DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF INSPECTOR GENERAL

Annual Report

April 1, 1977 - December 31, 1977

MADE PURSUANT TO SECTION 204(a) OF
PUBLIC LAW 94-505

March 31, 1978

ANNUAL REPORT FOR PERIOD ENDING
DECEMBER 31, 1977

FOREWORD

This report is essentially concerned with the first 9 months of operation by the Office of Inspector General (OIG), which was activated by Secretary Califano on March 29, 1977. Certain data have been brought to a more current date to enhance the usefulness of the report.

As required by Public Law 94-505, the report attempts to highlight principal problems encountered, recommendations made, and the status of actions taken.

Our first year has necessarily been characterized by the turbulence incident to establishing a new office in a Department which itself was undergoing substantial reorganization--both at headquarters and in its 10 regional offices. But, it is likely that the work program of the OIG in HEW will always be turbulent in the sense that the direction of its work and its priorities will be subject to sudden changes to meet the concerns of the Secretary and the Congress. In fact, one of the significant values of such an office is its ability to quickly assemble--and assign where needed--skilled teams tailored to specific problems. The fact that the structure of the OIG, as created by P.L. 94-505, is able to meet this challenge has been amply demonstrated in its first year of operation.

Since its establishment, the OIG has had the continuous interest and support of Secretary Califano and Under Secretary Champion. Their example has been a model to the Principal Operating Component Heads and the Principal Regional Officials.

The willingness of the OIG career staff to adjust rapidly to new demands and priorities--in order to meet the expectations of the Act and the Secretary has been noteworthy. The future success of the OIG will depend on such strong support from the Congress, The Secretary, and the OIG staff.

ANNUAL REPORT - OFFICE OF INSPECTOR GENERAL

C O N T E N T S

CHAPTER 1

AN INVENTORY OF "BEST ESTIMATES" OF FRAUD, ABUSE, AND WASTE IN HEW PROGRAMS

A wealth of information has resulted from Congressional hearings, GAO audits, HEW audits, quality control surveys, and other studies dealing with problems of fraud, abuse, and waste in HEW programs. Some of these span many years and reveal chronic failures to take corrective action. Others reveal dramatic progress in reducing losses due to errors and ineligibility rates. But no summary or analysis of these findings has ever been compiled. Hence, it was decided to compile an inventory of the "best available estimates" we could locate.

It must be stressed that this summary is no more than an initial inventory. It is not an independent study, although we believe the data are reasonable estimates. Because the sources are not complete, the inventory is not complete. Despite these limitations, it is the best perspective that has yet been assembled. In our view, it portrays a conservative measure of the extent of fraud, abuse, and waste in key HEW programs, and their causes.

It must also be acknowledged that it is virtually impossible to distinguish sharply between fraud, abuse, and waste, since frequently one problem involves all three. For purposes of rough definition, we have adopted the following:

--Fraud is defined as the obtaining of something of value, unlawfully, through willful misrepresentation.

--Abuse covers a wide variety of excessive services or program violations, and improper practices not involving prosecutable fraud.

--Waste is the incurring of unnecessary costs as a result of deficient practices, systems or controls.

As summarized below, this inventory of best estimates reveals that for programs involving Federal outlays in FY 1977 of $136.1 billion, the incidence of fraud, abuse and waste--at a minimum--ranged between $6.3 and $7.4 billion (Exhibit 1)

Exhibit 1

INVENTORY OF "BEST ESTIMATES" OF FRAUD, ABUSE, AND WASTE IN KEY HEW PROGRAMS, FY 1977

Program	Federal Outlays (Billions)	Best Estimates of Losses (In Millions)
A. Health Care		
Medicaid	$ 9.8	$ 2,310 - 2,640
Medicare	21.9	2,217
SUBTOTAL	31.7	4,527 - 4,857[1/]
B. AFDC	6.3	669
C. Income Security and SSI	89.7	494 - 1,201[2/]
D. Social Services	2.7	88
E. Student Financial Aid	3.6	356
F. ESEA Title I	2.1	97
G. Indirect	(In Above)	102
	$ 136.1	$ 6,333 - 7,370

[1/] Federal losses revealed by Medicaid Quality Control range from $330 million to $660 million, depending upon interpretation of data. This matter is under review by GAO. Higher number preferred by HCFA.

