Department of Health and Human Services
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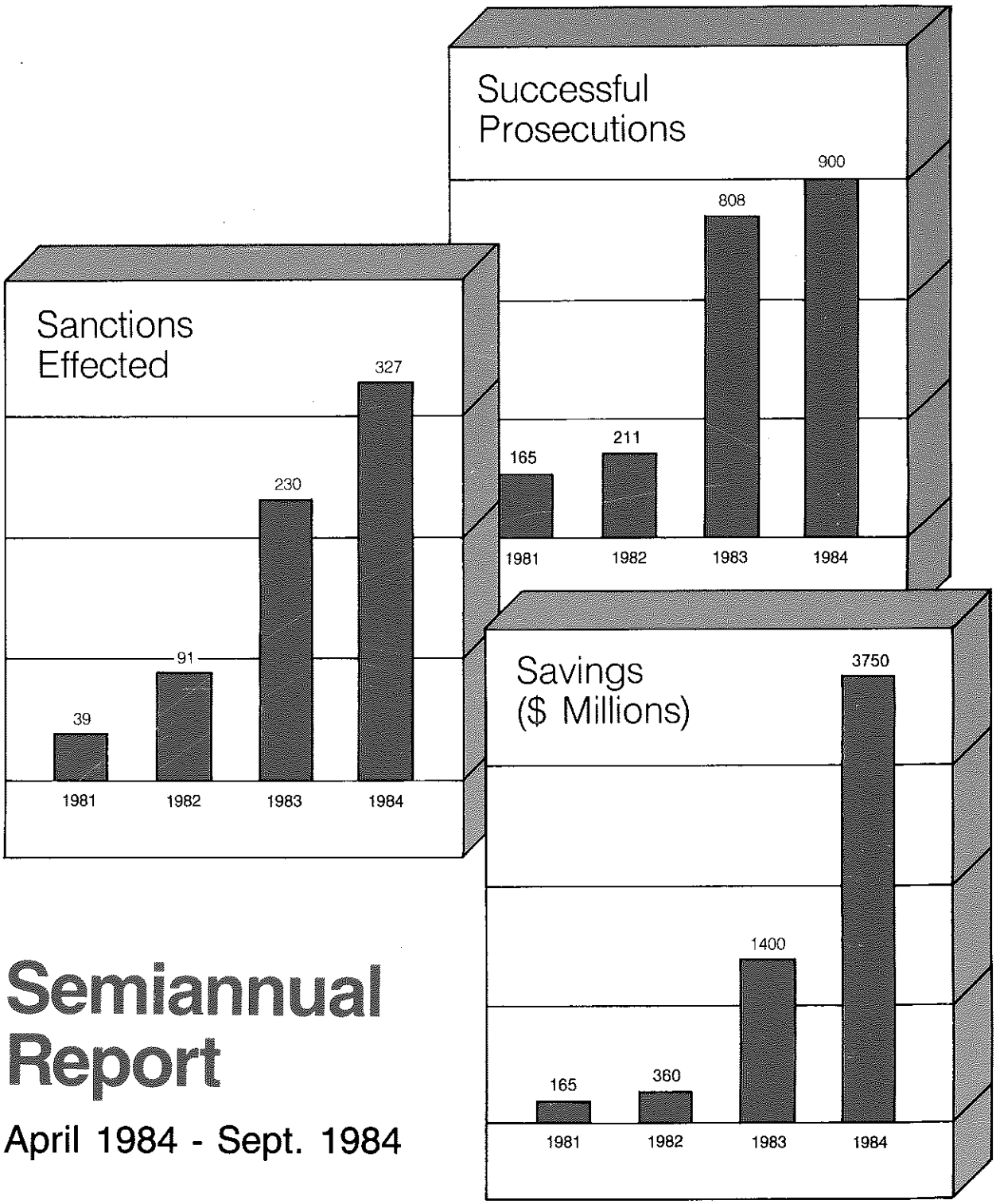
Inspector General

OFFICE OF INSPECTOR GENERAL



Semiannual Report

April 1984 - Sept. 1984

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CHAPTER I

OIG OPERATING HIGHLIGHTS

When Congress enacted legislation creating the Office of Inspector General (OIG), it established an organization whose basic mission was to reduce the incidence of fraud, abuse and waste in the Department of Health and Human Services (DHHS) and to promote economy and efficiency. This responsibility extends over a Department whose budget is the third largest in the world, surpassed only by the overall United States Federal budget and by the total budget of the Soviet Union. Since its inception in 1976, the OIG has made significant progress in achieving its Congressional mandate, but much remains to be done.

This Semiannual Report of the Department of Health and Human Services' (HHS), Office of Inspector General describes major OIG accomplishments during the period April 1984 - September 1984. For perspective, trends over the last 4 years are highlighted.

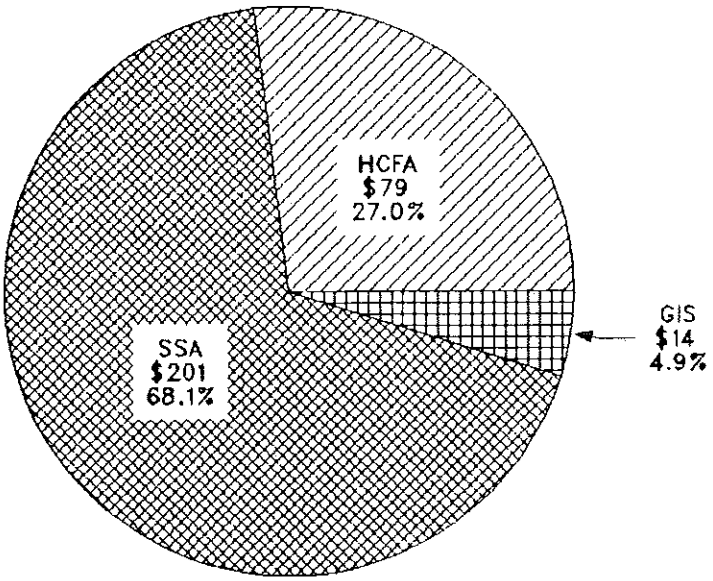
Departmental outlays have increased from $230.3 billion in FY 1981 to an estimated $294.3 billion in FY 1984. They are expected to grow to $318 billion in FY 1985. Chart 1 shows the FY 1984 breakout of HHS funds by major Departmental programs:

- Health Care Financing Administration (HCFA) at $79.4 billion includes the Medicare and Medicaid programs and represents the second largest portion of the HHS budget.

- Social Security Administration (SSA) at $200.5 billion includes the federally-administered Old Age and Survivors Insurance, Disability Insurance, Supplemental Security Income; and State-administered Aid to Families with Dependent Children, Low Income Energy Assistance, Refugee Resettlement, and Child Support Enforcement programs.

- Grants and Internal Systems (GIS) at $14.4 billion encompasses two Operating Divisions of the Department - the Public Health Service and the Office of Human Development Services - and overall Departmental management.

DHHS OUTLAYS BY PROGRAM CATEGORY
FY 1984



PROJECTED OUTLAYS
$294.3 BILLION

CHART 1

The goal of the OIG is to promote economy and efficiency and to reduce the incidence of fraud, abuse, and waste in HHS programs and operations. To do this we concentrated our limited resources on the areas of greatest vulnerability and highest possible return. The success of this strategy is depicted in Chart 2 which shows that savings resulting from OIG efforts have increased dramatically over the last 4 years while OIG resources have remained relatively constant.

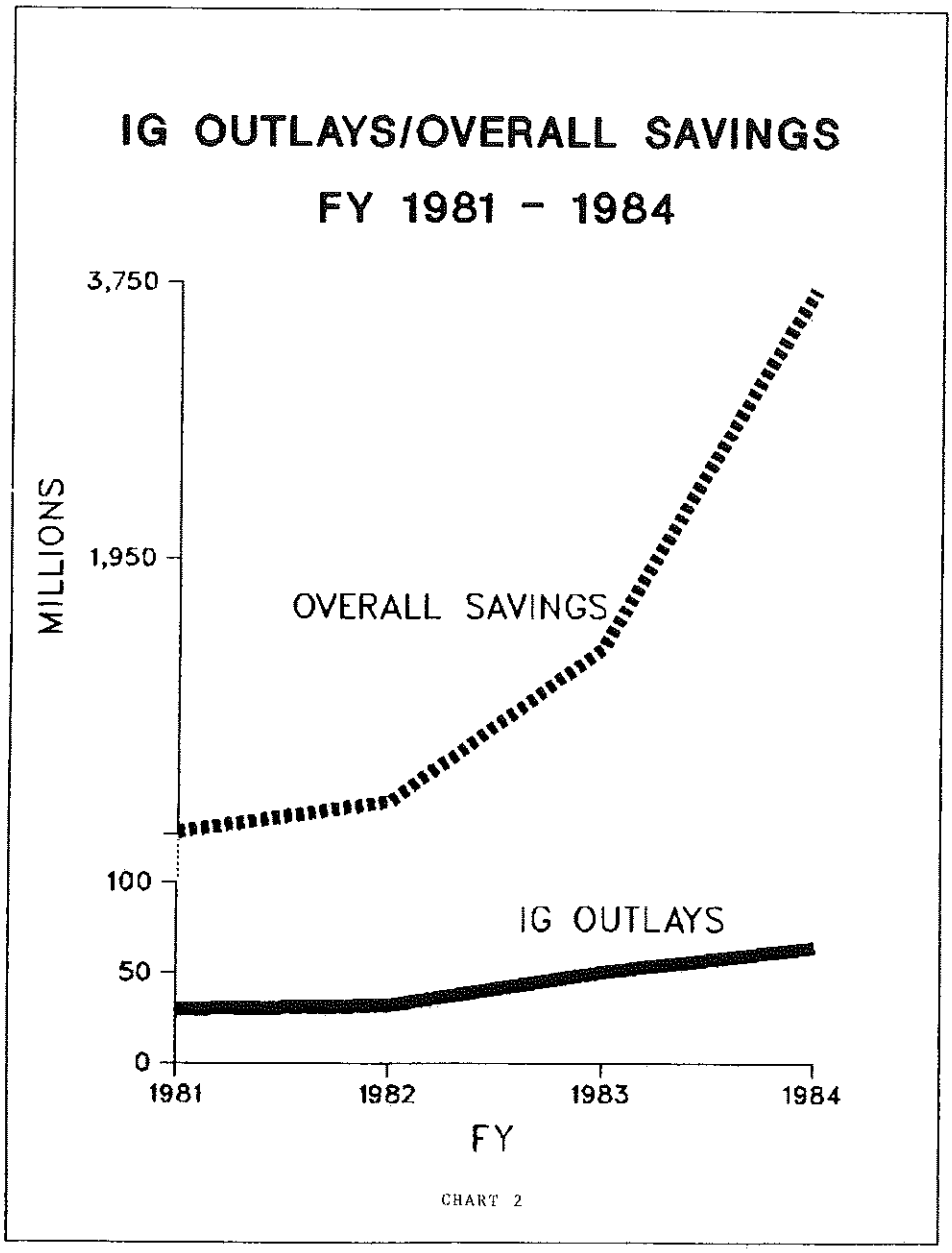
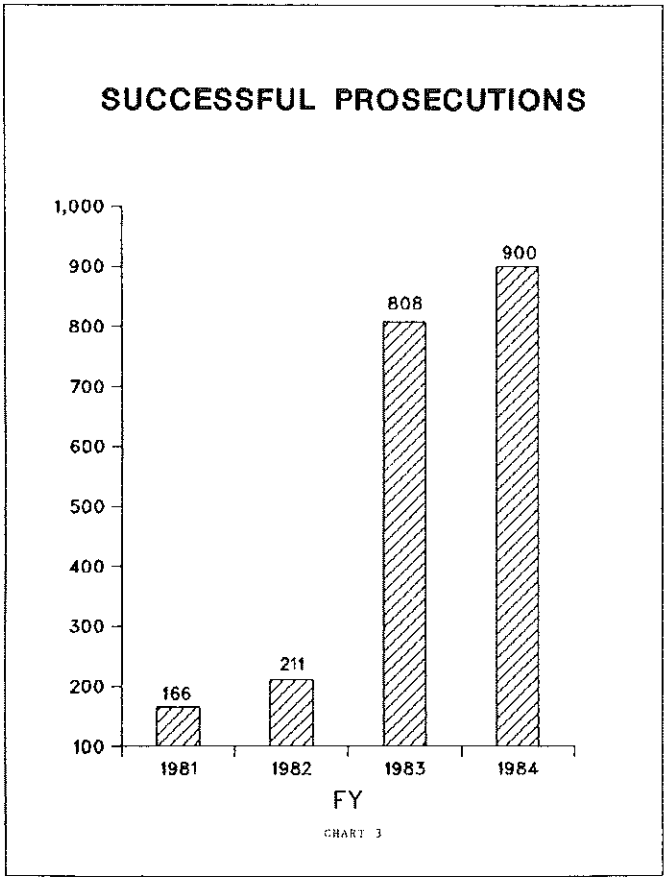
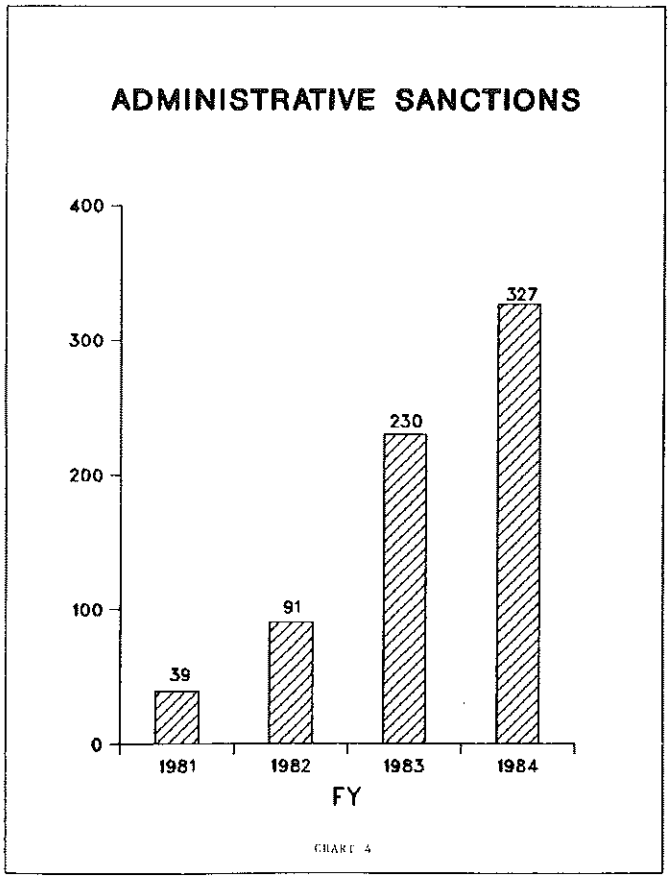


CHART 2

Since assuming responsibility for SSA and HCFA program integrity in 1983, OIG successful prosecutions have increased from 808 for FY 1983 to 900 for FY 1984, as shown in Chart 3. Administrative sanctions for 1981 and 1982 were imposed by HCFA prior to OIG receiving sanction authority. Since 1983 the OIG has had this responsibility and the number of sanctions has increased significantly, as shown in Chart 4.





