRESCRIBERS ARE MORE LIKELY TO BE EXTENDED OFFERS



Many physicians were offered gifts or payments that are now defined by the pharmaceutical industry's guidelines as inappropriate. In addition, the guidelines developed by the

American Medical Association (AMA) are not precise in some cases. During the time period assessed, pharmaceutical companies offered many physicians payments or gifts falling into these gray areas. The OIG recommended that PHS finalize guidelines distinguishing scientific interchange from promotional activity. The OIG also recommended that the Pharmaceutical Manufacturers Association work with the AMA to clarify gray areas in their guidelines. The PHS concurred with the recommendations and AMA responded that they have made or are working on many of the recommended changes to their guidelines. (OEI-01-90-00481)

Generic Drugs

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

During this reporting period, six former officials of one of the nation's major generic drug companies were sentenced for submitting false data to FDA and obstructing an investigation. The executive vice president was sentenced to 48 months in prison without parole and fined $1 million for submitting false test data from fictitious research and development batches, false representation of site of manufacture, substitution of brand name drugs disguised as generics in bioequivalency tests and switching the samples before an FDA inspection. Both the director and the manager of regulatory affairs were sentenced to 18 months in prison, another officer to 4 months home detention and two others to probation for falsifying bioequivalency tests.

The former vice president for manufacturing for another pharmaceutical company was sentenced to 8 months in prison, 4 to be served and 4 in a halfway house, for fraudulent failure to establish and maintain records of drug manufacture. He directed employees to make several lots of an antibiotic by an unapproved manufacturing process and to falsify production records to make it appear to FDA inspectors that the approved process was used. His company was fined $2 million for shipping adulterated drugs through interstate commerce.

Thus far in the ongoing investigations into the generic drug industry, some 40 individuals or organizations have been charged. By the end of the reporting period, 28 had been convicted and sentenced, and more than $18 million had been ordered in fines.

Allegations of Mismanagement at Food and Drug Administration's Newark District Office

In a review resulting from a congressional request, OIG found no evidence to support allegations that Newark District Office (NDO) management inhibited the proper inspection of generic drug manufacturers and other firms regulated by FDA. However, OIG determined that NDO operated with 18 percent fewer investigators than authorized, most of these investigators were relatively inexperienced and NDO was only able to complete 113 (34 percent) of its 335 budgeted inspections for FY 1991. The OIG did not find any records supporting allegations that funds were diverted or financial documents were removed from NDO offices to impede FDA's internal financial reviews. However, OIG concluded that NDO had improperly obligated and expended about $15,800 of Fiscal Year 1988 funds.

The OIG recommended that FDA: conduct internal control reviews of regional office responsibilities and performance; remind regions of proper practices for reobligating unused funds; expedite hiring to fill authorized investigator positions; and continue monitoring corrective actions to increase inspections and performance goals. The PHS generally concurred with OIG's recommendations. (CIN: A-02-91-02522)

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

The OIG conducted an audit of FDA's financial statements for its fund for Certification and Other Services for FY 1991, as required by the Chief Financial Officers (CFO) Act. The fund is used to account for revenue 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 used by the American public. The FDA supports these activities by requiring that insulin and color additive manufacturers prepay a fee for certifying their products. In FY 1991, over $3 million was collected from manufacturers.

Because FY 1991 was the first year the fund was subject to audit under the CFO Act, OIG was only able to express an opinion on the reasonableness of the fund's Statement of Financial Position. The OIG reported that FDA fairly presented its financial position. The OIG also reported that the fund has internal accounting control weaknesses affecting equipment inventory and cost, transfers of expenses and cash collections. The OIG concluded that the fund needs to better assure compliance with laws and regulations in four areas: requirements for setting fees; prepayment requirements for certification fees; requirements for accounting records; and the Federal Managers' Financial Integrity Act (FMFIA). The OIG made recommendations for FDA to improve the fund's internal controls and compliance with laws and regulations. The FDA generally agreed with the recommendations. (CIN: A-15-91-00053)

Youth and Alcohol

The OIG conducted two inspections profiling the dangerous and often unrecognized consequences of underage drinking. Although statistics related to youth crime and injury are not readily available, research findings indicate a strong association between alcohol or drug consumption and crimes of aggression, such as murder and rape. Additionally, research indicates that many victims of violent crimes are intoxicated at the time of the incident. Alcohol use is also associated with risky sexual behavior, suicide, water-related injuries or drowning, and school campus related problems. The OIG found that no State agencies maintain data on how many youth were under the influence of alcohol when they committed crimes. Also, researchers at the Department of Justice have limited information and data. Future technological advances may aid researchers in studying the link between underage drinking and crime. (OEI-09-92-00261; OEI-09-92-00260)

Alcohol, Drug and Mental Health Services for Homeless Individuals

An OIG inspection examined how States use the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant to serve homeless individuals with mental health, alcohol or other drug problems. The OIG found that many providers who receive ADMS dollars say they serve homeless individuals but lack data on numbers served and services provided; homeless individuals have problems that are more desperate, severe and difficult to treat than those of other clients; for the most part, grantees provide the same services to homeless individuals as to other clients, although some provide special services. Respondents say their services are appropriate for homeless individuals, but incomplete. They frequently refer clients elsewhere for services they do not provide, but referrals may not be effective. They strongly agree that special approaches are needed to serve homeless individuals.

The OIG recommended that PHS provide technical assistance to States and other PHS-funded grantees who serve homeless individuals. The ADAMHA should issue an advisory letter to all States with the next round of funding underscoring the importance of ADMS grantees including the following components in serving homeless individuals: specialized training for service providers, shelter personnel and volunteers for dealing with the unique problems of this population; and formal agreements with other service providers to promote information sharing, cross-training, technical assistance, development of model programs and model release plans for institutionalized persons.

The PHS concurred with the recommendations, but it did not agree that the ADMS block grant is the only mechanism to implement them, preferring to rely on the current programs funded under the Stewart B. McKinney Act. However, PHS plans to provide technical assistance and issue an advisory letter to State ADMS grantees. (OEI-05-91-00062)

Community Mental Health Centers Construction Grant Program

In a prior audit of the community mental health centers (CMHC) construction grant program, OIG assessed the appropriateness of the Continuing Medical Education, Inc. (CME) evaluations and recommendations, and of PHS' resolution of the CME reports. The current follow-up audit reviewed a random selection of CMHCs that had not been evaluated by CME to determine whether these CMHCs failed to comply with grant requirements as well. In addition, OIG evaluated PHS' monitoring of the CMHC construction grant program.

The OIG found that 15 of the selected grants (42 percent) were out of compliance with grant requirements, and that nine of those were seriously out of compliance with certain core program requirements. The OIG estimated that 171 of the 410 grants subject to review were out of compliance, of which an estimated 103 grants totaling $48.3 million were seriously out of compliance. The OIG concluded that PHS has made only limited progress in improving grantees' compliance since new monitoring procedures were instituted in 1984, few recovery actions have taken place and PHS did not perform adequate monitoring of the CMHC grantees. The OIG believes that many of the problems identified resulted from a material weakness in internal controls and could have been avoided had PHS provided adequate administrative and financial management guidance.

The OIG recommended that PHS: take action to ensure that the recommendations made to the audited CMHCs are implemented; review all remaining grantees for compliance with program requirements; take recovery action where appropriate; strengthen its monitoring program over the CMHC grantees; and issue appropriate regulations and guidelines to control the program. Further, PHS should report the existence of a material internal control weakness in the CMHC construction grant program in the Department's annual FMFIA report. The PHS generally concurred with the recommendations and indicated that it has taken or is taking actions to implement them. (CIN: A-05-91-00018)

National Institutes of Health's Management and Service and Supply Funds

The OIG audited the financial statements of NIH's Management and Service and Supply Funds for FY 1991 as required by the CFO Act. The funds finance a variety of centralized research support and administrative activities for the operation of numerous NIH programs and facilities, and had FY 1991 revenue totaling $597 million.

Because of concerns about amounts shown for inventory, property, plant and equipment and related accumulated depreciation, accounts payable and accrued expenses, OIG did not express an opinion on the financial statements . The OIG reported significant internal control weaknesses and noncompliance with Title 2 of the General Accounting Office's Policy and Procedures Manual for Guidance to Federal Agencies in three areas: inventory

management, accounts payable and electronic data processing security controls. The OIG believes that these three material internal control weaknesses meet the criteria to be reported under FMFIA. Recommendations were made to assist NIH in improving the funds' internal controls and compliance with laws and regulations. The NIH generally agreed with the recommendations, but raised concerns about whether the discrepancies noted should be disclosed as material weaknesses. (CIN: A-15-91-00044)

Interviews with Principal Research Investigators Concerning National Institutes of Health's Award Process

Performance Measure

The OIG conducted interviews with 94 principal research investigators (PIs) at 39 colleges and universities to obtain a cross section of opinions on NIH's award process for funding research and alternative approaches. The PIs generally supported NIH's award process. However, 80 percent of the PIs interviewed suggested improvements, identifying four general areas of concern: NIH's funding priorities are often targeted toward predetermined areas of research rather than being based on scientific merits of proposals; NIH's application and review process takes an inordinate amount of time and effort to complete; there is an absence of feedback from NIH; and indirect costs of research have questionable value. One-half of the PIs supported indirect cost caps. However, the PIs voiced substantial disagreement regarding the desirability of funding research through block grants or requiring mandatory institutional cost sharing. They generally agreed that these proposals would hinder research and make the entire process of funding research more political.

The OIG report did not draw conclusions or make recommendations. Rather, it was intended to provide NIH management with a body of knowledge to help identify areas where NIH may want to focus additional study and review. (CIN: A-06-92-00050)

Alleged Conflicts of Interest at National Institutes of Health

In response to allegations of conflicts of interest involving the NIH Consensus Development Conference on the "Treatment of Destructive Behaviors in Persons with Developmental Disabilities," the Senate Subcommittee on Investigations requested that OIG review the matter. Critics had claimed that the conference sanctioned use of a controversial electrical device because of relationships and financial ties between conference officials and device promoters.

Although OIG determined that the professional relationships and financial ties did exist, it found no evidence that conference officials gained financially. Also, OIG found no evidence that these associations influenced the conference officials in their decisions concerning the device. Rather, the conference concluded that use of the device and other aversive treatments should be discouraged and made only under restrictive conditions. However, OIG concluded that NIH had not implemented the most effective techniques for identifying, documenting and evaluating potential conflicts of interest for conference officials. Also,

OIG found that there had been no internal control review of the conference program as intended under FMFIA. In response, PHS undertook some corrective actions. The OIG is recommending that the effectiveness of these actions be evaluated and that an internal control review of the program be conducted periodically. The PHS concurred. (CIN: A-15-90-00009)

National Heart, Lung, and Blood Institute Contract

Based on a congressional request, OIG reviewed the National Heart, Lung and Blood Institute (NHLBI) contract issued to Pennsylvania State University for development of an artificial lung. The review was performed in response to concerns that the contract was awarded based on factors other than scientific merit; that there was a questionable, last minute change in the selection process; and that the integrity of the procurement process was in question since the awardee appeared to have been preselected.

The OIG found no evidence that the award was made based upon factors other than an independent evaluation of technical merit or that the contractor was preselected. Also, there was nothing to indicate a last minute change in selection of the contractor. It appears that one unsuccessful offerer misunderstood a routine request for information from the Department of Labor as an indication that they had been selected for the contract. In addition, OIG reviewed the significant internal controls related to this contract award and found those controls to be adequate and operating as designed. (CIN: A-15-92-00003)

Superfund Financial Activities at National Institute of Environmental Health Sciences: Fiscal Year 1990

During the period covered by the audit, obligations totaled about $36.3 million and disbursements totaled about $24.1 million. The OIG found that, with the exception of minor irregularities due to clerical errors, the National Institute of Environmental Health Sciences (NIEHS) generally administered the fund in accordance with Superfund legislation. However, OIG noted internal control weaknesses involving the: timeliness and accuracy of the interagency agreement between NIEHS and EPA; the adequacy of documentation maintained for billings; and compliance with time and attendance procedures. The OIG does not believe that the deficiencies noted meet the definition of a material internal control weakness under FMFIA. The PHS was in general agreement with most of the recommendations. (CIN: A-04-91-04026)

Indian Health Service's Advance Payment System for Contractors and Grantees

The OIG found that the controls in the advance payment system (APS) used by IHS to advance cash to its contractors and grantees did not ensure that the advances were limited to the immediate needs of the IHS contractors. Consequently, contractors routinely received

excess cash, which resulted in unnecessary financing costs. The OIG also found that contractors transferred IHS cash from designated bank accounts to non-IHS accounts until it was needed to pay for expenses incurred under IHS contracts. These actions violated the terms of agreement for special bank accounts. As a result, IHS could not accurately account for its cash advances by auditing the bank accounts and could not be assured that IHS cash was used only to fund IHS activities and programs. The OIG recommended that this be included as a material weakness in the Department's FMFIA report and PHS agreed.