[2/] Range of estimates provided by SSA. Only lower number is verified by them.

Exhibit 1

This was between 4.7 and 5.4 percent of the Federal outlays--although the range is from 1 percent of the Income Security Program to 24 percent or more of the Medicaid Program.

The detail supporting these data is contained in Appendix I and summarized in this chapter. It is clear that most of the loss is attributable to errors and faulty management systems --i.e., waste--rather than to fraud and abuse. While these categorizations are necessarily imprecise, they underscore the wisdom of Congress in defining the OIG charter so that it is concerned both with detecting fraud and abuse and fostering efficiency and economy, through better systems and controls.

A. MEDICAID LOSSES (FEDERAL SHARE)

This is the largest area of losses due to all causes.

	Causes		
	Management & Systems	Professional & Technical	Fraud & Abuse
	(Millions of Dollars)		
1. Errors, Ineligibility, Overpayments, Audit Findings	525 to 855		
2. Failure to Collect Third Party Liability	330		
3. Medicaid Mills			423
4. Clinical Labs			45
5. Excessive Hospital Beds		377	
6. Unnecessary Surgery		187	
7. Unnecessary Hospital Stays		41	
8. Excessive Physician Costs --Percentage Contracts		25	
9. Unnecessary X-Ray Costs		172	
10. Questionable Nursing Home Costs			185
TOTAL	$ 855 - 1,185	$ 802	$ 653

Range: $2,310 - 2,640 (24% - 27%)

It is recognized that additional sources of fraud and abuse are missing, particularly by pharmacists, physicians, home health agencies, and other providers. Further, some of the losses attributed to professional and technical reasons might be found to fit the category of fraud and abuse. The classifications shown are those identified by the inventory as interpreted by the IG.

B. MEDICARE LOSSES

This is the second largest category identified in the inventory:

	Causes		
	Management & Systems	Professional & Technical	Fraud & Abuse
	(Millions of Dollars)		
1. Excessive Nursing Differential		$185	
2. Renal Dialysis Costs		153	
3. Provider Overpayments	$141		
4. Audit Findings	27		
5. Excessive Hospital Beds		753	
6. Unnecessary Surgery		468	
7. Unnecessary Hospital Stays		83	
8. Excessive Physician Costs from Percentage Contracts		48	
9. Unnecessary X-Ray Costs		344	
10. Questionable Nursing Home Costs	____	____	$15
TOTAL	$168	$2,034	$15

TOTAL $2,217

Again, the limitations of the data are acknowledged but it is of interest to observe that losses due to (1) management and systems deficiencies, and (2) fraud and abuse are much lower than for Medicaid. However, far larger losses are identified due to "professional and technical" causes.

C. LOSSES IN THE AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM (AFDC)

The problems encountered in this program are widespread and characterized by payment errors, ineligibility, and beneficiary fraud and abuse. The best estimates are as follows:

	Amounts (Millions)
Payments to Ineligibles and Overpayments to Eligibles	$ 490
Fraud and Abuse	145
Quarterly Expenditure Report Reviews	13
Audit Exceptions	21
TOTAL	$ 669

As in case of Medicaid, the leading problems in AFDC are management and systems problems.

An area requiring continuing study is administrative costs, which have grown from $575 million to $1.3 billion (over 118 percent) between 1973 and 1977. Continuing findings of improper charges are occurring. A total of 66 State audits identified $78.2 million, claimed by States, as not eligible for Federal reimbursement during the 3-year period ending 8/31/77.

D. INCOME SECURITY AND SUPPLEMENTAL SECURITY INCOME

In terms of program dollars, these programs accounted for over $89.7 billion in Federal outlays in FY 1977. The problem areas, again, are largely concerned with systems, as illustrated by the following:

--SSI overpayments and payments to ineligible recipients (including nursing home residents) -- $334 million.

--Overpayments to Retirement and Survivors Insurance beneficiaries, Disability Insurance and Black Lung beneficiaries -- $867 million.

--Total -- $494 to 1,201 million.[1/]

Again, it is recognized that some portion of these amounts may be attributable to fraud and abuse.

E. SOCIAL SERVICES

In the Title XX area of $2.7 billion, $88 million of disallowances was revealed in FY 1977 by the Quarterly Expenditure Report Reviews ($82 million) and audit exceptions ($6 million). Disallowances represent improper expenditures due to overpayments, unallowable costs, services to ineligibles, etc. Other areas requiring further study are contracting for services (especially homemaker/chore), improper diversion of funds, etc.