While total savings for FY 1984 were $3.7 billion, savings during this report period, the last half of FY 1984, were $1.9 billion. A complete listing is contained in Appendix B of this report. (See page 81)

Brief statements of major OIG accomplishments are highlighted below under the following headings: OIG accomplishments for the report period and significant OIG findings that could result in savings. More detailed descriptions of OIG activities are included in the following chapters: Health Care Financing Administration, Social Security Administration, Grants and Internal Systems, Legislative and Regulatory Review, and President's Council on Integrity and Efficiency.

OIG accomplishments for the report period include:

- Administrative sanctioning by the OIG led to 93 health care providers being "kicked out" of HHS' Medicare and Medicaid programs. Investigations of Medicare/Medicaid fraud resulted in 234 convictions, and financial recoveries and savings of over $27 million, with an additional $5.5 million in Civil Monetary Penalties settlements. (See page 22)

- OIG investigations of Social Security fraud resulted in more than 400 successful prosecution actions, over $5 million in recoveries, and almost $15 million in savings. Over 180 of the prosecutions were against illegal welfare recipients and obtained through joint investigations with State agencies. (See page 39)

- OHDS agreed to enroll additional children in the Head Start program and to provide program improvements, a no-cost output enhancement. Programs which cannot meet average daily attendance targets, as required by a revised enrollment and attendance policy will have their funded slots reduced. OIG estimates the value of this enhancement to be worth up to $24.8 million. (See page 51)

- Under the aegis of the PCIE, the OIG has contracted with the Council of State Governments to publish the Computer Matching Report to provide technical assistance and share computer technology and applications with Federal, State, and local agencies. (See page 69)

Significant OIG findings that could result in savings include:

- Making Medicare Part A and B payments on a 30-day payment cycle could earn the Medicare Trust Funds an additional $320 million annually in interest income. (See page 10)

- Increased use of outpatient facilities for elective surgeries could reduce Federal expenditures for Medicaid by some $110 million annually. (See page 10)

- Increased use of electronic transmission of claims could save Medicare and Medicaid $125 million annually. (See page 13)

- Better monitoring to preclude improper Medicaid charges for educational costs at ICF/MRs could save the Federal Government $117 million annually. (See page 12)

- Applying limits to home health agency reimbursements by type of service rather than total costs could save Medicare as much as $35 million annually. (See page 11)

- Use of an alternative methodology in setting minimum AFDC quality control sample size requirements could save as much as $22.5 million annually. (See page 34)

- Implementing more effective repayment requirements under the Health Education Assistance Loan program could save $20 million annually. (See page 48)

- Paying for adoption assistance rather than foster care for special needs children saves the Federal Government $160 per month per child. Increasing adoptions of special needs children in IV-E Foster Care could save $11.5 million annually. (See page 51)

- Awarding special recruitment and retention pay to PHS Commissioned Corps physicians on the same basis as civilian medical employees and disbursing such pay monthly rather than as an advanced lump sum could result in savings of $10.1 million annually. (See page 49)

- Termination of payments of Title II (OASDI) benefits to deceased beneficiaries could save SSA $7.2 million. (See page 34)

- Strengthening provisions for identifying and recovering construction grant funds used for Developmental Disabilities program facilities that no longer meet program requirements could save $2 million annually. (See page 51)

HEALTH CARE FINANCING ADMINISTRATION

CHAPTER II

HEALTH CARE FINANCING ADMINISTRATION

The Health Care Financing Administration (HCFA), including its Medicare and Medicaid programs, represents the second largest portion of the Department's budget, estimated at $79 billion or 27 percent in FY 1984. Medicare finances health care services for approximately 28 million people aged 65 and older and 3 million disabled individuals. It consists of two programs, the Hospital Insurance program or "Part A" and the voluntary Supplementary Medical Insurance program or "Part B." The Medicaid program provides matching funds to States to finance medical services for 23 million low-income people.

Recently Congress enacted the prospective payment system (PPS) for hospitals, one of the more significant changes in the Medicare program since its inception. OIG has devoted considerable effort to the front-end review of PPS which has resulted in systemic improvements. Our prevention activities continue to focus on the priority of Department policies dealing with reimbursement for capital costs and their impending inclusion in the new PPS. In addition, significant effort was devoted to reviewing cost proposals from potential Peer Review Organizations (PROs).

As a result of our reviews during the second 6 months of FY 1984, we identified program changes that could result in savings of over $700 million. OIG reviews also identified improper program expenditures of $21.9 million. Recommendations were made calling for appropriate financial adjustments and/or procedural changes. In addition, combined investigative efforts of OIG and State Medicaid Fraud Control Units led to more than 450 successful prosecutions and 93 sanctions against those attempting to defraud or otherwise abuse HHS health care programs.

This chapter is divided into: (1) regulatory reform/policy change; (2) program administration; (3) program payments; (4) ongoing reviews in health; (5) computer applications; (6) legal and administrative sanctions of wrongdoers; and (7) recommendations not yet acted upon.

Regulatory Reform/Policy Change

OIG reviews identified three specific program areas where over $465 million could be saved annually with regulatory reform or policy change.

MEDICARE PAYMENT CYCLES

The Prompt Payment Act required Federal agencies to pay vendors timely. OMB, in its Circular A-125, also called for prompt payments but cautioned that the payments should be made as close as possible to a 30-day payment cycle unless discounts were offered for faster payment. This provision ensures that the Federal Government adheres to standard business practice and, at the same time, avoids loss of interest on its cash balances or higher interest on the public debt.

HCFA has not required either intermediaries or carriers to apply the intent of these cash management practices in their Medicare payment systems. Rather, HCFA encourages a quick processing turnaround. In FY 1983, Medicare intermediaries paid $18.9 billion in direct billings—mainly from the Part A Trust Fund—within an average of 10.5 days. During this same period, carriers paid Part B claims totaling $13.2 billion within an average of 9.9 days.

We estimate that the Health Insurance Trust Funds could earn between $1.6 billion and $2.1 billion in additional interest income over a 5-year period (or between $320 million and $423 million annually) if intermediaries and carriers adopted the 30-day payment cycle endorsed by OMB. Additional savings would result from discounts but the amount depends on their number and terms.

We are proposing that HCFA require intermediaries and carriers to implement the sound cash management practices espoused by OMB in their processing of Medicare payments. As indicated above, prompt action on the part of HCFA could save the financially imperiled Medicare Trust Funds as much as $2.1 billion over the next 5 years.

HCFA agreed with our recommendation and is analyzing various aspects of the loss of interest to the Trust Funds. The results should be available by December 1984. In the interim, HCFA notified all regional offices that contractors can lengthen the payment cycle but cannot shorten it.

AMBULATORY SURGERIES

A growing trend among private payers of health care is to encourage and require that elective surgeries be performed in less costly outpatient ambulatory settings whenever it is safe and feasible.

A review of how States and the District of Columbia are using ambulatory delivery systems to reduce their Medicaid costs revealed an assortment of efforts: 18 States had well-defined, comprehensive programs, 5 had limited programs at best, and 26 and the District of Columbia had none. Our conclusion: States can do more to shift elective surgeries from inpatient facilities to less costly outpatient settings.

Increased use of outpatient settings for elective surgeries on the part of States, will benefit Medicaid enormously. We estimate that the Federal portion of the resulting savings could be as much as $110 million annually with a corresponding savings in States' expenditures.

Recommendations call for HCFA to encourage States to maximize this concept and provide necessary guidance to States on how to develop effective ambulatory delivery systems.

LIMITS ON HOME HEALTH AGENCY COSTS

Congress has long been concerned with improving Medicare home health agency (HHA) reimbursement methodology and applying cost limits by type of service provided rather than to a home health agency's aggregate or total cost. In July of 1984, HCFA issued regulations to update the schedule of limits. The regulations—while reducing the amount paid per visit—require continued application of cost limits in the aggregate.

To determine if savings could be realized by applying the HHA cost limits by type of service, OIG performed a computer analysis of pertinent cost/reimbursement data submitted by 374 HHAs. We found that savings of $2.9 million would be realized for periods covered by these reports if HCFA had applied the cost limits by type of service. Nationally, the savings could amount to $35 million annually.

We recommended that HCFA, in accordance with Congressional intent, revise the regulations to require application of the home health agency cost limits by type of service rather than in the aggregate. HCFA has undertaken an analysis of the data base currently under development to determine the supportability of this change.

Program Administration

OIG reviews identified several areas where more efficient program management and tightened fiscal and internal controls would result in savings of over $200 million. Another $21.9 million were identified as questionable program expenditures requiring appropriate financial adjustment.

MEDICARE'S NEW HOSPICE CARE BENEFITS

Our review of hospice care projected that by, April 1985, only 20 percent of the approximately 1,070 hospices in the United States will be certified under the new Medicare hospice care benefit. Total payment for hospice care from

Medicare's Trust Funds will be less than anticipated under the first 2 fiscal years: less than $22 million in FY 1984 and less than $104 million in FY 1985. Because of our projections, HCFA has lowered its projected FY 1985 budget by $700,000 earmarked for surveys of hospices which had been expected to seek certification.

Since the legislation expires in September 1986, we recommended, and HCFA agreed, that the new hospice benefit should be considered a demonstration program in a market setting. In addition, HCFA will reexamine the premises and implications of the benefit structure and the current conditions of participation (particularly the core services requirement) and will keep lines of communication open with all segments of the hospice community. We also recommended that HCFA develop and improve standards and systems for evaluating the quality of care in hospice programs. In response, HCFA is now letting an outside contract to develop standards for quality assessment and has agreed to maintain and enhance its efforts with both State surveyors and fiscal intermediaries to deal with the issues of quality.

ICF/MRs

OIG continues to closely review State use of Federal Medicaid funds with respect to intermediate care facilities for the mentally retarded (ICF/MRs). As in the past, our focus is on whether Federal funds are being appropriately spent and whether residents are receiving the services paid for. At the Secretary's request we will intensify our efforts in this area to ensure State compliance with Federal program requirements.

EDUCATIONAL COSTS IN ICF/MRs

Recent and ongoing reviews have identified significant problems with States inappropriately using Federal Medicaid funds to carry out ICF/MRs educational activities at State-owned intermediate care facilities for the mentally retarded (ICF/MRs). While Medicaid regulations require that ICF/MRs provide training and rehabilitation services to all eligible residents regardless of age or degree of retardation, these same regulations specifically preclude the use of Federal Medicaid funds for vocational training and educational activities.

Based on results of our reviews, we believe that this condition exists nationwide and that more aggressive HCFA monitoring and follow-up could save the Federal Government about $117 million annually, or about $585 million in Medicaid program costs over the next 5 years.

Recommendations to HCFA call for development of a plan of action which will provide for a structured approach for resolving this problem, including surveys and follow-up reviews, the providing assistance to States to correct misconceptions regarding the use of Federal Medicaid funds for vocational training and educational activities.

ICF/MR RATES

Reviews in five States disclosed that per diem rates used to reimburse ICF/MRs were incorrectly established and resulted in overcharges to the Medicaid program totaling $5.3 million. In one State the ICF/MR rate included charges of $3.2 million for activities not related to patient care. In three States, rates were overstated by more than $1.1 million due to incorrect patient day counts or improper utilization of patient day statistics. Other rate determination discrepancies involved: duplicate charges ($450,000); erroneous depreciation charges ($74,000); and unsupported or unallowable costs ($38,000).

ACTIVE TREATMENT IN ICF/MRs

At one State-owned ICF/MR, residents were not receiving active treatment for at least a 6-month period during the fiscal year. Active treatment—program activities designed to help the individual reach full potential—must be provided as a condition for receiving Federal matching payments. OIG estimated that about $2.3 million Medicaid matching payments were improperly claimed.

Recommendations called for procedural changes and appropriate financial adjustment. Similar reviews are being planned in other States to determine the extent of this problem.

ELECTRONIC MEDIA CLAIMS

In fiscal year 1983, the Medicare and Medicaid programs processed about 263 million and 484 million claims, respectively. To process this heavy volume, medical providers, equipment suppliers, and paying agents such as Medicare carriers/intermediaries and Medicaid fiscal agents have increasingly moved away from "hard copy" paper claims. Instead, claims are transmitted electronically over telephone communication systems or by the physical delivery of magnetic tape.

HCFA has recognized the economies of electronic media claims (EMC) and has cooperated with the expansion of EMC usage over the years. HCFA is now promoting the increased use of EMC by providers and others involved in the Medicare program, and to a lesser degree, in Medicaid. However, an OIG review identified several barriers and disincentives to expanded EMC use by providers and contractors/fiscal agents, which, if removed, could result in $125 million in additional annual savings within 2 years.

HCFA agreed with our recommendations to more actively promote the use of EMC and to consider changing those program policies which may be acting as disincentives to its expanded use.

MEDICARE PREMIUMS

OIG found that HCFA was not utilizing accounting controls to monitor the collection of Medicare's Part A and B insurance premiums billed directly to enrollees. As a result, HCFA could not readily identify for follow-up action the

amount and age of unpaid premiums. An OIG survey estimated that some $87 million in premiums were billed during the first 6 months of FY 1984. In FY 1983, billings totaled an estimated $132 million, of which $51 million was estimated as delinquent.

We recommended that HCFA identify premiums billed to Medicare enrollees and set up an accounts receivable to record and monitor these transactions. HCFA is working to implement our recommendations under their current debt management initiative.

RECOVERED MEDICAID OVERPAYMENTS

Our summary report to HCFA on reviews in 38 States showed that 17 States had not promptly credited the Federal Government for about $28.2 million of overpayments recovered from Medicaid providers. Also, about $5.4 million of interest earned by States on recovered funds had not been credited to the Federal account. In individual reports to States—several of which had been discussed in previous Semiannual Reports—we recommended that $33.6 million be returned.

We recommended that HCFA more closely monitor States' compliance with Federal reporting requirements. HCFA agreed and corrective actions are underway.