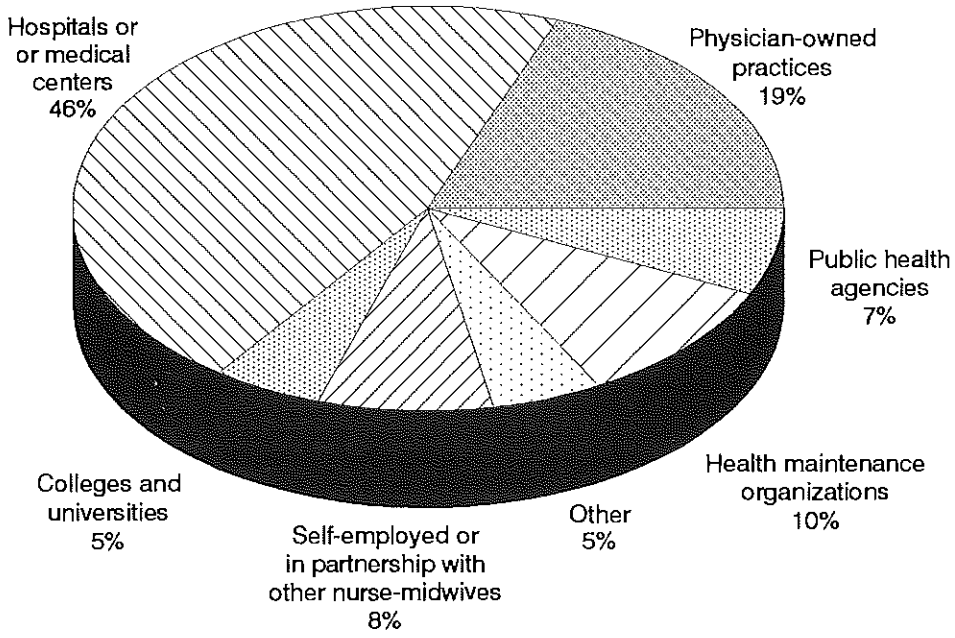
The OIG made recommendations to address the problems cited based on the assumption that IHS would continue to advance funds under the present system. However, OIG recognized that PHS might adopt a new payment system or use the Departmental Payment Management System, and that, if properly implemented, either of these alternatives could provide the necessary control and safeguards. The PHS generally concurred with the findings and recommendations, and stated that the advance payment function would be transferred to the Departmental Payment Management System. The OIG believes that this transfer is consistent with its recommendations. Prior to issuance of OIG's final report, the Department reported that it would transfer the system to PHS. (CIN: A-06-90-00001)

Certified Nurse-Midwives

A certified nurse-midwife (CNM) is a registered nurse who is educated in the two disciplines of nursing and midwifery, and has been certified by the American College of Nurse-Midwives. The CNMs can make prenatal care more accessible. They are historically credited with improving geographic distribution of care and providing care to underserved populations in inner cities and remote areas.

In a recent inspection that described the practices of CNMs and identified CNM-perceived barriers to their profession, OIG found that CNMs are well qualified, practice in a wide variety of settings and serve a wide range of patients. As illustrated in the following chart, most CNMs work for an organization or institution.

CERTIFIED NURSE-MIDWIFE EMPLOYERS



The CNMs cite attitudes and perception of the medical community as the most significant barrier to their profession. Other barriers frequently identified by CNMs included: limitations on prescriptive privileges, restrictive hospital admitting privileges, and attitudes and perceptions of the general public. The OIG found that those CNMs who are closely affiliated with physicians and physician-governed organizations are less likely to cite barriers. (OEI-04-90-02150)

Hill-Burton Program

The Hill-Burton program provided Federal grants to States and communities to construct needed hospitals and other health facilities. To be eligible for those funds, facilities were required to provide a reasonable volume of free services to persons unable to pay (uncompensated care obligation) and to make services available to all persons residing in their service area (community care obligation). The OIG found that 53 percent of the facilities are not meeting their uncompensated care obligation. The OIG identified a number of weaknesses in PHS's process for monitoring and oversight of the uncompensated care obligation and recommended procedural changes to strengthen its oversight.

Further, OIG found that the Office for Civil Rights (OCR) has developed comprehensive procedures for conducting its oversight of the community care obligation, but also identified a few weaknesses. A number of recommendations were made to strengthen OCR's enforcement efforts, including seeking legislative authority to allow administrative action against facilities that fail to comply with their obligations. (OEI-05-90-00260; OEI-05-90-00261)

National Practitioner Data Bank

The OIG issued three reports on the National Practitioner Data Bank. Currently, all malpractice payments must be reported to the Data Bank, regardless of amount. The Congress instructed PHS to prepare a report on the advisability of imposing a floor on the amounts that must be reported and of adding open malpractice claims to the Data Bank. Based on information received from malpractice insurers, State medical boards and the Data Bank, OIG concluded that the potential drawbacks of reporting open claims or imposing a reporting floor outweigh the potential benefits. The OIG study will be used by PHS in their overall report to the Congress.

The second report profiles the set of occasions, known as matches, on which the Data Bank has provided records of malpractice payments or adverse actions to requesting entities. The OIG found that, as of March 1992, nearly 21,000 matches had occurred. Almost all of these involved hospitals receiving information about physicians. Most of the matches concerned records of malpractice payments, with only 12 percent involving records of adverse actions. Nine percent of the matches involved practitioners who crossed State lines seeking work.

In a third inspection, OIG found that health maintenance organizations, preferred provider organizations, group practices and professional associations were registered by PHS under a self-certification process whereby such entities were not required to document their eligibility for querying the Data Bank. In order to prevent unauthorized access to the Data Bank by ineligible health care entities, OIG recommended that PHS strengthen registration procedures. The PHS was in general agreement with the recommendations. (OEI-01-90-00521; OEI-01-90-00522; OEI-12-92-00290)

Health Resources and Services Administration Grant Awards to National Association of Community Health Centers

The OIG reviewed HRSA's Bureau of Health Care Delivery and Assistance (BHCDA) grant awards to the National Association of Community Health Centers (NACHC) for FYs 1982 through 1991 for technical and nonfinancial assistance to community and migrant health center grantees. Based on the audit results, OIG recommended that: a clear definition of what constitutes technical and other nonfinancial assistance be established; future awards for technical and other nonfinancial assistance be competed or noncompetitive awards be approved by the HRSA Administrator; procedures be established to assure compliance with

minimum monitoring requirements ; and the nearly $275,000 of duplicate funding identified be recovered from NACHC.

In a report issued in March 1992, the General Accounting Office (GAO) also recommended that PHS take steps to make sure that BHCDA fully complies with all laws, policies and regulations regarding grant awards. Because of the serious weaknesses in internal controls found by OIG and reaffirmed by GAO, OIG recommended that these problems be reported as a material weakness under FMFIA. The PHS concurred with OIG's recommendations. (CIN: A-04-91-04067)

Superfund Financial Activities of Agency for Toxic Substances and Disease Registry: Fiscal Year 1990

Through interagency agreements with the Environmental Protection Agency (EPA), ATSDR obligated $45.2 million and disbursed $43.9 million in Superfund resources during FY 1990. The OIG concluded that, in general, ATSDR administered the fund in accordance with Superfund legislation. However, in addition to auditing ATSDR's FY 1990 disbursements, OIG analyzed the conditions cited in an August 1991 GAO report relating to ATSDR's health assessment program. The OIG determined that the deficiencies were of such magnitude that: HHS should report them as a material internal control weakness; ATSDR had not made provisions for all of its program activities for internal control reviews under FMFIA; and ATSDR had not developed and implemented a detailed corrective action plan to ensure the expeditious implementation of GAO's recommendations. The PHS disagreed that there was a material internal control weakness in ATSDR's internal control evaluation system and deficiencies related to the health assessment program, but totally or partially agreed with the rest of the recommendations. (CIN: A-15-91-00002)

Public Health Service's Service and Supply Fund

The OIG conducted a review of PHS' Service and Supply Fund in conjunction with its audit of the fund's financial statements for the fiscal year ending September 30, 1991, as required by the Chief Financial Officers Act of 1990. The OIG noted internal control weaknesses in the fund's process for assuring that general ledger accounts are routinely reconciled and agree with subsidiary ledgers and records, and in controls over accounts receivable. In addition, the fund was not in compliance with laws and regulations relative to Federal accounting requirements for capitalizing certain leased equipment and OIG could not determine whether the accounting controls for the fund had been reviewed as required by FMFIA.

The OIG recommended that PHS require that fund management develop specific guidance for implementing departmental requirements for reconciling general ledger accounts, and document how it has assured that the accounts have been reconciled as required. In addition, PHS should: designate responsibility for assuring effective accounting and

collection of accounts receivable; establish policies and procedures for assuring that expenditures are capitalized when appropriate; demonstrate the connection between FMFIA reviews that have been conducted and the fund management's statement that the fund has been subjected to FMFIA review; and ensure that reviews required by FMFIA evaluate the other activities of the system used for accounting for the fund's operations for deficiencies in internal controls and compliance identified by OIG. (CIN: A-15-91-00048)

Use of Recipient Capability Audits

Performance Measure

The OIG conducted a review to assess the use of recipient capability audits (RCAs) in FY 1989 by PHS agencies in determining whether or not to award funds to organizations that had no prior experience with governmental grants or cost-reimbursement contracts. The OIG found that 410 organizations received PHS funding for the first time in FY 1989. Of these, 172 organizations met the criteria to qualify for an RCA. However, OIG was requested to perform only 66 RCAs in FY 1989, covering proposed grant awards of $9.9 million. All requests for RCAs were from CDC. Based on the results, CDC denied funding to six organizations and instead awarded over $1 million to other, more capable organizations. The remaining 106 organizations, for which no RCAs were requested, received grant awards totaling in excess of $54 million in FY 1989.

The OIG recommended that PHS perform a greater number of financial evaluations of organizations applying for grant funds which do not have prior experience in managing Federal projects. Further, OIG proposed that PHS establish uniform policies and procedures for conducting these financial evaluations. The PHS agreed with the recommendations. (CIN: A-04-90-04012)

Administration for Children and Families, and Administration on Aging

Chapter V

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

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

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

tribes to help offset the cost of fuel for low income households, including recipients of AFDC, food stamps and supplemental security income. Other programs include Emergency Assistance, Refugee and Entrant Assistance, Child Care and Development Block Grant, At-Risk Child Protection, Community Services, Job Opportunities and Basic Skills Training (JOBS), and the State Legalization Impact Assistance Grants program. Expenditures for ACF programs will total approximately $27.8 billion for FY 1992.

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

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

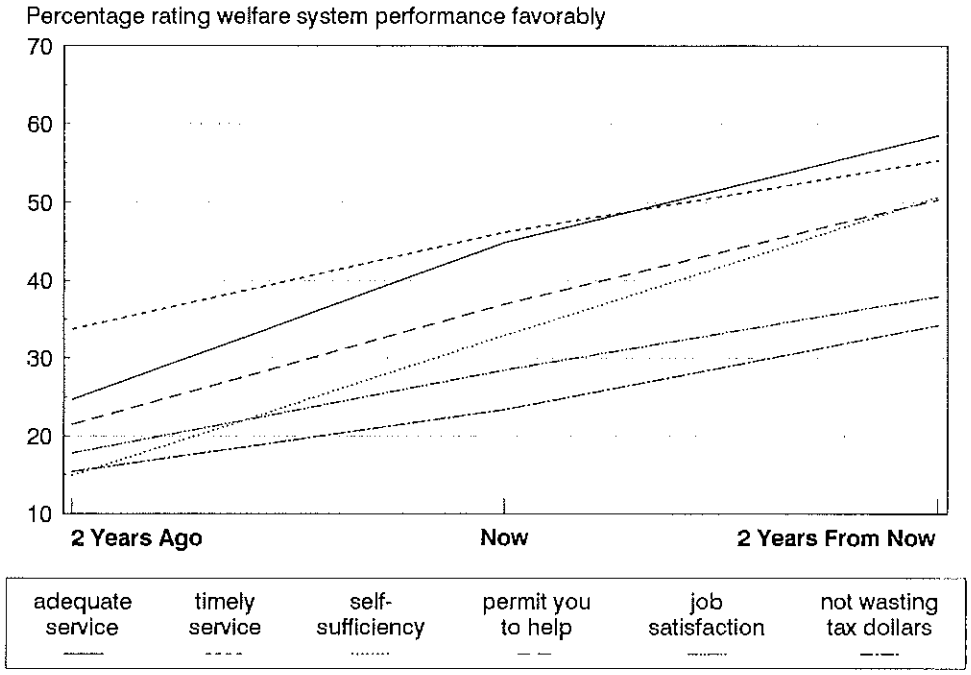
Family Support Act of 1988: Workers' Perspectives

Performance Measure

The Family Support Act was a comprehensive restructuring of the welfare system to reduce long-term dependency on welfare programs. The centerpiece of the Act was the JOBS program, created to provide AFDC recipients with educational and training opportunities, while providing them child care, transportation and other support. The Act also strengthened paternity establishment and child support enforcement. Front-line workers are the initial point of contact for the JOBS program, and their knowledge and attitude about the Act may influence the way they present this new program to clients. The OIG found that only one-third of front-line workers and supervisors report that they are "familiar" or "very

familiar" with the specific provisions of the Act. Overwhelmingly, front-line workers and their supervisors believe the Act will increase client self-sufficiency, as illustrated in the following chart.

FAMILY SUPPORT ACT EFFECT ON THE WELFARE SYSTEM
Will the system improve over time?