F. STUDENT FINANCIAL AID PROGRAMS

The five Student Aid Programs disbursed $3.6 billion in FY 1977. A wide range of problems was found by the inventory:

	Program	Amount (Million)
Excessive Payments and Payments to Ineligibles	BEOG	$ 120
Fraud and Abuse by Schools	NDSL & GSL	53
Fraud and Abuse - Defaulted Loans	NDSL & GSL	183
TOTAL		$ 356

These problems are primarily concerned with faulty management practices and systems, which have permitted and encouraged fraud and abuse.

[1/] It should be noted that a substantial amount of estimating is involved in this number, and Social Security states that at least $707 million must be considered "ball park" figures of "questionable reliability." They are offered here simply to denote an order of magnitude.

G. ESEA TITLE I

$2.1 billion in FY 1977 of Federal funds were granted to local educational agencies to meet the special needs of disadvantaged children.

Audits of these programs revealed the need for financial adjustments equal to 4.6 percent of funds, or $97 million in FY 1977, which have been improperly expended because of violations of regulations concerned with (1) supplanting of funds, (2) permitting students not eligible to participate, and (3) failure to meet the comparability standards.

H. INDIRECT COSTS

Last year $102 million was disallowed through reviews and negotiations with colleges, universities, hospitals, State and local governments, and other institutions who submitted indirect cost proposals in connection with their conduct of HEW programs. These negotiations are conducted by HEW's regional offices.

I. AREAS NEEDING FURTHER RESEARCH IN ORDER TO ESTIMATE FRAUD, ABUSE, AND WASTE

In the above discussions we have noted the absence of (1) any estimates for home health agencies and a variety of other health providers, (2) possible overcharges by contractors in the Social Services Programs, and (3) excessive administrative costs in the AFDC Program.

In addition to these, some major areas which we feel are especially worthy of further study are:

--Drug purchases, where Federal expenditures in FY 1977 were about $2.7 billion.

--Respiratory therapy, where the Federal expenditures in FY 1977 were reported as $272 million, and where the staff of the Senate Committee on Finance feels that abuses are occurring.

--The other Student Financial Aid Programs not discussed earlier, namely, the College Work Study and Supplemental Educational Opportunity Grants Programs.

This inventory will be repeated periodically and strong support given to expanding and sharpening all estimates, while

seeking more scientific measures. Project Integrity should make an important contribution to this objective in the health field, as well as the projects planned by HCFA's Office of Program Integrity (OPI).

J. SUMMARY OF BEST ESTIMATES INVENTORY FOR FY 1977

In the meantime, to place the above in an overall perspective, Exhibit 2 shows a breakout by program area and type of fraud, abuse, and waste. This analysis discloses the realtive importance of each area and highlights the need for improved management and systems.

In this connection, Exhibit 3 shows a recapitulation of HEW personnel resources by program now allocable to (1) quality control operations, (2) management and systems oversight, (3) accounting and auditing oversight, and (4) fraud and abuse investigations. The numbers in parentheses indicate the increases in staffing requested in the FY 1979 budget.

In summary this analysis reveals that there are today 4,282 personnel authorized in the several functional areas concerned with fraud, abuse, and waste. This number would grow to 5,636 in FY 1979. Of greater interest is a comparison of the distribution of these personnel by function in the two years, as shown in the following:

Function	% Distribution of Personnel	
	FY 1978 (4,282)	FY 1979 (5,636)
Quality Control	45%	43%
Management & Systems	10	8
Accounting and Auditing	25	20
Fraud and Abuse	20	29
	100%	100%

While much improved overall staffing is proposed in FY 1979 (including a very sizeable addition to collect defaulted loans in the Student Financial Aid Programs) the understaffing of the "management and systems" area is prominent in both years. It is our belief that there is now a significant imbalance because of this. While "Quality Control" operations properly require a large number of personnel to

Exhibit 2

INVENTORY OF LOSSES BY PROGRAM AND CAUSE
(Millions of Dollars)

