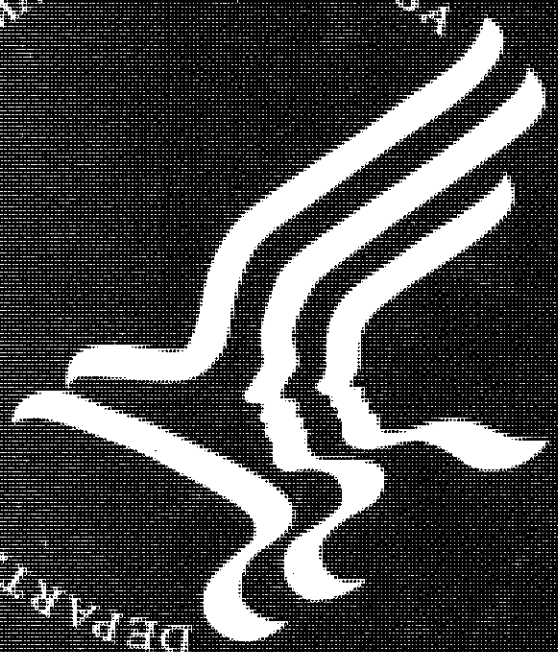
SEMIANNUAL REPORT
OCTOBER 1, 1989 - MARCH 31, 1990

# OFFICE OF INSPECTOR GENERAL




RICHARD P. KUSSEROW
INSPECTOR GENERAL

## STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

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

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 18, United States Code, sections on crime and criminal procedures as they pertain to OIG's oversight of departmental programs

Title 42, United States Code, sections 261, 263a(l), 271, 274e, 290dd-3, 300w-8, 300x-8, 406, 408, 707, 1320a-7(b), 1383(d) and 1395ss, the Social Security and Public Health Service Acts

Title 26, United States Code, section 7213

Title 5, United States Code, section 552a(i)

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

Title 42, United States Code, sections 1320 a-7, 1320 c-5, 1395l, 1395m, 1395u, 1395dd, 1395ss and 1396b

Title 31, United States Code, section 3802

# FOREWORD

*It is my pleasure to submit this semiannual report on the activities of the Department's Office of Inspector General (OIG) for the 6-month period which ended on March 31, 1990. This Semiannual Report of the U.S. Department of Health and Human Services (HHS) OIG is being issued in accordance with the provisions of the Inspector General Act of 1978 (Public Law 95-452), as amended.*

*In support of its mission, OIG endeavors to improve the efficiency and effectiveness of the Department's programs, to identify and take appropriate action against those who attempt to defraud or abuse those programs, and to ensure that the beneficiaries of those programs receive a high quality of care and service.*

*The OIG has departmental management and oversight responsibilities and is an active participant in the Department's program to ensure effective internal controls. The OIG's role has been to identify material weaknesses in internal control systems, to advise top management on internal control issues, to test the Department's process for evaluating internal controls and to review the Department's annual report to the President and the Congress on the status of internal control systems. In addition, OIG takes part in coordinating Governmentwide activities to reduce fraud, waste and abuse and to improve management processes.*

*The OIG's work also covers the five Operating Divisions of the Department. Each Operating Division is covered in a separate chapter in this report:*

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

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

- *The Public Health Service (PHS) 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 Family Support Administration (FSA) provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families.*

- *The Office of Human Development Services (HDS) includes a variety of programs that provide social services to American children, families, older Americans, Native Americans and the Nation's developmentally disabled.*

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

*The Office of Audit Services (OAS) is responsible for conducting audit services for HHS and overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.*

*The Office of Investigations (OI) conducts criminal, civil and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by service providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions or civil monetary penalties. The OI also oversees State medicaid fraud control units which investigate and prosecute provider fraud and patient abuse in the Medicaid program.*

*The Office of Evaluation and Inspections (OEI) conducts short term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress and the public. The findings and recommendations contained in the inspections generate rapid, accurate and up-to-date information on the efficiency, vulnerability and effectiveness of departmental programs.*

*The accomplishments outlined in this report reflect the dedicated efforts of our staff, as well as the assistance and support of departmental managers and Members of the Congress.*

*Richard P. Kusserow*
*Inspector General*

# REPORT HIGHLIGHTS

**Monetary Benefits** - Over $2.1 billion in settlements, fines, restitutions, receivables and savings not previously reported resulted from Office of Inspector General (OIG) activities and implementation of OIG recommendations. The following items highlight monetary benefits resulting from OIG activities and implementation of OIG recommendations:

- By amending the Immigration Reform and Control Act of 1986 to reduce the appropriation for the State Legalization Impact Assistance Grants for Fiscal Year (FY) 1990, the Government will save $555.2 million. (Appendix A)

- By discontinuing inappropriate Medicare payments for hospital costs under the prospective payment system, the Health Care Financing Administration (HCFA) will save $500 million in FY 1990. (Appendix A)

- The HCFA will save $300 million in FY 1990 by using information from the Social Security Administration (SSA), the Internal Revenue Service and individual employers to pursue private health insurance reimbursement for care rendered to Medicare beneficiaries. (Appendix A)

- The HCFA will save $190 million in FY 1990 as a result of the repeal of the requirement to base laboratory reimbursement on a national fee schedule which was to have become effective January 1, 1990. (Appendix A)

- By initiating action to recover or otherwise resolve overpayments and incorrect payments identified by OIG, SSA is in the process of collecting $31.6 million owed on the accounts of Social Security beneficiaries. (Appendix A)

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

- An OIG review identified over 65,000 absent parents who worked for the Federal Government and who owed as much as $284 million in past due child support payments. Additionally, OIG determined that child support payments could be increased by approximately $46.6 million by means of current wage withholding. (Page 74)

- The OIG determined that the Medicaid program could save $33 million annually if State child support enforcement agencies adequately detected and pursued available dependent health insurance. (Page 74)

- The OIG determined that the Medicare list of physician procedures performed outside the office setting which are subject to a reimbursement limit could be extended to additional settings. Such extension could result in program and beneficiary savings of $12.9 million and $3.2 million respectively at one carrier alone, and there is potential for additional savings if it were to be adopted by all Medicare carriers. (Page 22)

- The OIG estimated that Medicare is due $27.6 million as its share of pension asset reversions that were realized by two national hospital chains when they terminated their pension plans. (Page 22)

- The OIG determined that, on average, pharmacies buy drugs for 15.5 percent below average wholesale prices. The OIG recommended that HCFA continue to require Medicaid to discount average wholesale prices when making program reimbursements. (Page 26)

**Internal Control Review** - 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, programmatic, 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.

In the first half of FY 1990, OIG identified 9 significant weaknesses in the Department's internal control systems. Chapter I discusses OIG's role in the Department's FMFIA program. In addition, Chapters II through V outline individual weaknesses. The OIG tracks all significant nonmonetary findings and recommendations and publishes them in a separate report called Program and Management Improvement Recommendations (the Orange Book).

**Successful Judicial Prosecutions** - Investigations by OIG yielded 616 convictions of individuals or entities which engaged in crimes related to HHS programs during the first half of FY 1990. These successful judicial prosecutions resulted in more than $47.1 million in fines, recoveries, restitutions, and savings. A total of 486 individuals were convicted for fraud against the Social Security programs, and almost half of these for misuse of Social Security numbers. The OIG and State medicaid fraud control units together obtained 242 health care convictions. The following items highlight some particularly notable OIG cases:

- A billing service company which filed false Medicare claims for three New York hospitals had to pay more than $2.2 million in restitution, penalties, and forfeiture.

- Two pharmaceutical company officials and their companies were ordered to pay more than $800,000 in fines for giving unlawful gratuities to Food and Drug Administration employees.

- A Wisconsin man was sentenced to a year in jail for each of the checks he forged which were SSA and Department of Veterans Affairs benefits intended for his wife's deceased mother.

- More than $700,000 has been collected to date from physicians who received kickbacks from the owners of three Pennsylvania diagnostic laboratories. During this period the laboratory owners had to repay $267,000.

- Two individuals in California were given prison sentences and ordered to repay $70,000 they obtained by falsifying SSI applications for Southeast Asian refugees.

- More than $1 million was recovered from seat lift companies for billing Medicare for chairs that were not medically necessary.

- Restitution and fines of more than $384,000 were ordered from an unpaid volunteer worker convicted of embezzling Medicare and Medicaid checks from a South Carolina health agency.

**Administrative Sanctions** - A total of 408 health care providers and suppliers or their employees were administratively sanctioned during the first half of FY 1990 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 during this period:

- One hundred and forty-six of these health care providers were excluded from program participation on the basis of program-related criminal convictions.

- One hundred eighty-two providers were administratively sanctioned by exclusion from Medicare and Medicaid because of patient abuse or neglect, or as a result of licensing board revocations or suspensions.

- Seventeen persons were excluded from the programs because of convictions related to controlled substance abuse.

- Under the civil monetary penalty authorities, another 24 providers signed settlements for a total of $6.6 million in fines and penalties for submitting false Medicare or Medicaid claims.

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

- An OIG survey found that Medicare beneficiaries were very satisfied with the Medicare program. Eighty-five percent of the respondents said that they were able to get information about their benefits when they needed it. In a related survey, eighty-three percent of Social Security beneficiaries rated the overall quality of service they received as either good or very good. Ratings for quality and courtesy were virtually equal for both visits and telephone calls. (Page 19)

- The OIG found that limited information is available on why and how effectively consumers use home testing devices. The FDA should continue to emphasize consumer field evaluations to ensure the accuracy of home testing devices and continue to work with manufacturers to improve product design, labeling and instructions. (Page 67)

- Almost all Head Start grantees interviewed believed that Head Start was the program best able to serve the needs of children from dysfunctional families. The OIG proposed that the Head Start program revise its enrollment criteria to provide grantees greater flexibility in serving children from dysfunctional families. (Page 80)

- In a review of the unliquidated obligation accounts of the Health Care Financing Administration, the Public Health Service, the Family Support Administration and the Office of Human Development Services, OIG found that over $100 million in grants and contracts should have been deobligated and removed from the books as of September 30, 1987. (Page 12)

- The OIG found that SSA's modernized claims system allows certain employees to take, develop, adjudicate and effect payment on claims without any independent review or compensating controls, and that this creates a situation vulnerable to

error and/or abuse. The OIG suggested means by which SSA could improve controls in the claims process. (Page 52)

- The OIG determined that implementation of a system for preparing auditable financial statements similar to those prepared by the Department of Veterans Affairs could help improve financial management controls over clinical services funded by the Indian Health Service. (Page 68)

- The OIG identified a number of effective practices which States should consider adopting to improve their methods of establishing paternity. These strategies include soliciting support for the paternity establishment program, clarifying responsibility for obtaining intake information, promoting improved parental cooperation and streamlining adjudication of paternity establishment. (Page 75)

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# HHS AND GOVERNMENTWIDE OVERSIGHT

# CHAPTER I

# HHS AND GOVERNMENTWIDE OVERSIGHT

## INTRODUCTION

This chapter addresses the Office of Inspector General (OIG) departmental management and Governmentwide oversight responsibilities. The Department will spend in excess of $225 million in FY 1990 to provide overall direction for departmental activities and to provide common services such as personnel, accounting and payroll to departmental operating divisions.

The OIG's departmental management and Governmentwide oversight include reviews of implementation of the Federal Managers' Financial Integrity Act, debt management activities, grants and contracts and audit resolution. The OIG participated in Governmentwide reviews resulting from participation in the President's Council on Integrity and Efficiency (PCIE) activities pertaining to control of unliquidated obligations in "M" accounts and the use of contracts for advisory and assistance services. The PCIE, which was established in 1981, coordinates multiagency reviews designed to reduce the potential for fraud, waste and abuse with Governmentwide implications.

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.

## THE FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

The Congress enacted the Federal Managers' Financial Integrity Act of 1982 (Public Law 97-255) in response to continuing disclosures of waste, loss, unauthorized use, and misappropriation of funds or assets across a wide spectrum of Government operations. It is generally recognized that good internal control and accounting systems would have prevented, or made more difficult, these abuses. The goal of this legislation was to help reduce fraud, waste, and abuse, as well as to enhance management of Federal Government operations through improved internal control and accounting systems.

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

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

Although the Inspector General's role is not specified in the statute, 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:

- identifying material weaknesses in internal controls or material nonconformances in accounting systems as an integral part of OIG reviews of Department activities;

- following up to monitor corrective action taken regarding weaknesses identified by OIG, the General Accounting Office (GAO) and the Operating and Staff Divisions of the Department;

- advising top management on internal control issues;

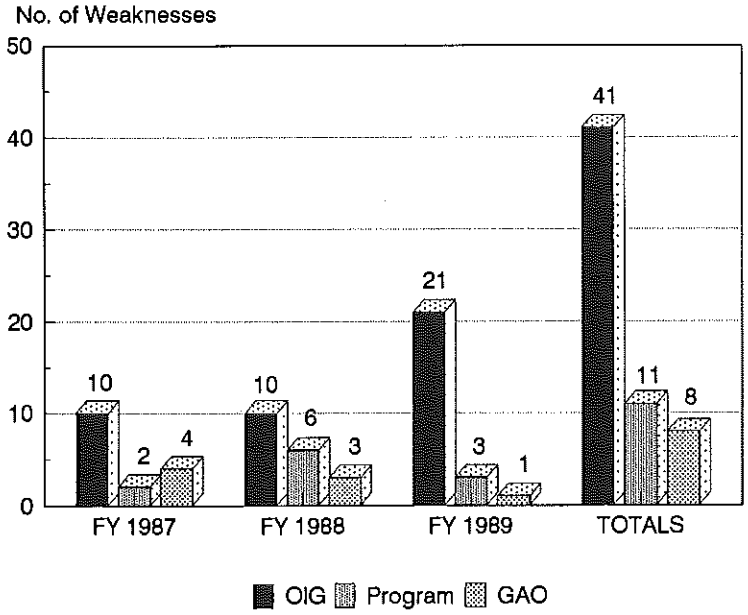
- reviewing the Secretary's FMFIA annual report to the President and the Congress on the status of internal controls.

Of the 19 significant weaknesses identified by OIG and outlined in the fall 1989 semiannual report, the Secretary included 17 in the Department's FMFIA report to the President and the Congress either as material weaknesses, nonconformances, high risk areas, or significant management concerns. The remaining two significant weaknesses identified in the fall semiannual report were not included in the Secretary's report; however, subsequent review by OIG identified valid reasons for no longer including those conditions as significant weaknesses.

The FMFIA was designed to be a program conducted by management officials. Accordingly, they have identified a significant number of nonmaterial weaknesses through their FMFIA internal control reviews and have instituted corrective actions. Most of the material weaknesses, however, have been identified by OIG. Over the last 3 years, less than 20 percent of the material

weaknesses were identified by management. Department managers are frequently reluctant to include the material weaknesses in the Secretary's FMFIA report because they may be unfairly criticized. Such reporting, they believe, may erroneously indicate weak management abilities on their part. The Secretary's FMFIA report identified 25 material weaknesses discovered in FY 1989; however, 21 of these weaknesses as indicated below were identified by OIG, and the vast majority were contained in the previous semiannual report as significant weaknesses.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES
## Sources Identifying Material Weaknesses and Nonconformances
## (Fiscal Years 1987 - 1989)




The Inspector General reports annually on the Department's implementation of the FMFIA program. The latest report, "Implementation of the Federal Managers' Financial Integrity Act for Fiscal Year 1989" (CIN: A-12-89-00139), was issued on January 3, 1990 and identified several improvements in the Department's program. Toward the end of FY 1989 the Department placed renewed emphasis on the FMFIA program. Management and OIG have been working together to continue improvements in the FMFIA program. Some of the noteworthy improvements included: institution of a management oversight council, implementation of a process for resolving materiality of findings, a prioritization process for correcting material weaknesses and increased staffing for FMFIA oversight. These initiatives should significantly upgrade the Department's program. However, as in prior years, the unavailability for testing of final Operating and Staff Division reports on their review results prevented OIG from fully assessing the reliability of program implementation.

While the OIG review identified progress implementing the program, opportunities do exist to remedy certain deficiencies in the scope, testing and reporting of important aspects of the Department's program. Certain Operating and Staff Divisions of the Department have expended considerable effort in reviewing administrative areas. Excessive commitments to the review of administrative areas may result in too few reviews in programmatic areas where most Government funds are expended. Reviews in these areas are necessary to determine if proper internal control procedures are adequate to prevent fraud, waste and abuse. Initiatives are underway to identify more program areas for coverage, but for FY 1989 OIG saw minimal coverage in these most important areas.

Directives and guidance have been issued to hold managers accountable by way of performance plans for their internal and system control responsibilities. However, OIG continues to find that performance plans are not uniformly in compliance with Department guidance. For example, OIG found instances where internal control responsibilities were absent, or vaguely addressed, in managers' performance plans, thus flawing the performance rating process.

Department management recognized the need to perform more effective systems reviews. The existing guidance for limited and detailed systems reviews is in need of review and update. The detailed reviews that are performed are often not properly documented, nor do they cover all the areas specified in OMB Circular A-127.

During the first half of FY 1990, OIG identified 9 significant weaknesses which were reported to management and are now undergoing review for a determination as to whether or not they are material, as well as what corrective actions are appropriate. The following indicates the distribution of the program weaknesses identified, with reference as to where they may be found in our semiannual report:

| | | |
|---|---|---|
| Health Care Financing Administration (HCFA) | 2 | (page 19) |
| Social Security Administration (SSA) | 1 | (page 44) |
| Public Health Service (PHS) | 5 | (page 63) |
| Family Support Administration (FSA) | 1 | (page 72) |

# RESOLVING AUDIT RECOMMENDATIONS

The tables below summarize the Department's actions 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 (Public Law 100-504).

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 | 295 | $166,687 | $39,681 |
| B. Which were issued during the reporting period | 232 | 171,290 | 41,702 |
| Subtotals (A + B) | 527 | $337,977 | $81,383 |
| Less: | | | |
| C. For which a management decision was made during the reporting period: | 316 | $169,033 | $30,476 |
| (i) dollar value of disallowed costs[1] | | $131,968 | $9,106 |
| (ii) dollar value of costs not disallowed | | 37,065 | 21,370 |
| D. For which no management decision had been made by the end of the reporting period | 211 | $168,944 | $50,907 |
| E. Reports for which no management decision was made within six months of issuance | 0 | 0 | 0 |

[1] See Appendix B

## 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. Legislative and programmatic actions on OIG recommendations are detailed in Appendix A.

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] | 60 | $4,753,763 |
| B. Which were issued during the reporting period | 34 | 820,725 |
| Subtotals (A + B) | 94 | $5,574,488 |
| Less | | |
| C. For which a management decision was made during the reporting period: | | |
| (i) dollar value of recommendations that were agreed to by management | | |
| (a) based on proposed management action | 43 | $664,690 |
| (b) based on proposed legislative action[2] | 13 | 2,650,000 |
| Subtotals (a+b) | 56 | $3,314,690 |
| (ii) dollar value of recommmendations that were not agreed to by management | 9 | $582,660 |
| Subtotals (i + ii) | 65 | $3,897,350 |
| D. For which no management decision had been made by the end of the reporting period[3] | 29 | $1,677,138 |
| E. Prior management decisions implemented in the period (See Appendix A)[4] | | |
| (i) based on management action | 2 | $41,400 |
| (ii) based on legislative action | 14 | $1,904,100 |

[1] The opening balance was adjusted to correct oversights made in prior period reports. As a result of net adjustments, the opening balance was reduced by $424.3 million.

[2] The OIG has reported as "management decisions made during the period" those line items in the President's FY 1991 budget that relate directly to OIG recommendations contained in issued reports. Management does not report these decisions in its table.

[3] Management decisions had not been made within 6 months of issuance on 6 reports with recommendations totaling over $1.5 billion. The status of these reports (CIN: A-05-89-00055; CIN: A-10-86-62016; CIN: A-03-86-62019; ACN: 02-60202; ACN: 03-60233; ACN: 03-50228) is detailed in Appendix D.

[4] 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 IG recommendation. Implemented savings reported by the IG are based upon completion of both management's final action and congressional action in the case of recommendations implemented through legislation.

## CONGRESSIONAL HEARINGS

Each year the Inspector General or his designee testifies at a number of congressional hearings on issues related to HHS programs and operations. The following list summarizes those appearances before the first session of the 101st Congress. Those appearances during this reporting period are described after the summary.

### A. Summary

| Date | Topic | Congressional Committee/Subcommittee |
|---|---|---|
| February 28, 1989 | Medicare Contractors | Subcommittee on Labor, Health and Human Services and Education, Senate Committee on Appropriations |
| April 4, 1989 | Peer Review Organization Process | Subcommittee on Intergovernmental Relations and Human Resources, House Committee on Government Operations |
| April 10, 1989 | Optometry and Ophthalmology Referral Arrangements | Subcommittee on Health, House Committee on Ways and Means |
| April 19, 1989 | Implementation of Drug Provision of the Medicare Catastrophic Coverage Act | Subcommittee on Human Services, House Select Committee on Aging |
| May 10, 1989 | Food and Drug Administration Generic Drug Program | Subcommittee on Oversight and Investigations, House Committee on Energy and Commerce |
| May 15, 1989 | Indian Health Service | Senate Select Committee on Indian Affairs |
| May 15, 1989 | Hospital Closures and Patient Dumping | Subcommittee on Health, House Committee on Ways and Means |

| | | |
|---|---|---|
| June 1, 1989 | Financial Arrangements Between Physicians and Other Health Care Businesses | Subcommittee on Health, House Committee on Ways and Means |
| June 8, 1989 | Medicare Payments for Clinical Laboratory Tests | Subcommittee on Health and the Environment, House Committee on Energy and Commerce |
| October 3, 1989 | Material Weaknesses | Senate Committee on Governmental Affairs |
| November 27, 1989 | Public Cholesterol Screening | Subcommittee on Regulations, Business Opportunities and Energy, House Committee on Small Business |
| December 7, 1989 | Public Cholesterol Screening | Subcommittee on Health and the Environment, House Committee on Energy and Commerce |

## B. Highlights of OIG Testimony

### 1. Material Weaknesses

On October 5, 1989, the Senate Committee on Governmental Affairs held the second in a series of hearings on management problems in the Federal Government. This hearing focused on problems in the Departments of Health and Human Services and Labor and the Environmental Protection Agency.

The IG testified on the Department's progress in implementing the FMFIA. The IG made the following recommendations to improve the FMFIA program:

- Agencies should continue to emphasize the commitment to the FMFIA program and hold all executives and appropriate management staff accountable for ensuring the full success of this process.

- The Assistant Secretary for Management and Budget should continue actions to implement and maintain an adequate overall system for tracking corrective actions.

- Further clarification is needed as to what constitutes a material weakness.

- The Department should underscore the intent of the Act that all program operations, administrative and financial functions be included within the process.

**2. Public Cholesterol Screening**

On November 27 and December 7, 1989, two separate subcommittees of the House of Representatives held hearings to discuss the growing public controversy concerning the appropriateness, utility and decision making process of the National Heart, Lung, and Blood Institute's National Cholesterol Education Program (NCEP). The IG testified on the results of OIG's study on public cholesterol screening. The results of the study revealed that:

- Public cholesterol screening in many areas of the country is both prevalent and growing. Providers of all kinds are conducting screenings.

- The NCEP guidelines were often violated. Five major areas of concern are the screening environment, staffing, sample collection, counseling and referral and infection control.

- Current State and Federal regulation of public cholesterol screening is minimal.

Based on these findings, the IG recommended that the Department discourage public cholesterol screening which does not meet the NCEP guidelines and regulate public cholesterol screening under the Clinical Laboratory Improvement Act Amendments of 1988 without applying the waiver provision.

## LEGISLATIVE AND REGULATORY REVIEW

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed 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 93 of the Department's regulations under development and 74 legislative proposals. During this process, OIG used as the primary basis for its comments the reviews, investigative experience and recommendations highlighted in this and previous semiannual reports.

The OIG develops regulations for civil monetary penalty and exclusion authorities which the Inspector General administers. In February, the Department published proposed rulemaking in

the Federal Register to implement civil monetary penalty authorities for violations regarding the misuse of certain terms and symbols associated with the Department's programs.

In recent years, the Department has received numerous complaints regarding mail solicitations and advertising claims that made use of certain program terms, acronyms or agency symbols. The symbols and wordings were used in such a way as to mislead or falsely represent the fact that items being offered were approved or endorsed by the Department, SSA or HCFA. The Congress has addressed these concerns by giving HHS new statutory authority through Public Law 100-360, Section 428(a) to impose civil money penalties for such violations. The proposed rules will be open to public comment for 60 days and should be published in final by the next reporting period.

Recommendations made by OIG for legislative and regulatory change can be found in the body of this semiannual report (for OIG reports issued during this reporting period) and in Appendices D and E for prior recommendations.

## GOVERNMENTAL ACCOUNTING

Based on leads developed from its nonfederal audit work, OIG continues to identify excessive administrative charges to Federal programs, totaling $31.3 million in this reporting period.