Those front-line workers and supervisors who are more knowledgeable about the Act's specific provisions are even more likely to believe it will increase client self-sufficiency. Finally, OIG found an inverse correlation between the knowledge and level of burnout of front-line workers and supervisors, i.e. the greater the program knowledge, the lower the level of burnout reported by the survey respondents. (OEI-05-89-01220)

Functional Impairments of Aid to Families with Dependent Children Program Clients

Performance Measure

The OIG conducted an inspection to determine whether and how States with JOBS experience are systematically identifying and dealing with the functional impairments of AFDC clients. Respondents identified a variety of impairments among AFDC clients, with learning disabilities and substance abuse most frequently cited. The OIG found that participation in the JOBS program increases the chances that a client's functional impairments will be identified. While referral for assistance does occur, it is not formal and

there is little follow-up. Clients are also prevented from getting the services they need by other obstacles, such as the lack of available publicly-funded services, transportation and coordination among the various assistance programs. The OIG identified special programs at the local level, all contracted through JOBS, which employ a variety of methods to facilitate self-sufficiency in the functionally impaired. These local programs exhibit common qualities and practices which maximize their effectiveness, as shown below.

The OIG recommended that States develop mechanisms to assure appropriate identification, referral and follow-up of clients with functional impairments. The ACF should assist States and local governments by publicizing effective practices for identifying, referring and serving the functionally impaired. The ACF should also conduct research on the extent and nature of impairments and interventions; this research could include coordination with research units whose primary focus is disability. The ACF does not believe it is practical for all States to develop mechanisms to handle functional impairments given the pressures associated with increased caseloads and declining fiscal resources. The ACF is considering conducting research on functional impairments and appropriate interventions. (OEI-02-90-00400; OEI-02-90-00401)

Welfare Fraud

Welfare assistance provided under the AFDC, Medicaid, Food Stamp and general assistance programs is based on State determinations of eligibility. As a result, welfare fraud is usually

perpetrated by making false claims about one's circumstances, such as claiming a nonexistent dependent child or concealing income which would render the applicant ineligible. Suspected fraud is discovered through a variety of mechanisms, ranging from disclosure by a disgruntled acquaintance or relative to computer matches of welfare lists against worker's compensation rolls or income tax returns.

For the past 3 years, OIG has been part of a series of task forces in one State that have had remarkable success in exposing welfare fraud. The task forces have included State auditors, county social services investigators where they exist, some local sheriff's offices, the U.S. Department of Housing and Urban Development, and occasionally the Postal Inspection Service. In the 10 counties covered thus far, some 420 defrauders have been uncovered, representing about $4.1 million in benefits. Of that amount, approximately two-thirds was in Medicaid and food stamps benefits.

The task forces have not only eliminated ongoing welfare fraud schemes, but also pointed the way to improved deterrence and detection. They have proved that grouping for prosecutive action cases which individually may involve relatively small amounts of money improves their appeal to busy prosecutors. Announcements of mass indictments also heighten public interest and enhance the deterrent impact. In addition, they have led local agencies to realize the importance of improving their own investigative capabilities. All the county social services agencies involved have either expanded their investigative staffs or created them where there were none.

Prenatal Substance Exposure

A recent increase in the number of substance exposed infants has focused attention on the problem of prenatal substance exposure. At ACF's request, OIG examined how provisions in State welfare laws dealing with prenatal exposure to illegal drugs, legal drugs and alcohol affect the handling of these cases. The OIG found that the only significant difference between States with child welfare laws addressing prenatal substance exposure and States without such laws is the way they investigate prenatal substance exposure cases. It appears that the major impact of these laws has been to lay the groundwork for developing special procedures and improving coordination. There appears to be little agreement among States about whether prenatal substance exposure should be considered child abuse or neglect. The OIG noted that, in the last 2 years, most of the prenatal substance exposure legislation has involved prevention, treatment and education initiatives rather than changes in child welfare laws. States may be emphasizing early intervention and education programs designed to prevent this problem from ever becoming a child welfare concern. (OEI-03-90-02000)

Child Support Enforcement Incentive Payments

The Congress provided incentive payments to encourage political subdivisions and States to cooperate in the collection of child support. In a review in nine selected States, OIG

concluded that incentive payments were used primarily to fund the State or local jurisdictions' share of CSE costs. The OIG found that some State governments realized significant savings from the State share of collections for AFDC, while their counties incurred the costs of operating the CSE program. Further, OIG determined that the method used for calculating incentives was often inconsistent with Federal CSE performance objectives. The OIG recommended that incentives be based on the States' demonstrated capability to meet Federal CSE requirements and performance objectives.

The Department's FY 1993 budget and legislative program includes a proposal to revise the federally-funded incentive payments. The purpose was to relate incentive payments to CSE program performance as a means of encouraging improved performance. The OIG supports ACF's efforts. (CIN: A-09-91-00034)

Child Support Enforcement: Assessing Fees to Non Aid to Families with Dependent Children Program Applicants

The Department's FY 1993 budget and legislative program includes a proposal to require States to pay or collect, from each nonAFDC individual who completes an application for CSE services, a mandatory $25 application fee and a mandatory $25 annual user fee. The proposal would also allow States the option of charging a $50 application fee and a $50 user fee only to those individuals who have income above 185 percent of the poverty income level.

In a review of States' practices in establishing CSE fees for nonAFDC cases, OIG determined that the anticipated application fee and revenues envisioned by the Congressional Budget Office were not being realized because a majority of States were charging a token application fee ($1 or less) for nonAFDC cases. The OIG conducted discussions with officials in six States and found that three States endorsed the mandatory $25 application fee and five States endorsed the $25 annual user fee. However, none of the officials endorsed the optional $50 application and annual user fees.

The OIG recommended that ACF continue to pursue the adoption of a legislative proposal to implement mandatory application and user fees in nonAFDC cases. In the absence of congressional sponsorship for the proposal, OIG suggested that ACF study acceptable revenue-raising alternatives, such as making application fees contingent upon recovery of support payments. (CIN: A-06-91-00048)

Child Support for Children in Foster Care

Performance Measure

The Child Support Enforcement Amendments of 1984 required State child support agencies to collect child support from biological parents on behalf of children receiving foster care maintenance payments where appropriate. An OIG study disclosed that few child support payments are made on behalf of foster care children; few foster care cases are referred to

child support agencies for possible collections; policies are vague on when to initiate collections, and coordination between foster care and child support agencies is limited; and although child support collections are low nationally, a few localities have developed effective referral practices resulting in collections on behalf of 48 percent of foster care children. The OIG attributed the significant collections at these "effective practice" sites to the following principles:

- Considering child support a priority
- Having effective patterns of communication between foster care and child support programs
- Being more aware of both biological parents' income sources
- Having one person or office to coordinate foster care referrals
- Including medical support in more support orders
- Reporting collections to the foster care agency

The OIG recommended that as a condition for receiving Federal matching funds for foster care administration, ACF should require States to develop and implement: criteria and procedures to assure that foster care agencies refer all appropriate cases to child support enforcement agencies for establishing child support orders and collecting child support; and a memorandum of understanding between foster care agencies and child support agencies with respect to determining appropriate cases for referral, and gathering and exchanging data. In addition, ACF should provide guidance and plans for coordination between foster care and child support enforcement agencies in support of such State initiatives. The ACF agreed with the recommendations to improve coordination between the child support and foster care programs, and has already started implementation activities for all of the OIG recommendations. (OEI-04-91-00530)

Use of Relatives as Foster Care Parents

The OIG released two reports concerning foster home care provided by the relatives of those children in the legal custody of State child welfare agencies. The OIG found that: few States collect detailed information about foster care placements with relatives; for those 29 States that could identify such placements, OIG computed a total of 80,000 children; over the last 5 years, States have made increased use of relatives as foster parents; States

frequently lack formal policies for licensing or approving foster homes; policies concerning the payment of foster care maintenance vary widely; and there is evidence that children placed with relatives remain the legal responsibility of the State for longer than children in other alternative care arrangements.

The OIG recommended that ACF encourage States to extend existing foster home standards to relative foster homes and develop consistent payment policies. The OIG also called for further research on the use of relatives as foster parents. The ACF generally concurred with the recommendations. (OEI-06-90-02390; OEI-06-90-02391)

Independent Living Program: West Virginia

The OIG performed a review of the West Virginia Independent Living Program (ILP), which was prompted by the findings in a previously completed nationwide review of the program. The State has submitted annual applications for ILP funds each year since the program was established in FY 1987 and has been awarded over $1.6 million by the Federal Government. At the time of the review, the State had not spent any of this award in accordance with Federal regulations. Specifically, the State misspent 37 percent of the awarded ILP funds, forfeited use of 48 percent of the funds and will forfeit use of the remaining 15 percent of the funds unless major improvements are made in its accounting system.

The OIG recommended that the State halt all future applications for ILP funds until it designs a method to properly account for and expend program funds. Further, OIG recommended that the State report to ACF the status of all ILP funds awarded, and make a financial adjustment of nearly $600,000 to the Federal Government. The State concurred. (CIN: A-03-92-00550)

Foster Care Maintenance Payments: Pennsylvania

The OIG reviewed Pennsylvania's claims for Federal financial participation (FFP) in FY 1989 under the Foster Care program for maintenance costs incurred by the Allegheny County Department of Children and Youth Services. The audit disclosed that the State was not entitled to about $2.3 million of the FFP claimed because 59 percent of the claims reviewed were in violation of one or more program requirements. In addition to making procedural recommendations aimed at improving the State's administration of the Foster Care program, OIG proposed a $2.3 million financial adjustment by the State for the ineligible claims identified. (CIN: A-03-91-00553)

Head Start: Program Attendance Goals and Nonfederal Resources

The OIG reviewed procedures used by ACF to ensure that established attendance goals are met and that waivers of nonfederal resource requirements for Head Start agencies are

sufficiently justified. The OIG found that 58 center-based grantees (about 29 percent of the 200 sampled) fell short of achieving the average daily attendance goal of 85 percent of funded enrollment. In addition, 18 Indian and migrant agencies (about 60 percent of the 30 sampled) did not meet their 20 percent nonfederal matching requirement.

The OIG recommended that ACF establish and implement procedures to: assure that consistent information is submitted through the Objective Tracking System; assure that Head Start agencies attain their expected attendance goal of 85 percent of funded enrollment; reprogram funds not being utilized to service children; and establish accounts receivable when appropriate. In addition, OIG proposed that ACF seek a regulatory change to require that an agency's funding level be based on current conditions and that it require Head Start agencies to submit current documentation to support requests for waiver of nonfederal requirements.

The ACF disagreed with the conclusions and recommendations regarding attendance goals, but concurred with those regarding nonfederal resources. The ACF also points out that, while cases where the 20 percent local share is not reached should generally remain the exception, the Congress has recently clarified its intent that the full match not be required in all circumstances by statutorily expanding the factors to be used by the Secretary to waive the full match in the new Head Start Amendments of 1992. The new provisions include situations, such as those found in many Indian and migrant communities, where there is a lack of local resources available and there would be a negative impact if the Head Start program ceased operations. (CIN: A-04-90-00010)

Health and Safety Standards at Native American Head Start Facilities

The OIG found that ACF has not assured that Native American grantees are complying with State and local licensing requirements and with program performance standards concerning health and safety. The OIG found that of the 106 facilities reviewed, 76 had fire safety problems, 55 had structural integrity concerns, 54 had water supply or restroom inadequacies, and 53 had playground deficiencies. Recurring, serious deficiencies were reported at 23 of the facilities. In most instances, health and safety inspections were performed by the responsible entities. However, health and safety inspections were not standardized and were sometimes inconsistent with previous inspections of the same facility. Inspections were not always performed annually, and in most cases, were conducted by agencies which lacked authority to require correction of observed deficiencies. In addition, the American Indian Program Branch of the Head Start Bureau does not have an adequate system to indicate when inspection reports are not received.

The OIG recommended that the ACF notify grantees that the health and safety of Head Start children and staff must be adequately protected by complying with the applicable performance standards. The ACF needs to work closely with the Indian Health Service to

provide more specific training to health inspectors; improve and standardize inspections; follow up on reported deficiencies; and obtain overall assurances that the facilities meet reasonable health and safety standards. Also, dissemination and tracking of inspection reports must be given priority by ACF and the Public Health Service (PHS). Comments from PHS and ACF indicated that they generally concurred with the findings and recommendations. (CIN: A-09-91-00134)

Head Start Fraud

The former director of a Head Start program in Georgia was sentenced to 4 months incarceration (home detention) for defrauding the program. She also was ordered to make restitution of $11,270. She was convicted for creating personal service contracts for fictitious consultants, producing fictitious invoices for toys and supplies, making out vouchers for nonexistent journeymen and forging signatures of consultants for services they did not provide.

Job Opportunities and Basic Skills Program: Skills Assessment

Performance Measure

The OIG examined the skills assessment process used in the JOBS program by reviewing the practices of several States with mature welfare-to-work programs. The OIG assessed the initial implementation of the JOBS skills assessment requirements and identified useful practices that other States could adopt. The review found that skills assessment is still in an early phase of development. Some principles and useful practices are emerging, but more experience and research are needed. (OEI-06-89-01610)

Performance Indicators in Job Opportunities and Basic Skills Program

Performance Measure

The Department has a legislative mandate to develop recommended performance standards for the JOBS program based upon the degree of success that may reasonably be expected of States in helping individuals to increase earnings, achieve self-sufficiency and reduce welfare dependency. These recommended standards must be submitted to the appropriate congressional committees by October 1, 1993. The first step in this process will be reaching consensus on key performance indicators that would be appropriate for standards. The OIG collected precursory information from States on the identification and use of performance indicators. The OIG found that States appear supportive of the need to measure performance in the JOBS program, but disagree on the best indicators to use to accomplish this. The OIG also found that States have undertaken a number of initiatives to develop and use performance indicators for their own monitoring purposes. While many States currently have systems that provide some data to support performance tracking, they identified barriers to the development of comprehensive systems. Most States want the Federal Government to act as a clearinghouse for information on what other States are doing.