	Management & Systems	Professional & Technical	Fraud & Abuse	Total
A. Medicaid	$ 855 - 1,185	$ 802	$ 653	$ 2,310 - 2,640
B. Medicare	168	2,034	15	2,217
C. AFDC	524	--	145	669
D. Income Security and SSI	494 - 1,201	--	--	494 - 1,201
E. Social Services	88	--	--	88
F. SFA	120	--	236	356
G. ESEA	97	--	--	97
H. Indirect Cost	102	--	--	102
TOTAL	$2,448 - 3,485	$2,836	$1,049	$6,333 - 7,370

Exhibit 2

DISTRIBUTION OF PERSONNEL

(Parenthetical Figures Requested in FY 1979 Budget)

Program	Quality Control	Management & Systems	Accounting & Auditing	Fraud & Abuse	Total
HCFA	359 (484)	105 (133)	1	379	844 (997)
SSA	1,597 (1,932)	78	5	125 (315)	1,805 (2,330)
PHS	--	19	36	--	55
OHDS	--	28	47	--	75
OS	15	123	900 (960)	114 (214)	1,152 (1,312)
OE	--	61 (65)	90 (92)	200 (710)[1/]	351 (867)
TOTAL %	1,971 45%	414 10%	1,079 25%	818 20%	4,282 100%
TOTAL FY %	(2,431) 43%	(446) 8%	(1,141) 20%	(1,618) 29%	(5,636) 100%

1/ In FY 1979, 510 permanent and temporary positions will be added to support the loans collection effort.

Exhibit 3

develop precise measures to depict trends, the staff available to plan corrective actions, test them, and provide consulting service and technical assistance is inadequate. Unless this staffing imbalance is corrected, the opportunities to cut the losses resulting from management and systems deficiencies will not be exploited.

This finding is borne out in the chapters which follow by numerous findings resulting from our audits and investigations. The message is that more attention must be given to tightening the "front end" of systems--especially eligibility determinations and claims payments--while simplifying reimbursement rules and procedures, and insisting on higher standards of integrity--by all concerned, beneficiaries, employees, and managers alike--in the expenditure of public funds on HEW programs.

CHAPTER 2

HIGHLIGHTS OF THE AUDIT AGENCY'S FINDINGS

CALENDAR YEAR 1977

In calendar year 1977, the Audit Agency prepared 2,453 reports with its own staff and processed another 4,263 prepared on behalf of HEW by State auditors and independent public accountants. POCs concurred in audit-recommended financial adjustments totaling $65.3 million.

It is the purpose of this chapter to provide a brief overview of the scope of the audit workload and the adequacy of coverage; and then to highlight key findings from the past year's work.

SCOPE AND COVERAGE

The universe of activities requiring periodic audit numbers 51,000 entities distributed as follows:

Department Installations	1,500 1/
State Agencies	545
Local School Districts	14,000 2/
Institutions of Higher Education	2,400
Other Educational Institutions	5,600
Other Grantees/Contractors	5,000 3/
Intermediaries and Carriers	128
Hospitals and Nursing Homes	20,089
Home Health Agencies	2,353
	51,615

1/ Excludes locations deemed too small to warrant audit.

2/ Includes only school districts participating in ESEA Title I for which there is an audit requirement.

3/ Estimated number grantees/contractors receiving sufficient funds to warrant audit.

Currently, we have resources to perform approximately 70 percent of the work generated by this scope of effort. This estimate is arrived at by the following:

	Staff-Years
--The total workload as measured in staff-years of effort based on Audit Agency studies over a period of several years and generally considered to have high validity.....	4,554

	Staff-Years
--Less work performed by others (CPAs, States)	(2,272)
	2,282
--Less authorized in-house staff	(900)
--Unmet need	1,382

The consequence of this deficiency in staffing is a lesser frequency of audits, particularly of medium-size and smaller institutions, and a severe strain on in-house resources caused by new initiatives such as Projects Match and Integrity.[1/] The latter two projects required the equivalent of 120 staff-years of effort during the past year, and it is hoped that a high level of effort can be continued on fraud and abuse initiatives in the future. The budget now before the Congress proposes to provide funds for an additional 60 staff-years of contract support, plus 60 staff-years of augmentation to the present in-house staff.

These increases are minimal.

While we will continue to diligently search for other alternatives to augment our audit capability, it is likely that we must continue to grow in succeeding years at an annual rate of at least 10 percent.