MEDICARE CONTRACTOR COSTS

During this 6-month period, we assessed the allowability of administrative costs incurred by Medicare intermediaries and carriers and recommended disallowances of approximately $1.2 million in costs considered unallowable for reimbursement.

Unallowable costs included: erroneous gain/loss adjustments on sale of medical facilities, administrative costs in excess of budgeted amount, and overcharges for nurse practitioner services due to improper billing practices.

INTERMEDIARY CONFERENCE

The Inspector General sponsored an Intermediary Case Conference in San Francisco in September. The conference was hosted by the Blue Cross and Blue Shield Association. The meeting was designed to provide a forum for discussion of ideas, approaches, and techniques to enhance their case development capabilities for fraud and abuse prevention. The meeting also provided a management level setting for addressing those issues which were considered most urgent in addressing our goals.

Program Payments

As part of our responsibilities, we reviewed specific types of program payments and a number of individual providers under Medicare and Medicaid. During

this 6-month period we identified over $279 million in overpayments and cost avoidance through this activity. The following are some of our more significant findings:

FAMILY PLANNING

A review of one State's claims for family planning services revealed improper billings. The Federal share of reimbursement to States for family planning services is 90 percent as compared with 55.1 percent which is the Federal share of payment for other medical services for this one State.

It was discovered that a number of claims were made for family planning services which should have been made for other medical services. These erroneous claims resulted in the Federal Government paying a higher percentage of the cost and an overpayment of over $7.1 million was uncovered.

THIRD PARTY LIABILITY FOR ESRD

The Omnibus Budget Reconciliation Act of 1981 makes Medicare benefits secondary to benefits payable under an employer group health plan for services provided to ESRD beneficiaries for a specified period up to 12 months. We conducted a review to assess if outpatient renal dialysis facilities in one State were billing Medicare properly. This review discovered that renal dialysis facilities were billing improperly, and, in addition, the Medicare carriers were reimbursing for services furnished to the beneficiaries with group health insurance benefits. It was estimated that these improper billings and reimbursements had resulted in an overpayment of over $4.9 million.

MEDICARE PAID FOR BLACK LUNG COVERED SERVICES

A review of Medicare reimbursement for Black Lung beneficiaries revealed improper billings. The review was of Medicare and Department of Labor payments of inpatient stays for beneficiaries covered by both programs. The review found that over 38 percent of the cases in the study were paid by the Medicare program but should have been paid by the Black Lung program. As a result of our review, Medicare will save over $4 million.

THIRD PARTY LIABILITY IN ACCIDENT CASES

A review in one State to ensure that the Medicare secondary payer provision is being applied to those services which are reimbursable under automobile, no fault or any liability insurance found that reports of accidents could be used to identify third party liability leads. Using these accident reports or leads we identified a number of incorrect Medicare payments and project that over $2.5 million could be saved in this State through use of these accident reports to identify services for Medicare beneficiaries which are reimbursable by other insurance coverage.

OXYGEN SUPPLIES AND SERVICES

As the allowed Medicare charges for rental of oxygen equipment and purchase of oxygen supplies by a Medicare carrier in one State increased by 112 percent,

the OIG conducted a review to verify that these increased charges were warranted. We found that 80 percent of the beneficiaries in the sample were furnished with liquid oxygen systems where less costly alternative systems would have satisfied their needs. We also discovered that 51 percent of the beneficiaries in the study for whom suppliers billed monthly rental of portable oxygen systems, did not have, use or infrequently used the portable systems. There were also numerous instances where the total number of pounds of oxygen billed in a month exceeded the maximum possible amount the beneficiaries could have used. As a result of our findings, we recommended that HCFA instruct the carrier to monitor oxygen claims, develop a prepayment review of liquid oxygen claims to assure that no claims are submitted for oxygen beyond that which the beneficiary could possibly use, and to investigate those instances where the suppliers billed for oxygen which was not provided. These measures will result in a savings of over $1.6 million to the Medicare program.

PREVAILING CHARGE FOR OXYGEN SERVICES

A review of the prevailing charges allowed by a Medicare carrier for oxygen and related equipment found that the prevailing charge for the most frequently used oxygen tank was significantly higher than that allowed by other carriers. We recommended that this carrier change its prevailing charge code for oxygen and related equipment. This change, which the carrier agreed to make, will save approximately $480,000.

MEDICAID NON-EMERGENCY TRANSPORTATION

A review of the types of and reimbursement allowances for Medicaid non-emergency transportation services provided in one State, found numerous examples of the non-emergency transportation services called livery being provided where its need was questionable. We recommended the State agency undertake an immediate evaluation of this category of services. These questionable services cost the Medicaid program in excess of $475,000 per year in unnecessary expenditures. We also recommended that savings of over $450,000 could be achieved if the State made greater use of available alternate modes of transportation.

ANESTHESIOLOGY SERVICES

A review of anesthesiology services in two States revealed numerous instances where anesthesiologists were billing Medicare and Medicaid for services rendered by hospital-employed certified registered nurse-anesthesiologists (CRNAs). It is estimated that savings of over $350,000 could be achieved if HCFA instructed the Medicare carriers to notify all anesthesiologists in the two States of the guidelines pertaining to billing for supervision of hospital-employed CRNAs and perform onsite reviews of anesthesiologists to determine if they are billing for their services properly.

CONSULTATION SERVICES

A review of consultation services claimed under Medicare in one State found that almost one-third of the claims in the review were not fully documented. We

recommended that the carrier recoup the resulting overpayment of over $180,000 and send an educational letter to all practitioners which outlines the criteria necessary to support a claim for a consultation visit.

PROVIDER REVIEWS

A couple of the more significant cases of our provider reviews were:

- A physical therapy company was found to have been overpaid in excess of $350,000 due to its billing for services which were not medically justifiable.
- A hospital was found to have been overpaid $600,000 due to its including non-allowable costs such as those for patient televisions and related party transactions.

Ongoing Reviews in Health

To prevent costly mistakes, OIG conducts front-end reviews of upcoming program changes, pointing out potential weaknesses and recommending preventive action. As previously reported, one such review is on Medicare reimbursement for medical facilities' capital costs now pending inclusion in the new Medicare prospective payment system. Related to this are our recently started preaward reviews of cost proposals submitted by potential peer review organizations. Highlights of these as well as several other ongoing reviews in the health area follow.

CAPITAL COSTS

The 1983 amendments to the Social Security Act significantly changed the procedure for determining the payment for Medicare inpatient hospital services so that the amount of payment is established prospectively for each discharge. However, the amendments permitted capital expenses, such as, interest and depreciation, to continue to be reimbursed on a reasonable cost basis until at least October 1, 1986. After that date, capital expenses will no longer be excluded from the prospective payment system if a method acceptable to Congress for including these costs is found.

Accordingly, we are working with Department officials to improve current Medicare (and by association, Medicaid) policies for paying capital costs on a reasonable cost basis. We are also seeking to establish an effective method for incorporating Medicare payments for capital costs into the prospective payment system. As indicated in the following, we are looking at current problems in the area of capital costs from several perspectives.

RETURN ON EQUITY CAPITAL

- Currently, the Medicare program is reimbursing proprietary hospitals about $200 million annually for return on equity capital. In our opinion, these payments appear unwarranted because providers, and in particular, proprietary providers, can realize profits under the recently implemented Medicare prospective payment system through more efficient operations. Therefore, prospective payments of capital costs should not include amounts for return on equity capital. Although our study is continuing, we have provided preliminary information to HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) because of its pertinence to the overall consideration of capital costs.

HILL-BURTON FINANCED PROVIDERS

- From 1946 until 1974 Hill-Burton funds provided a total of $4.4 billion in Federal dollars for building and modernizing health facilities. Medicare regulations and most State Medicaid programs provide for an allowance for depreciation on assets even if they were financed with Hill-Burton or other Federal funds. This results in double payment for health facilities. In our previous Semiannual Report, we had reported that HCFA could save the Medicare and Medicaid programs over $700 million by eliminating this depreciation allowance on assets financed with Hill-Burton funds. HCFA commented that eliminating this allowance now would be premature, but that serious consideration would be given our recommendation when developing prospective payment rates for capital expenses.

ASSET REVALUATION

- As previously reported, the Inspector General testified on March 21, 1984, before the Subcommittee on Health and the Subcommittee on Oversight of the House Committee on Ways and Means concerning our work in the areas of return on equity capital and gains from sales of hospitals and nursing homes. Subsequent to the Inspector General's testimony, legislation was enacted requiring that, on sale of hospitals or skilled nursing facilities, the valuation of assets after a change of ownership be limited to the allowable acquisition cost to the seller or buyer, whichever is less. The Congressional Budget Office estimates that this legislation will save the Medicare and Medicaid programs approximately $635 million over a 5-year period.

PEER REVIEW COST PROPOSALS

Under the prospective payment system (PPS), Medicare provider decisions will be subjected to peer review evaluation as to the quality of care and necessity of admissions. These reviews will be made by Peer Review Organizations (PROs) in each of the 50 States, the District of Columbia, and three Territories under fixed contracts with HHS.

Operating under a tight legislative time frame, HCFA asked OIG to perform preaward audits of approximately 150 cost proposals valued at $435 million.

With the aid of CPA firms, we are evaluating (1) the reasonableness of costs proposed by prospective PRO contractors and their supporting bid estimating procedures and (2) the adequacy of their accounting systems and internal controls.

FRINGE BENEFITS

Although our review of PRO cost proposals is still in process, we have already noted that peer review employees are not being required to share in the cost of their fringe benefits. Not requiring employee contributions is inconsistent with general industry and Government practice. For example, Federal employees pay about 40 percent of the average total cost of health insurance premiums and about 67 percent of the average cost of life insurance.

We are recommending that HCFA provide for the sharing of fringe benefit costs when negotiating the PRO contract awards. This action could save up to $11 million over a 2-year period. HCFA contract negotiators are currently considering the sharing of fringe benefit costs in all PRO cost negotiations.

VA/MEDICARE REIMBURSEMENTS

A coordinated review was performed in one State by VA and OIG staff to determine the adequacy of internal controls to prevent duplicate payments for medical services provided Medicare eligible veterans placed in community nursing homes reimbursed through VA-contracted per diem rates.

Preliminary results indicate a lack of adequate controls to prevent duplicate Medicare and VA payments. These duplicate payments could amount to approximately $3 million in the single State reviewed. We are continuing our efforts in coordination with VA's Office of Inspector General to determine the nationwide level of these overpayments. Recommendations now call for VA to provide listings to HCFA of veterans placed in community nursing homes. Medicare records could then be annotated with the VA eligibility information for Medicare prepayment screening.

ESRD PROGRAM

Under Medicare's End Stage Renal Disease program (ESRD), hospital and independent outpatient dialysis facilities bill for treatment using composite rates which include, among other items, payments for certain drugs and tests given patients. Non-routine drugs and tests may be billed separately.

We analyzed payments made for drugs by two intermediaries, concentrating efforts on one drug, Deca-Durabolin, because it was administered in substantial quantities as a non-routine drug to many ESRD patients. Our analysis disclosed that approximately 30 percent of patients received an equivalent of at least one 200 milligram injection per month, and that prices paid varied from a low of $22 to a high of $60 for a single 200 milligram dosage. This payment practice is

inconsistent with Federal regulations which require intermediaries to set limits on drug prices paid. Medicare and other payers could save approximately $.25 million per year just in this one State if a cost limit was established for Deca-Durabolin. If this condition exists nationwide, Medicare savings on this one drug alone could be as much as $5 million annually.

We also found that during a 5-month period one of the intermediaries paid an estimated $320,000 for separately billed routine drugs that had already been included in the ESRD composite rates. Similar overpayments estimated at $400,000 may have been made during prior periods.

In view of the problems identified by our limited analysis, we plan to expand our review of ESRD drug payments to identify overpayments for routine items billed separately and to study the feasibility of including currently non-routine items in the composite rate.

LIMITATION ON NON-EMERGENCY PHYSICIAN SERVICES

The Tax Equity and Fiscal Responsibility Act (TEFRA) provided that, effective October 1, 1982, Medicare reimbursement for non-emergency physician services provided in a hospital-related outpatient facility was to be limited to a percentage of the prevailing charge for similar services provided in a physician's office. This percentage was to take into account the associated overhead costs already included in the reasonable cost or charge of the facility. The October 1, 1982 Medicare regulations implementing this TEFRA provision set the reimbursement limit for such non-emergency services at 60 percent.

Our review in one State found that the local Medicare carrier had yet to implement the 60 percent limitation. Consequently, at one large outpatient clinic alone Medicare overpaid physicians $20,000 during a 7-month period. If this condition is indicative of Medicare carriers nationwide, overpayments could amount to several million dollars annually. We are expanding our review to additional States.

Computer Applications

During the last 6 months of FY 1984, OIG used 105 screens and other computer review techniques to spot problem areas in Medicare and Medicaid program operations. Highlights of several of these applications follow.

DURABLE MEDICAL EQUIPMENT

A computer application was developed to determine whether concurrent Medicare payments were being made to two or more suppliers of durable medical

equipment (DME) for the same recipient. Results of this application in two States indicated that $125,000 in such payments had been made over a 1-year period. This same application, however, also identified claims processing problems that allowed (1) more than one supplier to receive payment for same or similar items provided a recipient, and (2) duplicate payments to the same supplier for the same piece of equipment.

Our work in the DME area is continuing.

THIRD PARTY LIABILITY

With the passage of the Omnibus Budget Reconciliation Act of 1980, Medicare became the secondary payer in situations involving third party liability, such as accidents where medical coverage would likely be provided by a private insurer. OIG developed several computer applications to determine whether third party liability (TPL) was being recognized under Medicare.

MEDICARE PART A CLAIMS

To determine whether hospitals were inappropriately charging Medicare, OIG designed a computer application to identify Medicare Part A claims for hospital services that had trauma-related diagnostic codes, such as those for fractures and other injuries which could potentially be TPL related.

This application has been successfully applied in one State. Preliminary results indicate:

- Approximately 2 percent of claims examined at three hospitals had documented third party liability;
- Less than half of those documented had been previously identified by the hospital; and
- Claims for TPL recoveries, except for automobile accidents, were not identified by the hospital.

If these same conditions exist nationwide, lost TPL payments could be costing Medicare as much as $30 million annually. Our review is continuing.

MEDICARE PART B CLAIMS

OIG developed a similar application to determine whether physicians providing inpatient services were also failing to recognize third party liability and were inappropriately billing Medicare. In designing our application, we recognized that Medicare services provided hospital inpatients would normally generate both a Part A claim for hospital services as well as a Part B claim for physician services. Therefore, we set our parameters to identify those physician claims

that did not have a matching hospital claim (i.e., the hospital made no claim for Medicare payment).