### A. Internal Service Funds

Internal service funds are intended to be self-supporting by means of user charges. Accumulation of surpluses is not permitted under OMB Circular A-87. The State of Illinois accumulated revenues in excess of operating expenses of approximately $25 million as of June 30, 1988. An OIG review revealed that the Federal share of the net surpluses amounted to $2.5 million.

The OIG recommended that the State of Illinois coordinate with HHS to eliminate the surpluses in its internal service funds, restore the nearly $2.5 million to Federal programs and adjust future billings to users to preclude accumulating surpluses in the funds. State officials concurred. (CIN: A-05-89-00062)

### B. Tax Refunds

The purpose of this review was to determine if Illinois had properly credited Federal programs for refunded Federal Income Contributions Act (FICA) taxes that were originally paid from federally funded programs during the period January 1, 1979 to December 31, 1981. The review disclosed that, although the State had received refunds totaling over $4 million, no credit had been given to the Federal Government for its share of the refunds. The OIG estimated that almost $378,000 of the refunds should have been returned to the Federal Government. State officials concurred. (CIN: A-05-89-00027)

## NONFEDERAL AUDITS

Approximately half of Federal funds awarded to State and local governments and colleges and universities come from HHS programs. The OIG is assigned cognizance at about 75 percent of all colleges and universities. The OMB has assigned HHS audit cognizance of 22 State and 919 local governments. A major portion of this oversight responsibility is accomplished by relying on audit work performed by certified public accountants and State audit organizations. The OIG analyzes audit reports for indicators of grantee noncompliance with Federal regulations, initiates audit resolution procedures on reported recommendations and maintains a quality control review process to identify substandard audit work.

The OIG also continues an active role in the implementation of the Single Audit Act because of the magnitude of HHS funding to State and local governments. A major component of OIG's workload has been to assist State and local governments and their auditors with planning and performing single audits. The Department provides about $50 billion a year to State and local governments. All but 3 of the 50 States receive more funds from HHS than from any other department.

### A. Local Government Compliance

The level of Federal funding has great impact on the operations of the audited entities. Accordingly, OIG's concern for the quality of single audit reports and the adequacy of the Federal Government's system to properly identify State and local governments in noncompliance with the Single Audit Act goes far beyond the government entities for which OIG is presently assigned cognizance. The OIG is working with the States, for which it is assigned cognizance, to establish systems to assure compliance of local governments with the Single Audit Act. These systems complement the monitoring system at the Bureau of the Census by filling the gap in the Government's knowledge on compliance by local governments.

### B. Quality Control

To ensure that all audits meet generally accepted Government auditing standards, uniform procedures are used to review nonfederal audit reports. During this reporting period, OIG reviewed and processed 1,745 nonfederal audit reports containing $31.3 million in recommended cost recoveries. The reports also identified many opportunities for improving management operations. The following table summarizes those results:

| | |
|---|---|
| Reports issued without changes or with minor changes | 1,361 |
| Reports issued with major changes | 295 |
| Reports with significant inadequacies | 89 |
| Total audit reports processed | 1,745 |

Of those reports with significant inadequacies, 12 were referred to State officials and professional organizations for appropriate action. Several other referrals are pending. The OIG referrals of inadequate audit work result in significant disciplinary action against the accounting firms involved.

## MERGED APPROPRIATION ACCOUNTS

The merged appropriation ("M") accounts contain those obligated balances transferred on September 30 of the second fiscal year after the period of availability to an appropriation expires. Amounts transferred from the appropriation accounts for the same general purpose are merged into the "M" account for paying obligations.

As an initiative of the President's Council on Integrity and Efficiency, a review was performed of the "M" year accounts for HCFA, PHS, FSA and HDS. The OIG found that over $100 million in grants and contracts in the "M" year accounts should have been deobligated and removed from the books as of September 30, 1987. Other problems noted were: required annual reviews of the "M" accounts were not performed; documentation to support expenditures from the "M" accounts was inadequate; reported balances could not be reconciled to the accounting records; and significant delays were evident in closing out completed grant and contract files. The Department concurred with the recommendation to correct the reported deficiencies. (CIN: A-12-89-00130)

## CONTRACTS FOR ADVISORY AND ASSISTANCE SERVICES

The OIG annually reviews the Department's contracts for advisory and assistance services (CAAS) in accordance with Section 307(b) of the Supplemental Appropriations and Rescission Act of 1980. The Act requires, in part, that the Inspector General of each Federal agency evaluate management controls over the procurement process for consultant services. The OMB Circular A-120 includes consultant services in the definition of advisory and assistance services.

The 1989 review was performed in coordination with a President's Council on Integrity and Efficiency project responding to congressional concerns over the use of consultant services. The resulting report for FY 1989 was submitted on February 14, 1990 with the Department's annual budget justification to the Congress.

In total, CAAS expenditures represent only about 1 percent of the Department's contracting dollars. The OIG review assessed 30 of the 170 CAAS related contract actions during FY 1987 and focused on a variety of issues, such as the use of sole source contracts and unsolicited proposals, the extent of costly modifications and the actual use of deliverables. The review disclosed that the use of sole source contracts has been limited; there was only one instance of improper justification and no contracts were awarded based on unsolicited proposals. The OIG

also found that cost reimbursement contracts are particularly susceptible to numerous modifications; of 28 different contracts in the review, 25 were cost reimbursement contracts and 8 of those rose in price more than 45 percent.

In commenting on the draft report, the Assistant Secretary for Management and Budget (ASMB) agreed that, although no pervasive problems with CAAS were identified, there were opportunities to strengthen management controls over these procurements. The ASMB also agreed to take action to see that the report recommendations were implemented throughout the Department. (CIN: A-12-90-00014).

## GOVERNMENTWIDE ISSUES

Each year, State and local government entities receive over $100 billion in Federal grant funds. It is estimated that Federal agencies pay at least $8 billion for administrative costs of State and local governments.

During FY 1987, OIG launched a major initiative to identify improvements in the accounting process, strengthen Government cost principles and identify cost containment areas that contribute to Government-wide savings. The cost principles governing the charging of costs by State and local governments have not changed substantially for 20 years. As a result of the initiative, OIG identified 13 areas in need of improvement in OMB Circular A-87 regarding cost principles. These improvements have a savings potential in excess of $100 million. Proposed revisions to the circular were published in October 1988. The OIG is currently participating in an OMB-sponsored, multiagency task force which is responsible for evaluating public comments on the proposed revisions.

## EMPLOYEE ETHICS

In accordance with Executive Order 12674, which requires annual training on ethics and standards of conduct for certain Government employees, OIG worked with the Office of the Assistant Secretary for Personnel Administration (ASPER) and the Office of General Counsel (OGC) to develop an ethics training curriculum for the Department. The training consists of presentation of a videotape developed by OIG, ASPER, and OGC, followed by discussion of the tape contents. The tape uses vignettes prepared by the Office of Government Ethics and intersperses comments by a panel of the Inspector General, the Assistant Secretary for Personnel Administration, and the Associate General Counsel for Business and Administrative Law. Each participant in the training receives a copy of an ethics handbook that was developed by OIG. This handbook contains eleven chapters on areas in which employees get in trouble, including conflicts of interest, gifts and gratuities, travel, and outside employment. The handbook also discusses such concerns as reporting fraud, waste and abuse, and protection of whistleblowers.

In conjunction with OGC, each of the Operating Divisions of the Department will conduct the training for its own employees. The OGC is conducting question and answer sessions as an integral part of ethics training. The Office of the Assistant Secretary for Personnel Administration is monitoring Operating Division progress in conducting ethics training. The Office of the Assistant Secretary for Management and Budget will provide the training for Office of the Secretary Staff Divisions.

## COOPERATION WITH OTHER LAW ENFORCEMENT AGENCIES

During this semiannual reporting period, OIG investigations resulted in 616 convictions. Also during this period, 625 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 798 cases. 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 (SSNs) in a broad range of illegal activities, including bank and credit card frauds, licensing and income tax fraud, welfare fraud, drug trafficking, and racketeering as well as fraud in programs such as student loans, food stamps and unemployment compensation. Other agencies also benefit from OIG investigations, such as private health insurers, State Medicaid programs, and drug regulatory entities. Many of the cases in which OIG participates result in monetary fines, recoveries, restitutions or savings for these agencies. During this period, monetary fines, recoveries, restitutions or savings from these cases amounted to approximately $5.9 million for other public or private entities.

## SUCCESSFUL PROSECUTIONS BY UNITED STATES ATTORNEYS

| Federal District | Prosecutions |
|---|---|
| Northern Alabama | 3 |
| Middle Alabama | 8 |
| Eastern Arkansas | 4 |
| Central California | 9 |
| Eastern California | 2 |
| Northern California | 8 |
| Southern California | 2 |
| Colorado | 18 |
| Connecticut | 4 |
| District of Columbia | 5 |
| Northern Florida | 9 |
| Middle Florida | 9 |
| Northern Georgia | 8 |
| Southern Georgia | 1 |
| Idaho | 6 |
| Central Illinois | 14 |
| Northern Illinois | 22 |
| Southern Illinois | 3 |
| Northern Indiana | 2 |
| Southern Indiana | 2 |
| Northern Iowa | 3 |
| Southern Iowa | 4 |
| Kansas | 4 |
| Eastern Kentucky | 7 |
| Western Kentucky | 3 |
| Eastern Louisiana | 6 |
| Middle Louisiana | 3 |
| Western Louisiana | 1 |
| Maine | 2 |
| Maryland | 14 |
| Massachusetts | 10 |
| Eastern Michigan | 24 |
| Western Michigan | 2 |
| Minnesota | 7 |
| Southern Mississippi | 1 |
| Eastern Missouri | 5 |
| Western Missouri | 5 |
| Nebraska | 2 |
| Nevada | 2 |
| New Jersey | 14 |
| New Mexico | 6 |
| Eastern New York | 10 |
| Northern New York | 2 |
| Southern New York | 13 |
| Western New York | 4 |
| Middle North Carolina | 1 |
| Northern Ohio | 5 |
| Southern Ohio | 7 |
| Northern Oklahoma | 1 |
| Eastern Oklahoma | 1 |
| Western Oklahoma | 5 |
| Oregon | 1 |
| Eastern Pennsylvania | 19 |
| Western Pennsylvania | 3 |
| Puerto Rico | 5 |
| Rhode Island | 1 |
| South Carolina | 27 |
| South Dakota | 1 |
| Eastern Tennessee | 1 |
| Middle Tennessee | 2 |
| Western Tennessee | 5 |
| Northern Texas | 14 |
| Southern Texas | 29 |
| Western Texas | 10 |
| Utah | 5 |
| Vermont | 2 |
| Eastern Virginia | 10 |
| Western Virginia | 2 |
| Western Washington | 4 |
| Eastern Wisconsin | 8 |
| Western Wisconsin | 4 |
| Wyoming | 1 |
| State and Local Prosecutions | 149 |
| **Grand Total:** | 616 |

# HEALTH CARE FINANCING ADMINISTRATION

# CHAPTER II

# HEALTH CARE FINANCING ADMINISTRATION

## OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

In Fiscal Year (FY) 1990, the Medicare program will provide health care coverage for an estimated 34 million individuals. Medicare Part A (hospital insurance) provides, through direct payments for specified use, hospital insurance protection for covered services to persons 65 or older and to certain disabled persons. Financed by the Federal Hospital Insurance trust fund, FY 1990 expenditures for Medicare Part A are expected to exceed $63 billion.

Medicare Part B (supplementary medical insurance) provides, through direct payments for specified use, insurance protection against most of the costs of health care to persons 65 and older and certain disabled persons who elect this coverage. The services covered are medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services, and certain other medical and health services. Financed by participants and general revenues, FY 1990 expenditures for Medicare Part B are expected to be over $46 billion.

The Medicaid program provides grants to States for medical care for more than 25 million low-income people. Federal grants are estimated at $40 billion in FY 1990. Federal matching rates are determined on the basis of a formula which 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.

The OIG activities which pertain to the health insurance programs administered by the Health Care Financing Administration (HCFA) help curtail health care costs, 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 reduce unnecessary expenditures and improve inefficient health care delivery systems.

The financial impact of the prospective payment system (PPS) on hospitals, the increases in Part B expenditures, the implementation of physician payment reforms, medical effectiveness, and the cost implications of changes in health care technology and delivery will continue to be of particular interest to OIG. The OIG's reviews identify innovative cost containment techniques, probe for improper cost shifting and validate the adequacy of intermediary audits of hospitals'

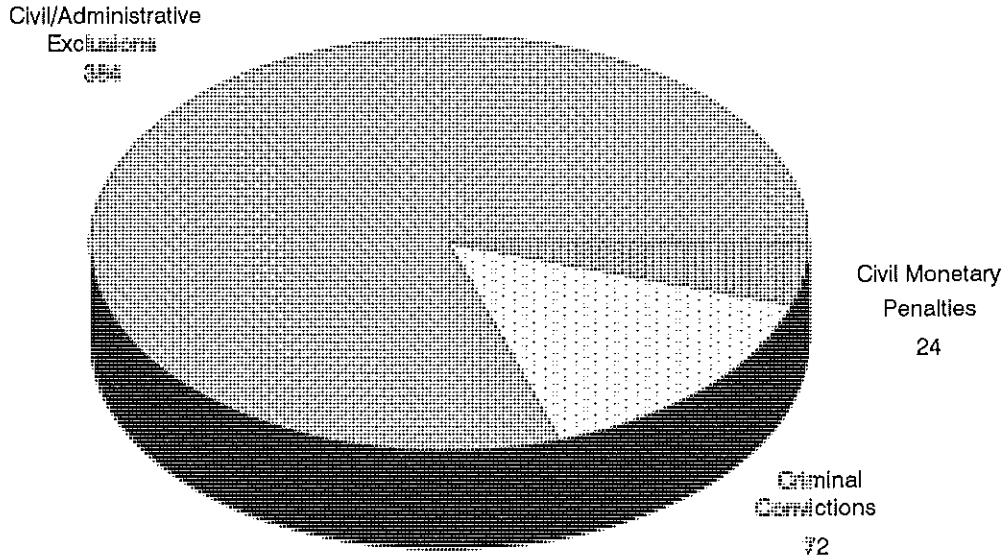
Medicare cost reports. Reviews detect overutilization of physician and related services and reduce vulnerabilities in payment systems. The OIG also seeks to identify mechanisms to contain increasing Medicaid costs, including monitoring States' collection of overpayments and costs claimed for treating patients residing in institutions for mental diseases and facilities for the mentally retarded.

As a result of actions taken in support of OIG recommendations in the first half of the fiscal year, Medicare and Medicaid will save over $1.3 billion (see Appendix A). During this reporting period, OIG identified program areas where legislative action, more efficient management and tightened internal and fiscal controls could result in significant additional savings. An additional $92.5 million in program expenditures were questioned as to their allowability under law, regulations or cost principles. In these instances, recommendations for financial adjustments and appropriate procedural changes were made.

Fraud and abuse of the Medicare and Medicaid programs or their beneficiaries may result in criminal, civil and/or administrative actions against the perpetrators. During the first half of this fiscal year, OIG was responsible for a total of 480 successful actions against wrongdoers.

## HEALTH CARE PROGRAMS

### Successful Criminal, Civil and Administrative Litigations



## INTERNAL CONTROL REVIEW

The OIG identified the following significant weaknesses within HCFA in the first half of FY 1990:

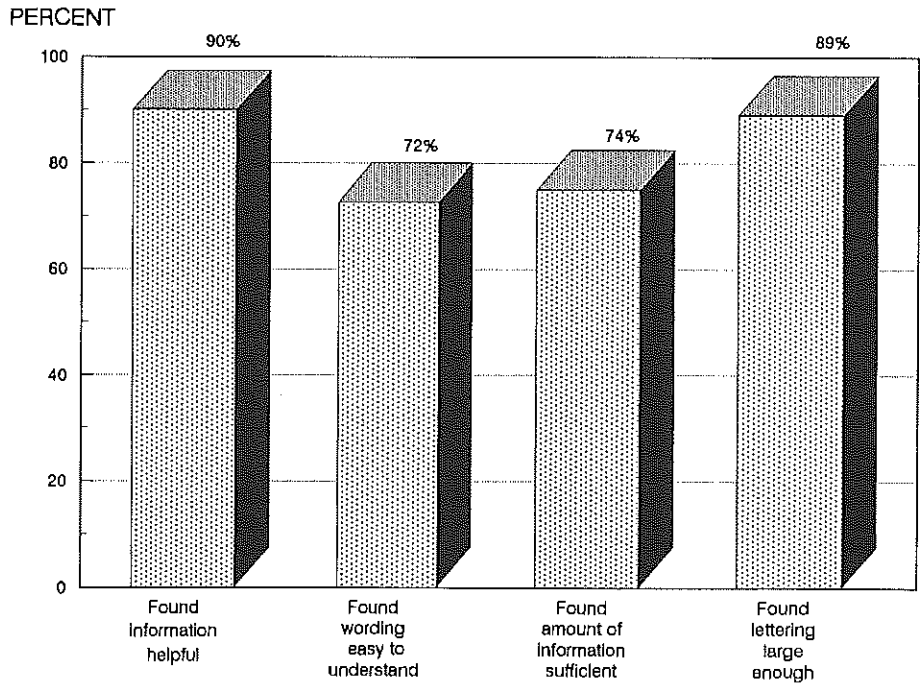
- A draft OIG report issued in February 1990 found that HCFA's cost allocation system was not in conformance with the principles and standards established by the Comptroller General. The OIG reviewed the system HCFA used to allocate $1.426 billion of program management costs. Within the four areas which account for 98 percent of HCFA's total program management costs, the review identified significant cost allocation problems only in the area of HCFA's administrative costs. This area represents approximately 17 percent (or $236 million) of HCFA's program management costs. The administrative costs were not accurately or equitably allocated to the areas receiving benefits. Consequently, OIG believes that the deficiencies constitute a significant weakness. (CIN: A-14-89-02036)

- The OIG issued a draft management advisory report in December 1989 showing that the internal controls inherent in HCFA's and the Food and Drug Administration's procedures for administering the Department's less than effective drug provisions were inadequate to prevent Federal reimbursements totaling $12.5 million in 19 States. This review was undertaken to determine whether HCFA had implemented recommendations which OIG made in a previous report (ACN: 03-60202). The OIG believes that this inadequacy constitutes a significant weakness. In September 1989, HCFA published a listing of identical, related and similar (IRS) drugs in the State Medicaid Manual and continues to work with FDA to establish a memorandum of understanding for ongoing identification of IRS drugs. Also, HCFA says it is developing a financial management review guide for use by HCFA regional offices to monitor States' control of IRS drugs. (CIN: A-03-89-00220)

## MEDICARE BENEFICIARY SATISFACTION

The OIG conducted a survey to assess beneficiary experience and satisfaction with the Medicare program. The survey found that, overall, beneficiaries were very satisfied with Medicare. Eighty-five percent of the respondents said that they were able to get information about their benefits when they needed it. Most found the information they received about Medicare to be helpful, as illustrated in the chart following.

## BENEFICIARY EVALUATION OF MEDICARE INFORMATION




Most of the respondents were satisfied with the way in which Medicare processed their claims and thought that they were paid quickly enough.

However, the survey also disclosed that most beneficiaries did not understand the provisions of the Medicare Catastrophic Coverage Act; did not adequately plan for the costs of long-term care should it be needed; did not seek second opinions prior to surgery; and did not know about the availability of special reports offered by Medicare, such as those on hospital mortality rates and on nursing home inspections.

The HCFA indicated an intention to improve their public information program and to address those areas where beneficiaries were found to be less well informed about Medicare. (OAI-04-89-89040)

## DRUG PROCESSOR PROCUREMENT

Prior to its repeal, OIG conducted analyses of various aspects of the Medicare Catastrophic Coverage Act (MCCA). The MCCA required HCFA to contract with drug bill processors for the

electronic point-of-sale (POS) system under the Medicare outpatient prescription drug benefit. An OIG review showed that HCFA did not have an adequate system of internal controls to properly conduct the POS procurement.

The Director and Deputy Director of HCFA's Bureau of Program Operations (BPO) were designated as contracting officer and project officer, respectively, for the POS procurement. In this manner, both the contract acquisition and program management functions for the POS system were assigned to BPO officials, creating a material weakness as defined by Office of Management and Budget Circular A-123. In addition, the BPO officials responsible for the POS procurement did not have the combined acquisition training and experience appropriate for this type of competitive procurement.

The OIG recommended that the Assistant Secretary for Management and Budget (ASMB) direct HCFA to strengthen BPO internal controls over procurements, provide aggressive monitorship of BPO's corrective actions to assure that necessary prerequisites for competitive procurements are met, and report the material weakness under the FMFIA.

The ASMB concurred that a more definitive separation of contracting officer and project officer duties was required, and reported this area as a material weakness in the FY 1989 report to the President and the Congress. The HCFA also agreed and planned corrective actions which will be monitored by ASMB. (CIN: A-14-89-02039)

## COST OVERRUNS FOR SKILLED NURSING FACILITY BENEFITS

The OIG performed a review prior to repeal of the MCCA to determine whether expenditures for catastrophic coverage were in line with budget estimates and whether HCFA had an adequate system to account for costs incurred for the new benefits.

The OIG found that HCFA did not have an adequate system to track costs incurred for the new coverage. More importantly, the review disclosed that payments for skilled nursing facilities (SNFs) under the catastrophic coverage provisions would exceed budget estimates in 1989, perhaps six times as much as that initially projected by HCFA and five times that projected by the Congressional Budget Office. Based upon this large overrun, OIG recommended in the draft report that Congress consider reducing or even eliminating the expanded SNF coverage.

After issuance of the OIG draft report, but before completion of the final report, the Congress eliminated the expanded SNF coverage. Therefore, in the final report OIG is recommending that, if legislative proposals for catastrophic coverage are reconsidered and enacted, HCFA make a more accurate determination of the expected costs and develop an accounting system to allocate actual program costs between catastrophic and other benefits. (CIN: A-09-89-00095)

## MEDICARE BENEFICIARY FRAUD

A Texas woman was sentenced to 5 years imprisonment and ordered to pay $149,700 in restitution for having submitted hundreds of false Medicare and private insurance claims for physician services. She altered and photocopied doctors' statements and receipts sent to elderly relatives, creating fictitious beneficiaries at her own address. The scheme was detected when she co-signed a check from a private insurance claim, and a company employee recalled that she had been convicted for fraud in 1976. (l2-88-00577-9, Betty Anderson)

## PHYSICIAN SERVICES OUTSIDE THE OFFICE SETTING

Pursuant to authority granted in the Tax Equity and Fiscal Responsibility Act (TEFRA), reimbursement for physician services of the type routinely furnished in physicians' offices, when furnished in outpatient settings, will be limited to no more than 60 percent of the prevailing charge of nonspecialists in office practice. This limitation is intended to ensure that Medicare does not make duplicate payments for overhead expenses by paying both the facility and the physician. It specifically addresses physician services furnished in outpatient settings, defined as services in hospital outpatient departments, clinics, emergency rooms, or comprehensive outpatient rehabilitiation facilities.

Based on a review conducted at one carrier, the OIG determined that the Medicare list of procedures subject to the 60 percent limitation could be extended to locations of service other than the outpatient service setting, such as inpatient hospitals and skilled nursing facilities. This could result in annual program and beneficiary savings of approximately $12.9 million and $3.2 million respectively at this one carrier, and it would offer the potential for significant additional savings if adopted by all Medicare carriers.

The OIG recommended that HCFA seek legislative authority to extend the 60 percent limitation to include physician services provided in additional settings; adopt a listing of procedure codes for carriers to consider incorporating under the 60 percent limitation; and periodically update the established listing and monitor carrier compliance. While HCFA agreed that there is a basis for extending the 60 percent outpatient limit and that program savings would result, they thought that the issue should be addressed in the context of legislation implementing physician payment reform. The OIG does not believe that action on extending the 60 percent limitation should be delayed until physician payment reform is enacted. (CIN: A-05-89-00059)

## TERMINATIONS OF PENSION PLANS

An OIG audit disclosed that two national hospital chains, Humana Corporation (Humana) and Hospital Corporation of America (HCA), realized significant gains, or profits, as a result of terminating their pension plans. Medicare, which paid its pro rata share of the pension contributions, did not share equitably in the gains that resulted from these terminations. The OIG

estimated that Medicare is due $22.1 million plus accumulated interest of $5.5 million, for a total of $27.6 million.