We are pleased that a number of States have expressed an interest in participating in audits now performed by the HEW Audit staff. Audit guides will be developed and tested for eligible areas suitable for State or CPA audits, including disability determinations, Medicare intermediaries and carriers, ESEA Title I, Vocational Education financial reviews, and others.

HIGHLIGHTS OF 1977 AUDITS

The following paragraphs summarize the findings under general program categories of health, education, income maintenance, human development, and HEW administrative. A more detailed overview is presented in Appendix II.

1. Health

Significant opportunities were found to improve economy and efficiency:

--Medicare payments systems in both Parts A and B

[1/] See Chapters 4 and 5.

were found to have resulted in overcharges to beneficiaries, as well as improper denial of claims, in some cases.

--Significant disallowances of administrative costs claimed by the 128 intermediaries and carriers were recommended in several areas--including electronic data processing costs and premium taxes.

--Improved controls over Medicaid claims processing were proposed to avoid improper payments to providers (audits identified $30 million of such payments).

--Improved procurement practices are needed in the development and installation of Medicaid Management Information Systems (MMIS).

--Improved State Medicaid fraud and abuse detection systems are needed, and more technical assistance to the States should be provided by HCFA staff.

--Improved management practices are required by the Professional Standards Review Organizations (PSROs), of which 39 were examined in 1977.

2. Education

In this broad area, audits were conducted in four major fields, yielding the following findings:

--Vocational education programs examined in seven States revealed significant variances from approved State plans; in seven other States it was found that these programs may not be responsive to employment opportunities.

--Elementary and Secondary Education, Title I funds, were improperly used to supplant rather than supplement State and local funds in 13 cases, involving recommended financial adjustments of $21 million.

--Adjustments of over $7 million were recommended in 6 audits of the Handicapped Children's Programs because institutions were not meeting mandatory eligibility criteria.

--A major problem area continued to be inadequate accounting and control systems in colleges and universities holding contracts and grants. One-third of the funds audited ($420 million) failed to meet the Federal criteria for accounting, workload distribution systems, and internal controls. A major program of reforms was directed by the Secretary on February 16, 1978, and the Audit Agency will be a key participant in its implementation.

--The Student Financial Aid programs were subjected to over 1,100 audits, half of which commented on administrative weaknesses, eligibility determinations, award procedures, refund practices, improper use of Fedral funds, loan collection procedures, and computation of interest billing.

3. Income Maintenance Programs

Findings in this universe of programs, administered by the Social Security Administration, included:

--AFDC administrative costs have more than doubled since 1973, reaching the sum of $1.3 billion. Over the past 3 years, audits revealed 182 instances of improper claims, totaling $78.2 million, for which recovery was recommended.

--Foster care deficiencies were revealed by 18 audit reports in 13 States. It appears that uniform minimum Federal standards may be needed for licensing and inspection of such facilities.

--Audits of the Supplemental Security Income Program revealed opportunities for improved practices in respect to one-time payments and interim assistance payments.

--In the Retirement and Survivors Insurance program the need was stressed for greater attention to potential underpayments affecting selected beneficiaries, and for greater automation of benefit recomputations.

--In the area of disability determinations, problems of unallowable administrative costs were disclosed in 14 States ($1.2 million), and the need for greater compliance with SSA's quality assurance procedures.

4. Human Development Services

Here reports were rendered covering Vocational Rehabilitation (VR) and Social Services programs as follows:

--Findings of a five-State, broad-based VR audit showed mixed program results, and only marginal economic gains even for the most successful clients. More attention to job placement services and individualized rehabilitation plans were proposed. (This review was conducted jointly with the Assistant Secretary for Planning and Evaluation.)

--Title XX program procedures for the purchase of services by State and local governments were the subject of 10 audits in 7 States. These identified significant weaknesses in contract monitoring, rates of payments to providers, and methods of charging costs to contracts.

5. HEW Administration

In this area attention was given to data processing and accounting operations, with findings as follows:

--The need for tighter security control over the Advanced Records Systems--a telecommunication system maintained by GSA but used by SSA offices, State agencies, private insurance companies for SSA purposes, and 33 other Federal agencies.

--The need for improved systems security for SSA's Data Acquisition and Response System (SADARS), including terminal facilities at SSA's Baltimore headquarters.