The application has been successfully applied to Medicare carrier claims in one State and data verified. Assuming results to date are indicative of a nationwide problem, Medicare may be inappropriately paying several million dollars annually for inpatient physician services. Our review is continuing.

Legal and Administrative Sanctions of Wrongdoers

A major thrust of the OIG is to identify and deal with persons defrauding or otherwise abusing HHS health care programs. A formidable arsenal of weapons is available to bring to bear against these wrongdoers. First, the investigative expertise of OIG agents, frequently with the assistance of other Federal, State or local agents, leads to prosecution and conviction of persons defrauding the Medicare program. The State Medicaid Fraud Control Units (MFCU's) serve the same purpose for the Medicaid program. During the past 6 months we have together been responsible for the conviction of about 235 health care providers and beneficiaries. Financial recoveries amounted to $1.6 million from our cases for this period, and $3.4 million for the year, with estimated savings of $2.2 million and $3.8 million, respectively. The MFCU's, for which the OIG has oversight responsibility, accounted for about $24 million over the last 6 months.

A second weapon in attacking health care fraud is the Civil Monetary Penalties Law (CMPL) which enables us to collect punitive damages from guilty providers. During this reporting period, 65 CMPL settlements were made, for a total of $5.5 million.

The third group of weapons we can use against health care providers who defraud the programs is administrative sanctions, through which we suspend, debar, or otherwise exclude such providers from participating in these programs. These administrative sanctions not only deprive them from obtaining money from the programs but also prevents them from victimizing some of our nation's most vulnerable citizens. In this report period, over 90 health care providers and suppliers were sanctioned for fraudulent or abusive practices.

PROVIDER FRAUD

Individuals involved in health care fraud are usually affiliated with institutions and organizations which are providers of health care services.

- A Michigan psychiatrist, the former director of a hospitalization program, was sentenced to 2 years in prison (18 months suspended) and fined $1,000 for Medicare and Medicaid fraud. Earlier he had pled guilty and agreed to pay $23,000 in restitution on claims for services never performed. The OIG, the Postal Inspection Service and the State MFCU investigated the case.

- In Kentucky, joint investigation with the State MFCU led to the conviction of a physician for billing the Medicare and Medicaid programs for ultrasound sonograms, x-rays, electrocardiograms, blood tests and other services never supplied. He was fined $47,000 and given 1 year and 1 day in jail.

- A durable medical equipment (DME) provider and hospital respiratory therapist in Louisiana pled nolo contendere to one count of making a false representation to obtain Medicare funds. His case had been opened as a result of information gathered during an investigation of a Texas DME company, to which he was suspected of referring patients for a fee. He had subsequently acquired his own company. A review of his claims indicated that he had submitted false arterial blood gas studies to support oxygen concentrator rentals or purchases. His sentence is pending.

- The former director of a respiratory therapy laboratory at an Ohio county hospital was convicted after being recorded offering a bribe to hospital personnel to divert Medicare business to his privately owned oxygen company. In addition, he was observed altering arterial blood gas test results in the presence of an undercover agent. By altering the test results, he hoped to make patients eligible for Medicare and get them to use his equipment.

- Through their corporation, two Missouri men bought hearing aids from a supplier for $68.50 each and billed Medicaid $174 as the acquisition cost. Each must repay $4,000 within 3 years.

- In Texas the president and owner of an ambulance company was convicted on 39 counts of Medicare fraud and 39 counts of mail fraud after billing Medicare for ambulance trips in which patients' conditions or diagnoses were falsified to make them eligible for Medicare payments. The 78 count conviction represents the largest ever received by an individual and the first ambulance company owner ever convicted in the Southern District of Texas. He was sentenced to 5 years probation and ordered to serve 1,000 hours of community service.

- A Virginia physician who styled himself as a "simple country doctor" too busy caring for poor and elderly patients to master Medicare's and Medicaid's

complicated bookkeeping was sentenced to 4 years probation, a $2,000 fine, full restitution of $18,500, and psychiatric counseling. The Virginia Board of Medicine subsequently lifted his license. The case was worked with the Virginia State MFCU.

- In 1982 a Texas man was convicted of Medicare fraud and sentenced to prison. While in prison the State Medicare carrier noticed new claims filed on his account. Investigation showed that he had used the names of jail mates and his Medicare provider number to file claims for fictitious ailments. About $15,000 was paid on $74,000 in claims and mailed to three other conspirators outside prison. The man was indicted on 14 counts of false claims and one count of conspiracy, and the other three persons were indicted on conspiracy charges.

- A Kentucky woman was indicted on 13 counts related to submitting false claims to Medicare. She was charged with altering physicians' bills to reflect services not provided. She was found to have an extensive arrest record for embezzlement and other fraud-related charges, and had previously served a prison term on a felony embezzlement charge.

COOPERATIVE EFFORTS

From its inception the OIG has worked closely with other investigative agencies. Since Medicare billings are susceptible to mail fraud charges, we frequently work Medicare cases with the U.S. Postal Inspection Services. In addition, we often work with the 34 State MFCUs, as in the earlier-described case of the Virginia "country doctor." We also work with the FBI, as in the pacemaker industry investigations and the joint task forces, both of which are described below.

We have also built cooperative elements into our proactive projects. Some of these projects are aimed at geographic areas susceptible to widespread health care abuses, while others concentrate on specific segments of the health care industry.

GEOGRAPHIC TASK FORCES

Concentration of Federal and State investigators on geographic areas having a large volume of health care beneficiaries has proved highly productive. The first effort, a Pennsylvania Medicare/Medicaid Task Force of OIG, FBI and State agents established in 1982, has resulted in 12 convictions. The persons involved in fraud ranged from cardiologists and diagnostic lab physician-owners to the owner of a shoe store who falsely claimed sales of prosthetic devices. Four of the convictions were obtained during this reporting period, and other indictments are under way.

The success of this Task Force led to the establishment last year of similar cooperative efforts in New Jersey and Manhattan. In New Jersey major indictments are before a Grand Jury. The Manhattan Task Force obtained its first conviction, that of a physician convicted of Medicare and private insurer fraud.

A formidable Task Force of OIG and FBI agents was also established in Florida, and in the past has obtained significant Medicare fraud convictions. Over the past 6-months some of the accomplishments from this effort are:

- A complex case involving a Miami hospital finally culminated in an agreement to repay Medicare more than $500,000, and the resignation of the executive director and the chairman of the board. The two had forced the hospital staff to pay kickbacks to a "development fund" and had not reported these monies to the Medicare program. As a result, the hospital received higher Medicare reimbursement.

- The Task Force recently reported the indictment of a Medicare carrier employee and a beneficiary for submitting almost $20,000 in fictitious Medicare claims.

- Two beneficiaries were indicted for embezzling Medicare funds, and five other participants in the scheme have already been sentenced.

- A psychologist not qualified to obtain payments was indicted for submitting 66 Medicare claims for psychological testing services totaling $15,000.

- A chiropractor was indicted on 20 counts of mail fraud after submitting false Medicare billings, and a physician was indicted on 10 counts of false statements.

The Florida Medicare/Medicaid Task Force has the advantage of an Assistant U.S. Attorney devoted exclusively to prosecuting its cases. This effort is a prime example of the invaluable assistance of the Department of Justice in the prosecution of health care cases in Florida over the last 2 years.

PROACTIVE PROJECTS

In the health care provider industry we have launched proactive projects aimed at ambulance, pharmaceutical, podiatry, laboratory, portable x-ray, cataract lens and pacemaker providers as well as other specialties, such as electromyograms, where the procedure or equipment may be unnecessary or fraudulently billed. While many of these projects are in the development stage, two have resulted in the following actions.

- In Arkansas the president of a pharmaceutical company and one of its employees pled guilty to aiding and abetting a pharmacist in causing a hospital to file a false cost report.

- A pacemaker kickback case reported in the last Semiannual Report, led to a national project. The project, conducted with the FBI, resulted in a guilty plea by another manufacturer and distributor of pacemakers based in Colorado. The firm admitted to paying a Rhode Island cardiologist kickbacks of more than $130,000 and to having leased equipment valued at $9,000 to a Florida cardiologist. Under a plea agreement the firm will make restitution of $240,000 to the Government in addition to any fine imposed by the court. The firm and its officers also agreed to cooperate fully in the ongoing investigation of the pacemaker industry.

MIRs AND FRAUD ALERTS

Management Implication Reports (MIRs) identify systemic problems observed during an investigation and are referred for analysis and corrective action. One MIR produced during this period pointed out that the lack of performance standards or specifications for transubcutaneous electrical nerve stimulators (TENs) made their sale susceptible to fraud and abuse.

Another attempt to prevent fraud has been the issuance of Fraud Alerts. These distinctive one-page fliers are sent to health care carriers and intermediaries to warn them of practices or procedures which should be initiated or eliminated to prevent potential fraud. Two Medicare and two Medicaid Fraud Alerts were issued during this period.

ADMINISTRATIVE SANCTIONS

Through administrative sanctions we bar providers from participating in the Medicare and Medicaid programs and keep them from victimizing recipients of health care services. Our existing administrative sanctions may be imposed for fraudulent activities or poor quality of care. Excluding providers from these programs also hits them where it hurts most—in the pocketbook. It prevents them from getting payments from these programs.

Examples of physicians or other practitioners who have been convicted of a Medicare or Medicaid-related crime and have been barred from Medicare and Medicaid programs follow:

- An ophthalmologist was barred from Medicare and Medicaid for 25 years for filing false information. He performed unnecessary and contra-indicated surgeries on Medicaid recipients for financial gain and provided false supporting information.

- A chiropractor was suspended for 10 years for fraud. He had demonstrated a disregard for the welfare of his patients.

- A medical center administrator was removed from participation for 15 years as a result of forgery of physicians' signatures.

- The director of a day care center was barred for 5 years for filing false statements while participating in the Title XX (social services) program.

An example of an action taken on the basis of a recommendation from a Professional Standards Review Organization (PSRO) that a practitioner or health care provider has failed to provide quality care or care which is medically necessary follows:

- A physician who provided poor quality of care, such as not documenting patient's cardiac conditions and neurological status, was excluded for 5 years.

Recommendations Not Yet Acted Upon

The following OIG recommendations included in previous reports to Congress and involving significant dollar savings have still not been implemented:

SECOND SURGICAL OPINIONS

Studies on Second Surgical Opinion Programs (SSOPs) consistently point out that mandatory programs are effective in reducing unnecessary surgery. For example, one study showed mandatory programs covering just the more common procedures could reduce elective surgeries nationwide by as much as 29 percent in Medicaid and 18 percent in Medicare at annual cost savings of about $65 million and $135 million, respectively, using 1984 dollars.

We had recommended that HCFA seek a legislative change to the Social Security Act that would require Medicare and Medicaid beneficiaries to seek a mandatory second surgical opinion for selected surgeries.

HCFA agreed that there is evidence that a mandatory SSOP might reduce the amount of unnecessary surgery performed. HCFA believed, however, there were many unanswered questions in this area and contracted for an evaluation of the overall effects of a mandatory SSOP and the long-term savings from such a

program. HCFA expects to have the results of this study by late 1984. (Report first discussed in OIG Semiannual Report, October 1982 - March 1983.)

PSYCHIATRIC SERVICES

At a number of health facilities that we reviewed, psychiatric services were not limited to traditional treatment, but included a broad spectrum of services usually provided at an off-site location.

Many of these services seem of a social, recreational, or educational nature and thus, suspect for reimbursement under Medicaid. The lack of clarity as to what constitutes "medically justifiable" services, coupled with the failure to define "billable encounters," in our opinion, results in significant abuses. At $54 authorized per patient visit, some $10 or $20 million annually could be involved nationwide.

HCFA recently started acting on our recommendation to see that Medicaid standards for outpatient psychiatric services are put into place. Questionnaires have been circulated to the States to determine the extent of this problem which will be a main topic of discussion at the next State Medical Group meeting. (Report first discussed in OIG 1980 Annual Report.)

HOUSEKEEPING SERVICES

One State charged the cost of housekeeping services such as shopping and ironing for recipients to the Medicaid program without requiring that they be medically necessary by being linked to a "physician's plan of treatment." We found that this one State alone claimed $15 million over a 15-month period for such services. On a nationwide basis, we estimate that improper claims of this type could run as high as $30 million annually.

Although HCFA agreed to revise the involved regulation to correct this problem, such revision has not been made. (Report first discussed in OIG 1980 Annual Report.)

MEDICARE ROUND DOWN

Based on a study at two carriers, we estimated Medicare Part B could save about $45 million annually or $225 million over a 5-year period if payments for odd-penny claims were rounded, on a per claim basis, to the next lower whole dollar.

The effect of such a policy on the individual beneficiaries or physicians/suppliers would be minimal—about 30 cents per paid claim. We proposed that HCFA seek authority to institute such a practice. (Report first discussed in OIG Semiannual Report, April 1983 - September 1983.)

UROLOGICAL AND NUTRIENT SUPPLIES

Before 1980, nursing homes purchased urological and nutrient supplies on the open market and included the related costs of these items in their Medicare cost reports. Starting in 1980, medical supply firms agreed to provide these supplies to some nursing homes at no cost (on consignment) and to bill Medicare directly for such items.

We compared prices being paid for these items by Medicare carriers in nine States to prices: (1) paid by other nursing homes on open market purchases; (2) paid by Federal agencies under GSA's multiple award Federal Supply Schedules; and, (3) available to State agencies under State contracts. We found amounts allowed by carriers in most cases ranged from two-to-four times more than market prices to wholesale consumers. We estimate annual savings to the Medicare program of about $17 million if the pre-1980 approach is reinstituted.

We recommended that HCFA seek legislative change and revise regulations to prohibit suppliers from billing Medicare directly, and require that nursing homes include the cost of such products in their per diem rates. HCFA took certain administrative actions to prevent excessive reimbursement, but believes that legislative change is premature at this time. (Report first discussed in OIG Semiannual Report, April 1983 - September 1983.)

SOCIAL SECURITY ADMINISTRATION

CHAPTER III

SOCIAL SECURITY ADMINISTRATION

Over two-thirds of the Department's budget is expended by the Social Security Administration (SSA). SSA operates the federally-administered Old Age and Survivors Insurance (OASI), Disability Insurance (DI), Supplemental Security Income (SSI), and Part B Black Lung Benefit programs. SSA also oversees the State-administered programs of Aid to Families with Dependent Children (AFDC), Refugee Resettlement, and Low Income Home Energy Assistance (LIHEAP).