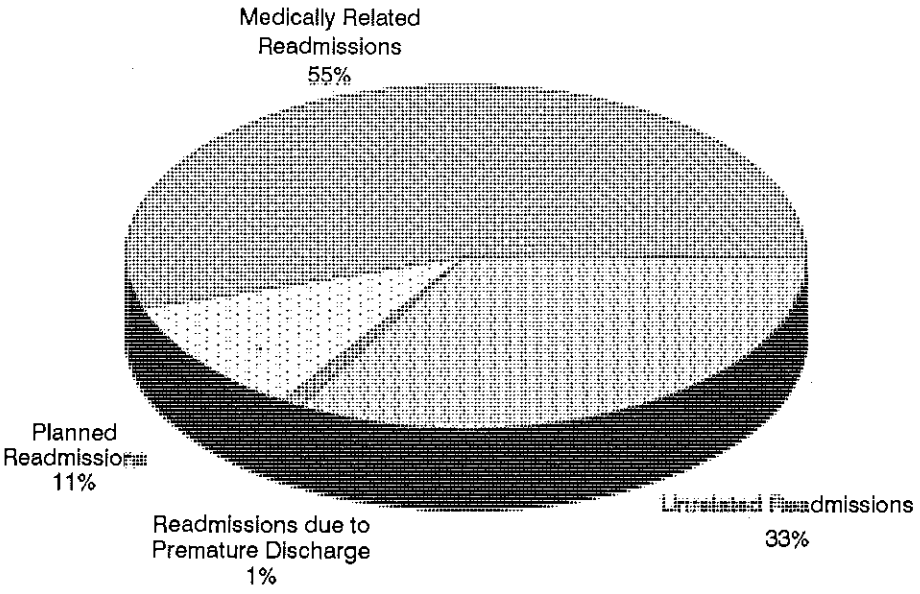
The OIG recommended that HCFA recover Medicare's share of pension asset reversions that were realized by Humana and HCA when they terminated their pension plans. The HCFA agreed that it was entitled to and should recover Medicare's equitable share of the reversions. However, HCFA would have to determine whether intermediairies could reopen cost reports, and would have to review the cost effectiveness of pursuing collection action before initiating any corrective actions. (CIN: A-07-89-00134)

## HOSPITAL READMISSIONS

Under PPS, a hospital receives a pre-established payment for each discharge based upon its diagnosis related group (DRG). An OIG inspection examined the causes and frequencies of multiple readmissions of Medicare beneficiaries, and the implications for management of the PPS. The readmission of a patient may result from premature discharge, scheduled re-hospitalization or natural recurrence of the disease, or it may have no relationship to the original cause of hospitalization. The peer review organizations (PROs) monitor hospital readmissions to identify premature discharges.

The OIG found that over one-half of readmissions occur because of the natural recurrence of the disease. Approximately one-third of readmissions do not medically relate to the initial admission. Nearly one-sixth of the readmissions are planned at the time of the previous discharge. Only 1 percent of readmissions are the result of a previous premature discharge.

### REASONS FOR HOSPITAL READMISSIONS



The OIG determined that PRO scrutiny of readmissions identifies no more clinical incidents of unnecessary admissions, poor quality care or premature discharge than random selection of cases for review. Discontinuing such scrutiny would eliminate nearly 37 percent of PRO reviews, the annual cost of which is estimated at $45 million to $55 million. The OIG also noted that hemoglobinopathies (which group to the DRG for red blood cell disorders) have significantly high rates of readmission, both necessary and unnecessary.

The OIG recommended that HCFA re-evaluate the effectiveness of PRO surveillance of readmissions versus surveillance of random admissions, and suggested that HCFA study the effectiveness of PRO utilization review of hemoglobinopathies. The HCFA disagreed with the recommendations. They stated that they cannot discontinue surveillance of readmissions without statutory change and that any significant reduction in the review sample size could violate congressional intent. The OIG continues to believe that HCFA should propose legislative changes and take administrative actions to implement the recommendations. (OAI-12-88-01220)

## PATIENT SATISFACTION WITH OUTPATIENT SURGERY

The OIG conducted a survey of Medicare beneficiaries to compare patient satisfaction in two outpatient settings: ambulatory surgical centers (ASCs) and hospital outpatient departments (OPDs). The OIG found that beneficiaries overwhelmingly preferred outpatient surgery to inpatient hospital stays, regardless of the surgical setting or procedure involved, and regardless of the beneficiaries' age or sex.

One third of the beneficiaries took care of themselves after surgery. For the vast majority of those beneficiaries who required assistance after surgery, at-home recovery did not impose a financial burden on caregivers because most did not have to take time off work to render the necessary assistance. The OIG also noted that most respondents reported symptoms which indicated that their procedures were medically necessary. (OAI-09-88-01002)

## SANCTION AUTHORITIES

During this reporting period, OIG imposed 408 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.

### A. Patient and Program Protection Sanctions

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

care license. Exclusion is mandatory for those convicted of program-related crimes or patient abuse. The following cases are examples of some of the sanctions imposed during this reporting period:

- The vice president of a New York home health service was excluded for 15 years for falsifying business records to show that his employees met the State Medicaid agency's requirements. Financial damage to the Medicaid program was more than $1 million. (2-89-40011e-9 , Israel Cohen, Martin Weissman)

- The two owners and the husband of one of the owners of an intermediate care facility were each excluded for 10 years. They had been convicted of neglecting the residents of the facility. Court documents indicated that the facility lacked basic supplies such as surgical dressings and protein liquids for tube feedings, and that prescribed medications were not obtained or administered. (4-89-40597-9 , Roger Dale, Jeanette & Milton Quinn )

- After being convicted of conspiracy and submitting a false claim to a private insurance company, a North Carolina nurse was excluded for 5 years. (4-89-40234-9, Pamela Gurgarrus )

- The owner of a Maryland counseling center and the center itself were convicted of obstruction of justice related to a Medicaid fraud investigation. In consequence, each was excluded for 5 years from the programs. (3-89-40147-9 , James Lee Hickey, Abundent Life Center Inc. )

- An Alabama pharmacist convicted of illegally dispensing controlled substances was excluded for 5 years. (4-89-40152-9 , Kevin Edward King )

- A New York physician was excluded indefinitely after his license was revoked by the State for professional misconduct. He engaged in conduct which caused injuries to his infant son and then failed to secure appropriate medical attention. The baby died. (2-89-40298-9 , Phillip F. Campolo )

- A New York medical corporation was excluded for 5 years because an excluded physician had a direct or indirect ownership of 5 percent or more in the corporation. (2-87-40876-9 , Omni Medical)

- A Wisconsin physician who furnished services in excess of the needs of his patients was excluded for 5 years. (5-86-41041-9 , Hugh McLane )

## B. Civil Monetary Penalty Settlements

Under the civil monetary penalty (CMP) authorities enacted by the Congress, health care providers may be assessed thousands of dollars in fines and penalties for each false item claimed

against Medicare and Medicaid. The following cases are examples of some of the more significant settlements made during the past 6 months:

- A billing service firm for three New York hospitals submitted improper Medicare claims. The firm and one of the hospitals signed agreements to pay a total of $3.5 million in settlement. Settlement with a second hospital is pending. The third hospital has closed. (2-87-30641-9, 2-89-30861-9, Prime Medical & Victory Memorial Hospital)
- Two psychiatrists in Oklahoma agreed to pay a total of $668,000 in fines, restitutions, and civil monetary penalties for falsely billing Medicare and Medicaid. The agreement was part of a global settlement which included a criminal plea to charges of not providing or documenting services as claimed. In addition, each is excluded from the programs for 5 years. (6-90-30145-9, Joe & Merli Ferrno)
- An administrative law judge held that an Iowa group of anesthesiologists had to pay $258,000 in restitution, penalties, and assessments for filing 211 false Medicare claims. Individual group members were also excluded from the program for 2 to 3 years for their parts in the scheme. Over a 3-year period, they had claimed they were supervising certified registered anesthetists when they were not. (7-85-30011-9, Anesthesiologists Affiliated)
- A $190,000 CMP settlement was reached with a Texas doctor and two of his nonmedical associates. They had filed Medicare claims for optometry services actually rendered by nonmedical personnel. (6-88-30432-9, Marvin Nobel and Associates, Ted Bogart & Lester Eisenberg)
- A Colorado physician who billed separately for biopsies included in billings for other services paid an $85,000 CMP. (8-89-30076-9, Bruce Webber)

## REIMBURSEMENT BASED ON AVERAGE WHOLESALE PRICES

At HCFA's request, OIG reported on the results of an ongoing review of average wholesale prices (AWP) used for reimbursing pharmacies participating in the Medicaid and Medicare programs. A current OIG review of drug purchase data found that, on average, pharmacies buy drugs for 15.5 percent below AWP. An earlier OIG audit (ACN: 06-40216), yielding similar results, proposed that HCFA revise Medicaid regulations to preclude the use of nondiscounted AWP in pharmacy reimbursement. The HCFA issued revised instructions to this effect in August 1989. The OIG recommended that HCFA continue to require State Medicaid agencies to discount AWP when making program reimbursements. (CIN: A-06-89-00037)

## FRAUD INVOLVING DURABLE MEDICAL EQUIPMENT

Fraud in the durable medical equipment (DME) industry continues to be a source of major concern to OIG. Seat lift chairs, wheelchairs, 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 prescription by engaging in aggressive sales practices, tricking physicians into signing authorizations, and even forging physician signatures. Some suppliers simply bill for items never delivered. The following cases are examples of some of the actions taken against suppliers during this reporting period.

- The two co-owners of two DME companies in New York were given 3-year and 14-month jail sentences for fraudulently billing Medicare and Medicaid for seat lift chairs. The two companies were fined a total of $270,900, and each had to pay $10,000 toward the costs of prosecution. In addition, the judge ordered forfeiture of $340,000 which the Medicare carrier had held in escrow. The subjects had received hundreds of thousands of dollars more than they were entitled to by submitting claims in areas where reimbursement was highest rather than where the sales were actually made. (2-85-01432-9, Health Med. Systems, Inc.)
- The owners and bookkeeper of a Texas-based DME company specializing in seat lift chairs were sentenced after conviction for Medicare fraud. The owners were given 5 years probation and fined a total of $22,500, plus special assessments of $1,350. They also must perform community service and be excluded from participation in the Medicare program for the length of their probation. The bookkeeper was sentenced to 3 years probation, a $2,500 fine, and a special assessment of $700. Employees of the company had contacted Medicare recipients offering "free" seat lift chairs. They then sent orders for the chairs to the recipients' physicians for authorization, saying the recipients requested them and threatening lawsuits if they did not sign. Medicare also was billed for purchase of "new" chairs which had been rented. In 1986 and 1987, Medicare paid the company approximately $1.5 million. (4-86-00239-9, Keith & Michelle Irby, Theresa Peters)
- The manager of another Texas DME company was sentenced to serve 6 months in prison, fined $10,000, and ordered to make full restitution of $2,500 for falsifying Medicare claims. Investigation showed that more than 25 percent of the beneficiaries for whom claims were filed never received any equipment. In other instances, equipment which was delivered but not covered by Medicare was billed as though it were. (4-85-00327-9, Medical of Washington County)
- The OIG conducted an investigation aimed at civil action against a man convicted for billing Medicare for equipment after it had been returned. During

the investigation it was discovered that he had billed Medicare for DME supplied to nursing homes by concealing the patients' true residences. He was ordered to pay $125,000 over 8 years, for a total, with interest, of $181,000. He was also suspended from the Medicare and Medicaid programs for 10 years. (5-85-31326-9, Larry Aronoff)

- The owner of a DME company in New York was sentenced to 30 months in jail and restitution of $137,000 for defrauding Medicare. He had submitted claims for oxygen concentrators and other items which were never delivered to patients. (2-86-00912-9, Home Convalescent Equipment, Henry Bessette)

## OXYGEN CONCENTRATORS

Medicare pays for medically necessary oxygen used by beneficiaries in their homes. Coverage is limited to oxygen needed for a home oxygen therapy program requiring delivery of oxygen as prescribed by the patient's attending physician. One method of oxygen delivery is the oxygen concentrator, an electrically operated machine that filters nitrogen and other components from room air to produce concentrated oxygen.

An OIG review of oxygen concentrator payments at five carriers disclosed overpayments of approximately $31 million for the year ending August 31, 1988. The OIG found that one-third of the beneficiaries sampled either did not need oxygen or did not need oxygen to the extent billed. Overpayments occurred because weaknesses in the internal control system did not hold the prescribing physician accountable for the documentation to support claims for home oxygen. Most of the information required to substantiate the need for home oxygen was provided to physicians by durable medical equipment suppliers.

The HCFA had established a standard certification statement for completion by the attending physician to document the need for home oxygen. The OIG recommended enhancements to that form and proposed that HCFA report the internal control weakness as a material weakness under the Federal Managers' Financial Integrity Act. (CIN: A-04-88-02058)

## PAYMENTS TO UNIFORMED SERVICES TREATMENT FACILITIES

The Uniformed Services Treatment Facility (USTF) program is a health benefit program administered by the Department of Defense (DOD). The USTFs are 10 former Public Health Service hospitals authorized to provide medical care to members of the uniformed services and their beneficiaries, and to retired members and their families. Some individuals who are eligible for the USTF program are also eligible for the Medicare program. Officials at DOD notified OIG that some USTFs bill Medicare for services covered and paid for under the USTF agreements. Medicare payment is not authorized under such circumstances.

The OIG proposed that HCFA require that each USTF refund any Medicare payments received on behalf of dually eligible beneficiaries. The OIG also recommended that HCFA clarify existing policy to indicate that Medicare should not pay for care provided to a patient eligible for the USTF program. (CIN: A-14-90-00325)

## LABORATORY KICKBACKS TO PHYSICIANS

Under Federal statutes, physicians are enjoined from accepting payments, or kickbacks, from laboratories for referring patients for diagnostic tests. Two major ongoing kickback cases have resulted in large recoveries to the Federal Government:

- A major laboratory corporation agreed to pay $1.5 million to settle liabilities under a Federal kickback statute. The OIG found that more than 100 physicians were investors in three California laboratories managed by the company. The doctors, who referred work to the laboratories, also received a percentage of the profits, thereby violating the prohibition against payments intended to induce referrals of Medicare and Medicaid patients. The agreement is the largest ever made under the anti-kickback statute. (9-90-44020-9, SmithKline Bio Science Labs)

- The two owners of three diagnostic laboratories in Pennsylvania were sentenced for paying kickbacks to physicians for referrals. Each was given 5 years probation, ordered to pay restitution of $100,000 and forced to relinquish $166,000 in claims held in escrow by the Medicare carrier. Through their cooperation with OIG and the United States Attorney, 331 demand letters were sent out and 18 civil judgments obtained against physicians who had accepted kickbacks. More than $700,000 has been recovered through these means by the Federal Government. (3-86-00095-9, 3-84-00013-9, 3-88-20220-9, Brill & Cortese

## INTRAOCULAR LENSES

The OIG conducted studies on the cost of intraocular lenses (IOLs) purchased through the Federal Supply Schedule (FSS) and by the Indian Health Service (IHS). An IOL is used to replace the natural lens missing from the eye, whether due to surgical removal, disease or congenital absence. Over 90 percent of all cataract surgery patients receive an IOL implant. The volume of Medicare-funded cataract surgery is increasing, with over 950,000 such surgeries in 1987. When purchased in an ambulatory surgical center, Medicare reimbursement for an IOL averages $350. Prices vary in other settings. Two previous OIG studies recommended that HCFA establish a $200 reimbursement cap for IOLs.

## HOSPITAL ACQUISITION OF COMPUTER SOFTWARE PROGRAMS

The OIG conducted an inspection to assess the impact of computer software used in medical records departments on Medicare reimbursement. With the advent of PPS, hospitals began using computer software programs to improve the accuracy of their coding of medical records and to anticipate the amount of reimbursement they would receive. Two types of software are being used. The first, called encoders, assists hospital staff in translating medical record documentation into diagnosis and procedure codes. The second, called groupers, makes DRG assignments based on these codes. Hospitals submit the diagnosis and procedure codes to their Medicare fiscal intermediaries who convert them into the appropriate DRG for payment. Each DRG is assigned a numerical weight reflecting the relative costliness of providing care. To provide a comparative measure of the aggregate mix of patient DRGs among hospitals, a hospital-specific case mix index (CMI) is computed. The CMI is the weighted average of DRGs for that hospital's Medicare discharges.

The CMIs were expected to increase over time due to changes in medical practice and the changing characteristics of the inpatient population. The estimated increase for the first 6 years of PPS was over 42 percent. The PPS was intended to include compensation for the increased use of hospital resources on more complicated cases. However, PPS was not intended to pay for higher-weighted DRGs resulting from improvements in coding practices, since these do not reflect increases in resources used in treating patients. The analysis of software acquisition and Medicare case index data indicated that the presence of a grouper, an encoder, or both, did not have an independent effect on a hospital's CMI. The OIG concluded that the increases in CMI since the inception of PPS were not attributable to the acquisition of this software by hospitals. (OAI-02-88-01310)

## PREMIUM COLLECTION BY THE RAILROAD RETIREMENT BOARD

The HCFA administers the Medicare Part B program and is responsible for ensuring that premiums are collected for all enrolled individuals. The Social Security Administration (SSA) is responsible for collecting premiums from beneficiaries of the Retirement, Survivors, and Disability Insurance (RSDI) programs and the Railroad Retirement Board (RRB) is responsible for collecting premiums from railroad annuitants.

In a follow-up to a HCFA internal report, OIG identified a problem involving individuals who, because of a change in their status, began receiving RSDI benefits in lieu of RRB benefits. The OIG estimated that 379 former RRB beneficiaries enrolled in Medicare Part B were not having premiums collected by either RRB or SSA because they had not been transferred to SSA's jurisdiction. The problem appeared to be in the data exchange between RRB and HCFA.

The HCFA implemented the OIG recommendation to establish a control on jurisdictional transfer cases from RRB. In addition, they developed procedures to verify the annotation of SSA's

records when responsibility for premium collection is transferred from RRB to SSA. The OIG estimates program savings of $1.5 million over the budget cycle as a result of these changes. However, HCFA did not respond to OIG's recommendation for periodic review of the jurisdictional status of all former RRB beneficiaries whose benefits terminated for reasons other than death. The OIG believes that such review is needed to ensure that the new controls are effective. (CIN: A-03-88-00006)

## END STAGE RENAL DISEASE NETWORKS

Created by statute in 1978, end stage renal disease (ESRD) networks are responsible for the collection and validation of ESRD medical information system data and for assuring the quality of service delivery to ESRD beneficiaries. They are also intended to encourage placement of renal patients in vocational rehabilitation programs, identify ESRD facilities that do not provide appropriate medical care, and establish procedures to evaluate and resolve patient grievances.

The OIG determined that the issue of legal liability prevents ESRD networks from performing their medical review responsibility. Current Federal law and regulations do not protect ESRD networks from law suits resulting from adverse medical review determinations or from the release of confidential information related to the performance of quality assurance and grievance processing duties. The OIG also found that, based on HCFA's interpretation of the statute, the networks are not currently monitoring quality of care for those individuals on home dialysis that elect to order directly from home dialysis suppliers.

The OIG recommended that HCFA, the Assistant Secretary for Planning and Evaluation and the Assistant Secretary for Legislation obtain legislative authority to resolve the liability and privacy issues and to permit ESRD networks to perform quality reviews for all ESRD patients. Section 6219 of the Omnibus Budget Reconciliation Act of 1989 applies the PRO liability protection to members of the ESRD network administrative organization, including the medical review board. (OAI-07-89-00220)

## MEDICARE REIMBURSEMENT OF BAD DEBTS

An OIG audit found that National Medical Care (NMC), a national chain of ESRD facilities, overstated its claim for reimbursable bad debts of 63 facilities by $2.2 million for 1987. This occurred because NMC inappropriately charged these facilities approximately $16 million in unallowable costs.

Medicare includes coverage for eligible persons suffering from kidney failure under its ESRD program. The HCFA utilizes a prospective method of payment for maintenance dialysis. Under this system, HCFA establishes a composite rate per treatment to reimburse independent renal dialysis facilities and hospital based facilities. The ESRD facilities are reimbursed 100 percent of their allowable bad debts, up to their unreimbursed Medicare reasonable costs. However, if the

facility's Medicare revenue exceeds its Medicare costs, there is no unrecovered cost and the facility is not eligible to receive payment for Medicare bad debts (unpaid deductible and coinsurance).

The OIG recommended that NMC establish procedures to exclude from future cost reports the type of unallowable costs identified during the review. In addition, OIG recommended that HCFA instruct the fiscal intermediaries to make the appropriate adjustments to NMC's reimbursable bad debts for 1987. (CIN: A-01-89-00511)

## RURAL PHARMACY CLOSURES

At the request of the Secretary of HHS, OIG conducted an inspection to examine the extent and causes of rural pharmacy closures in Georgia during FY 1989. Special attention was focused on the possible relationship between Medicaid reimbursement and pharmacy closures.

The OIG found that very few rural pharmacies in Georgia closed in the past year, and that those closings were the result of retirement and financial problems. None of the closures were attributed to Medicaid reimbursement policies. However, some respondents cautioned that as more Medicaid cost containment measures are implemented in Georgia, small pharmacies with a high percentage of Medicaid sales may encounter financial problems. (OAI-04-90-00990)

## PENNSYLVANIA HEALTHPASS CONTRACT

The Social Security Act permits the Secretary to authorize a State to implement a primary health care management system. The Pennsylvania Department of Public Welfare (DPW) received such an authorization to operate its HealthPASS program. The DPW had an open competition for a contractor and selected Healthcare Management Alternatives, Inc. (HMA) to operate the program for a 55 month period beginning July 1, 1989. The contract was estimated to cost approximately $633 million over its life span. Subsequently, DPW awarded HMA a $1.5 million contract to develop the case management system to be used in implementing the HealthPASS contract.

The OIG review of the State's contracting process disclosed favoritism and numerous other improprieties in the award of these contracts. The DPW did not adequately document its actions during the critical contractor selection and negotiation stages of these contract awards. In addition, there was a lack of adequate documentation to support the reasonableness of an award of a $1.5 million developmental contract to HMA. The OIG established that HMA was not able to safeguard these funds and that internal controls were virtually nonexistent.

The OIG recommended that HCFA not approve the State's contracts with HMA and not reimburse the State's related claims for Federal funds. The HCFA generally agreed with the recommendations and disapproved the DPW contracts. Subsequently, lawsuits were filed against

HCFA. As a result of a court approved agreement, all parties agreed to resolve the matter through the execution of a memorandum of understanding (MOU). The MOU requires an amended contract between DPW and HMA for an 18-month term and a reprocurement for the HealthPASS contractor effective January 1, 1991. (CIN: A-03-89-00238)

## UNAUTHORIZED CONTRACTUAL COMMITMENT

An OIG audit disclosed unauthorized contractual arrangements involving seven Medicare systems projects initiated by HCFA's BPO with three BCBSA subcontractors, a commercial Medicare intermediary and three Medicare Part B carriers. Totaling $17.5 million, these contractual arrangements were made from 1985 through 1987 as Medicare productivity investment projects.

The BPO officals who initiated the projects with three BCBSA subcontractors did not have contracting authority. Procurements on four additional Medicare systems improvement projects were improperly executed via memoranda of understanding.

The OIG recommended that the Administrator of HCFA or his designee take immediate action to ratify the seven intermediary and carrier contract commitments for those Medicare systems improvement projects and to issue contract modifications to properly authorize funds already expended. Further, OIG proposed that HCFA report these conditions as a material weakness under the Federal Managers' Financial Integrity Act. The HCFA agreed to ratify, as appropriate, the intermediary and carrier commitments and to follow up on those contract actions that were still in need of modification; and agreed to report these deficiencies as a material internal control weakness. (CIN: A-14-88-02026)

## UNLIQUIDATED OBLIGATIONS

An OIG audit was performed as part of a Governmentwide President's Council on Integrity and Efficiency initiative to determine the propriety of Federal administration of unliquidated obligations (ULOs) in HCFA's merged appropriation accounts ("M" accounts) as of September 30, 1987.

The review showed that HCFA had no formalized policies and procedures for reviewing "M" account balances and had not performed required annual reviews of appropriation accounts. The OIG determined that 90.8 percent of HCFA's ULO balances in their sample should have been deobligated prior to September 30, 1987. In addition, ULOs reported to Treasury were not always identifiable in the subsidiary records. The OIG found no instances of misuse of unspent obligated monies.

The OIG recommended that HCFA reconcile "M" account balances on the general ledger with the balances shown on the ULO aging schedule; take appropriate action to deobligate the remaining inappropriate ULO balances; formalize current policies and procedures for reviewing "M" account balances; and perform required reviews of ULOs in "M" accounts at least once a year and document the results of each review. The HCFA agreed with the recommendations.