Finally, while no consensus emerged on appropriate Federal performance standards, most States want flexibility in their development and use. (OEI-12-91-01380)

Youth Program Fraud

The former executive director of a neighborhood improvement agency in Colorado was sentenced to 5 years in jail for embezzlement. The agency is funded by Department grant money to be used in programs for helping runaway youths and keeping children off streets and drugs. Between October 1989 through June 1991, four Department grants totaling more than $363,000 were paid to the agency. During this time, the director deposited $145,000 in an unauthorized account from which he drew 191 checks of $200 to $500 each, payable to himself. Other checks were converted into cashier's checks and used to pay his mortgage. At times, the director wrote checks from the unauthorized account back to the agency's account, but he still owed $57,540 at the time he was caught. The director had previously been a minister and had embezzled $14,000 from a youth program. For this crime, he was given a deferred judgment and claimed to have paid the money back but had not. For the Colorado agency crime, he was fined $230 and, as a condition of parole, ordered to make full restitution.

Repatriation Program

The OIG performed a follow-up review to determine if the Office of Refugee Resettlement (ORR) had implemented the recommendations and corrected the material weakness identified in FY 1987. The OIG found that ORR had taken steps to improve operations, but the States are still submitting reports late and, in several cases, without adequate documentation. The material weakness was corrected, but ACF's corrective action review would have been improved if the testing performed was better documented. Also, OIG noted that ACF had not established an allowance for doubtful accounts receivable. Since as much as 90 percent of these are uncollected, the accounts receivable as reported by the program to the Department and external agencies is overstated. (CIN: A-12-92-00026)

Refugee Resettlement Program: Florida

An OIG audit covering the period February 1, 1988 through July 31, 1990 disclosed that Florida had made cash and medical assistance payments to refugees who were not eligible for assistance. In addition, the State had provided assistance under the Refugee Resettlement program (RRP) to some recipients who were not refugees. The OIG recommended procedural changes to improve Florida's administration of the RRP and a financial adjustment of more than $1.1 million for the ineligible cash and medical assistance payments. The State agreed to make certain procedural changes, but believed that the overpayments should be somewhat reduced. (CIN: A-04-91-00010)

Emergency Assistance Payments: District of Columbia

For FYs 1988 and 1989, the District of Columbia made payments totaling about $16.7 million under the Emergency Assistance to Needy Families with Dependent Children (EA) program and claimed about $8.3 million in FFP. An OIG review of a statistical sample of the EA payments claimed during this period disclosed that the District was not entitled to about $3.3 million of FFP because 59 percent of the payments reviewed were in violation of one or more program requirements. Perhaps the most serious violation was the fact that the District could not furnish a case file for 4.6 percent of the FY 1988 and 7 percent of the FY 1989 payments reviewed. This weakness in internal controls had not been corrected even though reported by ACF in FY 1987.

The OIG made procedural recommendations aimed at improving the District's administration of the EA program. In addition, OIG recommended that the District make a financial adjustment of over $730,000 in FFP reimbursed by ACF and reduce its FY 1989 claim for FFP, which has been deferred for payment by ACF, by $2.5 million. While the District disagreed with the findings and recommendations, ACF generally concurred. (CIN: A-03-90-00260)

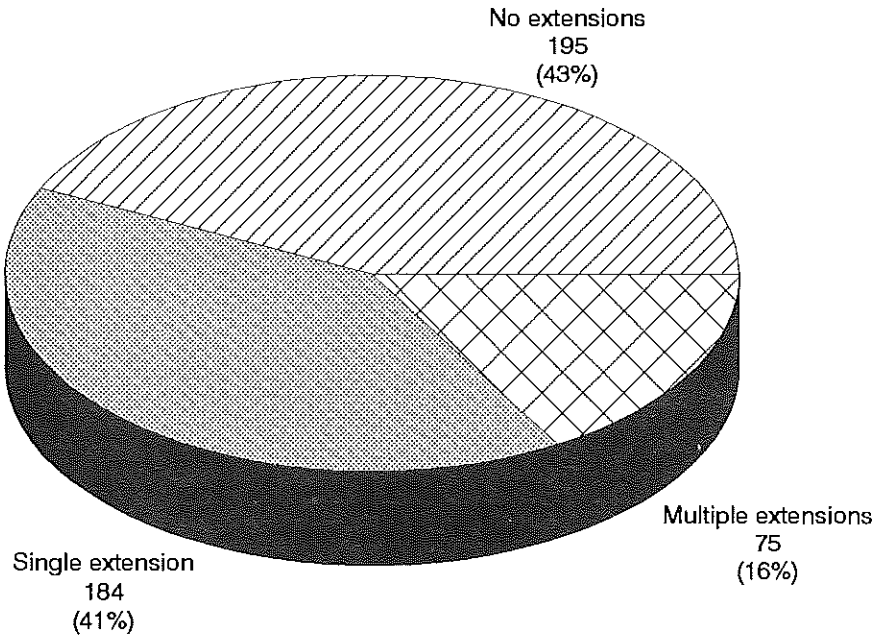
Low Income Home Energy Assistance Program Fraud

In New Jersey, a series of fraudulent schemes was uncovered in which LIHEAP was defrauded of approximately $150,000. The prosecutor's office reported to OIG that it appeared that at least two employees of the county social services agency were generating false applications under fictitious names and Social Security numbers (SSNs), and cashing the resultant checks at local stores in the area. Upon further investigation, it was found that not only was this scheme operative, but also a number of other county agency employees and private citizens were submitting false applications for energy assistance. These individuals, using their correct names and SSNs, concealed their entire income or made other false statements on their applications in order to qualify for assistance. Thus far, 12 individuals have been sentenced for their involvement in defrauding LIHEAP. Six of them were former county employees, and six were local store owners and other private citizens. Court restitutions ordered have totaled $77,850. Another 10 persons, including eight former agency employees, have been indicted and are awaiting trial.

Coordinated Discretionary Funds Program

The Coordinated Discretionary Funds Program (CDP) was established in 1982 to coordinate research, training and demonstration projects that cut across the agencies of the Office of Human Development Services (HDS), which, except for AoA have now been incorporated into ACF. An OIG review to determine the extent and characteristics of CDP grants that received time extensions and funding supplements examined 454 grants awarded in FYs 1986 through 1988. As the following chart illustrates, time extensions were common for CDP grants.

PERCENTAGE OF 454 COORDINATED DISCRETIONARY FUNDS PROGRAM GRANTS WITH TIME EXTENSIONS



Grantees with more than one time extension frequently reported that their award notices had arrived at the end of a fiscal year, causing them to get a late start. The OIG found that few CDP grants received funding supplements, and HDS staff generally followed requirements for approving both multiple time extensions and funding supplements.

The OIG recommended that ACF and AoA award CDP grants earlier in the fiscal year to allow needed lead time for grantees to begin projects on schedule and decrease the number of grants that receive time extensions due to late starts. The ACF and AoA agreed and are taking steps to award grants earlier. (OEI-04-89-00801)

Migrant and Seasonal Farmworker Program Discretionary Grants

Performance Measure

The OIG performed audits at eight Migrant and Seasonal Farmworker (MSF) program grantees located throughout the nation to determine whether project objectives were accomplished and grant funds were properly expended. The OIG found that: seven of the eight grantees did not fully accomplish one or more of their program objectives; six grantees either claimed costs that were not allowable for reimbursement, could not document compliance with the matching requirements of the grants, did not report grant related

income or did not return unexpended grant funds; three grantees did not comply with reporting requirements; and seven grantees had other management or operating deficiencies. The OIG recommended that ACF strengthen the management of the Office of Community Services discretionary grant programs. The ACF generally concurred with the recommendations. (CIN: A-09-91-00086)

Appendices

APPENDIX A

Implemented Office of Inspector General Recommendations to Put Funds to Better Use
April 1992 through September 1992

The following schedule is a quantification of actions taken in response to OIG recommendations to prevent unnecessary obligations for expenditures of agency funds or to improve agency systems and operations. The amounts shown represent funds or resources that will be used more efficiently as a result of documented measures taken by the Congress or by management to implement OIG recommendations, including: actual reductions in unnecessary budget outlays; deobligations of funds; reductions in costs incurred or preaward grant reductions from agency programs or operations; and reduction and/or withdrawal of the Federal portion of interest subsidy costs on loans or loan guarantees, or insurance of bonds. Total savings during this period amounted to $3,772.1 million.[1]

OIG Recommendation	Status	Savings in Millions
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 the Omnibus Budget Reconciliation Act (OBRA) of 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.	$2,200
Capital-Related Costs of Inpatient Hospital Services: Discontinue inappropriate Medicare prospective payment system (PPS) payments for hospital costs. (ACN: 14-52083; ACN: 09-52020)	Section 4001 of OBRA 1990 provides for a 10 percent reduction for capital-related payments attributable to portions of cost reporting periods or discharges occurring from October 1, 1991 and ending September 30, 1995.	720
Capital-Related Costs of Outpatient Hospital Services: Discontinue inappropriate Medicare PPS payments for hospital costs. (ACN: 14-52083; ACN: 09-52020)	Section 4151(a) of OBRA 1990 reduces payments for outpatient capital by 15 percent for portions of cost reporting periods in Fiscal Year (FY) 1991 and by 10 percent in FYs 1992 through 1995.	250
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 OBRA 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.	185

[1] *Not included in this listing are savings previously attributed to recommendations in the following areas: Administering the Medicare Secondary Payer Program (CIN: A-09-89-00100; OAI-07-86-00091; OAI-07-86-00017; OAI-07-88-00092; OEI-07-90-00764), Elimination of National Laboratory Fee Schedule (OAI-02-89-01910; CIN: A-09-89-00031), Fee Schedule Amounts (OAI-04-88-01080), Durable Medical Equipment (OAI-04-87-00017; OAI-02-88-00100; OAI-02-88-01110; OAI-02-88-00060; CIN: A-05-87-00138; CIN: A-04-88-02058; OEI-02-90-02090), Reimbursement for Prescribed Drugs (OEI-12-90-00800; CIN: A-06-89-00037; ACN: 06-40216), Overvalued Procedures (CIN: A-09-89-00082; OAI-09-86-00076; OAI-85-IX-046), and Prospective Payment System Update Factor (CIN: A-07-88-00111). In some instances, savings estimated by the Congressional Budget Office and other outside organizations have not been realized for outlying years. In others, recommendations have been surpassed by current thinking.*

OIG Recommendation	Status	Savings in Millions
Intraocular Lenses in Ambulatory Surgical Centers and Hospitals: In a 1988 report, OIG recommended that the Health Care Financing Administration (HCFA) establish a national Part B reimbursement cap of $200, with a handling fee not to exceed 10 percent, for any intraocular lens (IOL) billed to Medicare. After later studies found that IOLs were available for lesser amounts, OIG issued a report in June 1990 recommending that Medicare pay a flat $150 for all IOLs. (OEI-07-89-01664; OAI-07-89-01662; OAI-07-89-01661; OAI-07-89-01660; OAI-09-88-00490; OAI-85-IX-046)	Section 4063 of OBRA 1987 mandated a reduction in payment rates for IOL implants. On February 8, 1990, final regulations were published in the Federal Register (55 FR 4526 No. 27). Section 4151(c)(3) of OBRA 1990 maintains the $200 IOL allowauce provided for in the regulations as part of the ambulatory surgical center payment amount, through December 31, 1992.	$120
Anesthesia Services: Medicare should pay only the fractional time units for anesthesiologists aud 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.	50
Recovery of Retirement, Survivors and Disability Insurance Benefits through Income Tax Refund Offset: The Social Security Admiuistration should actively support legislation to allow offset of income tax refunds to recover certain overpayments. (OAI-12-88-01290)	Section 5129 of OBRA 1990 authorizes the recovery of Social Security overpayments from former beneficiaries by means of offsetting any income tax refunds due the individuals after affording them an opportunity to request waiver or arrange payment. The recoveries were effective January 1, 1991.	47.2
Coverage of Conventional Eyewear: Exclude Medicare coverage of conventional eyewear followiug cataract surgery. (CIN: A-04-88-02039)	Section 4153 of OBRA 1990 limited Medicare coverage of eyeglasses following cataract surgery to oue pair of glasses.	45
Payment Rates for Drug Epogen: Reimbursement for Epogen should be based on units administered rather than a flat rate. (CIN: A-01-90-00512)	Sectiou 4201(c) of OBRA 1990 based the payment rate for Epogen on 1,000 units rounded to the nearest 100 units.	37
Conversion Factors Used iu 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 couversion factor and reduce it by 7 percent.	35
Peer Review Organization Disallowances: Eliminate from contract awards and contract exteusions unallowable and overstated costs included in peer review organization (PRO) cost proposals.	The HCFA used OIG findings in reducing PRO contract awards and extensions.	33.8