In fiscal year 1984, about 50 million Americans received in excess of $200 billion in benefits from SSA. This outlay is expected to increase by more than 4.5 percent to $209 billion in FY 1985.

Two years ago, OASI and DI were facing a financial crisis. At that time OIG devoted considerable resources to scrutinizing SSA's operations. Since that time new legislation has relieved the immediate threat of the Trust Fund deficit and SSA has begun addressing its operational problems. OIG reviews have focused on areas of program and financial management, with the intention of effecting more efficient and effective program operations and to safeguard against fraud and abuse. As a result of our reviews in the last 6 months we have recommended financial adjustments totaling $13 million. In addition, we have made numerous procedural recommendations which should result in additional future savings of $32.5 million. Investigations of SSA cases resulted in 396 convictions, $5.3 million in financial recoveries, and savings of nearly $15 million.

This chapter is divided into: (1) program administration; (2) electronic data processing; (3) computer applications; (4) legal and administrative sanctions of wrongdoers; and (5) recommendations not yet acted upon.

Program Administration

The OIG concentrated on reviewing selected administrative aspects of SSA programs. Specific attention focused on: adequacy of internal controls, allowability of payments, and efficiency of operations. Several of these reviews involved use of computer applications.

QC SAMPLE SIZES Under the AFDC quality control system, current caseloads are sampled to measure rates of payments to ineligibles and over/underpayments to eligibles. Results of the sample are used to determine causes of error and to plan and implement corrective actions for the purpose of reducing the incidence of future errors. To assure continuing management attention on error level reduction, fiscal sanctions are imposed on States when annual error levels exceed predetermined rates.

Use of an alternative method that we are proposing to determine quality control sample sizes would substantially reduce resources devoted to sampling thereby providing the opportunity to redirect resources to more efficient methods of reducing error. Current SSA policy established minimum AFDC sample size based primarily on each State's caseload. Under our alternative method, minimum sample size would be based primarily on (1) desired sample reliability at a specified confidence level and (2) the incidence of error obtained from prior period sampling results. Thus, under this method, sample size would more directly relate to each State's error rate, and not to overall caseload.

AFDC quality control reviews have repeatedly identified the same major causes of error. Moreover, overall payment error rates have leveled off in recent years. Thus, the benefits derived from the current sampling process are diminishing. By using our alternative sampling methodology, "minimum" annual sample sizes in AFDC could be reduced from about 81,000 to 19,000—or by about 75 percent. Annual State resources now devoted to AFDC sampling (equally shared by the Federal Government and States) and annual Federal resources used for verifying State sample results could be cut by as much as $25 million and $10 million, respectively, and either taken as savings or redirected to more cost beneficial methods of reducing error.

SSA recently published a final rule allowing States to reduce their AFDC sample size to a lower minimally acceptable level when the State accepts the reliability of the reduced sample. The new minimum sample standard, however, continues to be predicated on caseload criteria rather than incidence of error.

Recommendations call for SSA to: (1) use our alternative methodology in setting minimum AFDC sample size requirements; (2) encourage States to adopt the new AFDC minimum sample size; and, (3) assist States in the use of alternatives to sampling, such as wage/bank matching, to further reduce error incidence in AFDC.

DEATH ALERTS Because HCFA and SSA computer systems share common information, HCFA will notify SSA of deaths of beneficiaries receiving Social Security benefits.

Once notified, SSA produces a death alert which is sent to the appropriate Program Service Center for verification.

At our request, HCFA performed a computer search for beneficiaries reported as deceased but still receiving Social Security Title II (OASDI) payments. Over 14,000 beneficiaries were identified, of which payment histories for 5,852 cases were selected for review.

Our detailed analysis of 336 cases showed that in 21 percent of the cases SSA did not determine if the person was deceased and payments should be stopped. For those that were processed, SSA took an average of 147 days to suspend payments from the date the Medicare alert was produced. We estimate that about $11.8 million in payments may have been issued to 3,198 beneficiaries after their deaths. In addition, about $7.2 million in incorrect payments will be avoided in the next year by terminating payments to those current payment cases. Recommendations call for improvements to ensure that death alerts are completely and timely processed, and incorrect payments are identified and recovered.

ROUNDING DOWN BLACK LUNG BENEFITS

Recent legislation requires rounding down of benefits to the next lower dollar in the Old Age, Survivors and Disability Insurance, the Supplemental Security Income and the Aid to Families with Dependent Children programs. If this same provision was extended to the Black Lung program, we estimate that the program could save $1.9 million annually or $9.3 million over a 5-year period.

We recommended that SSA initiate action with the Department of Labor, which has lead responsibility for the Black Lung program for claims filed after 1974, to round down Black Lung payments to the next lower dollar multiple. SSA agreed.

REFUGEE RESETTLEMENT PROGRAM

The Refugee Act of 1980 was enacted for the purpose of providing systematic procedures for the admission and resettlement of refugees admitted to the United States.

At the request of the Director of the Refugee Resettlement program, we performed a review of States' claims for cash assistance payments made. Based on preliminary results in one State and final results in seven others, adjustments totaling about $38 million will be recommended. The bulk of the adjustments involve:

- Payments to recipients who did not meet Federal eligibility requirements.

- Payments made to recipients after the period of eligibility had expired.
- Payments returned but not credited to the Refugee program.

Recommendations call for procedural changes to ensure that the States tighten controls over eligibility of recipients, computation of payments and accounting for returned and uncashed assistance checks.

AFDC/STATE WAGE DATA

Federal regulations require States to use wage data to help in determining applicant eligibility for public assistance. We looked at wage match programs of four States and one Territory to determine whether their programs were economically, efficiently and effectively operated. We found that in many cases wage data was not effectively used and, as a result, improper payments amounting to an estimated $6.8 million were made. Generally, State agencies were either not using or improperly using wage data made available to them. In separate reports to agencies involved we recommended immediate action to improve their wage data exchange programs. In addition, we plan to issue a summary report to SSA setting forth the problems noted in these reviews and the overall corrective action needed.

COST ALLOCATION PROBLEMS

OMB Circular A-102 calls for single, non-Federal audits of local governments. In keeping with the spirit of this Circular, the OIG devoted resources to looking into specific identified problem areas in the way certain States charged and allocated costs to various public assistance programs. During this period, three reports were issued recommending financial adjustments of $10.5 million. The bulk of the questioned costs involved:

- Charges to Federal programs which related to the State's General Assistance Medical program.
- Claims by another State that were incurred before the effective date of the Foster Care and Adoption Assistance program.
- Claims by a third State at higher Federal financial participation levels than allowed by Federal regulations.

DELINQUENT SOCIAL SECURITY CONTRIBUTIONS

Section 218 of the Social Security Act extends Social Security coverage to employees of State and local governments, if requested by the State. It requires States to report wages and deposit contributions.

A review of the wage reporting practices of nine (of the 188) Government employers of a Commonwealth found significant problems with reporting,

depositing, and accounting for Social Security contributions. Since 1978, a pattern of delinquent payments has developed. As of September 30, 1983 $43.9 million of $61.3 million in contributions owed by this Commonwealth were delinquent. We estimate that late payments over roughly a 5-year period have cost the Trust Funds at least $8.7 million in lost investment income. If and when collected, these losses would be partially offset by about $4.4 million in interest charges due on the late payments, leaving a net loss to the Trust Funds of $4.3 million.

Recommendations call for the Commonwealth to promptly deposit with SSA past due contributions and accrued interest charges and take immediate action to establish reporting procedures and controls.

EARNINGS ENFORCEMENT

As a labor saving effort, SSA eliminated four categories of cases from its 1981 earnings enforcement operation. This operation is intended to identify overpaid Title II beneficiaries who failed to report or underreported their earnings. We reviewed this policy because the exclusion of broad classes of beneficiaries with earnings reported for 1981 and later years would prevent the identification of significant collectible overpayments. SSA is going to refine its exclusion process by targeting appropriate subgroups where it would be cost-effective to do earnings enforcement.

REDETERMINATION REVIEW SYSTEM

SSA conducts a periodic redetermination for every SSI recipient to ensure that the amount and continuation of payment is proper. Under the Redetermination Review System (RRS), a sample of these cases is reviewed to determine the accuracy of this process and to develop appropriate corrective actions. We examined the RRS process to determine if the exclusion of certain sample cases was indicative of fraud or abuse. While no such problems were found, we discovered that cases were being excluded without proper justification and that redetermination materials were being lost within a short period after completion of the redetermination.

In response to our recommendations, SSA is placing greater emphasis on the location of RRS case folders and the monitoring of case exclusions.

DRIVERS' LICENSES AS EVIDENCE OF IDENTITY

We reviewed procedures used by Massachusetts to issue drivers' licenses. The review was conducted because drivers' licenses are used as evidence to establish the identity of applicants for Social Security numbers (SSNs) and monthly benefits. Issuance procedures were so lax that the value of the licenses as evidence of identity was lowered.

We recommended that SSA notify field office employees of these lax procedures. SSA agreed that field office employees should be aware of the drivers'

license issuance procedures for all States in their area. As a result, SSA is expanding their instructions to direct field office employees to become familiar with the issuance process so they can properly establish the value of drivers' licenses as evidence.

Electronic Data Processing

Virtually every payment made by SSA is triggered by a computer transaction. With 16 large scale computers, over 900 tape and disk drives, 3,800 telecommunication terminals and 6,500 programs, SSA operates one of the largest computer complexes in the country.

The OIG is reviewing, on a continuing basis, SSA's system development projects, including their Systems/Claims Modernization Project.

REDESIGN OF CLAIMS PROCESSING SYSTEM

Our ongoing monitoring of SSA's system modernization effort noted problems in the largest and most critical of SSA's software initiatives, the redesign of the Title II claims processing system, referred to as the Claims Modernization Project (CMP). Problems reported raise two issues of concern with regard to the overall systems modernization effort:

- SSA is developing or maintaining systems without adequate standards in place. While standards development is slow and difficult, certain minimum standards—for data definition, controls, planning and documentation—should be in place before system development. Without these, the chance of system success may be significantly reduced. Our report points out several areas where we believe priority should be given to developing standards.

- Though the systems' modernization plan calls for evolutionary software changes because "the risk of failure of a total system development is unacceptable," the CMP is to be totally redesigned from the initial capture of data in the field through establishment of master records which trigger benefit payments. While we recognize there is little in the present claims processing system that can be salvaged, the increased risk of a total redesign should be fully recognized. To reduce risk, our report recommends that the CMP be planned in at least two distinct and independently implemented phases, with the present system used as long as needed as a "safety net" to ensure proper processing of claims.

SOFTWARE CONTRACTING

Review of a computer software contract awarded by SSA to assist in their systems modernization effort disclosed that: Although a contractor had been paid $320,000 for automated software tools, the tools obtained did not improve any operational programs and, as far as can be determined, are no longer being used. We recommended canceling the contract and improving contracting procedures.

Legal and Administrative Sanctions of Wrongdoers

Diversion of Social Security benefits from their intended purposes is doubly onerous because the wrongdoers, sometimes in collusion with Department employees, are stealing funds desperately needed by the very young, widowed, disabled and geriatric beneficiaries these programs are designed to help. Investigations of Social Security cases during the second half of the year resulted in 405 convictions, $5.3 million in investigative recoveries, and savings of almost $14.8 million. Of these investigations, 180 resulted from joint investigations with State agencies of illegal AFDC recipients.

MASS SSA ACTIONS

The use of mass actions in which information or indictments are filed against several individuals at one time continues to be one of the keys to successful prosecution of Social Security cases. Grouping individual cases in a presentation for prosecution increases chances for action and a wide deterrent effect. During this period, a total of 77 persons were prosecuted in mass action cases. Since the beginning of the fiscal year, there have been 13 mass prosecution incidents involving 135 persons in nine States.

SSA EMPLOYEE FRAUD

The OIG investigated several cases referred by SSA of SSA employees participating in fraudulent schemes or criminal activities because of their access to system processes and records.

- Ten persons were arrested after a long-term OIG investigation into the sale of Social Security cards to illegal aliens in Southern California. Four of those arrested in the year-long OIG probe were current or former employees of the Social Security Administration. Arrest warrants charged ten, as well as one other still being sought, with conspiracy to bribe SSA employees into issuing valid cards to illegal aliens. The cards were sold for as much as $450 each to the illegal aliens who used them to convince employers they were here legally.

- An SSA claims representative in Texas was convicted for filing claims for more than 20 fictitious persons and ordered to serve 10 years in prison, and to repay about $300,000 to SSA and almost $52,000 to the State of Texas.

- An SSA employee of 9 years was sentenced to 6 months in jail for putting her name on a $500 money order overpayment returned by a recipient. She endorsed the money order and deposited the money to her account.

- A New York employee pled guilty to diverting over $67,000 in benefits to herself, relatives and friends.

- An employee in Maryland who had a criminal record and who was on probation was sentenced to 3 years in jail for causing checks to be issued to himself while working for SSA's Office of Disability Operations.

CALIFORNIA KICKBACK PROJECT

In November 1983, Alameda County officials discovered that Department of Social Service employees had reactivated closed AFDC cases, causing retroactive checks to be issued. Our investigation revealed that two employees had issued thousands of fraudulent AFDC benefit checks to persons posing as welfare recipients. The 2-year operation involved more than 150 people and cost Federal and State agencies more than $1.2 million. Of the 39 persons indicted, 21 have pled guilty. They were ordered to make restitutions totaling over $146,000.

ILLEGAL ALIENS

In April 1984, the OIG established a joint nationwide project with the U.S. Immigration and Naturalization Service to identify fraud involving illegal aliens. In addition to identifying names and SSN's used by deportable aliens, this project also identifies deportable aliens illegally receiving benefits. A national pilot project is being conducted to target instances of fraudulent use of SSN's. Copies of the data base are being sent to the States for matching against AFDC, general assistance, Food Stamp, Medicaid, and unemployment rolls.

FUGITIVE RECIPIENT

We instituted a joint effort in San Francisco with the U.S. Marshall Service to locate fugitives suspected of using fictitious names to obtain Social Security benefits. We verified the SSNs and identified the mailing addresses of 72 fugitives in California with assumed identities who were suspected of committing Social Security violations. As these violations were verified, we notified the Social Security Administration to suspend eligibility of the identified fugitives receiving Social Security benefits or Supplemental Security Income payments.