Similar problems were uncovered in other HHS Operating Divisions. The various findings will be consolidated by the Department and reported as a single material nonconformance to the President and the Congress under the Federal Managers' Financial Integrity Act. (CIN: A-14-89-02037)

## MEDICAL TRANSPORTATION FRAUD

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

- The co-owner of a Michigan ambulance company was ordered to make restitution of $4,000 and a civil monetary penalty of $14,600 for submitting false Medicare claims. He and his partner, who had received the same sentence, had contracts with three nursing homes to transport patients to scheduled doctor and dentist visits. They claimed to Medicare, however, that the trips were medically necessary and ordered by physicians because the patients were nonambulatory. Both partners and their company were suspended from the Medicare and Medicaid programs for 5 years. (5-86-00949-9, Daniel Barbacovi)

- The owner of several New York ambulance companies was sentenced to a year and a day in prison for filing false Medicare and Medicaid claims. Investigation by OIG showed that his companies submitted claims for ambulance transportation when ambulettes were used, billed for excessive mileage, and billed for trips never made. An earlier civil suit against his ambulance companies was settled for $3.2 million. (2-84-01290-9, Hugh Nastasi)

## FALSE CLAIMS

The range of individuals convicted during this period for filing false claims against the Medicare and Medicaid programs is illustrated by the following cases:

- An Illinois gynecologist was sentenced to 41 months in prison, 5 years supervised release (during which he is not to practice medicine and is to be monitored for drug aftercare) and restitution of $129,000. As the result of investigations by OIG and the Drug Enforcement Administration, he had pled

guilty to filing false Medicare claims, illegally dispensing prescriptions, and distributing cocaine. Over a 6-month period, he had filed office visit and test claims going back 2 years, some for a patient that had been dead for a year and others for patients who had received none or only part of the services billed. Included were claims for office visits on days the patients were in the hospital. (5-87-01393-9, Edward Tapper)

- A firm was sentenced in Michigan for submitting 837 false Medicare claims on behalf of a group of physicians between January 1983 and December 1984. An OIG investigation showed that the claims misrepresented patients as receiving holter monitoring services when they only received cardiac monitoring while being treated in the emergency room. The firm had to pay the maximum fine of $10,000 and restitution of $67,375. It was also excluded from the Medicare and Medicaid programs. (5-84-00277-9, Maraveleas Associates)

- An Illinois anesthesiologist and his brother-in-law, a chiropractor, agreed to settle a civil complaint by repaying $30,000 in Medicare funds and $5,000 in civil monetary penalties. The chiropractor had used his brother-in-law's provider number for services such as x-rays and physical therapy for which chiropractors may not be reimbursed. Investigation showed that most of the services had been performed at times when the anesthesiologist was not in the office. (5-88-20007-9, Zaplichi Boman & Witole Rybicki)

- Another Illinois anesthesiologist agreed to settle a false claims case by making restitution to Medicare of more than $8,700 and paying a penalty of $6,000. Investigation showed that he had billed Medicare for supervising nurse anesthetists for periods he was not present in the hospital. (5-88-20101-9, Edwin De Castro)

- The owner of an Arkansas nursing home was sentenced to 6 months in prison, $10,000 in fines and $14,200 in restitution of money he had illegally obtained from the Medicaid program. He was part of a scheme whereby his nursing home received lease payments for beds already owned. The owner of the medical supply company involved was sentenced earlier for devising the scheme. (4-89-00389-9, Ray Huckaby)

## MEDICAID INPATIENT PSYCHIATRIC BENEFIT FOR CHILDREN

An OIG review found a discrepancy between the law and regulations, involving the inpatient psychiatric benefit for children under Medicaid. The Social Security Act clearly limits this benefit to children receiving care in psychiatric hospitals which meet Medicare standards. Current Medicaid regulations, however, permit States to obtain Federal funding for children in nonhospital settings, such as residential treatment centers.

A survey by HCFA in 1985 identified eight States that were receiving Medicaid funding for children in psychiatric facilities other than hospitals. Recent payment data indicate that about $17 million in Federal Medicaid funds is being spent each year for such care in four of those eight States.

Based on the statutory language and its legislative history, OIG recommended that HCFA revise the regulations to limit this benefit to services provided in psychiatric hospitals which meet Medicare standards. In addition, OIG proposed that HCFA report this deviation from the statute to the President and the Congress as a material internal control weakness. The HCFA did not concur and replied that its policy offered inpatient psychiatric care for children in the most cost-effective setting. In addition, HCFA pointed out that the Omnibus Budget Reconciliation Act of 1989 requires the Secretary to report to the Congress by October 1, 1990 on recommended modifications to current law and policy concerning the provision of services in public sub-acute psychiatric facilities which serve patients who would otherwise be hospitalized. The OIG believes that cost-effectiveness is not at issue here. Absent express congressional authorization to the contrary, medical care provided to patients in psychiatric facilities has traditionally been the responsibility of the States, rather than the Federal Government. Unless the legislative amendment is enacted, therefore, HCFA should implement the OIG recommendations. (CIN: A-09-89-00111)

## FRAUD REFERRALS BY MEDICAID AGENCIES

Almost all Medicaid agencies contain a surveillance and utilization review subsystem which serves as the locus for identifying fraud and abuse by Medicaid providers and beneficiaries. Medicaid agencies are required by regulation to refer all cases of suspected fraud to the Medicaid fraud control units (MFCUs). Responsibility for investigating and prosecuting Medicaid fraud is assigned to the MCFUs, which are generally part of the States' Attorney Generals' offices. Federal oversight of the Medicaid program is vested in HCFA; Federal oversight of MCFU activity is vested in OIG.

An OIG inspection found that State Medicaid agencies are failing to refer a significant number of potential fraud cases to the MFCUs and that HCFA is not monitoring the system to ensure that appropriate referrals are made. The OIG determined that those States in which the Medicaid agencies and the MFCUs were most cooperative yielded the best results.

The OIG recommended that HCFA hold State Medicaid agencies accountable for making fraud referrals, encourage State Medicaid agencies to develop close working relationships with the MFCUs, and provide increased technical assistance to the agencies for the identification of fraud and abuse. The HCFA generally agreed with the findings and proposed to take some corrective actions. However, OIG believes that these actions, while constructive, are not fully responsive to the report recommendations. (OAI-03-88-00170)

## 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 care and treatment costs only when certain criteria are satisfied.

### A. California: Short/Doyle Program

**1.** The OIG determined that for Fiscal Years (FYs) 1970 through 1986, California allowed a large backlog of unresolved Short/Doyle audit reports to accumulate and had not properly credited the Federal Medicaid program for its share of the associated overpayments. The Short/Doyle program is a component of the California Medicaid program serving the mentally ill which is operated by the various counties in California. The counties bill the Department of Mental Health for their Short/Doyle costs, and these in turn are passed on to the Department of Health Services which submits claims for Federal cost sharing to HCFA.

Since September 1988, the Department of Mental Health has been reviewing its backlog of unresolved audit reports for Medicaid overpayments. It has thus far identified $3.5 million (Federal share) in unreported overpayments through FY 1983 and another $7.8 million in potential overpayments for the same period. The OIG recommended that California refund the entire $3.5 million in identified overpayments, promptly resolve the remaining backlog of audit exceptions and report the associated overpayments for refund in accordance with Medicaid law. The State and HCFA concurred with the findings and recommendations and $3.5 milion has been recovered through voluntary State adjustment. (CIN: A-09-89-00060)

**2.** A follow-up review of earlier OIG audits covering the four fiscal years ending June 30, 1986 showed that the State of California generally attempted to comply with OIG's recommendations. However, the review of FY 1987 expenditures disclosed two additional problem areas. The OIG found that the State claimed $740,000 in Federal Medicaid funds twice. Additionally, certain counties' charges to the program were based on provisional rates that substantially exceeded their actual costs, resulting in overclaims of Federal Medicaid funds totaling $4.5 million.

The OIG recommended that the State take steps to accurately account for the program's expenditures and refund $5.3 million. The State and HCFA concurred with the findings and recommendations and $5.3 million has been recovered through voluntary State adjustment. (CIN: A-09-89-00088)

### B. New Jersey

Medicaid law precludes Federal matching for patients under 65 in institutions for mental diseases (IMDs), except for patients under 22 in qualified psychiatric hospitals. Based on a review of patient records at a New Jersey intermediate care facility, OIG concluded that the institution had the overall characteristics of an IMD. Accordingly, OIG found that approximately $4 million in

Medicaid funds had been improperly claimed by the State as Federal reimbursement for patient care.

The OIG recommended that the State make a financial adjustment of $4 million for these federally nonreimbursable services. Although the State disagreed with the OIG report, HCFA concurred with the findings and recommendations and is preparing a disallowance action. (CIN: A-02-88-01029)

### C. Colorado

The OIG determined that during the 18 months ending March 31, 1987, Colorado overpaid its Medicaid providers by $10.1 million (Federal share). The OIG found that providers were overpaid; segments of the paid claims history file and individual claims forms were missing; the fiscal agent had issued duplicate payments; peer review organization certifications for hospital claims were either missing or had fewer days authorized than paid for by the fiscal agent; and medical providers were erroneously paid for services performed by other providers. During the audit, the State had its fiscal agent reprocess all nursing home, inpatient and outpatient hospital claims, resulting in a refund of $7.8 million by the State to the Federal government.

The OIG recommended that the State refund the remainder of the $10.1 million overpayment, and audit the results of its reprocessed claims for accuracy and acceptability. The State and HCFA concurred with the findings and recommendations. (CIN: A-08-89-00211)

### D. Missouri

An OIG review disclosed that Missouri overpaid intermediate care facilities for the mentally retarded (ICF/MRs) a total of $6.8 million (Federal share) under the Medicaid program for services provided between November 1, 1986 and September 30, 1988. The overpayments occurred because the State rebased ICF/MR payment rates effective November 1, 1986 without obtaining the required HCFA approval of a State plan amendment. Federal regulations mandate that a State plan specify the methods and standards to be used to set reimbursement rates.

The OIG recommended that Missouri return the $6.8 million in Federal funds for reimbursements in excess of the rates contained in the approved State plan. The OIG also recommended that Missouri establish procedures to ensure that only rates contained in its approved State plan were used for making payments to ICF/MRs. State officials disagreed with the OIG report. However, HCFA officials concurred with the findings and recommendations and is preparing a disallowance action. (CIN: A-07-89-00173)

## STATE MEDICAID FRAUD CONTROL UNITS

During FY 1988, Medicaid health care provider payments exceeded $48.7 billion dollars. These payments represent a 270 percent increase over the $18 billion dollars expended in 1978.

Medicaid fraud control units (MFCUs) are currently responsible for investigating fraud in more than 91 percent of all Medicaid health care provider payments.

Thirty-eight States now have units and are receiving funds and technical assistance from OIG. Following the mandate of the Congress, the MFCUs bring to prosecution persons charged with defrauding the Medicaid program and those charged with patient abuse and neglect. They also work with local survey and utilization review units to draft proposed regulations governing providers to ensure that these regulations will stand up in court.

During the first half of FY 1990, OIG administered $25.3 million in grants to the MFCUs and conducted 6 State recertifications and technical assistance visits. The MFCUs reported 170 convictions and $4.9 million in fines, restitutions and overpayments collected.

# SOCIAL SECURITY ADMINISTRATION

# CHAPTER III

# SOCIAL SECURITY ADMINISTRATION

## OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

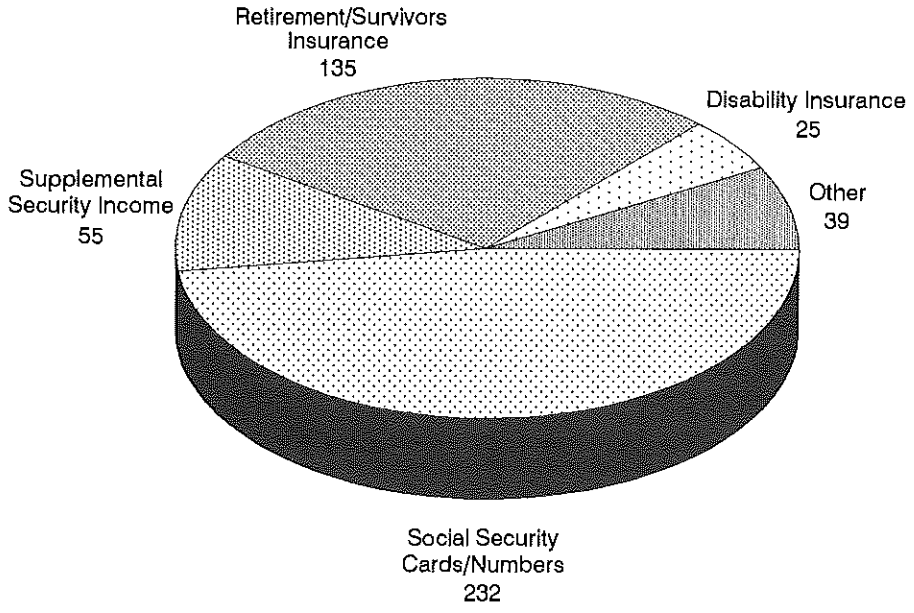
Fifty-five years ago, the Social Security Act established a national insurance system that would be financed through payroll taxes collected from workers and employers and would pay benefits to workers in their old age. The Retirement, Survivors, and Disability Insurance (RSDI) program, popularly called Social Security, is the largest of the Social Security Administration (SSA) programs. In FY 1990, SSA will pay approximately $243 billion of these benefits to more than 39 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-worker beneficiaries.

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 1990, SSA will pay SSI benefits in excess of $11 billion.

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

The OIG is currently undertaking a number of important initiatives with respect to SSA programs and operations. Prior OIG activities which resulted in substantial benefits include evaluations of SSA's financial statements; suggestions for important legislative and regulatory changes; and recommendations for more efficient and effective operations, reductions and/or recoveries of RSDI and SSI overpayments, and other improvements in SSA's operations and internal controls. During this reporting period programmatic savings totaled $41.4 million. An additional $500,000 in program expenditures were questioned as to their allowability under law, regulations or cost principles. As illustrated in the chart below, investigations resulted in a total of 486 convictions.

## SOCIAL SECURITY PROGRAMS
## Successful Judicial Prosecutions




## INTERNAL CONTROL REVIEW

The OIG identified the following significant weakness within SSA in the first half of FY 1990:

- An internal study conducted by the Office of Program Integrity Reviews disclosed that benefits of numerous SSI recipients had been improperly placed in payment suspense status. Through a memorandum, OIG informed SSA that this program problem constitutes a significant weakness because it denies the public needed services. Field office personnel at SSA regularly request information from beneficiaries to evaluate their continued eligibility and payment amounts. The premature suspensions resulted from the field office staff not allowing beneficiaries enough time to respond to the notices requesting such information. In many of the cases SSA examined, the beneficiaries lacked the capacity to comply with the request because of serious mental and physical impairments. To correct the erroneous suspensions and return the beneficiaries to pay status sometimes took more than 6 months. Officials at SSA did not consider this weakness to be reportable under the Federal Managers' Financial Integrity Act.

## SOCIAL SECURITY CLIENT SATISFACTION 1990

The OIG completed the sixth in a series of surveys designed to monitor client satisfaction with Social Security services during the downsizing of SSA and the transition to a new automated claims system. The current survey was based upon the experiences of 645 randomly selected clients who initiated Social Security claims transactions during the last week of October or the first week of November 1989.

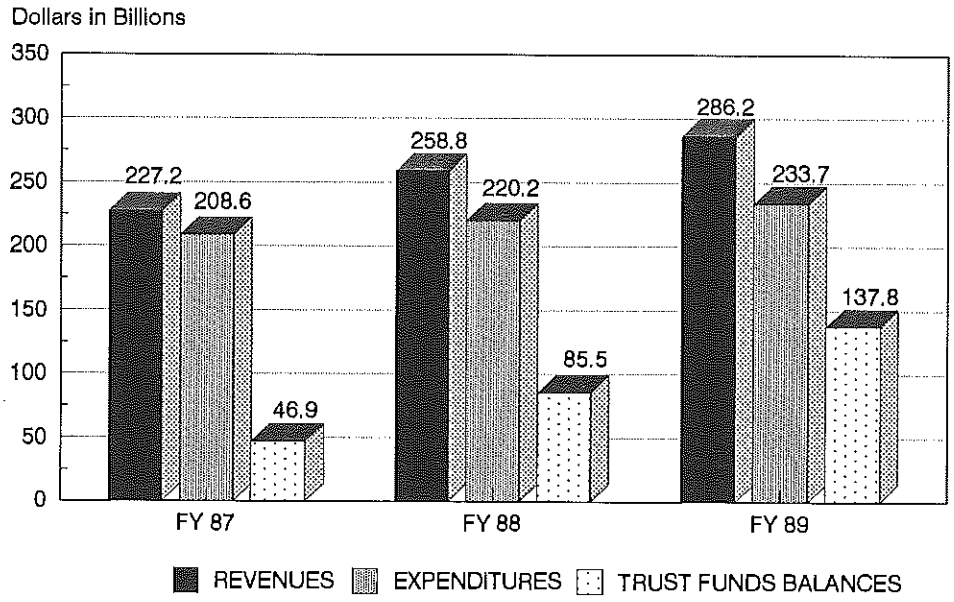
The OIG found that clients rated the overall quality of services high, with 83 percent reporting the services as either good or very good. This approximated the average findings of the five previous surveys. The OIG also found that clients' ratings for quality of service and courtesy were virtually identical regardless of whether they visited the office or telephoned. Half of those who telephoned SSA called the 800 number. A comparison of those who called the 800 number with those who called a local or long distance number showed that satisfaction was about equal, at 82 and 81 percent respectively. (OEI-02-90-00440, OEI-02-90-00441)

## AUDIT OF SSA'S FINANCIAL STATEMENTS

The OIG completed its third audit of SSA's financial statements by issuing an opinion for the fiscal year ending September 30, 1989. The preparation and audit of financial statements is in accordance with title 2 of the General Accounting Office (GAO) Policy and Procedures Manual for Guidance of Federal Agencies, and is an integral part of improving financial management and decision making in the Federal Government. The issuance of audited financial statements makes information about important Government programs accessible to those interested in the financial well-being of the programs.

As shown in the chart below, revenues, expenditures (benefit payments) and trust fund balances rose in each of the 3 fiscal years for which statements were prepared and audited. Each of these increases was expected as a result of actions initiated by the Congress. Administrative costs as a percentage of total expenditures remained relatively unchanged at about 1 percent.

## RETIREMENT AND SURVIVORS, AND DISABILITY INSURANCE TRUST FUNDS FYs 1987 - 1989



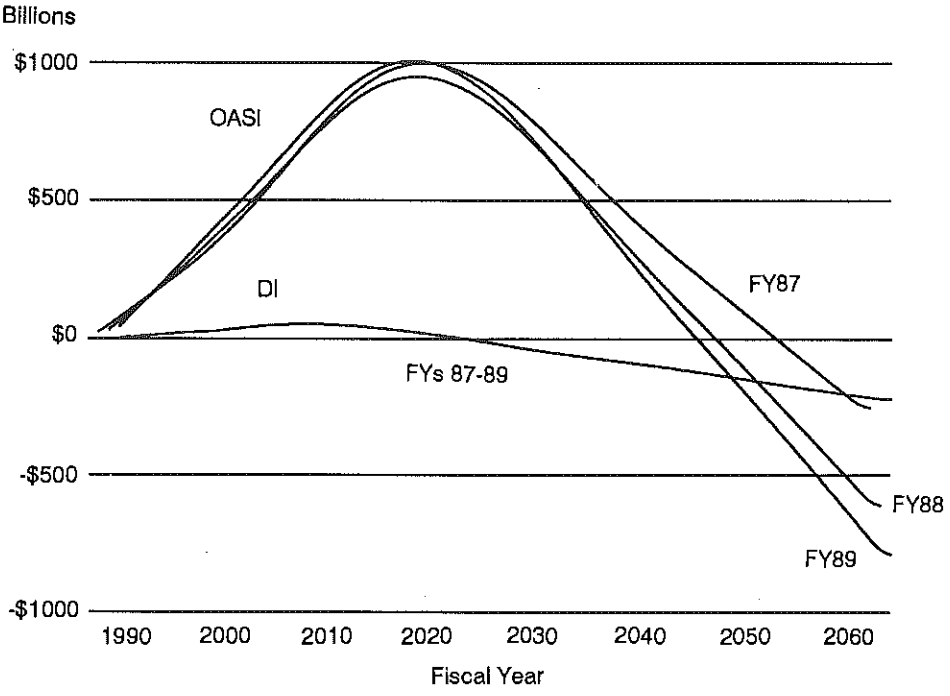

Source: Audited Financial Statements

Revenues increased from $227.2 billion in FY 1987 to $286.2 billion in FY 1989. This was due in large part to the 1983 Social Security amendments which included, but were not limited to, an increase in 1988 in the amount of Social Security FICA taxes paid by both employers and employees, and to other economic conditions, such as higher average wages. At the same time, expenditures rose from $208.6 billion in FY 1987 to $233.7 billion in FY 1989. This was due mainly to higher benefit payments based on expected increases in the numbers of eligible beneficiaries and scheduled cost-of-living increases. Because revenues exceeded expenditures each year, trust fund balances continued to increase and totaled $137.8 billion as of September 30, 1989. Again, this was an anticipated result of the 1983 amendments and was intended to build sufficient trust fund balances to pay benefits well into the next century.

In OIG's opinion, SSA's combined financial statements present fairly the financial position of the Social Security Administration at September 30, 1988 and 1989, in conformity with generally accepted accounting principles for Federal agencies. However, the audit opinion included qualifications for revenue amounts for FICA taxes recorded provisionally, of which the final resolution is uncertain; for SSA's benefit overpayments accounting system which does not meet accounting standards; and, for the lack of proper accounting procedures over property.

In accordance with title 2 of the GAO Policy and Procedures Manual, the audit of the financial statements did not include the future liability of the trust funds. However, the supplemental information included actuarial projections of the expected contributions and expenditures and accumulated trust fund balances for the next 75 years. The results of these projections, expressed in present values, are shown for comparative purposes in the chart below.

**75 YEAR ACTUARIAL ESTIMATES MADE IN FYs 1987-1989**




The projections show sufficient trust fund balances to make benefit payments until about the year 2046 for the Retirement and Survivors Insurance trust fund and between 2020 and 2025 for the Disability trust fund. While the projection for the Disability trust fund has remained relatively constant since OIG's first audit in FY 1987, the expected year of exhaustion of the Retirement and Survivors trust fund is earlier by 9 years. This information is useful to management and others responsible for assuring the adequacy of trust fund balances. (CIN: A-13-89-00029)

## PROCESSING DELAYED CLAIMS

A claim for RSDI benefits is put into delayed status when information to adjudicate the claim is incomplete. An OIG review showed that claims have remained in delayed status for unreasonable periods of time because SSA did not follow procedures for completing action on

them. In addition, SSA did not effectively utilize the SSA Claims Control System (SSACCS) to monitor disposition of such claims.

The OIG recommended that SSA emphasize to field personnel the importance of following processing procedures to finalize action on delayed claims; clarify SSACCS procedures for controlling delayed claims; strengthen the SSACCS system to improve automated controls over delayed claims; identify and properly dispose of all delayed claims over 6 months old; and establish a systematic follow-up control to ensure proper processing of delayed claims in the future. The SSA generally agreed with the recommendations and stated that appropriate changes were being implemented. (CIN: A-06-88-00037)

## RSDI BENEFITS FRAUD

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

- A woman in Virginia was given a suspended 4-year prison sentence for survivor's insurance fraud. An OIG investigation showed that, upon the death of the husband to whom she had been married for only 36 days, she had applied for mother and child survivor's benefits. Between November 1978 and December 1985 she had married two more times, continuing to file for benefits under her first married name and receiving more than $31,000. She was ordered to pay full restitution, serve 4 years active probation, and receive a psychiatric evaluation.
(3-87-00315-6, Patricia Angus)

- A Wisconsin man had to repay $56,700 and pay a fine of $1,000 for his part in a scheme whereby he helped create false company payroll records. Through this scheme, part of his reportable wages were allocated to his wife to circumvent automatic offsets against his retirement benefits.
(5-87-00922-6, Glen Geyer)

## ALIENS WORKING ILLEGALLY

Social Security numbers (SSNs) are assigned for various record keeping purposes to aliens legally admitted for nonwork reasons, such as visitors, students or temporary residents. While these SSNs are not valid for employment, if aliens violate the immigration law by working, they may have earnings credited to their Social Security accounts on the same basis as other workers.

Under current law and regulation, nonwork aliens who accumulate sufficient quarters of coverage may be entitled to RSDI benefits under title II of the Social Security Act. Eligibility is not based on a worker's citizenship or the legality of his residence or employment in the United States.

A 1985 OIG review of SSA data on nonwork SSN holders concluded that over $17 million in benefits would be paid in 1986 to aliens working illegally. An update based on more current data estimates that nonwork aliens who worked illegally received over $35 million in 1988, and that future benefits to aliens working illegally may range between $1.8 billion and $5.4 billion in the year 2032. The OIG recommended that SSA endorse pending legislation to prohibit RSDI benefits to aliens who have worked illegally. The SSA disagreed with this recommendation. (OAI-09-89-01880)

## ILLEGAL ALIENS AND SOCIAL SECURITY NUMBER FRAUD

Crimes involving the sale and use of fraudulent SSNs to illegal aliens are illustrated in the following examples of cases resolved during this reporting period:

- A foreign national was sentenced in New York to 14 months imprisonment and a $300 special assessment, after which he is to be deported. He had approached an SSA employee, offering money for Social Security cards. The employee alerted OIG. Put in contact with an undercover OIG agent, the foreign national gave the agent $400 for four Social Security card applications. A jury found him guilty of bribing an OIG agent and of Social Security number fraud. (2-88-00668-LE, Francis Barakaricasa)
- A former SSA employee in California was sentenced to 5 months probation, 2 of which were to be supervised, for SSN fraud. She had used her position to create SSA documents to shield illegal aliens from discovery. (9-87-00993-LE, Nicolerna Zipanay)

## DEPORTED ALIENS

The Social Security Act prohibits benefit payments to most deported aliens. However, it does allow payments to the aliens' auxiliary beneficiaries or survivors if they are U.S. citizens or present in the U.S.