OIG Recommendation	Status	Savings in Millions
Medicaid Provider Tax and Donation Programs: The HCFA shonld press forward with its proposed regulation to curb provider donation programs and to provide appropriate legislative amendments to control provider tax programs. The report cited Maryland as an example of a State with a provider tax program that increased the Federal share of Medicaid payments. (CIN: A-03-91-00203)	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) limited provider donation programs and regulations are being developed to implement the law. With regard to Maryland, HCFA issued two separate disallowance letters to the State for claims totaling $22.4 million. These claims related to provider fees for the third and fourth quarters of FY 1991 that were ineligible for Federal reimbursement because the State made no actual expenditures for medical assistance items and services in connection with the claimed amount under Maryland's Provider Fee Project.	$22.4
Foster Care Maintenance Payments: The State of Michigan should make appropriate financial adjustments for unallowable costs charged to the Foster Care program. (CIN: A-05-90-00132)	Michigan made voluntary financial adjustments totaling $10.3 million for unallowable social service costs included in its Foster Care claims for FYs 1987 through 1989.	10.3
Claim for Increased Costs by Blue Cross and Blue Shield of Colorado: Blue Cross and Blue Shield of Colorado had claimed cost increases of $10.9 million. The OIG concluded that the contractor's records only supported that there were $1.3 million in uncompensated costs due to the change orders. (CIN: A-08-90-00303)	The HCFA made a final settlement by increasing the fixed price contract by $4.2 million.	6.7
Indian Health Service Construction Project at Anchorage, Alaska: The Indian Health Service (IHS) should amend the project to reduce it by 11,315 gross square feet. In addition, it should provide additional support for the revised program justification document and program requirement, or reduce the size of the hospital from 158 to 150 beds. (CIN: A-09-89-00096)	The total square footage of the hospital constructed was reduced, space provided for inpatient hospital beds was decreased, the number of private rooms were decreased and additional adjustments were made to the hospital design.	4.2
Modernized Claims System's Internal Controls: Computer rejects of Social Security claims could be prevented with enhanced computer edits, which could save staff resources. (CIN: A-13-89-00020)	Enhancements have been made to the Social Security Administration's Modernized Claims System which will reduce handling of cases and save an estimated 65 work years over a 3-year period.	2.9

OIG Recommendation	Status	Savings in Millions
Replacement Hospital at Shiprock, New Mexico: The IHS should amend the approved project proposal for Shiprock Hospital by making adjustments for an estimated 56,9888 gross square feet of space relating to support space and appropriate staffing adjustments. (CIN: A-06-88-00008)	The IHS reported that, as a result of OIG's report, the size of the subject facility was reduced by 8,300 square feet.	$2.6

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 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
Medicare Coverage of All State and Local Employees: Require Medicare coverage for all State and local employees, including those hired before April 1, 1986, or make Medicare the secondary payer for retirees of exempt agencies. (CIN: A-09-88-00072)	A proposal to require Medicare coverage for all State and local employees, including those hired before April 1, 1966, is included in the President's Fiscal Year (FY) 1993 budget and legislative program.	$1,866
Indirect Medical Education: Modify Medicare payments to teaching hospitals by reducing the prospective payment system (PPS) adjustment factor. (ACN: 14-52018; ACN: 09-62003; CIN: A-09-87-00100; CIN: A-07-88-00101)	The President's FY 1993 Comprehensive Health Reform Program indicates that indirect medical education subsidies, for the most part, would be unnecessary under the President's reform proposal.	1,390
Reducing Federal Financial Participation: The Administration for Children and Families (ACF) should consult with the Congress on modifications to the Federal Medical Assistance Percentages 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 did not agree with the recommendation.	1,100
Laboratory Roll-In: Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89151)	The Health Care Financing Administration (HCFA) disagreed with the recommendation. The OIG continues to believe that it should be implemented.	1,000
Identify and Recover Medicare Secondary Payer Claims: Seek legislation to facilitate the identification and recovery of Medicare secondary payer (MSP) claims. (CIN: A-09-89-00100)	The HCFA has implemented a number of measures to improve the identification of beneficiaries with private health plan primary insurance and is considering additional measures, including legislative changes. The Department has reported the MSP issue as a high risk and material internal control weakness in the December 1991 Federal Managers' Financial Integrity Act report to the President and the Congress.	900

OIG Recommendation	Status	Savings in Millions
Revise Accounting for Penalties and Interest: The Social Security Administration (SSA) should support a legislative change to restore equity to the accounting process by requiring the Internal Revenue Service (IRS) to compensate the trust funds for interest and penalties collected which exceed the cost of IRS' administration of the Social Security tax. (CIN: A-13-86-62640)	Based on information from IRS, SSA does not believe that the current accounting method disadvantages the trust funds. The OIG has requested that the Department of the Treasury undertake a study of the current accounting method.	$844
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to various functions performed by the Food and Drug Administration (FDA), possibly including premarket review and approval for drugs and devices. (OEI-12-90-02020)	Various legislative proposals are being considered which would result in the expansion of user fees across FDA functions.	587
Extend Secondary Payer Provision: Extend the MSP provision for end stage renal disease (ESRD) beneficiaries beyond the current 1-year limit to the period of time that ESRD beneficiaries are covered by an employer group health plan (EGHP). (CIN: A-10-86-62016)	The provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1990 partially implemented the OIG recommendation by extending the MSP provision for ESRD beneficiaries covered by an EGHP to 18 months. This extension would save an estimated $370 million for the 5-year budget cycle. The OIG still recommends that the MSP provision be extended to the period of time that ESRD beneficiaries are covered by an EGHP. The General Accounting Office is required to evaluate the effect of the extension. An interim report to the Congress is due in January 1993 and a final report is due in January 1995.	503
Clinical Laboratory Tests: Set the Medicare lab fee schedules at amounts comparable to what physicians are paying and ensure that profile tests are appropriately reimbursed. (CIN: A-09-89-00031)	The OBRA 1990 provisions reduced payments for laboratory tests by limiting the annual fee schedule increase to 2 percent and reducing the national cap to 88 percent. There is a proposal in the FY 1993 President's budget that would cap laboratory fee schedule amounts at 76 percent of the median national fee schedule amount and give the Secretary discretion in determining future update amounts for the fee schedule.	426
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt payment policy. (CIN: A-14-90-00339)	The HCFA plans no further action on this report.	400

OIG Recommendation	Status	Savings in Millions
Limit Federal Participation in States' Costs for Administering the Foster Care Program: The ACF should limit Federal participation in the States' administrative costs for the Foster Care program. (CIN: A-07-90-00274)	The President's FY 1993 budget includes a legislative proposal to change the financing of State child welfare activities by creating and funding a new Comprehensive Child Welfare Services capped entitlement program. Under the proposal, each State will be required to maintain current efforts and previous levels of expenditures, and provide a match of 25 percent of funding, as opposed to the 50 percent match currently required for administrative costs.	$340
Reduce Payments of Medicaid Drug Expenditures: The HCFA should implement restricted drug lists. (OEI-12-90-00800)	The HCFA rejected this proposal since OBRA 1990 prohibits such restrictions.	226
Lodging Compensation: Include permanent lodging compensation for FICA coverage. (CIN: A-09-90-00050)	The SSA did not support the recommendation since it results in different Social Security and IRS treatment of the value of employer-supplied lodging and the IRS indicated the proposal would be difficult to administer. The SSA believes the impact of the proposal on the subject workers would be very small.	221
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services at the lower of cost or charges. (CIN: A-05-89-00055; CIN: A-05-92-00006)	The HCFA disagreed with the proposal, stating that payments for less than 1-day stays are part of the overall PPS formula which is designed to average out the payments among all Medicare cases. However, HCFA agreed that it may be appropriate to modify policy to encourage hospitals to treat cases involving observation after outpatient services as outpatient rather than inpatient cases, since it is not anticipated that these patients will require additional procedures. The HCFA intensified peer review organization (PRO) review of short-stay admissions as a first step in dealing with the problem, and has modified both the intermediary and hospital manuals in an effort to minimize the problem of inappropriate admissions. However, OIG's follow-up report indicated that problems still exist with intermediary instructions pertaining to inappropriate admissions, and that the instructions have not significantly reduced the volume of 1-day admissions on a national basis. The volume of 1-day admissions has increased approximately 150 percent over 1985 levels.	210

OIG Recommendation	Status	Savings in Millions
Medicare Prepayment Review - MSP Carrier Procedures: The HCFA should restore operations of the MSP units to a level equivalent to FY 1989, and consider demonstration projects to evaluate incentives to carriers to enhancing identification and recovery of inappropriate MSP payments. (OEI-07-89-01683)	The HCFA questions whether increased funding for the development of MSP situations is cost-effective, believing that other efforts will generate a larger return on investment. The HCFA will consider the qnestion of demonstration projects.	$199
Recover Supplemental Security Income Benefits through Income Tax Refund Offset: Take administrative action to recover certain Supplemental Security Income (SSI) overpayments through income tax refunds. (OAI-12-88-01290; OAI-12-86-00065)	The SSA has implemented tax refund offset to recover Retirement, Survivors and Disability Insurance (RSDI) overpayments. The SSA is performing a cost/benefit analysis to determine whether to use tax refund offset to collect delinquent SSI debts.	193.7
Tax Equity and Fiscal Reform Act Outpatient Limitation: Expand the list of procedures subject to the outpatient limitation and apply the limitation to physician services in additional settings. (CIN: A-07-86-62041; CIN: A-05-91-00006)	The HCFA does not concur with the recommendation. The HCFA will evaluate payment levels for appropriate physician services furnished outside the office setting. If physician payment reform has failed to make the appropriate distinction based on site of service, the Department will consider legislative options.	170
Reduce Payments for Intraocular Lenses: Medicare should pay a flat $150 for all intraocular lenses (IOLs). (OEI-07-89-01664)	The HCFA is currently prohibited by law from reducing the IOL reimbursement rate below the $200 cap until 1993.	169
MSP - Effectiveness of Current Procedures: The HCFA should require contractors to match their private health insurance data with Medicare files to avoid inappropriate MSP payments. (OEI-07-90-00761)	The HCFA is currently prohibited from requiring Medicare contractors to match their health insurance data with Medicare files to identify MSP situations.	143.7
Expand Mandatory Tip Reporting Requirements: Expand the requirements for mandatory reporting of tip income to include other types of businesses where tipping is a common practice. (CIN: A-09-89-00072)	The Treasury is conducting an in-house study before considering whether to endorse the proposal.	134
Recover Value Lost to the Trust Funds from Past Due Debts: Institute a policy change to allow recovery for each delinquent overpayment at the higher of the interest income lost to the trust funds or the value lost to the trust funds due to inflation. (OAI-03-88-00680)	The SSA disagrees with the proposed method of recovery in the absence of a clear legislative mandate. The OIG remains convinced that the recommendation is appropriate.	112

OIG Recommendation	Status	Savings in Millions
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 ACF concurred with the recommendation. In lieu of a regulatory change, draft legislation was sent to the Congress in February 1992 proposing a statutory change. The 102nd Congress did not act on this legislation prior to adjournment.	$110
Extracorporeal Shock Wave Lithotripsy: Apply inherent reasonableness factors to charges for extracorporeal shock wave lithotripsy (ESWL). (CIN: A-09-89-00082)	Although OBRA 1990 reduced payments for ESWL, these procedures are still overpriced.	110
Outpatient Surgery - Cataract Quality of Care Costs and Unnecessary Endoscopies: The HCFA should reduce the incidence of payments for medically unnecessary and poor quality cataract surgeries, upper gastrointestinal endoscopies and colonoscopies through a combination of efforts by PROs and carriers, including targeted review of certain providers. (OEI-09-88-01005; OEI-09-88-01006)	Contingent upon the approval of the fourth scope of work, PROs will review a 5 percent sample of certain outpatient surgeries in ambulatory surgical centers for medical necessity and quality of care.	106.1
Recover Medicare Funds From Terminated Pension Plans: Recover Medicare's share of pension asset reversions from terminated pension plans. (CIN: A-07-90-00262; CIN: A-07-88-00134)	The HCFA and OIG have mutually agreed to seek a joint HCFA/OIG Office of General Counsel opinion on the propriety of OIG's recommendations to recover Medicare funds from terminated pension plans, both retrospectively and prospectively.	92
Conventional Eye Wear: Exclude conventional eye wear from Medicare coverage for beneficiaries receiving IOL implants. (CIN: A-04-88-02038)	The OBRA 1990 limits coverage to one pair of eyeglasses following cataract surgery with an IOL implant.	72
Maryland Statewide Cost Allocation Plan: The State of Maryland should resubmit the statewide cost allocation plan with the questionable costs excluded and with expanded descriptions of cost center services. (CIN: A-03-92-00451)	Although the State did not agree with the recommendations, the Department's Division of Cost Allocation did. Negotiations are in process.	54.1
Use Credit Reporting Agencies to Help Collect Debts: The SSA should seek legislative authority to use credit reporting agencies to locate debtors and report certain delinquent debtors to credit reporting agencies. (CIN: A-03-89-02610)	The SSA will assess the utilization of income tax refund offset before considering whether to seek authority to use credit reporting agencies.	52.4