INTERNATIONAL SSA FRAUD

Project INTERFACE (International Fraud Analysis and Claims Evaluation) was established to investigate fraud in Social Security programs occurring outside

the jurisdiction of the United States. With assistance from the State Department's Foreign Service posts around the world and the Veterans Administration regional office in the Philippines, SSA receives, develops, and adjudicates claims for persons residing outside the United States. When fraud is suspected, the case is referred to the OIG for fraud determination and handling. In the initial 3 months of operation of this project we have identified savings of over $779,000.

MIRs AND FRAUD ALERTS

Management Implications Reports (MIRs) identify system vulnerabilities uncovered in HHS program administrative operations, legislative or regulatory reviews. The results of these analyses are then forwarded to the Department's Operating Divisions for corrective action. For example, a Denver investigation revealed that one beneficiary was overpaid $7,000 because of inadequate controls in issuing of retroactive disability checks. The MIR resulting from this case advises that the Social Security Administration tighten controls over the issuance of retroactive checks after benefits have been suspended. Based on the problems we uncover, we also issue Fraud Alerts which provide information on individual or group attempts at fraud. In the last 6 months the OIG issued 42 MIR's and 4 Fraud Alerts related to Social Security cases.

FALSE IDENTIFICATION

A growing number of investigative cases focus on fraudulent identification schemes. These cases frequently involve Social Security numbers (SSNs) and require cooperative efforts with other agencies because of the variety of authorities and schemes involved.

- An attorney in Montana receiving disability benefits concealed his income by reporting it under a professional law corporation while receiving benefits. Court records revealed that during the years of 1979 through 1984 he represented individuals in 40 cases.

- Two New York men conspired together to obtain SSA benefits under fictitious names. One signed SSA forms and bank signature cards attesting to knowledge of the other as a third person. Both have been sentenced, one to 6 years in jail and the other to 6 months.

- A Minnesota woman pled guilty to altering records to create a fictitious child. She used multiple SSNs to obtain AFDC, Food Stamps, and Medicaid benefits for herself and her children.

DISABILITY CLAIMS

A large number of SSA cases involve disability benefits fraud. The following examples illustrate how persons have avoided reporting income or working under someone else's or a fictitious SSN.

- A Maryland man was recently indicted for fraudulently obtaining more than $107,000 in SSA disability payments over the last 10 years. He was charged with perpetrating a large paperwork scheme involving the use of six different names. He worked for 2 years at a university as a "social worker" while receiving $360 a week in workman's compensation benefits from a private insurance company. He never reported either source of income to SSA. Additionally, he had posed as a doctor at the Maryland Penitentiary, a city school teacher, and a professor at another university and community college.

- A Massachusetts policeman working for a metal fabrication company was paid over $50,000 in policeman's disability, using his wife's Social Security number. His wife, on the basis of his work record, filed for unemployment compensation funds and income tax refunds. Sentencing for the couple is pending. The company pled guilty to falsifying data to the Social Security Administration and has been fined over $9,000.

DEATH MATCH PROJECTS

Project Spectre, our first computerized match of death records against benefit rolls, resulted in 200 convictions and pre-trial diversions and an estimated $25.2 million in recoveries. The success of this project has led to the development of similar computerized matches. One spin-off is Project BAD (Beneficiary Already Dead). This is a joint project with the Secret Service in Maryland to detect beneficiaries who were identified as dead during the original project but whose names somehow returned to the beneficiary rolls. Special computer programs were developed, and death records from Maryland were matched against the Social Security Master Beneficiary Record. Since the inception of this project, we have had $165,000 in recoveries.

Computer Applications

The use of computer applications has greatly increased our ability to detect fraud, abuse and waste within the Social Security programs. During this reporting period computer applications were used to identify unreported circumstances that if known to SSA would result in a person not being eligible to receive benefits. More importantly, procedural changes will be made to preclude future occurrences of the noted problems thus saving substantially more Federal dollars.

AFDC/VITAL STATISTICS MATCH

This application was designed to match one State's vital statistics file for deaths against AFDC assistance rolls. Results identified over 483 cases where assistance payments continued after death. The number of checks issued after death ranged from 1 to 24 checks per case for estimated overpayments of $45,000.

Records showed that at least 62 of the 483 cases were still active as of July 1, 1984. Our review is continuing to determine if fraudulent endorsements were made to cash the checks. Such cases will be investigated.

SSA/DEATH MATCH

A computer match of one State's death records against SSA's Title II Master Beneficiary Record disclosed that in 124 cases, beneficiaries have been overpaid $1.35 million after death. Overpayments will continue on 99 cases at the rate of $40,000 monthly until needed corrective action is taken. Our review covered calendar years 1979 through 1982. Presently, 110 cases are being investigated for possible fraudulent activity.

Recommendations Not Yet Acted Upon

The following OIG recommendations included in previous reports to Congress involving significant dollar savings have still not been implemented:

SOCIAL SECURITY DEPOSITS

The Inspector General's Semiannual Report for the period ended March 31, 1984 noted that Congress passed legislation mandating a semimonthly deposit schedule of Social Security contributions made by States on behalf of State and local employers. Social Security contributions made by the States total about $19 billion annually. The semimonthly schedule, effective January 1984, as estimated by our report, will increase Trust Fund interest income and contribution receipts over the next 5 years by $715 million and $1.1 billion, respectively.

Our final report on State deposit schedules, recommended a further legislative change requiring State and local government employers to follow the private sector schedule. Requiring individual employers to deposit on the private sector schedule directly with IRS would provide the flexibility in deposit timing which is needed by smaller employers. It would also accelerate the deposits of larger employers who generally can meet tight deadlines.

The semimonthly schedule requires States to make single consolidated deposits for all covered employers twice each month. To meet this requirement, individual employers are generally allowed about one week after a biweekly payday to get their deposits to the State for consolidation.

Smaller employers, who constitute about 35 percent of those reporting, are generally not capable of meeting such a time frame. Without a flexible deposit schedule that recognizes their processing limitations, noncompliance could be expected to become a significant problem.

Acceleration of State deposits resulting from adoption of the private sector schedule would further increase Trust Fund interest income and contribution receipts over 5 years by $480 million and $988 million, respectively. To encourage compliance with accelerated deposit requirements, our report also recommended that the six percent interest rate charged on late State Social Security deposits be increased commensurate with the market level rates currently charged on late private sector deposits. (Report first discussed in OIG 1981 Annual Report.)

LATE PAYMENTS TO SSA

A State may either supplement SSI benefits with monthly cash payments to recipients or enter into an agreement with the Secretary where SSA makes supplementary payments to recipients on the State's behalf. Currently, SSA makes supplemental payments on behalf of 27 States to SSI beneficiaries. These States must deposit the necessary funds with SSA for the monthly supplements on or before the date benefits are paid. There is no provision for interest or penalties in the event of late payment.

We examined the practices of States depositing funds with SSA for supplementation of SSI benefits. During FY 1983, SSA received $1.7 billion in such payments, some of which were frequently made late. These late payments resulted in interest expense to the Treasury of $1.3 million for that fiscal year.

We recommended that SSA take the necessary regulatory steps to implement procedures for assessing and collecting interest on late State supplementation payments. SSA said that it is not clear that the Federal Government loses interest as a result of present financial arrangements with the States. Further, if they were to charge interest the States might seek financial changes which could more than offset interest collected. (Report first discussed in OIG October 1, 1983 - March 31, 1984 Semiannual Report.)

AFDC/HUD SHELTER ALLOWANCE

An estimated one million AFDC recipients in 39 States live in federally or State subsidized housing. These same recipients often are also receiving a shelter allowance in their monthly AFDC benefit payment. As a result, we believe duplicative shelter benefits are being paid out by public assistance programs. We had recommended that SSA seek a legislative amendment to require all States to consider these allowances in determining AFDC assistance payments. OIG is currently working closely with SSA to find the most appropriate legislative solution for this problem. (Report first discussed in OIG 1981 Annual Report.)

GRANTS AND INTERNAL SYSTEMS

CHAPTER IV

GRANTS AND INTERNAL SYSTEMS

Grants and Internal Systems (GIS) encompasses two Operating Divisions, the Public Health Service (PHS) and the Office of Human Development Services (OHDS). An additional focus is on Departmental management: those functions that cut across Departmental lines, including procurement, debt collection, and employee-related activities.

Although program expenditures in these areas are substantially less than those administered by SSA and HCFA, the absolute amount is significant—approximately $8.6 billion in PHS, $6.0 billion in OHDS, and $0.3 billion in Departmental management. Over 86 percent of the Department's discretionary expenditures are in these areas.

During this reporting period OIG continued to focus substantial resources on improving the management efficiency and effectiveness of program operations and management systems that are vulnerable to fraud and abuse. We have identified areas where costs can be avoided or funds more judiciously spent. We have taken a proactive role in combating fraud, waste, and abuse.

A major thrust of the OIG's effort has been: (1) reviewing Departmentwide systems such as debt collection and cash management; (2) the adequacy of internal controls; (3) improving security at the Department's automated data processing (ADP) facilities; (4) reviewing the administration of specific programs such as Health Educational Assistance Loan (HEAL), Foster Care and Head Start; and, (5) identifying opportunities to cut costs through improved efficiency of Department operations.

From April 1, 1984 through September 30, 1984 we identified opportunities for cost savings of $68.4 million through increased efficiency in program operations and management. Recommended financial adjustments during the period amounted to $15.7 million. Investigations resulted in 26 successful prosecutions. Management areas such as debt collection, cash management, internal controls, ADP security and unemployment compensation were reviewed and recommendations for improvement made.

Public Health Service

PHS spent an estimated $8.6 billion in FY 1984 on health research, prevention of disease and other activities which generally support improvements of public

health. Our reviews during the period surfaced opportunities to more efficiently administer grants, contracts, and loan programs and save some $30.1 million annually by strengthening internal controls and program management. In addition, reviews identified questionable program expenditures of $5.4 million.

HEAL PROGRAM

The Health Education Assistance Loan (HEAL) program insures loans provided by non-Federal lenders for students in health professions schools. Congress intended this program to be self-supporting with Federal reimbursements to lenders for defaults, deaths or disabilities of borrowers financed by insurance premiums charged borrowers. As of February 1984, the HEAL insurance loan fund balance totaled $4 million and loan guarantees, plus accrued interest, totaled $500 million.

An OIG review disclosed several deficiencies that act against the Congressional intent of this program—which if left uncorrected raise the possibility of a Federal bailout being needed for HEAL of some $100 million over the next 5 years:

- Escalating default rate. Insurance premiums currently charged to borrowers are supposed to underwrite an estimated annual default rate of 2 percent. Our analysis shows, however, the actual default rate to be about 8 percent. Unless action is taken immediately to reduce the default rate, annual rates of 10 to 15 percent are likely.

- Unnecessary borrowing. Lack of a needs test, use of inflated student budgets, and loose regulations permitted students without demonstrated need to receive HEAL loans. For example, unnecessary loans were made to college seniors near, at, or sometimes, after graudation.

- Lack of effective procedures to keep loans in repayment. HEAL program requirements, while generally met by lenders and schools, fall short in keeping loans in repayment. Program regulations neither provide repayment schedules flexible enough to prevent forcing unnecessary default nor require borrowers to keep in contact throughout the loan/repayment process. Based on experience with other PHS student assistance programs, the HEAL default rate could be substantially reduced if more effective repayment requirements were implemented.

Because the program is relatively young—only 16 percent of loans guaranteed reached repayment status at the time of our review—the possibility of a Federal bailout could be avoided with immediate aggressive action. Recommendations call for increasing the insurance premium paid by borrowers, establishing a

needs test for students applying for HEAL loans, limiting the amount and kinds of expenses for which loans will be made, and establishing more effective collection procedures.

Our draft report is currently with PHS for review. PHS has already initiated action to increase the insurance premium and to restrict unnecessary loans.

PHYSICIAN SPECIAL PAY

In FY 1983, the Department paid about $28.3 million to about 3,200 doctors and dentists employed as officers in the PHS Commissioned Corps or as civilian staff. Special pay (authorized by appropriate statutes) is in addition to regular pay and is intended to enhance the recruitment and retention of highly qualified medical personnel.

Our review disclosed that the Department could save $10.1 million annually or $50.5 million over the next 5 years if legislation were enacted to authorize special pay only for those situations where it is needed as a recruitment or retention incentive. Specifically:

- Amounts of Special Pay. $8.9 million could be saved annually by applying the same factors used to determine need for special pay for civilian employees to special pay for Corps medical and dental officers. Because of differences in the authorizing statutes, special pay for Corps physicians is an entitlement while special pay is given only to civilian physicians filling positions experiencing significant recruitment or retention problems. The personnel perform basically the same duties.

- Disbursement of Special Pay. $1.2 million in annual Federal interest expense would be avoided by disbursing special pay to Corps physicians monthly with basic salary (as is special pay for civilian physicians) rather than as a lump sum advanced annually. Also, monthly disbursement of special pay would facilitate the recovery of such pay when Corps physicians do not complete their contract periods.

Recommendations call for PHS to seek the legislative and procedural changes needed to see these savings realized. Our draft report is currently with PHS for comment.

OFFSET OF NHSC DEBT

As of December 1983, 1,813 National Health Service Corps (NHSC) scholarship recipients had breached their Federal service agreements and elected to pay back obligations of $61.3 million. Of these recipients, 426 were delinquent in repaying the Department on their obligations of $13.1 million. To determine

OHDS that using the experience gained from the Hill-Burton recovery program, $2 million in recovery may be available for Developmental Disabilities program facilities if statutory change were sought to strengthen recovery provisions. Further, we noted, that similar statutory changes may well be appropriate for other OHDS programs making further recoveries possible. OHDS agreed this issue warranted investigation and they will prepare a program instruction/ issuance to States and University Affiliated Facilities which reiterates the need for compliance with current legislative and regulatory requirements and outline procedures to be followed in reporting changes in the status of facilities funded from Developmental Disabilities construction grants.

Departmental Management

The Office of the Secretary (OS) spent about $250 million in FY 1984 to provide executive leadership and direction for Departmental activities and to provide common services such as accounting and payroll to Department Operating Divisions. Reviews this period offered recommendations to streamline and improve these functions. Special emphasis was placed on strengthening Department internal controls, security of ADP facilities and other mechanisms.

INTERNAL CONTROL

OIG is continually monitoring the Department's efforts to establish and maintain effective internal administrative and accounting control systems required by the Federal Manager's Financial Integrity Act and OMB Circular A-123. The Secretary's first annual report on internal control to the President and Congress for calendar year 1983 included 200 material internal control weaknesses identified by Department evaluations as well as corrective action taken or promised. An OIG follow-up review of these items showed that corrective actions have generally been satisfactory. The Department, however, has been slow in making procedural changes implementing OIG and GAO recommendations to improve the overall system for evaluating internal controls. These audit reports pointed out that:

- The inventory of activities subject to internal control review omitted many operational and programmatic areas;
- Vulnerability assessments, intended to determine degree of risk in functions and activities, omitted factors vital to such determinations; and
- Internal control review procedures differed greatly from the event cycle approach advocated by GAO and OMB.