An OIG audit estimated that over 33,000 deported aliens have had earnings posted to their records for periods after their dates of deportation. Such aliens who work illegally in covered employment are earning credits toward Social Security benefits for their auxiliaries and survivors. The OIG also found that duplicate SSN cards have frequently been issued on the account numbers of deported aliens.

The OIG recommended that SSA implement a systems control to identify earnings posted to the records of deported aliens. Information regarding deported aliens with earnings should be referred to the Immigration and Naturalization Service (INS). Further, SSA should develop a means to prevent the issuance of duplicate SSN cards on the accounts of deported aliens. Both

SSA and INS supported the OIG recommendations. The SSA will pursue implementation of the proposals in FY 1990. (CIN: A-05-88-00070)

## AVAILABILITY OF REPRESENTATIVE PAYEES

The SSA requested that OIG conduct an inspection to determine the availability of representative payees for noninstitutionalized Social Security beneficiaries who were without a relative to serve in that capacity. One quarter of SSI beneficiaries and 3 percent of RSDI beneficiaries are adjudged incapable of managing their own benefits and require representative payees to act on their behalf. While most payees are relatives or institutions, 250,000 beneficiaries in each program must rely on other payees such as State agencies, board and care type facilities, and nonrelated individuals.

The OIG found that most beneficiaries who require payees have them. Only 0.6 percent of SSI and 0.2 percent of RSDI beneficiaries had their benefits suspended because payees could not be found for them. The OIG noted that beneficiaries who require payees are concentrated in a limited number of geographical areas. The OIG recommended that SSA and the Assistant Secretary for Planning and Evaluation (ASPE) identify successful payee programs and promote them in specific geographic areas. Both SSA and ASPE concurred, and they will be working together to explore ways of implementing this recommendation. (OAI-02-89-01420)

## 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.

- An Illinois man was ordered to repay $19,000 he had illegally obtained in survivors benefits for his two daughters, and to spend 8 consecutive weekends in prison at the end of his 5-year probation period. After his wife died while on active duty with the armed forces, he claimed the two girls were living with him. In reality, one was living with her grandparents and the other had been taken into protective custody by the Illinois Department of Children and Family Services.
(5-85-00945-6, Bernard Spier)
- A California woman was sentenced to repay $10,500 she had spent in SSA benefits paid on behalf of her daughter. She had failed to report that the child was no longer in her care. She was also ordered to participate in a drug counseling program.
(9-87-00658-6, Rose Benton)

## DEATH NOTICES FURNISHED BY FUNERAL DIRECTORS

The OIG conducted a study to determine which source of death information resulted in the fastest termination of Social Security benefits to deceased beneficiaries, thus preventing or reducing the payment of benefits after death. The study also sought to determine whether use of such source could be increased.

The OIG found that the Form SSA-721 (Statement of Death by Funeral Director) was SSA's quickest and most effective source of beneficiary death information. Moreover, OIG determined that increased use of this form, on which information is furnished voluntarily by the funeral directors, is possible. The OIG determined that reliance on the statement of death form from funeral directors as the initial source of death notification could prevent or significantly reduce payments to deceased beneficiaries.

The OIG recommended that SSA intensify its efforts to encourage funeral directors to forward death notices to SSA offices on a regular and timely basis. The SSA agreed with the recommendation. (CIN: A-02-88-00011)

## 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 to use such 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 result in a continuing investigative workload for OIG. The following cases are representative of those successfully concluded during this reporting period:

- A Wisconsin man was sentenced to 19 consecutive years in prison for passing 19 forged checks. The checks were VA and SSA benefits intended for the deceased mother of the man's wife, a borderline retarded person on whom he tried to pin his crimes. At his trial, the judge became so angry with his disruptive and deceptive behavior that he sent him to jail for 1 year for each of the 19 checks he was charged with passing. (5-87-00167-6, James Hodash)

- In South Carolina, the publisher of a magazine for millionaires was sentenced to 5 years probation, 100 hours of community service, and restitution of $24,900 he had obtained by using his deceased mother's benefits. When his mother died, he had her benefits converted from check to direct deposit to make it easier to get to

the money. Although the publisher had moved to South Carolina, he continued to use the money in his mother's account. He was the last of 21 defendents to be sentenced in Project Easy Money, a follow-up series of investigations resulting from a match of Ohio death records against Social Security beneficiary rolls.
(S-87-01240-6, Richard Haggart)

## VULNERABILITY IN THE MODERNIZED CLAIMS SYSTEM

The OIG found that under SSA's modernized claims system, certain employees are authorized to take, develop, adjudicate and effect payment on claims without any independent review or compensating controls. This creates a situation vulnerable to error and/or abuse.

The OIG recommended that SSA compare identifying information for each claimant to its master files; prevent employees who adjudicate claims from processing SSN applications for claimants without SSNs; compare all claims with SSA's death data and prevent payment if SSA files show the claimant as deceased; and prevent employees who can adjudicate claims from changing or deleting death data or death alerts.

Although SSA agreed in response to the draft report that controls needed improvement, it did not agree with the recommendations to develop automated preventive controls. Instead, SSA cited other control changes that are underway. (CIN: A-13-89-00025)

## IMPROVING THE DATA EXCHANGE PROCESS

States are required to obtain SSA information to help determine welfare eligibility and protect the integrity of many public benefit programs, especially Aid to Families with Dependent Children, Medicaid and Food Stamps. In assessing State and local welfare office experiences with SSA's data exchange systems, OIG found that 31 of the 50 States contacted felt that the information provided through this process was often unreliable. Moreover, local welfare agencies indicated that they needed additional information already in SSA's possession, particularly data on Department of Veterans Affairs (VA) benefits. Most States felt that communications with SSA were in need of improvement.

The OIG recommended that SSA take steps to ensure that the information provided to welfare agencies is correct; continue to expand the data fields providing information to welfare agencies; establish an ongoing communications network with welfare agencies; and actively involve State welfare agencies in data exchange planning.

The SSA generally concurred with the findings and steps are underway to implement some of the recommendations. The SSA disagreed with the recommendation that they include VA benefit information in the data exchange system, stating that they have no legal authority to capture and maintain this data for purposes other than those related to SSA program administration. The SSA

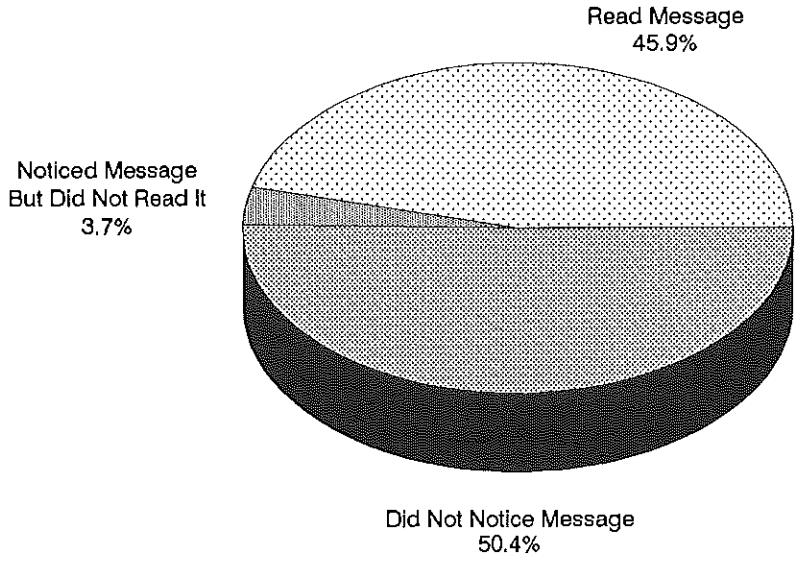
also rejected the recommendations to highlight changed data on the Beneficiary and Earnings Data Exchange System query and to establish a field office or central liaison to exclusively handle welfare office services. The SSA believes both proposals are cost prohibitive. (OAI-05-89-00820)

## SOCIAL SECURITY MESSAGES ON BANK ACCOUNT STATEMENTS

At the request of SSA, OIG conducted an inspection to determine the effectiveness of using bank account statements to send messages about their benefits to SSA beneficiaries. The OIG evaluated a pilot test conducted by SSA in January 1989. The test involved adding a message about the 1989 cost of living adjustment to the information transmitting the monthly benefit payment to a beneficiary's direct deposit account. The bank then included the message on the beneficiary's regular monthly account statement.

The OIG found that beneficiaries were not yet ready for a message on their bank account statements as a primary means of receiving important Social Security information. As illustrated below, many beneficiaries did not notice the message on the bank account statement, and of those that did, some did not read it.

**BENEFICIARY REACTION TO SSA MESSAGE ON BANK STATEMENT**



The OIG recommended that SSA proceed cautiously and address beneficiary concerns in instituting the use of messages on bank account statements. The OIG further proposed that SSA continue to conduct pilot tests, and work toward increased coordination with the Department of the Treasury and financial institutions in this area. The SSA implemented some of OIG's suggestions in its notification to beneficiaries regarding the January 1990 cost of living adjustment. (OAI-01-89-00570)

## RECLAMATION PROCEDURES

When a Social Security benefit check is issued erroneously or is obtained by someone other than the authorized beneficiary, it is considered an incorrect payment. In such an instance, SSA notifies the Department of the Treasury (Treasury) to reclaim the funds. If the check has been negotiated, Treasury should recover the payment amount from the financial institution that honored the check.

In an audit performed at OIG's request, Treasury's Office of Inspector General concluded that there are a number of deficiencies in Treasury's reclamation processes which adversely affect SSA program funds. The OIG estimates that, due to deficient Treasury procedures regarding reclamation of payments involving unauthorized endorsements, SSA-administered programs had losses or potential losses of about $10.5 million in calendar year 1986.

Although Treasury has the authority to reclaim incorrect check payments, SSA remains responsible for accounting for and controlling program assets. Accordingly, OIG recommended that SSA negotiate with Treasury to become more directly involved in reclamation activities.

SSA officials generally agreed with the recommendation and stated that they would continue to make reclamation an agenda item at their meetings with Treasury. However, they believed that they lacked the necessary leverage to successfully negotiate such matters with Treasury. The SSA suggested that OIG bring these problems to the attention of an appropriate oversight body. Since several recent OIG audits pointed out similar weaknesses in Treasury operations, OIG plans to prepare a summary report of SSA/Treasury operational problems for referral to such an oversight body. (CIN: A-04-87-03005)

## ABANDONED RECLAMATIONS

An OIG audit showed that SSA does not account for reclamation abandonments in either a consistent or complete fashion. Moreover, SSA does not pursue all other available avenues to recover these funds. The OIG estimated that the SSA trust funds may have already lost approximately $7.7 million due to abandonments (including reclamations which may have been abandoned, but for which documentation was inconclusive). In addition, an unknown number of abandonments have not been recorded by SSA. This results from SSA's lack of adequate policy

and procedure specifying how abandonments should be recorded and what additional recovery efforts should be made.

The OIG recommended that SSA record all abandonments in a complete and consistent manner, request recovery from Treasury for abandonments resulting from weaknesses in Treasury's reclamation process and provide additional SSA recovery measures.

The SSA agreed that both SSA and Treasury could make improvements in the process for handling abandoned reclamations. The SSA proposed that, since Treasury has the primary responsibility for reclamation actions, OIG should focus its recommendations on Treasury procedures and should bring these problems to the attention of an appropriate oversight body. The OIG is in the process of preparing a management advisory report (MAR) on operational issues which involve Treasury, and anticipates that the MAR will be issued to the Managing Trustee of Social Security Trust Funds. (CIN: A-04-89-03021)

## OVERPAYMENT CASES INVOLVING MORE THAN ONE BENEFICIARY

The OIG conducted a follow-up review on the adequacy of collection efforts in overpayment cases involving more than one beneficiary. In a prior audit (ACN: 03-62601), OIG determined that SSA's failure to comply with collection procedures resulted in an estimated $6.3 million in overpayments being placed in the terminated collection file prematurely. The OIG found that efforts were not made to recover the overpayments from contingently liable beneficiaries, who are those persons receiving benefits on the same earnings record as the debtor.

The follow-up review showed that SSA had taken action to improve staff compliance with collection procedures. An SSA study of terminated overpayments involving contingently liable beneficiaries living with the debtors showed that overpayments of about $7.8 million were collected at a cost of about $3.6 million. That study concluded that the efforts were cost effective and should be continued.

The current OIG review indicated that further collection increases were possible if SSA were to include in their recovery efforts those contingently liable beneficiaries who live apart from the debtor. The OIG recommended testing collection efforts on these beneficiaries to determine cost effectiveness. The SSA concurred. (CIN: A-03-89-02701)

## PURCHASE VERSUS RENTAL OF COPYING MACHINES

The OIG determined that SSA could have saved as much as $2.4 million over 4 years by purchasing low and medium-volume copiers instead of renting them.

Current Department policy requires that purchase versus lease cost benefit analyses be performed before acquisition of new copier equipment or renewal of existing leases or rental agreements. The OIG determined, however, that SSA does not perform such cost benefit analyses to determine if it is more economical to purchase the low and medium copiers. The SSA rents most of its low and medium-volume copiers because it believes that renting allows for more managerial flexibility and is more suitable to its operations.

The OIG recommended that SSA conduct lease/purchase cost benefit analyses before renewing existing leases on rental equipment and before acquiring new equipment. The SSA initially did not agree with the recommendation, but has since advised OIG that the Office of Acquisition and Grants has scheduled a procurement review for July 1990 to evaluate the purchase versus rental issues. (CIN: A-02-88-00008)

## EXTENT OF SOCIAL SECURITY NUMBER DISCREPANCIES

The OIG conducted an inspection to determine the extent of SSN discrepancies in record systems outside SSA. The study compared over 8 million SSNs from the files of 36 public and private organizations to SSA records. Ten percent of the SSNs checked did not match the SSN or related data (name, date of birth, sex code) on file.

Effective SSN verification methods are needed to detect discrepant SSNs. The OIG recommended that SSA publicize the availability of and restrictions on access to its SSN verification system; revise regulations to allow financial organizations that are required to report interest and dividend income to the Internal Revenue Service routine use of SSN verification; alert organizations for which SSN verification is not available about the extent of inaccuracies in self-reported SSNs; and encourage individuals to report name changes to SSA.

The SSA indicated that they would review the ramifications of the first three recommendations on their systems capacity and resources, as well as their disclosure and privacy policies. In addition, SSA agreed to continue encouraging individuals to report name changes. (OAI-06-89-01120)

## FRAUDULENT SOCIAL SECURITY NUMBERS

Along with birth certificates and drivers' licenses, the SSN or Social Security card is a foundation document in creating false identifications. These identifications are then used by individuals to perpetrate crimes involving billions of dollars. Social Security card/number fraud accounted for more than half of the SSA convictions obtained by OIG during this period. Many of the cases also involved the use of fraudulent SSNs in the commission of crimes not directly related to Department programs. The following examples illustrate the range of such cases:

- A member of an outlaw motorcycle gang involved in heavy narcotics trafficking and multiple homicides was sentenced to 16 months in Federal custody for misuse of a Social Security number. He had previously served time for rape, kidnapping, and narcotics violations and is the subject of at least two homicide cases. His conviction and sentencing for the use of false identification were the result of OIG work with a combined task force of the United States Marshals Service, the Drug Enforcement Administration, the Bureau of Alcohol, Tobacco and Firearms, the Pennsylvania State Police, the Philadelphia Police Department and the Delaware County Major Crimes Unit.
(3-88-00975-6, Anthony Nerkle)

- In Texas a man was sentenced to 6 years and 3 months in Federal prison and fined $290,000 for mail fraud and misuse of a Social Security number. He had allegedly suffered four minor injuries during 1986 and 1987 for which medical expenses amounted to $6,200. He submitted 153 different claims for these four injuries to several insurance companies, collecting more than $150,000. The case was worked jointly by OIG and the United States Postal Service.
(6-87-00428-6, John Sullivan)

- The OIG was able to help the FBI prove that a child in Texas had been kidnapped from Mexico. Through the false SSN used for the child, OIG obtained falsified records used by the woman who kidnapped the child to get AFDC benefits and Food Stamps.
(6-88-00570-6, Mary Delarosa

## DISABILITY DETERMINATION PROGRAM

The OIG conducted an audit of administrative costs in the disability determination program in New York for the period October 1, 1983 through March 31, 1987. The audit disclosed that of total program disbursements of nearly $246 million, over $3.8 million was not supportable by appropriate documentation and was not reimbursable under applicable Federal regulations. In addition, more than $500,000 earned on Federal funds that were prematurely drawn down for employee retirement contributions was not properly credited to the Federal Government. Although the State generally disagreed, SSA concurred with the findings. (CIN: A-02-89-00001)

## DISABILITY BENEFITS FRAUD

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

- A former postal worker was sentenced to 8 months in jail, 2 years probation, and full restitution of $54,600 he illegally obtained in disability payments. He also has to turn over the balance of his Federal pension to the Government. He

applied for and received disability payments while he was working for the Postal Service. After he retired his crime was discovered. This case was worked by OIG with the United States Postal Service. (3-88-00310-6, Edward Kelly)

- Faced with civil action, a Montana man repaid more than $134,000 which he, his wife, and his two children were overpaid in Social Security benefits. Since 1979 they had drawn disability benefits while the man was engaged in running a highly profitable ranching enterprise. (6-88-20150-6, Harvey Pitsch)
- A security officer at the Department of Veterans Affairs in Virginia was sentenced to 2-1/2 years in prison for fraud related to disability benefits. After a heart attack and by-pass surgery in 1979, he applied for and received the benefits. Investigation showed that since then he had taken various security positions and jobs as police chief in two different locations while using false SSNs. He was also ordered to pay restitution of $110,000. (3-89-00398-6, William Johnson)

## SSI BENEFITS FRAUD

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

- An employee of the Department of Veterans Affairs (VA) in California was sentenced to 18 months in prison as the result of a joint investigation by OIG, the VA and the Department of Labor. She received worker's compensation, a veteran's widow pension, and Supplemental Security Income and failed to report her return to full-time employment. Total loss to the Federal Government amounted to more than $167,000. (9-85-00670-6, Helene Schropp)
- Two people in California were sentenced to prison and ordered to pay restitution of more than $70,000 for carrying out a fraudulent scheme to collect SSI payments. They had offered counseling and interpreting services to non-English-speaking Laotian and Vietnamese refugees in applying for SSI, using falsified medical conditions and eligibility factors. They then collected and used the payments for their own purposes. They identified 23 persons for whom they had collected payments ranging from $500 to $4,000 each. (9-87-00985-6, Ona Rady & Henry Nguyen)
- A former supervisor in the Milwaukee office of the Social Security Administration (SSA) was sentenced to 6 months incarceration, 36 months probation, and full restitution of $6,000 she embezzled from SSA. She directed

employees to issue an additional $30,000 in benefit checks to her daughter, but the checks were recovered before she could cash them.

(5-89-00341-6, Linda Brimley)

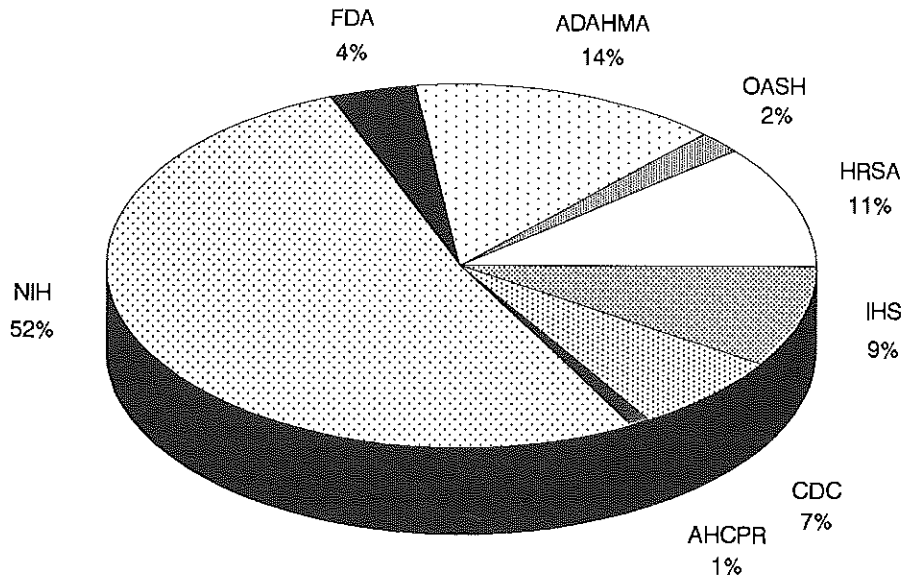
# CHAPTER IV

# PUBLIC HEALTH SERVICE

## OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

The activities conducted and supported by the Public Health Service (PHS) represent this country's primary defense against acute and chronic diseases and disabilities. The PHS's programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. The PHS encompasses: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed food, drugs and medical devices; Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), to assist States in uncovering the physiological and behavioral bases for understanding, preventing and treating mental illnesses and alcohol and substance abuse; Centers for Disease Control (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support through financial assistance, the development of our future generation of health care providers; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; and the newly established Agency for Health Care Policy and Research (AHCPR), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services. The PHS will spend approximately $14 billion in FY 1990.

## DISTRIBUTION OF PHS RESOURCES
## (FY 1990 Budget $14 Billion)




This year, OIG is continuing to respond to commitments made to the Secretary, the Congress and the Assistant Secretary for Health to increase oversight of PHS programs and activities. A separate PHS audit division concentrates on issues within PHS, such as acquired immune deficiency syndrome (AIDS), medical effectiveness, substance abuse, biomedical research and scientific misconduct. In addition, since the majority of contract and grant funding provided by HHS to colleges and universities is awarded by PHS, responsibility for audits of these institutions was transferred to the new division effective June 1, 1989. The division provides the resources to conduct internal and external reviews promoting: effective and efficient program operations; compliance with laws and regulations; financial accountability; as well as prevention and detection of fraud, waste and abuse. The Office of Evaluation and Inspections conducts evaluations of PHS program areas which focus on the quality and responsiveness of services provided by PHS.

During the first half of FY 1990, OIG identified questionable charges to PHS programs totaling $2.6 million.

## INTERNAL CONTROL REVIEW

The OIG identified the following significant weaknesses within PHS in the first half of FY 1990:

- The OIG reported in December 1989 that the preparation of inaccurate or incomplete project justifications for IHS housing, and the need to strengthen the review and approval process for planned construction constitute a significant weakness. The PHS has indicated that management improvements made and still underway, including incorporation of many OIG suggestions for improving project justification and review processes, have proven very successful in avoiding construction of unnecessary quarters. The PHS therefore believes that there is not a current significant internal control weakness in this area. The OIG will be confirming the appropriateness of improvements made by PHS. (CIN: A-09-89-00136)

- In a January 1990 draft report, OIG determined that certain FDA reports concerning the assignment of generic drug applications to reviewers were inaccurate. While the Secretary's FY 1989 FMFIA report identified a material weakness in the generic drug approval process, OIG believes that an additional weakness needs to be addressed. Specifically, the lack of an adequate management information system will preclude FDA from effectively implementing that part of its comprehensive, corrective action plan which calls for improved management and oversight of the generic drug review and approval process. This may significantly impair the agency's mission of providing competitively priced drugs to the public in a timely manner. Accurate reports are needed to monitor the application process, and compare and analyze application review and approval time. The PHS noted that FDA has implemented a number of improvements to address deficiencies in its management information system. The PHS stated that the newly improved generic drug management information system coupled with the newly installed management monitoring system provides FDA's management with adequate oversight capability. The PHS noted that details of the various actions taken were provided to OIG in a March 9, 1990 memorandum from the Assistant Secretary for Health. However, OIG noted that this memorandum did not adequately address major weaknesses, and OIG is concerned that they may continue to exist. The OIG will continue to monitor FDA's progress in improving its oversight of the generic drug application and review process. (CIN: A-15-89-00063)

- In a September 1989 draft report to PHS, OIG reported that FMFIA evaluations had not been conducted of IHS' programs for delivering health care services. The FMFIA evaluations have not been conducted to establish whether the internal controls in IHS programs provide reasonable assurance that only eligible patients are provided services without charge, the quality of services provided meets minimum acceptable standards, and costs incurred for providing the services are reasonable. Officials at IHS noted that they have various mechanisms for evaluating the adequacy of internal controls over IHS programs. However, they acknowledged that these mechanisms had not been reviewed as required by the FMFIA to determine whether they provide reasonable assurance that fraud, waste and abuse are deterred, and that IHS health delivery services programs are efficiently and effectively managed. The IHS stated that they have some such reviews underway and that others are planned. (CIN: A-15-89-00068)

- In a final report issued in January 1990, OIG noted that IHS' current accounting data are of limited usefulness because they fail to identify specific costs. The OIG also found that internal controls are not sufficient to assure that costs are applied to the appropriate IHS hospitals and other facilities that provide clinical services. This significant weakness precludes in-depth analysis of operational costs for these facilities. (CIN: A-15-89-00049)

- A FY 1988 alternative internal control review conducted by FDA of its enforcement program for imported products disclosed that FDA was inspecting only a small percentage of imported items, and some of the inadmissable items were not denied entry, destroyed or reexported, as required, but rather found their way into the U.S. market. The OIG report to FDA noted that these deficiencies constitute material weaknesses in FDA's import enforcement program. The FDA agreed, and the Department included this weakness in the Secretary's report for 1989. (CIN: A-15-90-00001)

## FDA PROGRAM-RELATED INVESTIGATIONS

Since its inception, OIG has conducted investigations of potential criminal violations relating to FDA programs and operations at the request of FDA officials. In recent years, the number of investigations grew substantially, from 12 cases in 1988 to nearly 200 in 1990. The joint efforts by OIG and FDA offered the advantages of the unique skills and expertise of both.