OIG Recommendation	Status	Savings in Millions
Recover Medicare Payments Made for Beneficiaries Eligible for Other Government Health Insurance: Recoup part of unauthorized Medicare payments made on behalf of the Uniformed Services Treatment Program members. (CIN: A-14-90-00325)	The HCFA agreed to the recommendation. The OIG will verify the effectiveness of HCFA's corrective action plan.	$50
Repay Mortgages Early: Use trust fund money to liquidate the remaining mortgage balances on three program service center buildings. (CIN: A-09-88-00131)	The SSA reduced the mortgages, but has not paid them off. The tight budget of the last few years has not provided ample discretionary funds to pay off the mortgages, nor will any be available in the foreseeable future. The SSA has closed its tracking on this issue.	48
Inpatient Psychiatric Care Limits: New limits should be developed to deal with the high cost and changing utilization patterns of inpatient psychiatric services. (CIN: A-06-86-62045)	There is no legislative proposal addressing this issue in the FY 1993 President's budget.	48
Improve Child Support Enforcement Collection Process: The ACF should identify absent parents who work for the Federal Government and improve the child support collection process. (CIN: A-12-89-00154)	The ACF regional offices are conducting program reviews which include looking at immediate wage withholding. A guide to wage withholding for employers describing their responsibilities has been developed and distributed.	46.6
First Month of Eligibility: The SSA should submit a legislative proposal establishing a consistent definition of eligibility for age-based retirement and survivor payments. (OEI-12-89-01260)	The SSA did not agree with the recommendation and thought that it should be supported with a stronger rationale.	40
Monitored Anesthesia The HCFA should study the appropriateness of paying the same amount for monitored anesthesia care and general anesthesia in view of the fact that other insurers are more restrictive than Medicare. (OEI-02-89-00050)	Further discussions are planned with HCFA regarding this recommendation.	28
Overpayments to SSI Recipients: Nursing homes should be required to report to SSA admissions of SSI recipients within 1 day after they are admitted. (CIN: A-07-91-00376)	The SSA generally concurred but believed that HCFA should develop and issue regulations. The HCFA did not concur.	22
Age Attainment: The SSA should define attainment of age as occurring on one's birthday instead of following the common law that age attainment occurs on the day before a person's birthday. (CIN: A-09-89-00073)	The SSA did not concur since it believed administrative costs would outweigh savings and that short term savings would be offset by long range costs.	21.4

OIG Recommendation	Status	Savings in Millions
Halt Medicaid Payments for Less than Effective Drugs: Work with FDA to provide to all States periodic lists of less than effective drugs identified by FDA. (CIN: A-03-89-00320)	The OIG has been informed that on March 12, 1992, HCFA and FDA entered into an intra-agency agreement (IAA) under which both agencies agreed to share, on a periodic basis, information on less than effective and identical, related and similar drugs. The HCFA anticipates that the first list resulting from the IAA will be provided to the States by September 30, 1992.	$16
Develop Cost Standards for Disability Determination Services: The SSA should adopt the reimbursement method for laboratory fees used by Medicare for use by the Disability Determination Services (DDSs). (OAI-06-88-00820)	A new draft notice of proposed rulemaking has been developed which would apply Medicare laboratory fee schedules for use by DDSs. The SSA will defer action however, until gaining a year's experience using the new consultative examination regulation which was published in the Federal Register on August 1, 1991.	15.3
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; CIN: A-03-92-00451)	The ACF agreed and submitted a legislative proposal. The ACF is planning to resubmit the proposal as part of its FY 1994 legislative package.	14.4
Improve Management Efficiency of Head Start's Performance Evaluations and High Risk Determinations: The ACF should establish and implement improved procedures to assure that the extent of an agency's compliance with performance standards is determined and used as a basis for establishing uniform ratings for agencies. (CIN: A-04-90-00009)	The ACF has indicated their agreement with OIG's conclusion that the identified weaknesses are a significant management concern.	14.3
Cash Management by State Child Support Agencies : The States should take steps to increase the accuracy of information recorded; increase the efficiency of the enforcement of child support; and decrease the chance of lost or misappropriated collections. (CIN: A-12-91-00018)	The ACF generally concurred with the recommendations and indicated that increased efforts would be made to promote adequate internal controls at the State level.	13.8

OIG Recommendation	Status	Savings in Millions
Unreported Worker's 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 worker's 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
Improve Reclamation Procedures: Deficient Treasury procedures related to reclaiming check payments involving unauthorized endorsements caused losses to the trust funds. The SSA should negotiate with Treasury for more direct involvement in the reclaiming of checks. (CIN: A-04-87-03005)	The SSA agreed that there were problems in the reclamation process, but stated that SSA lacks the authority to correct the problem. The SSA suggested that OIG report this to an oversight body.	10.5
Modify Earnings Enforcement Process: The SSA should modify its earnings enforcement operation to include late posted earnings reports, suspense reinstatements, and earnings adjustments and corrections. (CIN: A-13-89-00031)	The SSA's automated data processing (ADP) plan now contains initiatives to include late posted earnings, suspense reinstatements, and earnings adjustments and corrections. However, SSA estimates actual savings will be much lower than OIG's projections.	10
Cost of Research at Colleges and Universities: The Public Health Service (PHS) should establish $120,000 as the maximum salary rate for federally supported research at colleges and universities. (CIN: A-12-89-00128)	The National Institutes of Health (NIH) agreed with the recommendation and the FY 1990 Appropriations Act was amended to specifically establish $120,000 as the ceiling salary for individuals involved in federally sponsored research supported by funds from NIH and the Alcohol, Drug Abuse and Mental Health Administration. However, subsequent appropriations acts and NIH's program manuals do not address this issue.	10
Eliminate a Separate Carrier for Railroad Retirement Beneficiary Claims: Discontinue the use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)	The HCFA is currently evaluating OIG's recommendation.	9.1
Revise Criteria for Waiving Overpayments: The SSA should pursue a regulatory or statutory change in waiver criteria to eliminate waivers for persons under age 59 so that it could pursue collection when and if the individual developed an ability to repay. (CIN: A-05-90-00034)	The SSA disagreed with OIG's recommendation.	9

OIG Recommendation	Status	Savings in Millions
Collect Nonresident Alien Taxes: Use automated systems to identify and collect alien taxes involving benefit payments for retroactive periods. (CIN: A-13-90-00041)	The SSA's ADP plan now includes a project to address this issue.	$7.7
Abandoned Reclamations: The SSA and Treasury need to improve policies and procedures regarding abandoned reclamations. (CIN: A-04-89-03021)	Several problem areas between SSA and Treasury are still in need of negotiation and resolution, including abandoned reclamations.	7.7
New Cards for New Brides: The SSA should actively pursue the acquisition of computerized marriage records from States having this capability. (OEI-06-90-00820)	The SSA agreed with this concept, but will study quantitative and cost issues before agreeing to implement.	5.5
User Fees for Attorneys: Determine administrative costs for processing attorney fee payments and assess user fees. (CIN: A-13-90-00026)	The SSA rejected this proposal since it believes it needs legislative authority.	5
Zip Code Software: Acquire commercial zip code software which will verify and correct address records, attach carrier route and zip+4 codes to address field, etc. (CIN: A-13-87-02656)	The SSA began using the 9-digit zip code for benefit check mailings and further savings may be achieved.	3
Intercept Direct Deposit Transfer to Deceased Beneficiaries: The SSA shonld arrange for interception of erroneous direct deposit payments made to beneficiaries who died after the 23rd of the month. (CIN: A-13-89-00037)	The SSA rejected OIG's proposal.	2.9
Mail Practices: The SSA should use third-class bulk mailing where feasible. (CIN: A-13-89-00038)	The SSA did not agree to use third-class mail for some recommended mailings, but plans to conduct a study to determine its feasibility for other mailings.	2.5
Recovery of Overpayments in the Aid to Families with Dependent Children Program in Florida: The State of Florida should establish and implement improved controls and procedures to ensure that financial reports of overpayments in the Aid to Families with Dependent Children program submitted to ACF are accurate and snpported by State accounting records. Also, Florida should strengthen procedures and practices to ntilize all available methods to ensure increased recoveries of overpayments. (CIN: A-04-91-00015)	The State generally agreed with the recommendations.	2

OIG Recommendation	Status	Savings in Millions
Reimbursement for Multiple Source Prescription Drugs: The HCFA should review its prices on the upper limit list for possible savings. (OEI-03-91-00470)	The HCFA has agreed to review its calculations and will automate the process of calculating upper price limits.	$2
Recording, Maintaining and Reconciling Sustained Audit Disallowances: The Regional Administrative Support Center in Region IV should improve its controls over recording, maintaining and reconciling audit disallowances. (CIN: A-04-91-00001)	The Office of the Assistant Secretary for Management and Budget generally agreed with the recommendation and corrective action is nnderway.	1.5
Discontinue Payment for Broken Medical Appointments: The SSA should uot pay State agencies for consultative exams that are canceled or otherwise not kept. (CIN: A-01-87-02004)	Thc SSA has deferred action until after a ycar's experience with the new consultative examination regulations has been acquired.	0.9

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

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

OIG Recommendation	Status
False Evidence Submitted to Obtain a Social Security Number: The SSA should systematically identify all original Social Security number (SSN) applications from U.S. born applicants over age 24 and require a second level review of such applications. (OEI unnumbered management advisory report, October 1987)	The SSA conducted a nationwide study of selected SSN applications to validate the results of an earlier regional study. A report of the study was issued in April 1992. Based on the report, SSA is considering implementing stronger controls over the issuance of original SSNs to U.S. born applicants over the age of 18.
Social Security Payments for Vocational Rehabilitation: The SSA should require the States to establish a formal mechanism to screen and enroll those SSA clients who show the greatest potential for successful rehabilitation. (OAI-07-89-00950)	The SSA is reviewing the entire area of vocational rehabilitation referral, and has established a task force with the Rehabilitation Services Administration to jointly develop a framework for better screening mechanisms and a more effective referral process.
Improvements Needed in Processing Controls for Retirement, Survivors and Disability Insurance Diary Actions: The SSA should emphasize to staff the importance of completing diaried actions, incorporate standards into managers' merit pay plans and perform internal control reviews after the proposed automated diary system is completed. (CIN: A-13-88-00024)	The SSA has issued regular reminders regarding prompt processing; rejected OIG's proposal to include items in merit pay plans; and incorporated plans to evaluate the effectiveness of the new system.
Suspended Payments Need to be Resolved Timely: The SSA should, in direct deposit cases where the beneficiary is placed in suspense status, institute stronger controls to ensure that timely action is taken to resolve these suspensions so that SSA can either terminate or reinstate payments. (CIN: A-13-89-00027)	The SSA agreed to proceed with policy and procedural changes.
Modernized Claims System Needs Controls to Compensate for Lack of Separation of Duties: The SSA needs to implement controls in the modernized claims system since employees are authorized to take, develop, adjudicate and effect payment on a claim without any independent review or compensating controls. (CIN: A-13-89-00025)	The SSA generally agreed and has proposed corrective action.
Undeliverable Notices Need to be Better Controlled: The SSA needs better controls to make the undeliverable notice process an effective tool for detecting unreported deaths. (CIN: A-13-88-00035)	The SSA agreed to make improvements.
Representative Payee Procedures: The SSA should review accountability reports to identify high risk cases and verify the information reported, and should also verify a random number of reports. (CIN: A-07-90-00266)	The SSA performed a study to determine high risk representative payees and developed plans to perform other verifications as additional resources permit.
Improved Controls Necessary in Field Office Processing of Death Alerts: The SSA should ensure that field offices comply with instructions for processing death alerts and issue monthly reports to management on cases pending over 60 days for beneficiaries in current pay. (CIN: A-09-90-00044)	The SSA agreed to remind field offices of procedures and to more closely monitor compliance. A systems capability to have on-line information is under consideration.

OIG Recommendation	Status
Improved Controls Necessary in Field Office Processing of Death Alerts: The SSA should provide for a separation of duties in death alert processing at field offices since staff are also involved in other claims data. (CIN: A-09-90-00044)	The SSA generally agreed to improve controls.
Further Improvements Necessary to 800 Telephone System: The SSA 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 did not support the other recommendations.
Review of HCFA's Cost Allocation System for Fiscal Year 1988: The Assistant Secretary for Management and Budget (ASMB) should provide HCFA with guidance on how to refine its cost allocation system and periodically monitor the system to ensure that it is being properly implemented and maintained. The HCFA should establish a system to document actual central office staff activities; distribute administrative costs to the trust funds and the general fund on the basis of actual employee activity; and identify costs contained in the administrative cost pool as either direct or indirect. (CIN: A-04-89-02036)	The HCFA and ASMB agreed with the recommendation. The cost allocation system has been revised and is being tested.
Follow-up to the General Accounting Office's Audit on Use of Medicaid Data to Monitor Controlled Substance Diversion: The HCFA should work with the Department of Justice (DOJ) to identify ways in which the Medicaid management information system (MMIS) controlled substance data can be used by regulatory, licensing and law enforcement agencies. It should also make information obtained from OIG's computer program for MMIS controlled substances data available through DOJ to law enforcement, regulatory and licensing agencies outside the Medicaid program. (CIN: A-14-90-02047)	The HCFA has developed a corrective action plan and implementation is underway.
Indian Health Service Contracting Practices: The Indian Health Service should implement post-award monitoring of contract compliance and document all contract compliance evaluations; establish post-award monitoring performance standards for all project officers; establish a process to ensure that project officers are provided with evaluations and data on a contractor's performance; and establish a process for the review and approval of public vouchers by the project officer. (CIN: A-06-89-00066)	The Oklahoma City Area Office concurred with all of OIG's proposals. Corrective actions were completed by PHS in all areas except for the establishment of a process to ensure that project officers are provided with evaluations and data on a contractor's performance. The PHS stated that a written policy is being developed to ensure that project officers receive this information.
Commissioned Corps Identification Cards: The OASH should immediately perform a review of internal controls over the issuance of Commissioned Corps identification cards. (CIN: A-15-91-00010)	The PHS has scheduled the internal control reviews of card issuance for Fiscal Year (FY) 1993.