--Opportunities for the elimination of duplication in information systems at the National Institutes of Health were revealed.

--Serious accounting weaknesses in the Department's Federal Assistance Financing System were revealed, including failure to record payments,

duplicate recordings, and incorrect recordings. This system is designed to provide timely cash flow to HEW grant recipients.

It is significant to note that in the FY 1978 audit plan, the Audit Agency is seeking balanced attention to all concerns of the Office of Inspector General, and proposes to allocate its resources (900 staff-years) as follows:

--16 percent, to participate in special Inspector General's fraud and abuse initiatives (e.g., Projects Match/Integrity) and special investigative audits designed to help prepare cases for prosecution.

--27 percent, to audit State and local agencies, including related Departmental administration. Of primary interest: Medicaid programs with known fraud and abuse problems. Other areas include selected education, health, and human development programs.

--34 percent, to audit institutions of higher education, other nonprofits (emphasizing larger universities assigned to HEW for audit, Government-wide, by OMB). Also involved: Student Financial Aid programs, Health Maintenance Organizations, and Professional Standards Review Organizations.

--11 percent, to check into the validity and equity of costs claimed by Medicare intermediaries and carriers--adequacy of claims processing and provider settlements.

--12 percent, to focus on the Department's internal operations. Special attention is planned to accounting and procurement activities. Also involved: indepth reviews of selected aspects of the Old Age Survivors and Supplemental Security Income programs.

Analysis of unresolved audit reports between April 1 and December 31, 1977, indicates the need for more attention to this area. Although the total number of open audit reports decreased from 1,848 to 1,798 during this period, the dollar amounts associated with these reports increased from $151.9 to $170.8 million.

More indicative of the need for improvement in this area is an analysis of reports which have been open for 6 months or longer. It shows that audit reports in this category have increased from 761 to 911 with related dollars also increasing from $82.7 to $99 million. This is a major problem.

It is imperative that the Principal Operating Components (POCs) achieve a permanent reduction in open audit reports. This concern is shared by Secretary Califano who has asked that the OIG work closely with the POCs in developing acceptable time frames and goals for reducing the overall inventory of open audit reports.

CHAPTER 3

HIGHLIGHTS OF ACTIVITIES OF THE OFFICE OF INVESTIGATIONS AND OTHER AGENCIES WHICH INVESTIGATE HEW CASES

An inventory of HEW investigative activities and actions has never been compiled. During our first year, the pressure of coping with growing caseloads precluded the systematic compilation of such data on a current basis. 1/ We have, however, assembled three types of information in preparing this report which provide a useful starting point for the future. These data are:

A. A best effort to document criminal convictions of defrauders of HEW programs in CY 1977. While the data are incomplete, they provide a useful profile of the principal types of fraud which resulted in such convictions. It is recognized that most were based on investigations in 1976 or prior years.

B. An analysis of the current Inspector General/ Office of Program Integrity backlog of cases, including the Project Integrity backlog.

C. An evaluation as required by P.L. 95-142 of the handling of referrals to the Department of Justice under Titles XVIII and XIX of the Social Security Act.

Future annual reports should be able to address these subjects more completely and with greater validity.

1/ The Office of Investigations has created a Division of Law Enforcement Coordination and Data Collection to support the investigative and fraud prevention and detection programs through the collection, retrieval, analysis and dissemination of data reflecting HEW's investigative activities as well as those of other Federal, State, and local law enforcement and prosecutive agencies. The Division's analyses will provide the basis for assessing the effectiveness of these investigative and prosecutive activities, identifying trends and problem areas, and recommending new investigative initiatives.

A. Best Available Inventory of Criminal Convictions Obtained Against Defrauders of HEW Programs

Exhibit 4 provides a recapitulation of convictions from the following sources:

Office of Investigations cases (OIG).....	51
Office of Program Integrity cases (HCFA)....	62
FBI cases reported to OIG.....	23
State cases reported to HCFA.....	129
TOTAL	265

A brief description of each of the cases reported by OI and OPI is contained in Appendix III, and a summary of all 265 by program is presented below:

--Employee cases:

(1) False lodging claims

(2) Manipulation of Social Security payments systems by an employee to provide a benefit payment to an ineligible family member.

(3) Theft of benefit payments checks by an employee.

(4) Acceptance of rebates from contractors.