In 1988, troubling allegations surfaced indicating corruption in the FDA generic drug approval process and complicity by FDA officials. As a result, the Commissioner of FDA, the Inspector General and the General Counsel formally agreed on certain FDA investigative responsibilities for OIG, first in a memorandum of understanding and subsequently in a delegation of authority from the Secretary. This delegation authorized OIG to conduct investigations of felony criminal violations in the FDA area.

Subsequent events have altered this arrangement. An opinion by the Department of Justice (DOJ) raised questions about the authority of an Inspector General to investigate cases other than those involving Federal employees or recipients of Federal dollars. On the basis of interpretation of the DOJ opinion, the Secretary rescinded the delegation of FDA investigative authority, effective January 29, 1990.

In accordance with these actions, OIG has withdrawn from FDA and has referred ongoing cases and new allegations of violations of the Federal Food, Drug and Cosmetic Act to the Office of Consumer Litigation in DOJ's Civil Division for review and determination of their proper handling. Where investigations were being conducted with other Federal law enforcement agencies, OIG has withdrawn and transferred the case to the fellow law enforcement agency. The United States Attorneys have been notified of these actions, to alert them to possible delays in their prosecutions.

The following paragraphs describe some of the successes OIG achieved during the short period of investigation into FDA program-related fraud.

### A. Fraud in Generic Drug Approval

The Generic Drugs Division of the FDA approves an average of 700 generic drugs each year for public consumption. Purchasing these drugs can save taxpayers millions of dollars since they are less expensive than the name brand drugs. However, a company which is first to gain FDA approval to market a generic drug can expect an environment relatively free of competition until other companies obtain the same approvals. With a widely used drug, early marketing can mean millions of dollars.

Attempting to assure faster approval for their products, some generic drug manufacturers gave review chemists in FDA's Generic Drug Division illegal gratuities in the form of cash, gift certificates, trips and other items of value. The OIG investigations into these corruption cases led not only to conviction of FDA chemists and manufacturers, but also to evidence of false statements and misrepresentations by pharmaceutical companies about the samples they submitted for approval. The investigations have raised serious questions about the integrity of the FDA review process and the safety of generic drug products now on the market.

As a result of an ongoing investigation into corruption in the generic drug approval process of the FDA, five individuals and two drug companies were sentenced for wrongdoing:

- The president of a pharmaceutical company was given an 18-month prison sentence, suspended, and 12 full months of service to the American Cancer Society. Both he and the drug company must pay a $250,000 fine. In sentencing him, the judge expressed deep concern about the negative effect giving gratuities to employees had on FDA. He stated that the resulting diminishment of FDA had an adverse bearing on the welfare of the American public, and that the sentence he was imposing was a message to the industry and the public that such activity would not be tolerated.

- The president of another pharmaceutical company and the company were each fined $150,000 for giving unlawful gratuities to an FDA employee.

- Three review chemists in the Generic Drug Division, including a branch chief, were sentenced to work release programs, community service and/or fines for accepting gratuities from pharmaceutical companies. ~~(W-00110-3~~ (W-00110-3 (W-88-00110-4) (W-88-00009-4)

**B. Steroid Abuse**

Anabolic steroids have become popular with athletes and body builders as a means to increase muscle bulk and strength. The FDA has approved these drugs for certain specific uses only. They can produce ill or even fatal effects when used improperly. Early in 1989, OIG began investigating criminal activities associated with anabolic steroids. These activities included illegal diversion of steroids from legitimate manufacturers, counterfeiting brand name steroid products without FDA approval, and smuggling steroids legally and illegally manufacturered abroad into the United States.

The OIG has had tremendous success, especially in joint efforts with the Drug Enforcement Administration, the United States Customs Service, the United States Postal Service, United States Attorneys offices and State and local law enforcement agencies, chalking up 25 convictions or arrests in a few months' time. The following cases are examples of some of these successes:

- Two persons were given suspended jail sentences in Ohio after pleading guilty to charges related to the illegal sale of steroids. Theirs were the third and fourth successful actions in Project Bulk-Up, a joint investigation by OIG, the Ohio State Pharmacy Board, and the Ashtabula County Narcotics Agency. The project was initiated after the steroid-related death of a high school athlete which brought to public attention abuses in the sale and use of the drugs.

(5-88-00434-9, 5-89-00361-9, 5-89-00297-3

- In New York, ten persons were arrested in a series of steroid "buy-bust" operations. Using an electronically wired informant to purchase the drugs, specially deputized OIG agents raided the premises and arrested the seller, who frequently became a "buyer" or gave the agents other leads. As a result of these investigations, informants reported that OIG significantly reduced illegal trafficking and distribution of anabolic steroids in the New York area.

## HOME TESTING DEVICES

Based on a congressional request, OIG conducted a study to assess the adequacy of the FDA's clearance process in assuring the safety and effectiveness of medical testing devices or technology intended for home use and the degree to which their efficacy is monitored once they are available for sale.

Home use medical devices, like professional use medical devices, must be cleared by FDA prior to marketing. Once devices are cleared for the market, FDA monitors their performance primarily through the reports of problems by manufacturers and health care professionals, and inspections of manufacturing facilities, operations and records.

The OIG found that limited information is available on why, and how effectively, consumers use some of these tests. Professional health association representatives interviewed by OIG believed that FDA acted cautiously and appropriately in applying the law concerning home use tests. However, they expressed concern about ensuring the reliability and proper interpretation of test results obtained in the home, and about how FDA will react to the proposed marketing of certain home tests (such as tests for the HIV virus) which would have serious repercussions for individual and public health if false results were obtained or proper follow-up did not ensue.

The OIG recommended that FDA devise ways to increase its knowledge of actual consumer experience with home use testing devices; place continuing emphasis on consumer field evaluations to ensure the accuracy of home testing devices; and continue its efforts to work with manufacturers to improve product design, labeling and instructions in order to enhance the public's ability to make appropriate use of the home testing kits. The PHS generally concurred with the recommendations, although it questioned the availability of resources at FDA to implement them fully. (OAI-12-89-01360)

## PERSPECTIVES OF DRUG MANUFACTURERS

The OIG surveyed 24 drug manufacturers to assess how they viewed FDA's new drug and generic drug approval processes. Virtually all the respondents interviewed believed that FDA was effective in ensuring that only safe and effective drugs entered the market. Those who discussed FDA approval of new drugs were generally satisfied with FDA. However, those who

were interviewed about FDA approval of generic drugs were generally dissatisfied with agency performance. They were critical of FDA guidance, communication and decision-making.

Respondents in both categories identified inconsistencies in FDA's review of applications as their primary concern. They felt that the information required on an application, as well as the amount and nature of evidence on safety and effectiveness required, differed depending on the division and reviewer involved. The respondents made a number of suggestions that they believed would improve agency performance if implemented. (OAI-12-90-00770, OAI-12-90-00771).

## ENFORCEMENT PROGRAM FOR IMPORTED FOODS

A FY 1988 alternative internal control review conducted by FDA of its enforcement program for imported products disclosed that FDA was inspecting only a small percentage of imported items. Moreover, some of the inspected items that were denied entry were not destroyed or reexported, as required, but rather found their way into the United States market. The FDA attributed these problems to a shortage of personnel and an inadequate penalty system which did not effectively deter violators.

An OIG management advisory report to FDA concluded that these deficiencies constituted a material weakness in FDA's import enforcement program. The FDA agreed, and HHS included the material weakness and planned corrective actions in the Secretary's internal control report to the President and the Congress for 1989. (CIN: A-15-90-00001)

## AUDITABLE FINANCIAL STATEMENTS FOR IHS FUNDED FACILITIES

The OIG determined that implementation of a system for preparing auditable financial statements similar to those prepared by the Department of Veterans Affairs (VA) could help improve financial management controls over clinical services funded by IHS. The IHS' current accounting data are of limited usefulness because they do not identify specific costs, and internal controls are not sufficient to assure that costs are applied to the appropriate IHS hospitals and other facilities that provide clinical services. Managers are, therefore, unable to perform in-depth analyses of operational costs for these facilities, and IHS officials cannot fully rely on existing accounting reports in making management decisions.

The OIG recommended that the Assistant Secretary for Management and Budget (ASMB) require IHS to determine whether VA's system for preparation of financial statements could be used by the Department. Whether using VA's approach or one independently developed, ASMB should take whatever steps are necessary to assure the timely preparation of auditable financial statements for clinical facilities in IHS. Further, the internal control weaknesses resulting from problems with IHS' financial management system should be reported to the President and the Congress under the Federal Managers' Financial Integrity Act. The ASMB agreed that the preparation and audit of financial statements is essential to improving financial management.

The IHS plans to visit VA to look at its financial statements and determine whether VA's experience can be of benefit to IHS. (CIN: A-15-89-00049)

## GRANTEE AND EMPLOYEE FRAUD

- A former PHS commissioned officer was sentenced in Saipan, Commonwealth of the Northern Mariana Islands, for accepting payment for work for which he was also receiving a Federal salary. Assigned to Saipan as a sanitation officer with the Environmental Protection Agency, he designed a sewer system for a hotel for which he would also be an approving official. He was given a 1-year suspended sentence, ordered to make restitution of $62,000, and fined $10,000. His PHS commission was terminated. The OIG was assisted by the Department of Interior in the investigation. (9-88-00436-4, Nathaniel Good)

- The former bookkeeper for a tribal health agency in Wisconsin was sentenced to 1 year in prison and repayment of $63,000 for embezzlement. She stole the money from the agency, which is largely supported by IHS funds, by getting checks for small amounts countersigned, then altering them to show larger amounts. She used the money mostly to gamble on bingo games. As a condition of her 3-year probation she is to enter a counseling program and refrain from gambling on bingo. (5-89-00564-4, Rose Churchill)

- The financial director of a community health center was given 6 months in jail and ordered to repay $174,800 she had stolen by making out checks to herself. (2-89-00188-4, Judy Selvage)

- A secretary with the CDC in Georgia was convicted of submitting false travel vouchers in the names of actual and fictitious employees. She was given 3 years probation and ordered to pay $2,600 in restitution and fines. (4-87-00324-4)

# FAMILY SUPPORT ADMINISTRATION

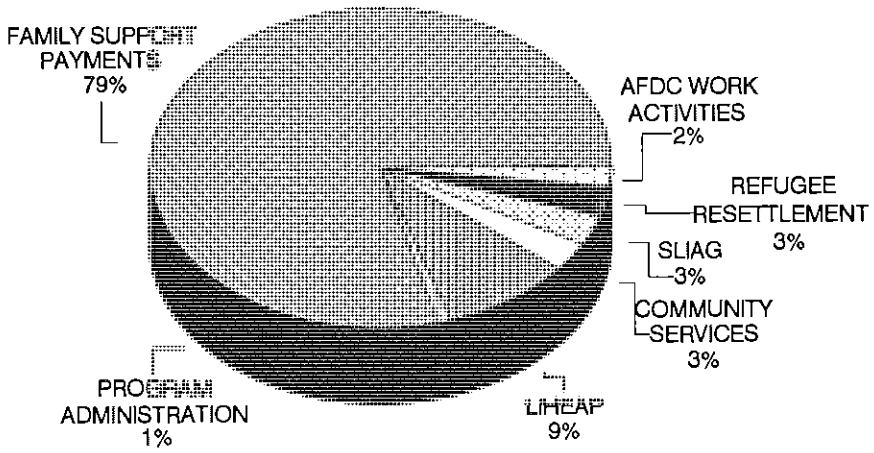
# CHAPTER V

# FAMILY SUPPORT ADMINISTRATION

## OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

The Family Support Administration (FSA) provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. Family support payments to States encompass: Aid to Families with Dependent Children (AFDC), a cooperative program among Federal, State and local governments which reaches 3.8 million families consisting of 11 million individuals each month; the Child Support Enforcement (CSE) program, which provides grants to States to enforce obligations of absent parents to support their children by locating absent parents, establishing paternity when necessary, and establishing and enforcing child support orders; and Child Care, which frees eligible welfare mothers for training and employment. The Low Income Home Energy Assistance program (LIHEAP) provides block grants to the States and Indian tribes to help offset the increased cost of fuel for recipients of AFDC, food stamps, supplemental security income, as well as certain other individuals. Other programs include Emergency Assistance, Refugee and Entrant Assistance, Community Services, Job Opportunities and Basic Skills (JOBS) training and Work Incentive programs. The FSA is also responsible for the State Legalization Impact Assistance Grants (SLIAG) program, created by the Immigration Reform and Control Act of 1986 (Public Law 99-603). Expenditures for FSA programs will total $15.2 billion for FY 1990.

**DISTRIBUTION OF FSA RESOURCES**
**(FY 1990 Budget $15.2 Billion)**



The OIG performs audits to review recipient eligibility, determine the fairness of program benefits, and evaluate the economy and efficiency of operations. 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 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. During this reporting period, OIG recommended recovery of $4.8 million in questionable grantee charges.

### INTERNAL CONTROL REVIEW

The OIG identified the following significant weakness within FSA in the first half of FY 1990:

- The OIG reported in a March 1990 management advisory report that OCS needs to establish a management system that would ensure complete and timely documentation of the acquisition and disposition of real property by grantees using Federal funds. Currently, no system exists to show the total value of assets (land and facilities) or the location of the properties. (CIN: A-12-90-00020)

## THE SLIAG PROGRAM

The State Legalization Impact Assistance Grants (SLIAG) program was established under the Immigration Reform and Control Act of 1986 to reduce the financial burden of providing public assistance, public health assistance and educational services to eligible legalized aliens. In FY 1988, $928.5 million in program funds were allocated to States, and funds will continue to be allocated through FY 1992. The FSA recognized that implementation of SLIAG would involve unique problems. Some of the difficulties were expected to center on the diversity of programs which SLIAG encompassed, the cultural and language barriers associated with the service population, the need for confidentiality of information and the extremely short time frame for the grant award process.

The FSA requested that OIG conduct reviews in 10 locations to determine the progress of States' implementation of the program. In completed reports on the 10 jurisdictions (Arizona, Massachusetts, Washington, California, Colorado, Florida, Illinois, New York, Texas and the District of Columbia), OIG noted some positive steps taken by FSA and the States to identify problem areas and develop effective solutions for them. However, in each instance, the OIG also noted some funds control vulnerabilities and made specific recommendations to improve

implementation of the program. The OIG recommended that appropriations for SLIAG be reduced by $500 million in both FY 1990 and FY 1991. Public Law 101-166 reduced the FY 1990 SLIAG appropriation by $555.2 million. This funding and authorization was restored for FY 1992. The FSA and the States generally agreed with the OIG findings and instituted some immediate corrective actions. (OAI-07-88-00440; OAI-07-88-00441; OAI-07-88-00442; OAI-07-88-00443; OAI-07-88-00444; OAI-07-88-00445; OAI-07-88-00446; OAI-07-88-00447; OAI-07-88-00448; OAI-07-88-00449; OAI-07-88-00450)

## IMPLEMENTATION OF THE FAMILY SUPPORT ACT

The OIG contacted State welfare officials in all 50 States and the District of Columbia to obtain baseline information on State implementation of the Family Support Act and to identify problems encountered in implementing the Act. Most of the States' activities in this area have centered around the JOBS provisions of the Act. At the time the review was conducted, the States were at various stages of implementation.

The OIG found that the States are faced with major changes to their existing work programs and are concerned about providing the range of employment, education, child care, and transportation services required by JOBS. Many States anticipate budget problems, while others are concerned about staffing levels and training for staff.

Welfare clients entering the JOBS program must be assessed prior to placement in training, education or employment components. This assessment is to be used in determining client skills, education, experience and needs. The States are concentrating on developing effective skills assessment and skills development programs. Many States are planning for the use of a two-tiered approach to assessment. The first assessment would identify basic client needs and might also identify those clients who were job-ready and place them directly into a job search component. A second, more intensive tier of assessments might be conducted at a later time if needed. The OIG also found that the States are placing more emphasis on education as a means of developing client skills and preparing clients for self-sufficiency. (OAI-05-90-00720)

## JOB OPPORTUNITIES AND BASIC SKILLS TRAINING

The Family Support Act of 1988 requires the States to implement a new, more aggressive work program for AFDC recipients, known as the JOBS program. Under JOBS, States are required to inform all AFDC recipients of the services available; assess the educational, child care, medical, and other support service needs of each participant, as well as the participant's job skills, work history and employability; and work with each participant to prepare an employability plan.

The OIG conducted an inspection to study the operations of a number of established, respected, comprehensive work programs for AFDC recipients and to relate the insights of the administrators of those programs. The OIG found that job readiness was not regarded as a

discrete, easily defined activity, but one that had to be integrated into other services. Group job search was the most highly regarded of the JOBS components. This component was usually divided into two parts: the first in which job related issues were discussed in a classroom setting, and the second in which participants took part in a supervised job search, making phone calls from a phone bank, applying for jobs and doing interviews.

All of the programs studied used a case management approach where a single case manager worked with each participant throughout all phases of the program. Program managers considered that approach important to achieving program success. The OIG also found that the majority of the programs emphasized local level flexibility, allowing local State welfare offices discretion in how to implement the work program. (OEI-12-89-01320)

## CHILD SUPPORT ENFORCEMENT

### A. Collection

The OIG initiated a project to identify Federal employees who were delinquent in child support payments and to find ways of improving the collection process. Federal employment data was matched with the Office of Child Support Enforcement (OCSE) tax intercept data on absent parents who were in arrears on their child support payments. The match identified over 65,000 absent parents who worked for the Federal Government and who owed as much as $284 million in past due payments. Additionally, OIG determined that child support payments could be increased by approximately $46.6 million by means of current wage withholding. The OIG recommended that OCSE take certain steps to improve enforcement, and to encourage States to more effectively implement wage withholding and make greater use of the State and Federal parent locator service. The FSA concurred. (CIN: A-12-89-00154)

### B. Medical Support

The OIG conducted an inspection to determine if State child support enforcement (CSE) agencies petitioned for inclusion of medical support as part of all child support orders, as Federal regulations require, and if State Medicaid programs avoided expenditures for medical services as a result of such support orders. The OIG determined that the Medicaid program could save $33 million annually if State CSE agencies adequately detected and pursued available dependent health insurance.

The inspection compared data collected from State CSE case files in 1986 with 1988 case files. There was no improvement found over the 2-year period in efforts to pursue medical support. The OIG determined that CSE agencies do not routinely collect information on health insurance and, even when they are aware of available health insurance, they often do not forward that information to the Medicaid agency. The CSE agencies do not routinely petition the courts for medical support, and OCSE reviews do not adequately address medical support.

The OIG recommended that OCSE enforce current regulations regarding medical support by amending its Program Results Audit Guide; require review of medical support as part of their regional reviews; and apply penalties to States found negligent in the detection and enforcement of medical support. The OIG further recommended that OCSE propose a legislative amendment to require insurance companies to extend family coverage to all dependents for whom they are legally responsible, including those living outside the home. The FSA agreed with most of the recommendations and indicated that they have already taken actions to address some of the issues raised in the report. Although FSA amended the OCSE audit guide, OIG believes that some additional changes are needed. (OAI-07-88-00860)

## EFFECTIVE PATERNITY ESTABLISHMENT PRACTICES

The OIG interviewed 77 State and local officials in 12 States who were expert in child support enforcement to identify difficulties in establishing paternity and effective means of overcoming those difficulties. The greatest and most frequently cited barriers to establishing paternity were reported to be parental resistance and the complexity of adjudication of paternity cases. The most significant improvements made by State and local offices were in the areas of more effective case management and the streamlining of the case adjudication process.

The OIG identified a number of effective practices which States should consider adopting, including specific strategies to: solicit support for the paternity establishment program; clarify responsibility for obtaining intake information; promote improved parental cooperation; streamline adjudication of paternity establishment; institute effective case management controls; simplify case processing; and upgrade and improve staff utilization. (OAI-06-89-00910, OAI-06-89-00911)

## ENFORCING CHILD CARE REGULATIONS

The OIG conducted two inspections to describe current State regulatory enforcement efforts in child care and to catalog effective State enforcement practices. The OIG interviewed child care licensing officials and inspectors in all 50 States and found that regulations regarding child care arrangements varied significantly among the States. Many types of settings were not regulated. Even when a setting was regulated, the nature and force of the regulations varied in such areas as health and safety requirements, child care staff requirements and staff to child ratios. Enforcing the regulations that did exist was just as problematic; inspections were time consuming, and legal sanctions were difficult to enforce, even in cases of imminent danger.

The OIG identified effective practices which States should consider adopting to improve their enforcement of existing regulations. These practices included administrative closures, consent agreements, investigative protocols, inspection review techniques, monetary incentives and penalties, and training and technical assistance for providers. (OEI-03-89-00700, OEI-03-89-00701)

## REFUGEE RESETTLEMENT

### A. Administrative Costs

An OIG review of administrative costs claimed by Virginia's refugee resettlement program disclosed that in FY 1988 the State implemented a random moment time study method to allocate costs to the refugee program. However, the time study results were inaccurate and administrative costs were not properly allocated. This was due mainly to the staff's lack of familiarity with the time study method and the absence of an adequate monitoring system. As a result, more than $152,000 in costs that did not benefit the program were improperly charged.

No financial adjustment was recommended since allowable administrative costs exceeded the congressionally mandated ceiling for FY 1988. However, because of the likelihood that the misuse of the random moment study method would affect future periods, OIG recommended procedural changes to the program. The State agreed. (CIN: A-03-89-00257)

### B. Cash and Medical Assistance Payments

An OIG audit of the refugee resettlement program administered by the State of Maryland during the period October 1, 1985 through September 30, 1988 identified 214 cases in which more than $203,000 in cash and medical assistance payments were made to clients whose eligibility had expired. Of this amount, almost $96,000 had been previously identified by the Office of Refugee Resettlement and the required financial adjustments were made. The erroneous payments resulted from the lack of an eligibility edit in the State's automated income maintenance system, and the fact that local offices did not receive timely notice of changes in the Federal maximum eligibility period. The State concurred with the recommendations for financial adjustment and procedural changes. (CIN: A-03-89-00256)

## PUBLIC ASSISTANCE PROGRAMS

An OIG audit revealed that New Jersey improperly claimed approximately $2 million (Federal share) in administrative costs under various federally supported public assistance programs in fiscal years 1985 through 1988.

The audit disclosed that approximately $8.7 million in unallowable costs related to the operation of an automated data processing system was incorrectly allocated to federally supported programs, of which $1.59 million was claimed for Federal financial participation (FFP).

Further, approximately $1.1 million in electronic data processing charges were duplicated. An additional $1 million overcharge resulted from allocation of annual budgeted costs, rather than quarterly actual costs, for telephone, insurance and postage. The OIG estimated that the FFP claimed as a result of these two errors was $380,000.

The OIG recommended that the State process a financial adjustment. The State and the Department's Division of Cost Allocation agreed with the findings and recommendations. (CIN: A-02-88-02025)

## LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

The OIG conducted a review of the Low Income Home Energy Assistance Program (LIHEAP) administered by the Georgia Department of Human Resources to determine if funds were expended in accordance with provisions of the State plan. The review showed that 366 LIHEAP households received overpayments totaling more than $95,000 during the period October 1986 through September 1987. The overpayments were caused by oversights in the eligibility determination process.

The OIG recommended that Georgia recover the amount of the overpayments and coordinate the disposition of the recovered amounts with FSA. The State agreed with the recommendations and has initiated action. (CIN: A-04-89-00097)

## AFDC FRAUD PROJECTS

One form of welfare assistance, which includes Medicaid, food stamps and AFDC benefits, is based on State determinations of AFDC eligibility. As a result, welfare fraud is usually perpetrated by making false claims about one's circumstances, such as claiming a nonexistent dependent child or concealing income which would render the applicant ineligible. Suspected fraud is discovered through a variety of mechanisms, ranging from disclosure by a disgruntled acquaintance or relative to computer matches of welfare lists against worker compensation rolls or income tax returns. Individual cases of welfare fraud typically involve relatively small amounts of money and little notoriety and, therefore, are relatively low on the agenda of prosecutors. The OIG seeks to make prosecution attractive by grouping several cases for convenience of prosecution and maximum deterrent effect. For example, the Chicago Welfare Fraud Project, which was initiated in mid-1988, has resulted in 26 indictments and 9 convictions, and restitutions of more than $169,000. The project is being worked jointly with Illinois welfare and investigative agencies and State and county prosecutors. Another 30 to 40 indictments are expected.