OIG Recommendation	Status
New Cards for New Brides: The SSA should target its public information efforts to newlyweds. (OEI-06-90-00820)	The SSA is implementing this recommendation by developing public service advertisements, mailing posters to State Bureau of Vital Statistics offices and field offices for display in the community, and rewriting an employee pamphlet.
Project Clean Data: The SSA should develop, maintain and widely disseminate a software package for detecting invalid SSNs patterned after Project Clean Data. (OEI-12-90-02360)	The SSA agrees with the objective but believes greater use of the enumeration verification system would be more effective. The SSA will conduct a pilot test in FY 1993 to assess employer interest and use.
Availability of Representative Payees: The SSA should correct coding problems to facilitate ongoing monitoring of beneficiaries who require representative payees. (OEI-02-89-01420)	The SSA agreed and is taking corrective action.
Drug Addicts and Alcoholics: The SSA should work with PHS and HCFA to develop clearer definitions for drug addiction and alcoholism status, treatment and successful rehabilitation. (OEI-02-90-00950)	The SSA agreed that significant improvements are needed in this process and identified the cooperative efforts that are planned to make the indicated improvements.
Delayed Notices of Planned Action: Because of the potential cost implications of field office failure to maximize opportunities for overpayment avoidance by using manual notices of planned action in the Supplemental Security Income (SSI) program, OIG recommended that SSA initiate a review to determine the extent of the problem. (OEI-04-90-02160)	The SSA had already planned a comprehensive review of the same subject. The OIG will defer its actions until after the results of SSA's studies are compiled.
Carrier Maintenance of Provider Nnmbers: The HCFA should establish adequate safeguards for detection of abusive providers. (OEI-06-89-00870)	The HCFA is taking steps to address the problems identified in the report, which OIG will monitor.
Independent Physiological Laboratories: The HCFA should increase its monitoring of independent physiological laboratories (IPLs), including determining what testing is appropriate in IPLs, and establishing a regulatory or certification program to promote stronger quality assurance in IPLs. (OEI-03-88-01400)	Although it will not pursue the actions outlined in the recommendations, HCFA is studying data from Medicare carriers and its regional offices to determine if it is necessary to regulate or set standards for these laboratories.
Certified Wages: The SSA should take prompt action to certify wages for tax years after 1978 by using as a basis its own wage records or seeking legislation to change the basis. (CIN: A-13-91-00210)	The SSA sought the views of the General Accounting Office, which provided options for consideration. The SSA plans to resolve this issue quickly.
Illegal Work Activity and Duplicate SSN Cards Associated with Deported Aliens: The SSA should implement a systems control to identify earnings reported to deported aliens, refer this information to the Immigration and Naturalization Service and prevent issuance of duplicate SSN cards to deported aliens. (CIN: A-05-88-00070)	The SSA generally concurred and agreed to develop systems controls.

OIG Recommendation	Status
Improvements Needed in Processing Delayed Claims: The SSA should follow procedures and better utilize its claims control system to prevent claims from remaining in delayed status for unreasonable periods. (CIN: A-06-88-00037)	The SSA generally agreed and stated that changes have been made or are in the process of being made.
Better Controls Would Help Post More Earnings to Wage-Earners' Accounts: The OIG made 29 recommendations which, if implemented, should substantially improve SSA's capability for correcting name and SSN errors for reported earnings. (CIN: A-13-89-00040)	The SSA agreed with most of the recommendations. It has started to implement some of these as well as other recommendations made by its own work group convened to explore wage reporting problems.
Financial Management: The SSA needs to improve controls relating to financial management in the SSI program. (CIN: A-13-90-00036)	The SSA did not concur.
Debt Management: The SSA should expedite the development and implementatiou of its new debt management system. (CIN: A-13-91-00210)	The SSA agreed. It has made considerable progress with phased implementation.
Payments to Vocational Rehabilitation Agencies: To prevent making reimbursements without adequate supporting documentation, SSA should continue to review minimum documentation criteria, identify overpayments and pursue collection. (CIN: A-13-91-00210)	The SSA has implemented a process to evaluate the adequacy of documentation and to identify overpayments with individual claims.
Work Incentives for Disabled SSI Recipients: The Commissioner of SSA should take the lead in organizing efforts to identify and study ways to encourage employers to hire severely disabled workers. (OEI-09-90-00020)	The SSA believes that coordination of agency efforts is a good idea, but that it should not assume the lead for such a Governmentwide effort. However, SSA has initiated several pilots to test different approaches to encourage the disabled workers to return to work.
National Practitioner Data Bank - Controls over Authorized Agents: The PHS should revise Data Bank forms and procedures in order to strengthen controls over authorized agents. (OEI-12-90-00530)	The PHS has prepared, in draft form, revised guidelines for dealing with authorized agents.
Review of Internal Controls Over the Third Party Draft System in the Regional Administrative Support Ceuter, Region IV: The ASMB should take a number of actions to increase oversight of the third party draft (TPD) system nationwide and implement internal controls that assure that TPDs are controlled in accordance with applicable laws aud regulations. (CIN: A-04-91-00009)	The ASMB agreed with OIG's recommendations except the one proposing that certain items should be paid by Treasury rather than by TPD's. The ASMB will evaluate the TPD system and institute required improvements.

OIG Recommendation	Status
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 non-profit 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.
Department's Health Benefits Program: The Assistant Secretary for Personnel (ASPER) should: require performance of an internal control review of the health benefits program; confirm controls to be sure the Department pays the employer's share of insurance premiums for every enrolled employee; provide central oversight of the reconciliation process; and require servicing personnel offices to inform carriers of all terminations and changes in coverage in a timely manner. (CIN: A-12-91-00008)	The ASPER is taking corrective action.
Child Support Enforcement Payments - Financial and Program Implications: The ACF should consider the following options for legislative changes: limit the payments of incentives to a State's cost; eliminate incentive payments to performing States; and reduce the Federal matching rate in child support enforcement costs to 50 percent to increase States' financial participation in the program. (CIN: A-09-91-00147)	The ACF agreed that there is a need to modify the incentive formula. However, it had concerns about the viability of the recommended options to reduce Federal costs.
Controls to Prevent or Detect Unauthorized Alteration of Timecards: The ASPER should provide training and reemphasize to all timekeepers and leave approving officials (LAOs) the necessity to: compare earnings and leave statements with administrative time and leave records in order to identify discrepancies; maintain documentation to support timecards; separate duties regarding timecard processing; designate alternate timekeepers; require that timecard processing duties and controls be included as a critical element in performance plans for timekeepers and LAOs; and monitor adherence to prescribed timekeeping requirements. (CIN: A-12-90-00006)	The ASPER concurred with all the recommendations, except that timecard duties be included as a critical element in LAOs' performance plans. The OIG continues to believe that LAOs have direct responsibility for the performance of the timekeepers, who have accountability for billions of dollars in departmental resources. Monitoring will be done through improved internal control reviews.

OIG Recommendation	Status
Regional Offices' Time and Attendance Recording and Reporting Practices: Each departmental component should: instruct supervisors on their responsibilities to review time sheets, particularly regarding any violation of core time to ensure the accuracy of hours worked and reported; provide training to timekeepers and supervisors; monitor alternate work schedule time and attendance system implementation; and ensure compliance with the Comptroller General's policy and procedures. (CIN: A-01-90-02511)	The ASPER generally concurred with the recommendations and advised that corrective actions were underway. Monitoring will be done through improved internal control reviews.
Low Income Home Energy Assistance Program: The ACF should: continue its efforts to seek a legislative change which would explicitly permit States to consider other energy subsidies in determining Low Income Home Energy Assistance Program benefits and coordinate with the Department of Housing and Urban Development and the Farmers Home Administration to ensure that the change is effective. (CIN: A-04-90-00005)	The ACF agreed and submitted a legislative proposal. The ACF is planning to resubmit the proposal as part of its FY 1994 legislative package.
Ability of Employers to Effectively Implement Wage Withholding: The ACF should consider: requesting all jurisdictions within the United States to use standardized formats and language in court order forms among State Child Support Enforcement (CSE) agencies, and requiring the use of standardized forms and covers when issuing legal processes for child support to employers; requiring courts and State CSE agencies to limit data requested from employers, stop requesting the employer to hold monies after the garnishment is made, and to make child support garnishment orders continuous, until the court deems that an adjustment needs to be made; establishing an electronic fund transfer system capable of expediting the payment process; notifying courts and other authorities to promptly deliver legal processes for child support to appropriate addresses and officials for employers; and notifying States of their obligation to serve court orders, and the availability of the Parent Locator System. (CIN: A-12-91-00016)	The ACF advised that it is working with the States and taking action as appropriate.
Community Food and Nutrition Program Discretionary Grants: The ACF should monitor grantees' progress reports to ensure that they address the grants' objectives; require project officers to take appropriate action when satisfactory progress is not made; monitor financial reporting more closely; suspend or terminate funding when grantees are nonresponsive and/or violate grant terms and conditions; and update their corrective action plan for Office of Community Services (OCS) discretionary grants. (CIN: A-09-90-00148)	The ACF generally concurred with the findings and recommendations and advised that corrective action was being taken.

OIG Recommendation	Status
Discretionary Grants under the Rural Housing and Rural Facilities Program: The ACF should require the Office of Financial Management and OCS to: clarify and reemphasize program eligibility requirements for communities and individual recipients; instruct applicants as to the limitations of using Federal funds for their public/private contributions; monitor financial reporting more closely to assure that required reports are submitted and unexpended Federal funds are refunded timely; assure that technical reports address the status of each major objective of the grant, and that program managers evaluate the progress being made and promptly take any necessary actions. (CIN: A-12-90-00042)	The ACF generally concurred with the findings and recommendations and advised that corrective actions were being taken.
Federal Financial Assistance for the Aid to Families with Dependent Children, Foster Care and Adoption Assistance Programs: The ACF, working jointly with HCFA, should consult with the Congress on the distribution of Federal assistance under the Federal medical assistance percentage (FMAP) formula. Legislative modifications could be made to the formula which would change distribution and cost outcomes, bringing about less variation among the States in terms of program coverage, payments and limitations, providing more consistent treatment of Americans in poverty and moderately reducing the escalation of program costs. (CIN: A-06-90-00056)	The ACF generally concurred with the recommendations.
Hough Area Development Corporation: The ACF should assure that its current efforts to improve the grants process address the type of deficiencies found in the administration of the Hough Area Development Corporation (HADC) grants. Measures need to be taken to use these properties in a way to help promote the economic and social welfare of the Hough community. (CIN: A-05-90-00051)	The ACF is upgrading the grant solicitation, selection, monitoring and close-out process. Controls are being upgraded to ensure that required audits are performed and Federal interest in property is better protected. The HADC board has been reconstituted and OCS has taken action to transfer the property.

APPENDIX D

Congressional Hearings

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

Date	Topic	Congressional Committee/Subcommittee
January 29, 1992	Audits of Indirect Costs at Colleges and Universities	House Subcommittee on Oversight and Investigations, Committee on Ways and Means
February 28, 1992	Access and Disclosure of Social Security Information	Senate Subcommittee on Social Security and Family Policy, Committee on Finance
March 18, 1992	Hospital Closures and Medicare Credit Balances	House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce
March 26, 1992	Access to Care in the Medicaid Program	House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce
April 1, 1992	Fiscal Year (FY) 1993 Appropriations	House Subcommittee on Labor and Health and Human Services, Education and Related Agencies, Appropriations Committee
May 7, 1992	Health Care Fraud and Abuse	House Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations
May 14, 1992	Fraudulent and Misleading Advertisements	House Subcommittee on Social Security and the Subcommittee on Oversight, Committee on Ways and Means
May 16, 1992	Home Health Agency Fraud	Senate Budget Committee
May 21, 1992	Health Care Fraud in the Medicare Program	House Subcommittee on Medicare and Long-Term Care, Select Committee on Aging
June 9, 1992	FY 1993 Appropriations	Senate Subcommittee on Labor, Health and Human Services and Education, Appropriations Committee
July 28, 1992	Health Care Fraud	Senate Judiciary Committee
July 30, 1992	Native American Alcohol aud Substance Abuse Programs	Senate Select Committee on Indian Affairs

Highlights of OIG Testimony

Audits of Indirect Costs at Colleges and Universities

The House Subcommittee on Oversight and Investigations, Committee on Ways and Means, held a hearing to discnss OIG's audits of indirect costs charged to research grants awarded to colleges and universities. The OIG testimony detailed the final results of audit work at 14 colleges and nniversities. Additionally, OIG discnssed its progress and continned efforts in reviewing indirect costs and insuring compliance with recent changes to the Office of Management and Budget Circnlar A-21, Cost Principles for Ednca tional Institutions.

Access and Disclosure of Social Secnrity Information

The Senate Snbcommittee on Social Security and Family Policy, Committee on Finance, invited OIG to testify concerning access to and disclosure of confidential information at the Social Security Administration (SSA). The OIG focused its remarks on its responsibility for safeguarding confidential information, and made several legislative and management improvement recommendations to protect the accessibility and integrity of SSA's data bases.