(5) Misuse of a Government credit card in making purchases at an NIH store.

(6) Theft of funds from the Federal Credit Union.

--Grantee and contractor problems included:

(1) Embezzlement from an HEW-funded Senior Citizens' program.

(2) False claims by contractors for work not done and materials not purchased.

(3) Embezzlement from a Community Action Center.

(4) Embezzlement from a Head Start project.

Exhibit 4

NUMBER OF CRIMINAL CONVICTIONS OBTAINED AGAINST DEFRAUDERS OF HEW PROGRAMS, CY 1977

PROGRAM AREA	INVESTIGATING AGENCY				TOTAL
	IG OFFICE OF INVESTIGATIONS	HCFA OFFICE OF PROGRAM INTEGRITY	FBI	STATE AGENCIES	
1. Employees	8	-	4	-	12
2. Grantees and Contractors	7	1	4	-	12
3. Student Assistance	4	-	10	-	14
4. Medicaid/Medicare	32	61	5	129	227
Long Term Care	(6)	(9)	(3)	(56)	(74)
Physicians	(4)	(22)	(1)	(21)	(48)
Pharmacies	-	-	-	(22)	(22)
Other Practitioners	(2)	(8)	-	(16)	(26)
Laboratories	(11)	(16)	-	(11)	(38)
Other	(9)	(6)	(1)	(3)	(19)
SUBTOTAL	51	62	23	129[1/]	265
5. AFDC	-	-	17	18,475[1/]	N.A.

[1/] Incomplete

Exhibit 4

--Student Financial Aid program violations involved:

(1) Diversion to personal or corporate use of student loan funds for alleged students who never attended the school.

(2) False statements on applications for grants under the BEOG and NDSL programs.

(3) Conspiracy between a Student Financial Aid Officer and certain students to defraud HEW loan and grant programs.

The largest number of convictions (85%) occurred in the Medicaid/Medicare programs. In analyzing these cases, it is interesting to note that the most numerous were in the long-term care field (nursing homes and health care agencies) followed by physicians, laboratories, other practitioners, pharmacists, and a miscellaneous group. Pharmacists showed up only under State agency prosecutions and hospitals were absent.

--Long-term care: Three officers of a home health agency in Florida were convicted of kickbacks to physicians for referral of patients. In New York City the U.S. Attorney convicted the business manager of a nursing home for falsification of records and diverting funds to his personal use. The most extensive and effective work in the nursing home area was reported by Special Prosecutor Charles J. Hynes of New York State, using the team concept for investigating and exposing fraud, as reported in Appendix IV of this report. We will continue to follow this work with much interest.1/

--Physician cases typically involved billing for services not rendered. This problem is being thoroughly reviewed nationwide under Project Integrity, as discussed in Chapter 4. Among the convictions reported by OPI, false billings were revealed through complaints from beneficiaries after reviewing the "Explanation of Medical Benefits" letters.

--Pharmacy cases are a significant part of the workload being identified in Project Integrity, and account for half of the potential fraud

1/Mr. Hynes published an annual report dated January 10, 1978.

cases now in full field investigation. It is notable that States have been particularly active in this area of investigation. Among the cases reported was a pharmacist convicted of submitting false claims, billing for prescriptions never filled or ordered, substitution of generic drugs for brand-name drugs, and billing for quantities in excess of those specified in the prescription.

--Other practitioners covered a wide range, including podiatrists, therapists, chiropractors, dermatologists, opthalmologists, and others. Again, the typical problem was false statements and billing for services not rendered.

--Laboratories were convicted for kickbacks, fraudulent invoices, falsification of qualifications, and billing for services not rendered.

--Other fraudulent cases concerned abuses by ambulance companies and companies providing durable equipment and supplies--including billing for services not rendered and billing for more equipment than in fact was delivered.

We canvassed other HEW programs for data on criminal or civil actions. The AFDC program advised that in FY 1977, 40,721 individual cases had been referred to State law enforcement agencies, and that prosecutions were initiated in 18,475 of these cases.

In respect to Student Financial Assistance cases, we were advised 2,100 defaulted accounts have been referred to the Department of Justice for civil action--over 1,500 in the past year.

In respect to the FDA we were furnished lists of monthly seizures due to violations of the Food, Drug and Cosmetic Act, and of litigation for false representation by companies under the mail fraud statutes. Due to highly-specialized nature of these cases--which are handled fully by FDA's Associate Commissioner for Compliance--we are not summarizing them in this record.