The Department is now moving aggressively to develop and implement revised procedures.

In addition, we found that SSA, the largest of the Department's components, completed by mid-September less than half of its 1,100 planned reviews. Moreover, we noted that during this calendar year PHS was giving priority to controls over travel while its grant function, accounting for almost half the PHS budget, is not scheduled for review until 1986. These observations have been reported both to the individual components as well as to the Assistant Secretary for Management and Budget.

UNEMPLOYMENT COMPENSATION CROSSMATCH

OIG participated in a Federal employee/unemployment compensation crossmatch project led by Department of Labor (DOL) under the auspices of the President's Council on Integrity and Efficiency. During our review, we noted that the Department was not effectively implementing Federal regulations to prevent former Federal employees from improperly receiving unemployment compensation (UC).

Each month, States send DOL a bill for UC benefits paid Federal claimants. DOL pays the bill for all Federal agencies, and in turn, bills each agency for their share. States also send quarterly listings of cumulative billings for each claimant to the Federal agency responsible for the reimbursement. Federal agencies provide State unemployment offices with wage and separation information for former employees who apply for unemployment payments. During FY 1982, HHS reimbursed $6.4 million in UC to States for about 8,000 claimants.

Based on a computer crossmatch of HHS payroll files and unemployment payment files in 14 States, 97 former or current HHS employees were found to have improperly received $110,000 in UC payments at the same time they were receiving a Federal salary or severance pay. In addition, another 93 cases are still under review since the primary source documents, such as time cards, needed to determine a claimant's eligibility were either missing or illegible.

We also found that information required by States to determine a claimants' eligibility and amount of UC was often provided late by the Department and contained incorrect or missing information. Individual State billings were not reconciled to the total amounts paid by HHS even though there were large variances. Further, State billings received by the Department for each claimant paid UC were not validated to determine if payments were proper. Appropriate recommendations were made to correct these problems.

ADP SECURITY

Because of the importance associated with the automated processing of personal, proprietary, and other sensitive data, the adequacy of physical security at the

Department's automated data processing (ADP) facilities is a high priority of the OIG. Results of reviews of physical security practices at 11 of the Department's ADP facilities disclosed weaknesses in controls over access to data files, data processing areas, operating manuals, and processed data. Also, some facilities' contingency plans for emergencies and risk analyses of needed measures for protecting and assuring integrity of data were either inadequate or nonexistent. Recommendations called for corrective actions by managers having direct responsibility for the facilities and that the Department increase oversight and training to promote an increased awareness of the need for good physical security over ADP operations.

CONTROLS OVER DISBURSEMENT

OIG reviewed controls over direct payments processed by the finance office of one Departmental Staff Division, one Operating Division and four Regions. Annual payments at the locations visited totaled $500 million (33 percent) of the $1.5 billion in direct payments made each year by the Department.

Although disbursement controls at the finance offices reviewed were generally adequate, improvements were needed to reduce vulnerability in some areas. Analysis of internal controls at several sites disclosed a pattern of problems which may exist at other finance offices. We found that (1) issuing officers did not properly safeguard and control Government Transportation Requests (GTRs) having an estimated value of $4.2 million, and (2) voucher examiners did not obtain refunds of unused airline tickets or effectively apply required examination procedures on transactions valued at $.7 million.

Recommendations were made to correct the problems noted and to require that other finance officers: (1) make an assessment of their own controls; (2) ensure that corrective action is taken if similar deficiencies are found, and (3) reassess the deficient areas during future internal control reviews.

CASH MANAGEMENT

Each year substantial cash advances are made by the Department to various entities receiving discretionary funds. OIG has been closely monitoring this area to minimize interest costs to the U.S. Treasury by assuring entities draw Federal cash as close to the time of disbursement as possible. Several cases were identified where states drew down substantial funds in excess of need:

- One State agency maintained an actual average daily cash balance of about $3 million during one year costing the Federal Government unnecessary interest costs of about $258,000.

- Another State's Low Income Home Energy Assistance (LIHEAP) and Social Services programs maintained excessive cash balances averaging about 19

and 12 days' cash needs, respectively, costing the Federal Government an estimated $359,000 in interest expense for one year. If the State maintained this persistent cash drawdown pattern, unnecessary interest costs could reach about $1.8 million over a 5-year period.

- The Medicaid and LIHEAP programs in a third State maintained excessive cash balances averaging between 7 and 12.7 days, respectively. As a result, the U.S. Treasury incurred estimated interest costs of about $202,000, representing interest on the average daily balance for the period reviewed. This drawdown pattern could result in unnecessary interest costs of $2.8 million over a 5-year period.

Appropriate procedural recommendations were made to correct the noted deficiencies.

NON-FEDERAL AUDIT ACTIVITY

OMB policy calling for single audits of recipients of Federal funds, relies heavily on work done by non-Federal auditors such as public accountants and State auditors.

The OIG closely monitors and reviews this work by evaluating reports and, on a test basis, supporting audit workpapers, to make sure that standards of Governmental auditing are followed. For example, for the period April through September 1984, some 1,208 reports prepared by others, mostly CPAs and State auditors, were reviewed and evaluated.

OIG staff found that in those cases where problems were noted, we could build upon the audit work already performed by the non-Federal auditor and develop more fully the documented issues or problems. In other cases, identified problem areas will be included in future OIG work plans. For example: review of the statewide single audit report for one State found that the State had accumulated a surplus of about $138 million in its internal service funds account as of June 30, 1983—$23.5 million Federal share. The surplus resulted because the State's billing rates were designed to recover from user agencies all fund outlays, including projected expenditures for future equipment purchases and contingency reserves. These billing practices are contrary to cost principles in OMB Circular A-87 which preclude charges to Federal programs in excess of cost. Besides recommending appropriate financial adjustment and procedural change in this one State, we will be reviewing internal services funds in a number of other States.

DEBT COLLECTION

For the 6-month period ended June 30, 1984, debts due the Department increased $326 million, collections decreased $75 million and write-offs of

accounts receivable decreased $277 million. A breakdown of Department collection activities is shown on page 58.

OIG monitors the Department's debt collection activities on a cyclical basis. For this period, we examined PHS and SSA debt collection activities/procedures. We also assessed action taken by PHS and SSA in resolving prior problems in reporting debts in accordance with OMB, Treasury and Department requirements.

- PHS: Though the number of accounting errors noted in prior reviews have been reduced, errors still exist in subsidiary ledger entries for loans receivable for the Health Professional Student Loan (HPSL) and Nursing Student Loan (NSL) programs. Ledger reconciliation has begun with a target completion date of December 1985. Full implementation of a new on-line accounts receivable module (scheduled for FY 1985) should improve PHS tracking of debts.

- SSA: Since our last review SSA has shown continuing progress in improving debt collection practices and preventing overpayments to beneficiaries. The Interim Billing and Follow-up System, which produces bills to debtors not in payment status and alerts debt collection units to contact delinquent debtors, has been implemented in SSA's six Program Service Centers.

  SSA is also pursuing several initiatives which are designed to prevent overpayments to beneficiaries. In one, selected beneficiaries will be asked on a recurring basis to provide SSA with information affecting monthly payment amounts. These beneficiaries have been identified as having a high risk of being overpaid. SSA estimates that $201 million per year in overpayments can be avoided from this one initiative.

AUDIT RESOLUTION

OIG closely monitors the Department's performance for promptly resolving final audit reports having monetary findings. The following information on Departmental audit resolution activity is provided in accord with the Senate Appropriations Committee report pertaining to the Supplemental Appropriations and Rescission Act of 1980 (P.L. 96-304).

Reports with Costs Questioned

	Total	Over 6-months old
Unresolved audits, April 1, 1984	213	7
Unresolved audits, September 30, 1984	197	3[1]
	Number	
Reports issued during period	347	
Reports resolved during period	363	
	Amount (in millions)	
Costs questioned during period	$ 50.7	
Costs sustained during period	$134.7[2]	

[1] These reports are with the following OPDIVs for resolution:

	SSA	OS	Total
Reports	1	2	3
Monetary findings	$681,375	$159,012	$840,387

[2] Subject to reduction as result of appeal and/or uncollectibility.

probation. The former department chairman was sentenced 5 years probation and ordered to repay almost $64,000, and the former State bureau chief received 5 years probation and ordered to repay $46,000.

- The president of a Massachusetts company and his wife, who served as company treasurer, were convicted on a variety of mail fraud, false statement and false claims charges in relation to Federal contracts. One of these was a HCFA contract to assist the State Medicaid agency. The president was sentenced to 1 year in prison, with 11 months suspended and 3 years probation. During 2 of the 3 years probation he must perform 20 hours of public services each week. The wife was given 2 years probation, and the company was fined $65,000. The case was worked jointly with the Department of Defense.

LEGISLATIVE AND REGULATORY REVIEW

CHAPTER V

LEGISLATIVE AND REGULATORY REVIEW

PREVENTION

The Office of the Inspector General places a high priority on preventing fraud, abuse, and waste in HHS programs by reviewing legislative and regulatory changes before they are implemented. These legislative and regulatory changes govern the future operations of HHS programs and have a major impact on whether there is vulnerability to waste or misuse of funds. The OIG review focuses on changes to promote economic and efficient program operations and controls that prevent and detect fraud and abuse. Without this preventive review, deficiencies in new and revised programs might remain undetected until audits and other studies disclose that funds have been wasted or misspent.

REVIEW HIGHLIGHTS

The OIG reviewed 84 regulatory and 210 legislative changes during the Semi-annual reporting period from April - September 1984. Among the important regulations reviewed by the OIG was the FY 1985 revision of the Medicare prospective payment regulation. This regulation made changes in the system for controlling $44 billion in payments for hospital services under Medicare. The OIG made a number of recommendations that program officials adopted including refinements in the warning to physicians of the fraud and abuse penalties associated with falsification of hospital payment documentation, and safeguards to prevent double payments and unjustified cost increases. The OIG also provided extensive review of the Departmentwide regulations to implement the Debt Collection Act of 1982. The main purpose of the OIG review was to provide the strongest basis possible for debt collection in HHS by eliminating unneeded exceptions to charging of interest and penalties on overdue debts and use of administrative offset to collect debts.

CHANGES IN EXISTING REGULATION AND LEGISLATION

In addition to review of proposed changes in regulations and legislation, the OIG also recommends changes in existing regulations and legislation to safeguard HHS programs. These recommendations are transmitted to HHS' Operating Divisions in audits, inspections and other reports. OIG legislative recommendations of this kind that have not been enacted are summarized in Appendix A of this Report.

SANCTIONING AUTHORITY

The OIG administers the HHS authority to sanction health care suppliers and providers for defrauding or abusing the Medicare or Medicaid programs. Fourteen new authorities that were previously proposed are listed in Appendix

A of this report. In addition, the OIG has recently proposed the following expanded sanction authorities. These proposals are currently under review within HHS:

1. Exclusion of Health Professionals Based on the Actions of State Licensing Authorities

   - To exclude health care professionals from Medicare and Medicaid participation based on findings of inferior care or inappropriate conduct made by a State licensing authority.

2. Minimum Suspension Period for Persons Convicted of Medicare and Medicaid Crimes

   - To require that individuals convicted of a Medicare and Medicaid criminal offense be barred from participation in the Medicare and Medicaid programs for a minimum of 5 years.

3. Preservation of Assets in Civil Monetary Penalty Proceedings

   - To provide authority to seek an injunction in U.S. District Court to preserve the assets of an individual or entity who reliable evidence indicates is or is about to dissipate or conceal his assets prior to a Civil Monetary Penalty assessment.

4. Civil Penalty for Kickbacks in the Medicare and Medicaid Programs

   - To provide an alternative civil remedy for kickback violations. This authority is intended to supplement current criminal penalties.

5. Clarification of Administrative Sanctions under the Prospective Payment System

   - Technical amendment to clarify the authority to levy administrative sanctions against providers who engage in practices intended to circumvent the prospective payment system.

6. Falsification of Conditions of Participation Application

   - Technical amendments to expand the Department's ability to pursue

criminal cases against all providers (i.e., laboratories, portable x-ray facilities) who falsify information on their conditions of participation application.

7. Exclusions Based on Peer Review Organization (PRO) Findings of Medicaid Violations

   - To permit exclusions from Medicare and Medicaid participation based on PRO findings of inadequate, excessive or improper documented care made during a Medicaid review performed by a PRO under contract with a State.

8. Withholding of Medicare and Medicaid Payments to Practitioners, Providers, and Suppliers Under Investigation for Fraud

   - To clarify and expressly state the Department's statutory authority to require carriers, intermediaries, and States to withhold payment on Medicare and Medicaid claims submitted by practitioners, providers, and suppliers under investigation for fraud.

9. Exclude Health Professionals from Medicare and Medicaid Who are in Default on their PHS Loans and Scholarships

   - To encourage physicians to arrange to pay back their financial obligation with PHS by excluding those who default on those obligations from participation in the Medicare and Medicaid programs.

PRESIDENT'S COUNCIL ON INTEGRITY AND EFFICIENCY

CHAPTER VI

PRESIDENT'S COUNCIL ON INTEGRITY AND EFFICIENCY

President Reagan established the President's Council on Integrity and Efficiency (PCIE) in March 1981 to coordinate Governmentwide activities which attack waste and fraud in Government and to improve management processes. In addition to strengthening the role of the Inspectors General in performing audits and investigations to identify the sources of waste and fraud, the PCIE has focused on cooperative interagency activities which enhance the Federal Government's overall ability to combat fraud, abuse, and waste.

COMPUTER MATCHING REPORT

The PCIE Long-Term Computer Matching Project has published the Computer Matching Newsletter for the past 2 years. We have procured the services of the Council of State Governments to publish future issues of the Computer Matching Report. The purpose of the Report is to share information about computer technology and applications and to provide technical assistance and heighten awareness of vulnerabilities in Federal, State, and local Government programs.

FEDERAL MATCHING INVENTORY

In June 1984, the PCIE Long-Term Computer Matching Project published an expanded and updated inventory of computer applications used by Federal agencies. The expanded inventory includes computer applications designed to accomplish specific objectives of an audit, investigation, or review—not just computer matches. The inventory describes the many computer applications designed by the HHS Inspector General to prevent and detect fraud, waste, abuse, and mismanagement.