Hospital Closures and Medicare Credit Balances

At this hearing before the Honse Snbcommittee on Oversight and Investigations, Committee on Energy and Commerce, OIG discussed hospital closnres and Medicare credit balances. The OIG submitted reports addressing both of these issues. With regard to hospital closures, OIG fonnd that 56 hospitals closed in 1990, 20 fewer than in 1989. The hospitals closed were small and had low occnpancy, few patients were affected, and most had emergency and inpatient medical care available within 20 miles. Concerning credit balances, OIG found that the chief causes of these Medicare overpayments are duplicate billings to Medicare, services being reimbursed by another insurer as well as Medicare, and services being billed but never rendered. The OIG offered several recommendations and is working with the Health Care Financing Administration (HCFA) to recover these overcharges.

Access to Care in the Medicaid Program

This hearing at the House Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, concerned access to quality health care services for Medicaid recipients. The OIG testified and released three studies related to this issne: "Use of Emergency Rooms by Medicaid Recipients," which found that Medicaid recipients continued to utilize emergency rooms for nonurgent care largely because of lack of access to primary health care; "Medicaid Hassle: State Responses to Physician Complaints," which discnssed States' responses to physician complaints about Medicaid's administrative burden; and "Quality Assurance in Medicaid HMOs," which discussed the standards used by States to evaluate quality of care in Medicaid health maintenance organizations.

Health Care Fraud and Abuse

The OIG testified before the House Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, and discussed significant issues pertaining to the Department's health care programs and the issue of health care fraud. The OIG discussed the coordinated effort involved in investigating health care fraud and outlined several current issues that need further attention, some of which were: durable medical equipment, reimbursement manipulation, provider numbers, kickbacks and laboratory fraud. Additionally, OIG cited its Cost Savers and Program and Management Improvement handbooks and presented numerous recommendations to combat health care fraud.

Fraudulent and Misleading Advertisements

The House Subcommittee on Social Security and the Subcommittee on Oversight, Committee on Ways and Means, held this hearing to discuss fraudulent and misleading advertising that seeks to misuse the official names and symbols, emblems or names in reference to SSA and Medicare. The OIG presented several cases where organizations used these terms and symbols to foster an erroneous impression that items or services have been approved, endorsed or authorized by the Federal government. Also, OIG proposed for consideration recommendations to change Section 1140 of the Social Security Act to aid OIG in its enforcement of the law.

Home Health Agency Fraud

This hearing by the Senate Budget Committee concerned home health care fraud. The OIG testimony referenced several categories of fraud which occur throughout the United States. This fraud includes: cost reporting fraud, excessive services or services not rendered, use of unlicensed staff, falsified plans of care and forged physician's signatures, kickbacks, etc. The OIG described numerous recommendations it has made to HCFA concerning home health care fraud and quality of care, and cited some of the work underway by HCFA.

Health Care Fraud in the Medicare Program

The House Subcommittee on Medicare and Long-Term Care, Select Committee on Aging, held a hearing to discuss health care fraud in the Medicare program. The OIG's testimony focused on its investigations of health care fraud and its coordination and work with the National Health Care Antifraud Association, Department of Justice, Federal Bureau of Investigation, State Medicaid Fraud Control Units and private health insurers. The OIG outlined several current issues and offered recommendations to solve some of the problems that need further attention. Some of the issues discussed were: durable medical equipment, kickbacks, home health agency fraud, reimbursement manipulation and credit balances.

Health Care Fraud

This Senate Judiciary Committee hearing discussed fraudulent practices in the health care industry. The OIG described several cases of fraudulent activity and described OIG's work with the Department of Justice. Additionally, OIG expressed support for legislation that would address the need for more stringent penalties for health care fraud; expand the Federal mail fraud statute; provide authority for Federal law enforcement agencies to seize and forfeit ill-gotten gains resulting from health care fraud; and provide greater resources for investigative agencies and prosecutors.

Native American Alcohol and Substance Abuse Programs

The OIG testified before the Senate Select Committee on Indian Affairs, presenting the findings of its review of the Indian Health Service's (IHS') alcohol and substance abuse programs. The OIG testimony discussed, among other items, the progress being made by IHS and the Bureau of Indian Affairs (BIA) toward better coordination of their respective programs. The OIG reported that IHS and BIA have not achieved the level of coordination envisioned by the Congress, and because of this limited coordination, the continuum of care and a holistic approach for treating Indian alcohol and substance abuse is being undermined. The OIG recommended that IHS and BIA review, update, and streamline their Memorandum of Agreement.

APPENDIX E

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 $1.8 million.

[2]Included in the reports issued during the period are questioned costs totaling $77,157 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-05-89-00101 Illinois Department of Public Aid: $19.3 million in disallowed costs were subsequently allowed.

CIN: A-04-90-00020 State of North Caroliua: $5 million in disallowed costs were subsequently allowed.

Not detailed are additional revisions to previously reported decisions totaling $.9 million.

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

A. Resolution of the following reports will be through the departmental conflict resolution process:

CIN: A-07-90-00262 Review of Asset Reversions from Pension Plan Terminations Occurring After the Implementation of the Prospective Payment System, May 1990, $92,000,000

CIN: A-07-89-00134 Medicare is Losing Millions of Dollars from Terminations of Pension Plans, January 1990, $27,600,000

CIN: A-03-90-00232 Maryland Medicaid Eligibility Review, September 1991, $1,202,060

CIN: A-03-91-15226 Allegheny County Human Resources Development Commission, May 1991, $168,121

CIN: A-05-90-05159 Red Lake Band of Chippewa Indians, February 1990, $52,514

CIN: A-04-92-17411 Franklin Vance Warren Opportunity Inc., January 1992, $52,050

CIN: A-06-92-18037 Pine Belt Multi Purpose Agency, Inc., March 1992, $3,996

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

CIN: A-12-91-00018 Cash Management Practices by State Child Support Agencies, August 1991, $13,200,000 (Related recommendation of $13,800,000 outstanding on Table II)

CIN: A-05-91-00050 Community Mental Health Construction Grant - Phase 1, October 1991, $6,823,979 (Related recommendation of $235,000 outstanding on Table II)

CIN: A-03-91-00551 Pennsylvania Foster Care, January 1992, $6,786,678

CIN: A-02-92-16749 City of San Juan Puerto Rico, December 1991, $6,678,673

CIN: A-03-89-00046 Maryland Blue Cross/Blue Shield Part B Administrative Costs, September 1991, $5,996,278

CIN: A-05-92-00026 Associated Insurance Co., February 1992, $2,530,409

CIN: A-02-91-01006	Blue Shield of Western New York Medicare Administrative Costs, September 1991, $2,379,239
CIN: A-05-90-00090	Blue Cross Blue Shield Administrative Costs Contract Audit, November 1990, $1,825,677
CIN: A-01-90-00509	Medicare Secondary Payer Review-Aetna, February 1992, $1,471,233
CIN: A-03-90-00051	Maryland Blue Cross/Blue Shield Part A Administrative Costs, August 1991, $1,438,414
CIN: A-05-92-16405	Indiana Department of Human Services, October 1991, $1,377,474
CIN: A-03-92-17195	Virginia Department of Social Services, January 1992, $1,171,905
CIN: A-07-91-00413	Union Sarah Economic Development Corp., August 1991, $961,000
CIN: A-02-92-16422	Office of Economic Opportunity, October 1991, $741,558
CIN: A-04-91-05172	State of Florida, December 1991, $527,316
CIN: A-03-92-17153	Virginia Department for Rights of Disabled, January 1992, $323,006
CIN: A-05-91-05017	Indiana Department of Human Services, October 1990, $292,920
CIN: A-05-91-00064	Delaware Blue Cross Administrative Costs, October 1991, $211,422
CIN: A-04-91-06641	Clark Atlanta University, November 1991, $197,253
CIN: A-10-92-00005	WPS Administrative Cost Audit, February 1992, $179,891
CIN: A-02-91-01021	Cooperative Medicare Administrative Costs, September 1991, $118,682
CIN: A-03-91-14545	Commonwealth of Pennsylvania, December 1990, $87,922
CIN: A-06-92-17478	Santo Domingo Pueblo, January 1992, $74,803
CIN: A-03-91-03324	The Circle, Inc., September 1991, $68,879
CIN: A-03-91-02002	Delaware Blue Cross Administrative Costs, October 1991, $66,858
CIN: A-06-91-06844	Arkansas Department of Human Services, October 1991, $66,106
CIN: A-06-91-00067	Hispanic Multi-Purpose Service Center, January 1992, $40,634
CIN: A-07-91-14263	State of Missouri, April 1991, $25,431
CIN: A-07-92-17150	Iowa Protection and Advocacy Services, January 1992, $22,960
CIN: A-04-90-04009	Laboratory Animal Breeders, July 1990, $21,274 (Related recommendation of $224,668 on Table II)
CIN: A-09-91-05313	American Samoa Government, April 1991, $14,504
CIN: A-07-92-17979	Santee Sioux Tribe of Nebraska, February 1992, $6,409
CIN: A-06-91-00034	Collection and Credit Activity, January 1992, $5,081
CIN: A-06-91-06790	Chitimacha Tribe of Louisiana, July 1991, $4,213
CIN: A-08-92-17463	Oglala Sioux Tribe, January 1992, $3,677
CIN: A-06-92-17939	Inca Community Services, Inc., February 1992, $3,446
CIN: A-10-92-00002	WPS Terminations Costs, January 1992, $3,380

	CIN: A-09-91-00081	Computational Analysis Corporation, June 1991, $2,272
	CIN: A-05-92-16914	West Central Wisconsin Community Action Agency, December 1991, $1,165
C.	Reports in Litigation:	
	CIN: A-04-91-04050	United Schools of America, July 1991, $169,448
	CIN: A-03-91-16232	Unisys Corporation, September 1991, $61,754
	CIN: A-03-91-15237	Unisys Corporation, May 1991, $1,427

Table II

[1]The opening balance was adjusted to reflect a downward revaluation of recommendations in the amount of $644.5 million.

[2]The Office of Inspector General (OIG) and the Health Care Financing Administration (HCFA) have determined that final action on a previously reported management decision (CIN: A-09-86-06213, Medicaid Can Reduce Costs by Eliminating Premature Admissions for Elective Surgeries, $18.5 million) has been superseded by legislation. The Omnibus Budget Reconciliation Act of 1990 requires HCFA to provide the Congress with a report on preadmission testing programs and same day admissions for elective surgeries by January 1993. The congressionally mandated report will be the basis for HCFA's actions.

[3]The Administration for Children and Families agrees with the recommendations in OIG's report OEI-04-91-00530, Child Support Collection for Foster Care Children, but does not agree with the estimated savings of $11.3 million.

[4]Included are sustained management decisions totaling $12,784 attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

[5]Management decisions have not been made within 6 months of issuance on 9 reports. Discussions with management are ongoing and it is expected that the following reports will be resolved during the next semiannual reporting period:

OEI-07-89-01683	MSP Procedures at Carriers, August 1991, $361,000,000
CIN: A-05-92-00006	Follow-up Audit of Medicare Prospective Payment System Reimbursement of Hospital Admissions Not Requiring an Overnight Stay, January 1992, $233,000,000
OEI-09-88-01006	Outpatient Surgery: Unnecessary Endoscopies, August 1991, $54,800,000
CIN: A-03-90-00201	Medicaid Limits on Payments for Drugs, September 1991, $35,000,000
CIN: A-09-91-05300	Kass Management Services, Inc., April 1991, $79,829
CIN: A-05-92-17665	Illinois Valley Economic Development Corp., February 1992, $27,207
CIN: A-09-90-07111	Yomba Shoshone Tribe, January 1990, $12,832
CIN: A-05-52-17136	Downriver Community Services, Inc., January 1992, $2,957
CIN: A-04-92-16849	Singing River Educational Association, Inc., December 1991, $2,813

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

ACRONYMS

ACF	Administration for Children and Families
ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
ADP	automated data processing
AFDC	Aid to Families with Dependent Children
AoA	Administration on Aging
ASMB	Assistant Secretary for Management and Budget
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control
CFO	Chief Financial Officers
CMHC	community mental health center
CMP	civil monetary penalty
CNM	certified nurse-midwife
CSE	child support enforcement
CWF	common working file
CY	calendar year
DDS	disability determination service
DME	durable medical equipment
DMS	debt management system
DOJ	Department of Justice
DRG	diagnosis-related group
EGHP	employer group health plan
ESRD	end stage renal disease
FBR	Federal benefit rate
FDA	Food and Drug Administration
FFP	Federal financial participation
FI	fiscal intermediary
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
ILP	Independent Living program
INS	Immigration and Naturalization Service
IOL	intraocular lens
IRM	information resources management
IRS	Internal Revenue Service
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance program
MFCU	Medicaid fraud control unit
MMIS	Medicaid management information system
MSP	Medicare secondary payer
NIH	National Institutes of Health
OASH	Office of the Assistant Secretary for Health
OBRA	Omnibus Budget Reconciliation Act
OCR	Office for Civil Rights
OMB	Office of Management and Budget
OS	Office of the Secretary
PCIE	President's Council on Integrity and Efficiency
PFCRA	Program Fraud Civil Remedies Act
PHS	Public Health Service
PPS	prospective payment system
PRISM	project to redesign information systems management
PRO	peer review organization
RASC	regional administrative support center
RRP	Refugee Resettlement program
RSDI	Retirement, Survivors and Disability Insurance
SNF	skilled nursing facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
SWCAP	statewide cost allocation plan
WC	workers' compensation

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