## AFDC STATES BENEFITS PROJECT

In 1981, OIG initiated a project to assist State and local agencies in California in the prosecution of fraud against Federal and State income maintenance and benefit programs. The project was established in response to the perception on the part of the agencies that successful completion of their cases was frustrated by the amount of time it took to obtain necessary information and documents from Federal agencies. The OIG developed a mechanism for State and local investigators and prosecutors to verify SSNs, get information about Social Security payments and

obtain photocopies of the checks. The success of the project led OIG to expand it nationwide in 1983. About 15,000 requests for assistance were received during the life of the project from hundreds of State, county and municipal jurisdictions. Their reporting to OIG on the outcome of cases was sometimes sporadic, but at least 1,350 convictions and an estimated $15 million in monetary returns were obtained. As of January 31, 1990, this project was turned over to the Social Security Administration, which will now process the requests for assistance.

## GRANTEE FRAUD

The former executive director of a community action agency serving the needy and elderly in five Wisconsin counties was sentenced to 4 years in prison and restitution of more than $12,300 he misused in agency funds. He had caused the agency, which receives most of its funding from the Department's community services block grant program, to pay for personal items for himself and for salary for individuals working in his private woodcutting business. Disgusted with his behavior in and out of court, the judge sentenced him immediately, and he was led from the courtroom directly to prison.

# OFFICE OF HUMAN DEVELOPMENT SERVICES

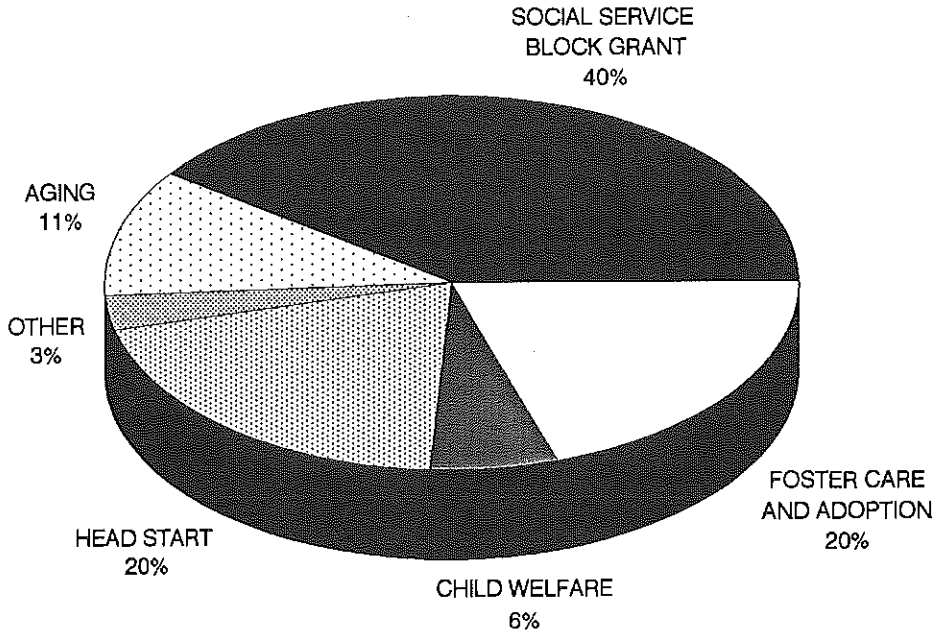
CHAPTER VI

# OFFICE OF HUMAN DEVELOPMENT SERVICES

## OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

The Office of Human Development Services (HDS) oversees a variety of programs that provide social services to the Nation's children, youth and families, developmentally disabled, older Americans and Native Americans. Head Start is a $1.3 billion per year program which provides comprehensive health, educational, nutritional, social and other services primarily to pre-school children and their families who are economically disadvantaged. Foster Care and Adoption Assistance is an entitlement program that provides grants to States to assist with the cost of foster care and special needs adoptions, maintenance, administrative costs to manage the program and training for staff. The goal of this program 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 programs for the aging provide for supportive centers and services, congregate and home-delivered meals and in-home services for the frail elderly. Expenditures for HDS programs will total $6.7 billion for FY 1990.

**DISTRIBUTION OF HDS RESOURCES**
**(FY 1990 Budget $6.7 Billion)**



During this reporting period, OIG identified questionable grantee charges to HDS programs of $3.4 million.

## HEAD START

The OIG conducted an inspection of the Head Start program to examine the needs of dysfunctional families and to identify ways to overcome service delivery barriers. According to Head Start grantees, the problems most frequently faced by dysfunctional families include substance abuse, lack of parenting skills, child abuse, domestic violence and inadequate housing. While some grantees were concerned about the additional demands that these families placed on their programs, almost all agreed that Head Start was the program best able to serve their needs.

The OIG found that many grantees have implemented creative methods for dealing with dysfunctional families, such as mental health training, parenting programs and support groups, and tracking of families after they leave the program. Grantees expressed a belief that current income guidelines, performance standards and lack of resources limit their ability to serve some of the most needy families, particularly the working poor.

The OIG recommended that Head Start revise its enrollment criteria to provide grantees greater flexibility in serving children from dysfunctional families. The OIG also proposed that Head Start use its discretionary grant authority to develop ways of providing better access to community resources, develop and test new approaches to assist dysfunctional families, and collect and disseminate information on grantees' successful strategies and best practices. The HDS generally concurred with the recommendations and is taking steps to implement them. (OAI-09-89-01000)

## HEAD START PROGRAM FRAUD

The former executive director of a California parents council funded by the Head Start program was given a 2-year suspended prison sentence and ordered to repay $15,000 he had embezzled from the program. He had had a series of checks issued to himself as "loans" which he never repaid.

## FOSTER CARE

Under title IV-E of the Social Security Act, the Federal and State governments share in the costs of providing care and maintenance on behalf of eligible children in licensed or approved foster care homes and private child care institutions.

An OIG review found that for the period April 1, 1983 through September 30, 1987 the State of Iowa charged the foster care program more than $850,000 (Federal share over $496,000) for

maintenance payments made on behalf of children in voluntary foster care. However, these payments were determined to be ineligible for Federal financial participation (FFP) because the State was not responsible for the children's placement and care and did not provide the required dispositional hearings.

The OIG recommended that Iowa return the overclaim to the foster care program, and that the State limit FFP claims and provide the required dispositional hearings to those children whose placement and care are the State's responsibility. State officials disagreed with the recommendation to return the overclaim. However, HDS officials concurred with all the recommendations. (CIN: A-07-89-00183)

## YEAR-END SPENDING

Commencing in FY 1980, the Department established the Advance Acquisition Planning System (AAPS) to control excessive year-end spending. Under AAPS, each of the Department's Operating and Staff Divisions prepares and maintains annual procurement plans outlining expected procurements by quarter. These plans and quarterly updates comparing expected and actual procurements are submitted to the Office of the Assistant Secretary for Management and Budget (ASMB). In addition, a 30 percent cap on fourth quarter spending was imposed for FY 1988. The departmental divisions were required to obtain the approval of ASMB before exceeding the cap.

An OIG audit of HDS implementation of the procurement spending program and justification of fourth quarter procurement actions identified no material problems in the areas reviewed. The audit found that fourth quarter procurement actions were adequately justified. Nonetheless, the accuracy, completeness and timeliness of reporting required by the AAPS could be improved.

The OIG recommended that HDS ensure that controls are maintained to verify the accuracy of data reported, that all required expenditure data are obtained and included in the reports, that reports are submitted timely, and that these procedures are adequately implemented. The HDS officials concurred with the OIG findings and recommendations and indicated that corrective actions were underway. (CIN: A-12-88-00111)

## EMPLOYEE FRAUD

A former contracts administrator for HDS was sentenced to 10 to 30 months in jail and fined $5,000 for defrauding the Department of more than $50,000. He had arranged that payments be made in his wife's name for fictitious work. The man left HDS in 1985. His crimes were discovered as a result of divorce proceedings in late 1987, during which his wife made an inquiry to the Department about a supposed payment of $9,000 to her. A subsequent OIG investigation uncovered the extent of his crime. A civil suit has been filed to recover the amount defrauded plus damages.

# APPENDICES

# APPENDIX A

## IMPLEMENTED OIG RECOMMENDATIONS TO PUT FUNDS TO BETTER USE OCTOBER 1989 THROUGH MARCH 1990

This schedule documents budgetary savings resulting from legislative or regulatory actions or policy determinations of management on behalf of OIG recommendations. Efforts of departmental managers and Members of Congress have, in many instances, been instrumental in implementing these recommendations. Legislative items represent funds or resources that will result in budgetary savings over a 5-year period. Savings shown are those for FY 1990. Programmatic savings are calculated by OIG using departmental figures for the year in which the change was effected. Total savings during this reporting period amounted to $1,945.5 million.

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **State Legalization Impact Assistance Grants:** Based on the current rate of State draw downs of appropriated funds for FYs 1988 and 1989, the FY 1990 and 1991 appropriations for State Legalization Impact Assistance Grants should each be reduced by $500 million. (OAI-07-88-00440) | Funds appropriated for FY 1990 under section 204(a)(1) of the Immigration Reform and Control Act of 1986 were reduced by $555,224,000. | $555.2 |
| **Capital Related Costs:** Discontinue inappropriate Medicare payments for hospital capital costs. (CIN: A-14-52083; CIN: A-09-52020) | Sections 6002 and 6110 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 reduced capital-related payments by 15 percent for FY 1990 cost reporting periods. | 500 |
| **Medicare Secondary Payer Activities:** The HCFA needs better and more timely information in order to pursue private health insurance for care rendered to Medicare beneficiaries. (CIN: A-09-89-00100; OAI-07-86-00091; OAI-07-86-00017; OAI-07-88-00092) | Section 6202 of OBRA 1989 will enable HCFA to obtain information from SSA, the Internal Revenue Service and individual employers. This additional information will enable HCFA to increase MSP recoveries. | 300 |
| **Fee Schedule Amounts:** The HCFA should request that the Congress repeal the requirement to base laboratory reimbursement on a national fee schedule begiuning in 1990. (OAI-04-88-01080) | Section 6111(a) of OBRA 1989 eliminated the requirement for a nationwide fee schedule effective January 1, 1990. | 190 |
| **Coronary Artery Bypass Graft Surgery and Cataract Surgery:** The HCFA should place special limitations on reasonable charges for the primary surgeon's fee for coronary artery bypass graft (CABG) surgery, and should consider consolidating payments for primary surgeons, assistant surgeons and anesthesiologists. The HCFA should periodically assess the changes in surgical procedures and technology and mandate adjustments to Medicare reimbursement. (OAI-09-86-00076; OAI-85-IX-00046) | Section 6104 of OBRA 1989 requires a further reduction from those imposed in OBRA 1987 in the Medicare reimbursement rates for CABG surgery and for cataract implant surgery effective April 1, 1990. | 168.9 |

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **Laboratory Reimbursements:** The HCFA should take advantage of the economies of scale present in the laboratory industry by making reductions to the fee schedule amounts. (OAI-02-89-01910; CIN: A-09-89-00031) | Section 6111(a) of OBRA 1989 established the ceiling on fee schedule payments at 93 percent of the median for a particular test in a particular laboratory setting, beginning January 1, 1990. | $85 |
| **Intraocular Lenses:** The HCFA should treat cataract extraction with intraocular lens (IOL) implant as one procedure and reimburse it at 100 percent of the appropriate facility rate. The HCFA should also establish a national Part B reimbursement cap of $200, with a handling fee not to exceed 10 percent for any IOL billed to Medicare. (OAI-09-88-00490) | The OBRA of 1987 requires that payment for an IOL inserted in conjunction with cataract surgery be included in the facility payment rate. Implementing regulations treating cataract extraction with IOL insertion as one procedure and establishing a $200 allowance for IOLs to be included with facility fee for the insertion procedure were issued in final on February 8, 1990, 55 FR 4526. The new program rates are effective for services beginning March 13, 1990. | 60 |
| **Continuous Ambulatory Peritoneal Dialysis Supplies:** The HCFA should limit payment allowances to suppliers who deal directly with end stage renal disease (ESRD) patients to amounts allowable under a single composite rate to an ESRD facility. (CIN: A-09-87-00108) | Section 6230 of OBRA 1989 reduced payments for supplies to no more than the amounts paid under a single composite rate to an ESRD facility, beginning February 1, 1990. | 45 |
| **Overpayments:** The SSA should recover or otherwise resolve 124,039 incorrect payments or overpayments which were recorded as incorrect payments. (CIN: A-03-86-62600) | The SSA agreed and the cases deemed collectible were processed. The SSA added $31.6 million to its accounts receivable, and collection is under way. | 31.6 |
| **Process Nonresident Alien Tax Cases:** The SSA should develop policies for resolution of alien tax overpayments and underpayments. (CIN: A-13-86-62631) | The SSA issued policies and procedures to process cases involving overpayments and is working on the backlog. | 9.8 |

# APPENDIX B

## RECEIVABLES FROM OIG QUESTIONED COSTS

## OCTOBER 1989 THROUGH MARCH 1990

This schedule represents significant examples of the dollar amounts placed in accounts receivable for recoupment during this reporting period as a result of management determinations in favor of audit findings and recommendations. Audit receivables for this period totaled $171.2 million and were comprised of OIG receivables of $132 million and HCFA program disallowance receivables of $39.2 million. In accordance with the provisions of the Inspector General Act of 1978, as amended, a complete listing of OIG audit and inspection reports is being furnished to the Congress. Due to the volume of reports involved, however, the listing is being provided under separate cover. Copies are available upon request.

| OIG RECEIVABLES | DOLLARS IN MILLIONS |
|---|---|
| • Unallowable costs claimed for skilled nursing facilities and intermediate care facilities by the State of Indiana (CIN: A-05-86-60150) | $41.9 |
| • Unallowable charges for Medicaid services provided to undocumented aliens by the State of California (CIN: A-09-89-00085) | 10.2 |
| • Reimbursement for excess reserve balances in the State of Michigan's Self-Insurance Fund (CIN: A-05-88-00082) | 8.8 |
| • Overclaim of Medicaid funds by Califoruia under the Short/Doyle program, a special mental health program (CINs: A-09-89-00088, A-09-89-00060) | 8.7 |
| • Reimbursement of Medicaid's share of excess pension assets that were realized when the Blue Cross of California terminated its pension plan (CIN: A-07-88-00096) | 4.6 |
| • Overclaim of administrative costs by the New York State Department of Social Services related to the Social Security Disability Determiuation Program (CIN: A-02-89-00001) | 4.4 |
| • Improperly claimed costs incnrred in operating a mental health complex by the State of New Jersey (CIN: A-02-88-01029) | 4.0 |
| • Unallowable charges claimed by the New York City Department of Social Services in connection with the Emergency Assistance to Needy Families with Children Program (CIN: A-02-88-00002) | 3.8 |
| • Reimbursement of Medicare costs that were chargeable to the Department of Veterans Affairs (CIN: A-04-88-02049) | 3.2 |
| • Overclaim of administrative costs from October 1979 through September 1984 by Blue Cross and Blue Shield of Michigan (CINs: A-05-86-62032 and A-05-86-62030) | 3.2 |
| • Unallowable Medicaid charges claimed by the State of Illinois for presumptively eligible recipients (CIN: A-05-88-00005) | 2.6 |
| • Reimbursement by the Puerto Rico Department of Health for expired checks not credited to HHS (CIN: A-02-88-02020) | 2.6 |
| • Interest income not offset to interest expeuse arising from funds borrowed by Boston University for renovation/construction projects (CIN: A-01-88-02502) | 2.5 |
| • Unallowable costs charged to SSA's Disability Determination Program (CIN: A-06-87-00076) | 2.1 |

- Additional unallowable reserve funds were identified as a result of a follow-up audit in the State of Oregon (CIN: A-10-88-00012) ..... $1.9
- Single audit disclosed unallowable charges to HHS programs in Florida (CIN: A-04-88-05096) ..... 1.7
- Unallowable costs for Foster Care maintenance payments claimed under title IV-E of the Social Security Act by the Commonwealth of Virginia (CIN: A-03-88-00550) ..... 1.7
- Single audit disclosed unallowable charges to HHS programs in Florida (CIN: A-04-88-05096) ..... 1.7
- Unallowable costs claimed for abortion-related services by the New York State Department of Social Services (CIN: A-02-88-01026) ..... 1.4
- Overpayments made to providers participating in the Medicaid program by the Pennsylvania Department of Public Welfare (CIN: A-03-89-00607) ..... 1.3
- Reimbursement of payments made for less than effective drugs by the State of Pennsylvania (CIN: A-03-89-00602) ..... 1.3
- Single audit disclosed unallowable charges to HHS programs in Rhode Island (CIN: A-01-89-05005) ..... 1.3
- Ineligible costs claimed under the Refugee Resettlement program by the Commonwealth of Pennsylvania (CIN: A-03-88-00254) ..... 1.2
- Overclaim of administrative costs by Aetna Life Insurance Company (CIN: A-01-86-65120) ..... 1.1
- Unallowable charges to the Adoption Assistance Program under title IV-E of the Social Security Act by the District of Columbia (CIN: A-03-88-00552) ..... 1.0
- Overclaim by nursing home providers participating in the Medicaid program in Maryland (CIN: A-03-89-00606) ..... 1.0
- Improper charges under the Medicaid program for youth psychiatric services by the State of Louisiana (CIN: A-06-87-00061) ..... .9
- Single audit disclosed unallowable charges to HHS programs in the State of South Carolina (CIN: A-04-88-05005) ..... .9
- Overcharge of costs by the Dallas County Community Action Committee (CIN: A-06-89-08063) ..... .8
- Reimbursement for Federal Government's portion of FICA tax credit received by the Commonwealth of Puerto Rico (CIN: A-02-89-02017) ..... .7
- Single audit disclosed unallowable charges to HHS programs in the State of Washington (CIN: A-10-89-06236) ..... .7
- Unallowable Medicaid charges claimed for services provided by the State of Missouri (CIN: A-01-89-00002) ..... .7
- Unallowable administrative costs claimed by Blue Cross/Blue Shield of Rhode Island (CIN: A-01-88-00513) ..... .5
- Other audit determinations (under $500,000) ..... 7.6
- **Total Receivables** ..... **$132.0**

| HCFA PROGRAM DISALLOWANCES | DOLLARS IN MILLIONS |
|---|---|
| • Medicaid reimbursements claimed during periods of invalid provider agreements | $26.2 |
| • Medicaid payments to providers for individuals whose eligibility was not properly documented | 5.0 |
| • Medicaid payments exceeded State plan limits for outpatient hospital clinical services | 2.8 |
| • State Medicaid agency claimed ineligible training costs | 1.6 |
| • Providers reimbursed by Medicaid in excess of customary charges | 1.4 |
| • State agency claimed unallowable contract costs | .5 |
| • Other determinations (Under $500,000) | 1.7 |
| • **Total Receivables** | **$39.2** |

# APPENDIX C

## INVESTIGATIVE RECEIVABLES
## OCTOBER 1989 THROUGH MARCH 1990

This schedule represents the dollar amount of fines, savings, restitutions, settlements and recoveries determined through judicial or administrative processes in support of OIG investigative findings. These figures include both actual and ordered recoupments for the Treasury of the United States, the Social Security and Medicare trust funds and departmental programs victimized by fraud and abuse. Receivables of $23.7 million are reported for this period. An additional $30 million realized in investigative savings is included in Appendix A under Medicare Secondary Payer Activities.

- Company improperly billed Medicare for services for three New York hospitals. ..... $2,253,300
  (2-87-20641, Prime Medical)
- Major laboratory corporation in California paid percentage of profits to physician investors making Medicare and Medicaid referrals. ..... 1,500,000
  (9-90-44020-9, SmithKline Bioscience Labs)
- New York hospital improperly claimed Medicare reimbursement through billing service company. ..... 1,231,500
  (2-89-20861-9 Victory Memorial Hospital)
- Pharmaceutical company officials paid FDA review chemists unlawful gratuities to speed up approvals. ..... 814,400
  (W-88-00110-4, Charles Chang et al)
- Co-owners of two New York DME companies submitted claims for seat lift chairs iu areas where Medicare and Medicaid paid highest rates. ..... 680,500
  (2-85-01432-9, Health Med Systems Inc.)
- Oklahoma psychiatrists submitted Medicare billings for undocumented or nonperformed services. ..... 668,000
  (6-90-30145-9, Joe & Merli C. Fermo)
- Ophthalmologist and optometrist in California both billed Medicare for follow-up care for same cataract surgery ..... 648,900
  (9-89-30421-9, Morry Walsberg)
- Indiana seat lift company overpaid for medically unnecessary items. ..... 524,900
  (5-89-00461-9, Liftchair Inc.
- Maryland ambulance service billed Medicare for transporting wheelchair patients two at a time in ambulances. ..... 400,000
  (3-90-20024-9, William Runyon)
- Unpaid volunteer worker in multi-county health agency in South Carolina deposited Medicare and Medicaid checks in personal account. ..... 384,200
  (4-87-00715-9, Joyce Douglas)
- Co-owners of Pennsylvania diagnostic laboratories paid kickbacks to physicians for referrals. ..... 267,000
  (3-84-00013-9, Medco Diagnostic Service Inc.)
- Iowa anesthesiology group filed 211 false Medicare claims. ..... 258,000
  (7-85-30011-9, Anesthesiologist Affiliated)
- California pharmacy sold generic drugs to nursing homes but billed for name brand drugs, skewing Medicaid cost reports. ..... 244,400
  (9-86-00860-9, Wilshire Medical Pharmacy)
- Maine nursing home group included phantom employees, personal electrical appliances, and other improper charges in Medicaid cost reports. ..... 194,000
  (1-89-30071-9, Green Acres Manor)
- Texas doctor and associate billed Medicaid for optometry services performed by nonmedical personnel. ..... 190,000
  (6-88-30432-9, Marvin Nobel, Ted Bogart, Lester Eisenberg)
- Michigan DME supplier billed Medicare for items returned, claimed nursing home patients were at home. ..... 181,000
  (5-85-31326-9, Larry Aronoff)
- Neonatologists in Colorado billed Medicare for services after infants had died, been discharged, or turned over to other specialists. ..... 173,400

- Woman in Texas created fictitious beneficiaries and submitted false bills to Medicare and private insurers. ..... $149,700
  (6-88-00577-9, Betty Anderson)
- Employee of Ohio Rehabilitiation Services Commission cashed checks sent by SSA to the Commission. ..... 141,300
  (5-89-00131-6, Douglas Devoe)
- Owner and office manager of New York DME company submitted false claims to Medicare for oxygen concentrators, other items. ..... 137,400
  (2-86-00912-9, Home Convalescent Equipment)
- Montana man drew disability benefits for self and family while running a highly profitable ranch. ..... 134,700
  (8-88-20150-6, Harvey Pitsch)
- Salaried director of stroke unit at Massachusetts hospital also billed Medicare as if he were attending physician. ..... 115,200
  (1-88-30225-9, Bertam Howard)
- Man in Virginia received disability benefits while working as police chief and security officer. ..... 110,800
  (3-89-00398-6, William Johnson)
- Illinois gynecologist filed Medicare claims for deceased patients and others not treated, and for office visits when patients were hospitalized. ..... 108,000
  (5-87-01393-9, Edward Tapper)
- New York man obtained disability payments while working for the Postal Service. ..... 92,300
  2-88-00916-6, Mark Holman)
- Colorado physician billed separately for biopsies already included in other billings. ..... 85,000
  (8-89-30076-9, Bruce Webber)
- Michigan physician group billed Medicare for cardiac monitoring services as if they were holter monitoring. ..... 77,400
  (5-84-00277-9, Mararelas Associates)
- New York man concealed work to obtain disability payments. ..... 73,200
  (2-88-00701-6, Richard Flaxman)
- California couple falsified information to obtain SSI benefits for Southeast Asian refugees. ..... 70,900
  (9-87-00895-6, Henry Nguyen and Ona Tady)
- New York man transferred benefits of deceased aunt to his bank account. ..... 67,200
  (2-89-00374-6, Stephen Fanfaro)
- Kansas radiation therapist billed Medicare for services not performed. ..... 59,000
  (8-86-00577-9, Gilbert Lawrence)
- California man obtained SSI benefits under name of deceased brother. ..... 58,600
  (9-87-00164-6 Harold Dow)
- Wisconsin man had his wages reported as his wife's to avoid offsets against his retirement benefits. ..... 57,800
  (5-87-00922-6, Bob Russell)
- Massachusetts hospital emergency service billed Medicare for undocumented services. ..... 57,800
  (W-86-00254-9, Stanley A. Hoffman)
- Husband and wife in Massachusetts concealed marriage and work to receive disability and welfare benefits. ..... 56,300
  (1-88-00188-6, Robert & Eleanor McFarland)
- New York woman cashed deceased aunt's SSA checks for own use. ..... 55,000
  (2-88-00852-6, Miriam Dalrymple)
- Man obtained disability payments while working for the Postal Service. ..... 54,600
  (3-88-00310-6, edward Kelly)
- Tennessee man concealed work to obtain disability benefits. ..... 54,200
  (4-87-00728-6, John T. Graves)
- Ohio doctor billed for services not rendered. ..... 53,900
  (5-88-00933-9, Anne D. Deblaere)
- Illinois general practitioner and minister billed Medicare for unsubstantiated home visits, psychotherapy, and medical services. ..... 51,800
  (5-86-00270-9, John n. Crawford Jr.)
- Disability beneficiary in Tennessee was employed under son's SSN. ..... 51,500
  (4-89-00317-6, Hugh Hudson)
- Kentucky pharmacist and two employees falsified Medicaid claims as prescriptions for brand name drugs. ... 50,500
  (4-87-01237-9, Dan Salyer, Wanda Sue Ferguson, Veronica Martin)