FRONT-END ELIGIBILITY VERIFICATION

The PCIE established the Front-End Eligibility Verification Systems work group to stimulate technology transfer among the States and to prevent erroneous benefit payments. To accomplish these goals, the work group surveyed the States about their front-end use of computer applications to verify eligibility for AFDC, Food Stamps, Medicaid, and Unemployment Insurance. Preliminary results of the survey reveal that front-end verification is usually focused on verifying income data or verifying that an applicant does not receive duplicate benefits. Survey findings will be compiled in a catalog and will be made available to State officials to assist in identifying techniques that can reduce the incidence of fraud and abuse in their programs.

COMPUTER SECURITY

On June 5th, we co-hosted a 1-day conference on Computer Security. The conference, sponsored by the President's Council on Integrity and Efficiency and the newly created President's Council on Management Improvement, was designed to heighten awareness of and provide opportunity for dialogue by Inspectors General and Assistant Secretaries for Management/Administration on the growing problem and changing environment of computer security and information resources management.

LAWS AT WORK CONFERENCE TASK FORCE ON FALSE IDENTIFICATION

In May, we co-chaired with the Commissioner, Immigration and Naturalization Service, and the Director of Special Operations, Passport Services, a task force on the Criminal Implications of False Identification for the citizens-sponsored Laws At Work Fifth Conference on the Judiciary. The task force included representatives from Congressional staffs, Federal and State program agencies, local law enforcement groups, professional organizations, the business community, and private citizens.

The task force focused on the three Federal document areas—social security cards, immigration documents, and passports—and their impacts on the large State and locally run health, welfare, and unemployment programs. The task force arrived at 16 practical recommendations to improve the false identification problem, including: improved investigation and prosecution of false identification crimes, improved identification document production, increased use of computerized verification techniques, State consideration of improved birth certificate issuance systems, and increased used of front-end automated verification prior to benefit payment. The task force report will be included in the Laws At Work conference report to be published by the end of the year.

WORK GROUP ON FRONT-END EDP SYSTEMS REVIEW AND SECURITY

Attempting to clarify the role of the OIG/EDP auditor vis-a-vis other critical participants in the development of an automated system or major modifications to existing systems, an HHS/OIG work group prepared a "responsibility matrix" and a listing of critical documentation requirements. Agency managers and the OIG/Audit community were surveyed for their comments and observations. A final "matrix" report will be available to the PCIE and EDP managers. The report will serve as a management tool and as a basis for audit involvement in the review of automated systems.

Further, the work group has begun to clarify the structure and content of an audit guide/approach for the audit community to use in conducting EDP audits and

reviews of developing systems. We are working closely with the National Bureau of Standards on that effort.

DEFICIT REDUCTION ACT

Most of the provisions of the "Income and Eligibility Verification" section of the Deficit Reduction Act, P.L. 98-369, are a direct outgrowth of the PCIE Computer Matching Project which we co-chair. For example, requirements to use computer matching standardized formats and the applicant's or recipient's social security number as a key matching element were recommended by the project. Because of our extensive accomplishments the OIG co-chairs the Interagency Steering Committee to direct the development of regulations and guidelines to implement the new requirements.

APPENDIX A

Appendix A

UNENACTED LEGISLATIVE RECOMMENDATIONS

The following legislative recommendations have been made in specific OIG audits and other reports and have not yet been enacted by Congress. Recommendations discussed in this report are referenced by page number. This list does not include preliminary recommendations described in this Report which are still under consideration by the OIG.

Health Care Financing Administration

- Second Surgical Opinions (Audit Control Number 03-30211)

  Require Medicare and Medicaid beneficiaries to seek a second surgical opinion for selected elective surgeries. (See page 27)

  Savings: $65 million for Medicaid and $135 million for Medicare in FY 1985, with increasing savings in succeeding years.

- Rounding Down of Medicare Part B Payments: (Audit Control Number 03-42006)

  Require round down of odd-penny claims to the next lower dollar. (See page 28)

  Savings: $45 million in FY 1985, with increasing savings in succeeding years.

- More Economical Payment Methods for Urological and Enternal Therapy Project. (Audit Control Number 06-42002)

  Require nursing homes to purchase these products and be reimbursed through nursing home rate, rather than through Part B. (See page 29)

  Savings: $17 million annually.

- Verification of service methods used by State Medicaid Agencies (Service Delivery Assessment - "The Medicaid Explanation of Benefits Requirement: A Brief Inquiry Concerning Its Implementation," dated April 1983)

  Allow States greater administrative flexibility in determining methods used to verify services provided to recipients for which payments are claimed.

  Savings: $3-5 million annually (75 percent of which is Federal).

Social Security Administration

- More frequent Social Security Deposits (Audit Control Number 13-32601)

  Accelerate State Social Security contribution deposits by adopting the private sector schedule. (See page 43)

  Savings: $988 million in contribution receipts and $480 million in interest income over 5 years.

- Duplication of Shelter Allowance (Audit Control Number 01-20252)

  Require States to consider shelter allowance received from other Federal programs in determining AFDC programs. (See page 44)

  Savings: $377 million annually previously reported is being revised.

Office of Inspector General

The Office of Inspector General administers the HHS authority to exclude health care providers from Medicare and Medicaid for fraud and abuse. The following changes would strengthen the Inspector General's authority to protect the integrity of these programs. The list does not include new proposals that are currently under review within HHS. The new proposals are listed on page 63.

Proposed Amendments Regarding Exclusion of Health Care Providers and Practitioners from Medicare and Medicaid

- Based on Convictions Outside the Medicare and Medicaid Programs.

  To exclude any entities that have been convicted in connection with (1) the delivery of health care; or (2) a Federal, State, or local Government program, of:

  - fraud or financial abuse;
  - neglect or abuse of patients; or
  - unlawful manufacture, distribution, or dispensing of controlled substances.

- From Medicare if Sanctioned under Medicaid

  To exclude from Medicare participation individuals and entities who have been sanctioned by a State for defrauding or abusing the Medicaid program of that State.

- Failure to Disclose Ownership or Control by Convicted Persons

  To exclude an entity which fails to make required disclosures that it is owned or controlled by convicted individuals.

- Based on Kickbacks

  To exclude individuals or entities from Medicare and/or Medicaid who violate the anti-kickback provision of the Social Security Act.

- Failure to Grant Access to OIG for Investigative Purposes

  To exclude any individual or entity that fails to grant immediate access, upon reasonable request, to the OIG for the purpose of review of records, documents, or other data necessary to the OIG in the performance of his statutory functions.

- Medicaid Providers who Fail to Disclose Required Information

  To expand present Medicare authority to Medicaid providers to exclude individuals or entities who fail to:

  - furnish to the Department required information concerning subcontractors and wholly owned suppliers; and

- provide information necessary to verify their claims for payment.

Amendments Regarding Civil Monetary Penalties

- To permit unified judicial review of the imposition of monetary penalties imposed under the Civil Monetary Penalties Statute, and Medicare and Medicaid suspensions.

- To provide Civil Monetary Penalties where claims are submitted after the date of exclusion from Medicare based on the findings of a Peer Review Organization determination.

- To increase State share of Civil Monetary Penalty awards to encourage State investigation and referral of Medicaid fraud cases.

- To clarify that the type of claims subject to Civil Monetary Penalties include claims that a person knew or had reason to know were false or fraudulent.

- To provide a 6 year statute of limitations for Civil Monetary Penalty actions.

Reorganization of Statutory Authorities

- As noted in the Semiannual Report for October 1983 - March 1984, the OIG supports a reorganization of the current fraud and abuse provisions of the Social Security Act to consolidate the provisions setting forth administrative remedies and criminal penalties for fraud and abuse in the Medicare and Medicaid programs into one section of the Act.

APPENDIX B

APPENDIX B

ANALYSIS OF COST SAVINGS
APRIL 1984 THRU SEPTEMBER 1984

This analysis includes savings resulting from management commitment not to expend funds or to more efficiently use resources thereby avoiding further unnecessary expenditures. Also shown are recoveries which include: (1) management commitments to seek recoveries of funds based on OIG recommendations; and (2) fines, penalties, recoveries and restitutions from investigations.

HEALTH CARE FINANCING ADMINISTRATION

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS $ MILLIONS
Based on reviews started as early as 1978, we recommended that HCFA develop a new reimbursement system that would reduce Medicare and Medicaid payments for laboratory services. (ACN: 09-42604)	The Deficit Reduction Act of 1984, signed into law July 17, 1984, included a provision to lower Medicare rates of payments for laboratory services.	974*
Limit revaluation of assets after sale for Medicare/Medicaid reimbursement purposes. (ACN: 07-32006)	The Deficit Reduction Act of 1984 included a provision which limited revaluation of assets after sale to the seller's original acquisition cost (includes both Medicare and Medicaid programs).	635*
Ensure that all Medicare intermediaries maintain effective claims processing procedures to preclude improper payment of hospital claims for costs included in Medicare prospective payment rates. (ACN: 10-42003)	HCFA agreed that tightened intermediary processing systems are necessary to avoid double payments. HCFA is now in process of issuing instructions to assure where necessary that intermediaries develop the appropriate processes to detect duplicate billings.	20.3
HCFA collect overpayments identified where State improperly billed for family planning services. (1-05-4002-7)	HCFA agreed to this action.	7.1

*Based on Congressional Budget Office estimate for a 5-year budget cycle.

ANALYSIS OF COST SAVINGS
APRIL 1984 THRU SEPTEMBER 1984

HEALTH CARE FINANCING ADMINISTRATION

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS $ MILLIONS
Review in one State found educational costs at ICF/MRs being improperly included in Medicaid claims. Disallowance had been recommended and accepted. (ACN: 01-20201)	As a result of our report, HCFA identified—and disallowed—additional educational costs included in subsequent period Medicaid claims.	5.9
HCFA take steps to recover funds improperly paid by Medicare for services to beneficiaries who have coverage under employer group health plans. (1-07-4001-14)	HCFA concurred with the recommendation.	4.9
Ensure that services related to Black Lung illness are billed to that program in lieu of Medicare. (2-04-2084-19)	HCFA agreed to this action.	4.0
Ensure that services to Medicare beneficiaries involved in automobile accidents are billed to the appropriate insurance entity before billing Medicare. (3-06-4904-01)	HCFA agreed with this recommendation.	2.5
HCFA instruct the carrier to monitor oxygen claims, develop a prepayment review of liquid oxygen claims to assure no claims are submitted for more oxygen than can be used and investigate instances where suppliers billed for oxygen not providers. (1-02-3004-21)	HCFA agreed with these recommendations.	1.6
Disallowance of Medicaid costs claimed by one State for long-term care provider in uncertified facilities. (ACN:09-70213)	HCFA disallowed costs claimed.	.7

ANALYSIS OF COST SAVINGS
APRIL 1984 THRU SEPTEMBER 1984

SOCIAL SECURITY ADMINISTRATION

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS $ MILLIONS
SSA terminate Title II payments and not authorize payments to be issued by the Railroad Retirement Board (RRB) for deceased beneficiaries. (ACN: 13-42618)	SSA took actions to terminate Title II payments and to not authorize payments for issuance by the RRB for deceased beneficiaries.	7.8
SSA implement procedures to prevent duplicate payments between AFDC and SSI programs. (ACN: 13-32361)	SSA has incorporated our recommendations into their procedures manual.	2.5
SSA should terminate beneficiaries who are identified as ineligible for Black Lung benefits. Additionally, SSA should incorporate terminations due to divorce, marriage, or remarriage into the planned Master Beneficiary Record/Black Lung systems interface improvements. (ACN: 13-32683)	SSA terminated payments to the beneficiaries who were determined to be ineligible. Additionally, SSA will consider our recommendations in their Systems Modernization Plan.	2.1
SSA should vigorously pursue agreements with State and jurisdictions to receive death data on a continuing basis for computer matching to SSA payment files. In addition, SSA should implement additional controls to eliminate erroneous benefit payments to deceased individuals. (ACN: 13-32607)	P.L. 98-21 enacted April 1983 established a program for HHS to obtain and use State death certificate information to prevent erroneous benefit payments to deceased individuals. Additionally, SSA's Systems Modernization Plan will apply effective, automated transaction controls to the processing of death notices.	1.1
SSA terminate payments after death for SSI and Retirement, Survivors and Disability Insurance recipients in one State. (ACN: 13-42629)	SSA took actions to stop payments to 169 deceased beneficiaries from both the SSI and Retirement, Survivors and Disability Insurance programs.	.2

ANALYSIS OF COST SAVINGS
APRIL 1984 THRU SEPTEMBER 1984

GRANTS AND INTERNAL SYSTEMS

OIG RECOMMENDATONS	ACTION TAKEN	SAVINGS $ MILLIONS
PHS improve recoveries of construction grant funds provided to facilities no longer meeting program requirements. Programs covered by this recommendation are Health Professions Teaching Facilities, Nurse Training Facilities and Community Health Centers. (ACN: 12-43217)	PHS agreed and has reviewed grant records and will pursue the recovery of grant funds where circumstances warrant.	28.0
OHDS fill empty head start slots or decrease funded slots to grantees not complying with attendance requirements. (OPI-001-84-10)	OHDS agreed to implement recommendations and to improve reporting, monitoring and auditing practices.	24.8
Eliminate unallowable and overstated costs from indirect cost rate proposals. (ACN: 09-37014)	As a result of this audit, the Division of Cost Allocation was able to establish indirect cost rates which were more equitable than those proposed.	21.0
PHS should refine its drug procurement process to take advantage of savings possible by buying from the most economical Government source and by purchasing generic drugs. (ACN: 12-43208)	PHS is establishing a comparative pricing system which includes centralized screening and monitoring of brand name drugs and increased use of large volume purchasing contracts with other Federal Departments.	12.8
To reduce project costs, PHS should take appropriate action to assure compliance with required review and approval procedures in awarding renovation and construction contracts. (ACN: 12-33194)	PHS and all other HHS components involved in the construction or renovation of PHS facilities will comply with review and approval requirements and ensure appropriate scope, budget amounts and funding sources of active PHS projects.	4.0
Savings resulting from investigations		17.7
Total (in millions)		1,778.0

APPENDIX C

APPENDIX C

SCHEDULE OF COST SAVINGS
APRIL 1984 THRU SEPTEMBER 1984

		SAVINGS $ MILLIONS
Total Cost Savings	April - September 1984	$1,778.0
Total Agreements to Recover	April - September 1984	172.6
Recoveries for Investigations	April - August 1984	11.5
Total	April - September 1984	$1,962.1
Total Savings	October 1983 - March 1984	1,792.8
FY 1984 Grand Total		$3,754.9

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