**Other Receivables Which Did Not Meet the $50,000 Threshold for Individual Reporting: ..... $11,103,800**

# APPENDIX D

## UNIMPLEMENTED OIG RECOMMENDATIONS TO PUT FUNDS TO BETTER USE THROUGH MARCH 1990

This schedule represents over $14.1 billion in potential annual savings or a one-time recovery 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 |
|---|---|---|
| **Bridging the Coverage Gap:** Require mandatory Social Security coverage for all part-time and temporary State and local government employees not participating in any employees' retirement system. (CIN: A-02-86-62604) | The proposal was included in the President's FY 1991 budget and legislative program. | $2,300 |
| **Mandate Medicare Coverage:** Medicare Part A coverage should be extended to all State and local government employees. (CIN: A-09-86-62050) | This proposal is included in the President's FY 1991 budget and legislative program. | 1,866 |
| **Unfunded Actuarial Liabilities in Pension Plans:** The OMB should revise Circular A-87 to disallow the interest expense associated with unfunded actuarial liabilities. (CIN:A-09-87-00031) | The OMB has included part of the recommended changes in its proposed revision to Circular A-87. | 1,300 |
| **Indirect Medical Education:** Modify Medicare payments to teaching hospitals by reducing the prospective payment system adjustment factor. (ACN: 14-52018, ACN: 09-62003, CIN: A-09-87-00100, CIN: A-07-88-00101) | The President's FY 1991 budget and legislative program includes a proposal to reduce the IME adjustment factor from 7.75 percent to 4.05 percent. | 1,030 |
| **Accounting for Penalties and Interest:** The SSA should support a legislative change which would restore equity to the accounting process by requiring IRS to compensate the trust funds for interest and penalties collected by IRS which exceed the cost of IRS' administration of the Social Security tax. (CIN: A-13-86-64640) | The SSA agreed and will seek to negotiate with IRS to assess the impact of such a change. | 844 |
| **Disproportionate Share Payments:** Disproportionate share payments to hospitals should be ended without redistributing the funds to the prospective payment system. (CIN: A-04-87-01004) | This proposal was not included in the President's FY 1991 budget and legislative program. | 800 |

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **Hospital DRG Rates:** Rebase Medicare hospital PPS rates to correct for inclnsion of overstated operating costs. (ACN: 09-62021; CIN: A-08-87-00003) | This proposal has not been inclnded in the President's FY 1991 bndget and legislative program. However, the President's FY 1991 budget does contain a proposal to update PPS rates at the market basket, minus 1.5 percent. | $640 |
| **Medicare as Secondary Payer:** Extend the Medicare Secondary Payer provisions for end stage renal disease beneficiaries beyond the current 1-year limit. (CIN: A-10-86-62016) | The President's FY 1991 budget would extend the current 1-year period to 18 months and save an estimated $30 million. | 600 |
| **Buy-in Program:** Eliminate Federal financial participation in monthly Part B premiums paid by States on behalf of Medicaid recipients eligible for Medicare buy-in program. (ACN: 03-50228; CIN: A-03-86-62019) | The proposal is not included in the President's FY 1991 budget and legislative program. | 380 |
| **Payroll Taxes:** Require recipients of Federal funds to deposit payroll taxes at the time Federal funds are drawn down to meet payroll needs. Under this concept, the only basic change in grantee procedures would be in the timing of deposits of payroll taxes. Instead of waiting for a "trigger date," the grantee would deposit payroll taxes almost simultaneously with the Federal cash draw. (CIN: A-12-88-00110) | The recommendations are being considered by OMB. | 360 |
| **Medicaid:** Eliminate premium matching rates under Medicaid. (ACN: 03-60223) | The proposal was not included in the President's FY 1991 budget and legislative program. | 360 |
| **Reimburse Trust Funds for Unnegotiated Checks:** The SSA and Treasury should redetermine the dollar value of unnegotiated checks so as to most completely reimburse the trust funds. (CIN: A-04-87-03004) | The SSA believes prior estimates are defensible. However it will bring cited problems to the attention of Treasury to see if an adjustment is warranted. | 338.8 |
| **Medicare Deductibles:** Raise the Medicare Part B deduetible to $100 and appropriately index it. (ACN: 09-52043) | The proposal was not included in the President's FY 1991 budget and legislative program. | 280 |
| **Multiple Visits in Skilled Nursing Facilities:** Apply the "multiple visit" concept to Medicare payments for physician visits to patients in skilled nursing homes and hospitals. (ACN: 03-42005) | The HCFA has not adopted the multiple visit concept. | 240 |

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **Inpatient Psychiatric Care Limits:** New limits should be developed to deal with the high cost and changing utilization patterns of inpatient psychiatric services. (CIN: A-06-86-62045) | The proposal was not included in the President's FY 1991 budget and legislative program. | $238 |
| **SSA and SSI Overpayments - Tax Refund Offsets:** The SSA should actively support legislation to allow offset of income tax refunds to recover certain RSDI overpayments. The SSA should take administrative action to recover certain SSI overpayments through income tax refunds. (OAI-12-86-00065; OAI-12-88-01290) | The SSA agreed and has included this item in its FY 1991 legislative proposals. The SSA continues to negotiate with IRS to administratively implement the SSI refund offset. | 193.7 |
| **Child Support Disregard:** Eliminate the $50 child support payment to the AFDC family. (CIN: A-02-86-72606) | The proposal was not included in the President's FY 1991 budget and legislative program. | 175 |
| **Rounding Medicare Premiums:** Round Medicare Part B premiums up to the next higher dollar. (ACN: 09-52008; CIN: A-08-87-00003) | The proposal was not included in the President's FY 1991 budget and legislative program. | 175 |
| **Physician Office Laboratories:** The HCFA should impose a registration fee to fund the laboratory registration and inspection process. (OAI-05-88-00330) | The OBRA 1989 requires charging a registration fee. The HCFA is preparing a Notice of Proposed Rulemaking to implement this provision. | 173 |
| **Foster Care:** Limit Federal participation to one of several limitation methods: (1) none in administration and training costs, (2) only in administration and costs based on a percentage of maintenance costs, (3) in program costs using a percentile limitation based on previous costs, or (4) in administration and training costs based on specific fixed dollar amounts. (CIN: A-07-86-60551) | A cap on administrative costs is included in the President's FY 1991 budget and legislative program. A work group is being assembled to address issues regarding how to gather more information about State administrative cost expenditures, and how best to limit or control administrative costs in the event that the cap is not enacted. | 147 |
| **Mandatory Tip Reporting:** Expand the requirements for mandatory reporting of tip income to include other types of business where tipping is a common practice. (CIN: A-09-89-00072) | The SSA concurred, contingent upon Treasury views. The Treasury expressed concerns and will consider the proposal in light of an in-house study. | 134 |

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **Rural Referral Centers:** Reimbursement rates to rural referral centers (RRCs) should be based on the relationship of costs of RRCs to costs of urban and other rural hospitals. (CIN: A-03-87-00001) | This proposal was not included in the President's FY 1991 budget and legislative program. | $127 |
| **SSI Cross Program Adjustment:** The SSA should resubmit its legislative proposal authorizing the adjustment of RSDI payments to recover overpayments from former SSI recipients. (OAI-12-86-00029) | The proposal is included in the Department's 1989 Social Security Amendments submitted to the Congress last year. | 120 |
| **Reimbursement for One-day Hospital Stays:** The HCFA should seek legislation to pay for inpatient services not requiring an overnight stay as outpatient services, or pay for these services at the lower of actual charges or the DRG amount. (CIN: A-05-89-00055) | The HCFA disagrees with the need for legislation and is relying on PRO reviews to resolve the problem of medically unnecessary admissions. The HCFA did administratively revise the definition of an inpatient which should also help prevent unnecessary admissions. | 115 |
| **Ambulatory Surgeries:** Increase use of outpatient facilities for elective surgeries under Medicaid. (ACN: 09-50205) | The HCFA is preparing a proposed rule which will encourage the use of outpatient surgery. Implementing regulations are currently scheduled to be published during FY 1990. | 110 |
| **Poor Quality Care - National DRG Validation Study:** The HCFA needs to issue regulations to implement the 1985 COBRA provisions giving PROs authority to deny Medicare reimbursement for patients receiving substandard medical care. (OAI-09-88-00870) | The HCFA is preparing the final regulations to implement this recommendation. | 110 |
| **Dialysis Reimbursement Rates:** The HCFA should develop separate dialysis rates for independent and hospital based ESRD facilities. (CIN: A-01-87-00500) | The HCFA disagrees with the recommendations. | 109 |
| **Crossover Claims:** Limit Medicaid "Buy-in" payments for Medicare deductible and coinsurance to the Medicaid fee schedule. (ACN: 02-60202) | The proposal is not included in the President's FY 1991 budget and legislative program. | 100 |

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **Viability of Health Education Assistance Loan/Student Loan Insurance Fund:** Eliminate the current 8 percent ceiling on insurance premiums over the life of a loan; link insurance premium assessments to risk categories; require a 20 percent cost-sharing by lenders; permit lenders to require co-signers; eliminate Federal guarantee for loan amounts in case of death or disability; and impose a lender's processing fee for default claims filed. (ACN: 12-73276) | The proposal was last submitted to the Congress in the Department's Health Education Assistance Loan Amendments of 1989. The proposal was not acted on and was not included in the President's FY 1991 bndget. | $74.7 |
| **Shared Living Arrangements:** Require that households with multiple AFDC family units be budgeted as a single economic unit for determining the amount of the grant award. (ACN: 09-72615) | The proposal was not included in the President's FY 1991 budget and legislative program. | 73.5 |
| **Ambulance Claims:** Require Medicare carriers to implement effective claims screening procedures to detect noncovered ambulance services. (ACN: 04-62006) | The HCFA is evaluating the need for claims processing improvements at all carriers. | 64 |
| **Mandatory Second Opinion:** Mandate that Medicaid beneficiaries obtain second surgical opinions for selected surgeries. (ACN: 03-30211) | The HCFA's regulations had to be delayed until a report required by the Omnibus Budget Reconciliation Act of 1986 was submitted to the Congress. The report was submitted on June 16, 1989. Implementing regulations are currently scheduled to be published during FY 1990. | 63 |
| **Medicare Round Down:** Round down to the next whole dollar Medicare Part B and other payments for Medicare services. (ACN: 03-62006; ACN: 14-52085) | The OIG has submitted a second report; however, this proposal was not included in the President's FY 1991 budget and legislative program. | 63 |
| **Intraocular Lens Implant:** Exclude conventional eye wear from Medicare coverage for beneficiaries receiving intraocular lens implants. (CIN: A-04-88-02038) | The HCFA is reviewing the issue but has no plans to implement the recommendation. | 60 |
| **State Sales Tax:** Disallow State sales tax charged to Federal programs. (CIN: A-04-86-00040) | The OMB has made sales tax assessed by a governmental unit upon itself an unallowable cost in the proposed revisions of Circular A-87. | 54 |

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **Financing SSA Buildings (Early Repayment of Loans):** Use trust fund monies to liquidate the remaining mortgage balances on the three program service centers' contract method of financing. (CIN: A-09-86-62611) | The SSA has authorized GSA to spend up to $40 million to buy back some outstanding certificates, and will consider further liquidation as funds become available. In the initial year of implementing this proposal, there would be a oue time cost. | $48 |
| **Anesthesia Services:** Medicare should pay only for the actual time for anesthesiologist and CRNA services, not rounding up. (CIN: A-07-89-00193) | Section 6106 of OBRA 1989 specifies that anesthesia time units are to be based on actual time, not rounded up. Implementation is effective April 1990. | 35 |
| **User Fees:** The OIG identified three premarketing approval functions where FDA has not proposed a user fee. (CIN: A-01-87-02522) | The proposal was included in the President's FY 1991 budget and legislative program. | 30.9 |
| **Nonphysician Services:** Require fiscal intermediaries to implement computer edits to prevent improper payments to hospitals for nonphysician services reimbursed through DRG rates. (CIN: A-01-86-62024) | The HCFA is taking action to improve intermediary systems and recover identified overpayments. | 28 |
| **Physicians' Services in Outpatient Settings:** The HCFA should expand the list of procedures subject to the TEFRA outpatient limitation and make the list uniform among all carriers. (CIN: A-07-86-62041) | The HCFA has agreed in audit resolution to submit to carriers an expanded list of procedures to be reviewed against the TEFRA limitation. | 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 because it believed administrative costs in systems changes and staff time, and higher long-range costs would outweigh short-term savings. | 21.4 |
| **Excessive Federal Financial Participation in States' Costs of Provider Survey and Certification Activities:** The HCFA should bring the Federal financial participation (FFP) matching rates used for costs of States' survey and certification activities into agreement with the authorizing provisions of the law. (CIN: A-14-88-01000) | The HCFA disagrees with our recommendation. They believe that the FY 1991 implementation of the OBRA-87 FFP matching provision will settle the issue. The HCFA plans no action on this recommendation. | 20 |

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **Accounting for Payments After Death:** The OIG recommended procedures to improve accounting for payments after death and processing death terminations. (CIN: A-04-87-03007) | Although some improvements were implemented by SSA, not all were. The SSA agreed to implement the remaining recommendations. | $20 |
| **Premature Admissions:** Minimize premature admissions for Medicaid elective surgeries. (CIN: A-09-86-60213) | The HCFA is developing a proposed rule which will encourage the use of preadmission testing and preadmission review systems. Implementing regulations are currently scheduled to be published during FY 1990. | 18.5 |
| **Access of Dialysis Patients to Kidney Transplantation:** The OIG sent to HCFA a series of recommendations that would help ensure that dialysis patients are afforded a full and fair opportunity to receive a kidney transplant. (OAI-01-86-00107) | Both HCFA and PHS are collaborating with professional societies to develop guidelines for patient transplant suitability. | 18.3 |
| **Emergency Assistance to Needy Families (EAF):** The FSA should revise the EAF regulations to limit EAF benefits to one period of 30 consecutive days or less in 12 consecutive months. This would bring the regulations into compliance with the intent of the Congress. (CIN: A-01-87-02301) | The FSA concurred and issued a proposed rule change. The Congress enacted moratoria on changes to the EAF program which extended through September 30, 1990. However, in accordance with congressional instructions, revised regulations are being drafted. | 18 |
| **Nursing Home Per Diem:** Revise Medicare regulations to prohibit suppliers from billing directly for urological and enteral therapy supplies and require that nursing homes include the cost of such products in their per diem rates.(ACN: 06-42002) | The proposal was not included in the President's FY 1991 budget and legislative program. | 17 |
| **Cost Standards for DDSs:** Cost and performance standards should be developed for disability case processing. (OAI-06-88-00820) | The SSA is developing separate regulations concerning cost per case standards and adjusted costs per weighted case. They anticipate issuance in FYs 1990 and 1992, respectively. | 14.5 |
| **Arterial Bypass Surgery:** Eliminate Medicare coverage of extracranial-intracranial (EC/IC) bypass surgery. (CIN: A-09-87-00005) | The HCFA agrees and is drafting a proposed regulation to withdraw Medicare coverage of certain ineffective EC/IC surgery. | 10.7 |

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **Collect Delinquent FICA Taxes Owed by Puerto Rico:** The Puerto Rican Department of Treasury should promptly remit to SSA unpaid contribution balances due for periods prior to January 1, 1987. (CIN: A-02-87-00008) | The SSA and Puerto Rican Department of Treasury agreed and collection efforts are underway. | $10.7 |
| **Pacemaker Monitoring:** Reclassify pacemaker monitoring under Medicare from the current physician-assisted service to the lower-paying routine service. (ACN: 08-52017) | The HCFA issued guidelines as part of studies mandated by the Deficit Reduction Act of 1984, and is exploring alternative approaches to the problem. | 6 |
| **Multiple Surgical Procedures:** All carriers should uniformly limit reimbursement for second surgical procedures to 50 percent of reasonable charges. (CIN: A-03-86-62008) | The HCFA has no plans to establish a national limit for multiple surgical procedures at this time, but has agreed to bring our findings to the atteution of the carrier involved. | 5.2 |
| **Unreported Marriages:** The SSA should take appropriate action on cases of unreported beneficiary marriages identified by OIG. (CIN: A-09-87-00052) | The SSA is continuing its recovery efforts on the cases identified in the OIG report. Acquisition of computer marriage records from States is being addressed as part of SSA's strategic plan and the issue is being considered under the "Expanded Automated Data Exchange" project. | 5.2 |
| **Collect Nonresident Alien Taxes for Retroactive Periods:** The SSA should use automated systems to identify retroactive nonresident alien taxes due and develop procedures to facilitate collection. (CIN: A-13-86-62658) | The SSA generally agreed, but delayed action because of higher priorities. | 4.4 |
| **Premium Collection:** Improve Medicare Part B premium collection procedures on Civil Service annuitants. (CIN: A-03-86-62009) | The HCFA agrees with this proposal and is in the process of taking corrective action. | 2.4 |
| **Nonpayment for Broken Consultative Examinations:** The SSA should not pay State agencies for consultative examinations that are canceled or otherwise not kept. (CIN: A-01-87-02004) | The SSA developed a regulatiou to implement the OIG proposal. The proposed rule was published in the Federal Register in October 1988. The SSA has received comments and is reviewing plans for publication of a final regulation. | 1.5 |

| OIG RECOMMENDATION | STATUS | SAVINGS IN MILLIONS |
|---|---|---|
| **Improve Controls Over Improper Cashing of Replacement Checks:** Weak procedural controls and a systems deficiency resulted in lost accountability for overpayments due to improper cashing of replacement checks. (ACN: 13-62635) | The SSA concurred and has established interim measures to improve controls. | $1.3 |
| **Multiple Payments:** The SSA should use a computer program to identify and correct situations of unauthorized multiple payments to the same person at the same address. (CIN: A-04-87-03001) | The SSA is testing computer programs to identify such unauthorized payments. | .6 |

# APPENDIX E

## UNIMPLEMENTED OIG PROGRAM AND MANAGEMENT IMPROVEMENT RECOMMENDATIONS THROUGH MARCH 1990

This schedule represents recent OIG findings and recommendations that resulted in or which, if implemented, would result in substantial benefits. The benefits primarily relate 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 |
|---|---|
| **Patient Dumping After the Consolidated Budget Reconciliation Act:** The HCFA should require hospitals to report suspected cases of dumping as a condition of their participation or as part of their provider agreement. (OAI-12-88-00830) | Regulations were proposed that required hospitals to report violations as part of their provider agreements. The final regulations are currently under development. |
| **False Evidence Submitted to Obtain an SSN:** The SSA should systematically identify all original SSN applications from U.S. born applicants over age 24 and require a second level review of such applications. (Notice of Program Vulnerability, October 6, 1987.) | The SSA will validate the results of an earlier regional study before committing to a more intense review of selected high risk cases. They plan to issue a final report in June 1990. |
| **Postings to SSA's Master Earning File:** The SSA should install a mechanism to prevent the postings of earnings to the master earnings file subsequent to an individual's date of death and create an alert if the SSN is being used by another person subsequent to the death of the account holder. (Management Advisory Report, March 3, 1988) | The SSA has implemented a procedure to require a check of the NUMIDENT file for a death indicator prior to posting to the master earnings file. They have also instituted a process to electronically generate correspondence to employers to investigate earnings reported after death. |
| **Increase Financial Viability of Rural Hospitals Subject to the Prospective Payment System:** The HCFA should consider budget-neutral legislative proposals to assist rural hospitals subject to the prospective payment system. (CIN: A-14-88-02506) | The HCFA believes that additional legislative relief is not necessary. They believe that it is prudent to await the impact of current legislation. |
| **Specify in Peer Review Organization Contracts Excess Profit Clauses-Medicare:** The HCFA should consider both peer review organization (PRO) and non-PRO business of all prospective PRO contractors when evaluating offerors' estimated costs for future PRO contracts. (ACN: 14-62158) | The HCFA commented that due to the firm fixed-price nature of the contracts, there is no basis for adjusting the contract price based on the PRO's cost experiences. |

| OIG RECOMMENDATION | STATUS |
|---|---|
| **SSI Payments Under Recently Issued SSNs:** The SSA should systematically monitor SSI claims under SSNs that have been issued within 2 years of the SSI application. (Notice of Program Vulnerability, September 27, 1985) | The SSA is conducting a pilot program in two regions that will require a management review of all new SSI claims with high risk characteristics. They anticipate implementation nationwide in Spring 1990. |
| **The PRO Program: Sanction Activities:** The Department should submit a legislative proposal to amend section 1156 of the PRO statute to strengthen the monetary penalty to $10,000 per violation. (OAI-01-88-00571) | This recommendation is currently under consideration within the Department. |
| **Integrity of Medical Evidence:** The SSA should institute appropriate procedures to ensure the integrity of medical evidence submitted to support claims for disability benefits. (OAI-03-88-00670) | The SSA has developed draft procedures for a national review of medical evidence submitted by sanctioned physicians to DDSs. |
| **Medicare Reimbursement for At-Home Oxygen Care:** The HCFA should issue immediately a uniform medical necessity certification form. Included on this form should be a strong physician attestation statement. This attestation places the responsibility with the physician for the accuracy of the information contained on the certification form. (OAI-04-87-00071) | The HCFA has established a medical necessity certification and attestation statement. These are currently being implemented nationally. |
| **Ophthalmology/Optometry Relationships in Cataract Surgery:** The HCFA should develop national guidelines covering the number of postoperative days includable in a global fee for cataract surgery and the percentage allocations of a global fee to surgery and postoperative care. (OAI-07-88-00460) | The HCFA concurred but has taken no action to implement national guidelines. |
| **Itinerant Surgery:** The HCFA should develop guidelines regarding the percentage allocation of global fees for surgery and postoperative care. (OAI-07-88-00850) | The HCFA concurred and is in the process of developing guidelines and carrier instructions. |

# ACRONYMS

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|---|---|
| ADAMHA | Alcohol, Drug Abuse, and Mental Health Administration |
| AFDC | Aid to Families with Dependent Children |
| AHCPR | Agency for Health Care Policy and Research |
| AIDS | acquired immune deficiency syndrome |
| ASC | ambulatory surgical center |
| ASMB | Assistant Secretary for Management and Budget |
| ASPER | Assistant Secretary for Personnel Administration |
| ATSDR | Agency for Toxic Substances and Disease Registry |
| AWP | average wholesale price |
| CAAS | contracts for advisory and assistance services |
| CDC | Centers for Disease Control |
| CMI | case mix index |
| CMP | civil monetary penalty |
| CSE | child support enforcement |
| DME | durable medical equipment |
| DOD | Department of Defense |
| DOJ | Department of Justice |
| DRG | diagnosis related group |
| ESRD | end stage renal disease |
| FDA | Food and Drug Administration |
| FFP | Federal financial participation |
| FICA | Federal Insurance Contribution Act |
| FMFIA | Federal Managers' Financial Integrity Act |
| FSS | Federal supply schedule |
| FY | fiscal year |
| GAO | General Accounting Office |
| HRSA | Health Resources and Services Administration |
| ICF/MR | intermediate care facility for the mentally retarded |
| IHS | Indian Health Service |
| INS | Immigration and Naturalization Service |
| IOL | intraocular lens |
| JOBS | Job Opportunity and Basic Skills |
| LIHEAP | Low Income Home Energy Assistance program |
| MAR | management advisory report |
| MCCA | Medicare Catastrophic Coverage Act |
| MFCU | Medicaid fraud control unit |
| MSP | Medicare as secondary payer |
| NIH | National Institutes of Health |
| OBRA | Omnibus Budget Reconciliation Act |
| OGC | Office of General Counsel |
| OMB | Office of Management and Budget |
| OPD | outpatient department |
| PCIE | President's Council on Integrity and Efficiency |
| PPS | prospective payment system |
| PRO | peer review organization |
| RRB | Railroad Retirement Board |
| RSDI | Retirement, Survivors and Disability Insurance |
| SLIAG | State Legalization Impact Assistance Grants |
| SNF | skilled nursing facility |
| SSACCS | Social Security Administration case control system |
| SSI | Supplemental Security Income |
| SSN | Social Security number |
| TEFRA | Tax Equity and Fiscal Responsibility Act |
| ULO | unliquidated obligation |
| USTF | uniformed services treatment facility |
| VA | Department of Veterans Affairs |

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