The Social Security Administration reported that 9,700 beneficiary fraud complaints were received in 1977. About 800 were referred to U.S. Attorneys and 200 convictions were obtained.

B. ANALYSIS OF OPEN CASES

The active caseload within the Inspector General's immediate responsibility totalled 1,349 as of 2/28/78 as shown in Exhibit 5. Of this number, the Office of Investigations (OI) has full responsibility for 538; and the Office of Program Integrity, HCFA, (OPI) has a workload of 313, some of which have criminal potential and will concern OI at the point where that potential is established.[1/] The remaining 475 are Project Integrity cases being investigated primarily by State personnel, or by teams consiting of HEW and State personnel, joined in a few cases by other Federal agencies.

1. Cases other than Health Care.

Of the 345 active non-health care cases, by far the largest number concern Student Financial Assistance--and the largest portion of these involve proprietary schools. Our program of work to cope with these problems, in cooperation with the Bureau of Student Financial Assistance (OE) is described in Chapter 6.

Next most numerous are cases involving misconduct and conflicts of interest by HEW employees, contractors, and grantees. These groups of cases, and our program of work, are discussed further in Chapter 7.

AFDC beneficiary cases currently in the OI inventory represent a group of HEW employees who are on the District of Columbia welfare rolls. We have been assisting the District and the U.S. Attorney in reviewing all of these cases, the original number of which was 216. These are part of Project Match, a national effort that is further discussed in Chapter 5.

2. Health Care cases.

Seventy-five percent of our caseload today is found here. The total number is inflated somewhat by including the full OPI caseload, although many of these cases may not reach the criminal prosecution stage. Nonetheless, it is instructive to examine the full backlog of Health Care cases to observe the key problem areas. In subsequent inventories it is hoped to obtain information from the States on the cases which they are investigating.

[1/] There are 36 such cases at this time.

Exhibit 5

INVESTIGATIONS IN PROCESS AS OF 2/28/78

Type of Case	Investigating Agency	Number of Cases	
1. Employee Conduct and Other Internal Problems	OI	40	
2. Contractors and Grantees	OI	76	
3. Student Financial Assistance	OI BSFA	114 23 1/	
4. Social Security Beneficiaries	OI	38	
5. AFDC Beneficiaries	OI	54	
SUBTOTAL Non-Health Care Cases			345
6. Health Care Cases Other than Project Integrity	OI OPI	156 313 2/	
SUBTOTAL Health Care Cases			469
7. Project Integrity Cases	OI States, Monitored by OI/PI	60 475	
SUBTOTAL Project Integrity			535
TOTAL			1,349 3/

1/ BSFA reports 23 active cases, of which 6 are joint with OI.

OI=Office of Investigations, OIG OPI=Office of Program Integrity, HCFA

BSFA=Bureau of Student Financial Assistance, OE

2/36 cases are being worked jointly with OI.

3/Unduplicated total is 1,307.

Exhibit 5

Exhibit 6 shows the spectrum of provider groups represented in the caseload. It is dominated by physicians and pharmacists because of Project Integrity-I which has concentrated on these two categories. This effort is discussed in Chapter 4. The regular health care caseload--i.e., these cases reaching OI on referral from the Audit Agency, OPI, and numerous other sources, is dominated by nursing homes and home health agencies, laboratories and clinics, and a scattered group of other providers. OPI has a large number of laboratory and clinic cases in its inventory.

Our OI staff reports that cases involving individual providers pose the least investigative problems. The typical fraud schemes which have been identified include billing for services not rendered, misrepresentation of services, upgrading of services, and double billing. Patient interviews, record reviews, and confrontation interviews with the provider and the provider's employees are the principal investigative tools utilized in these investigations. Varying interpretations of pertinent regulations and failure, in some instances, to require the provider to sign claim forms may present problems in proving the provider's intent, upon which a successful fraud prosecution is predicated.

In contrast, institutional providers pose very difficult investigative problems requiring extensive staff resources and investigative time to review, in detail, the data contained in cost reports, and to pursue investigative leads derived therefrom. These are, essentially, accounting type investigations and require multi-disciplinary teams of investigators and auditors. This matter will be discussed in Chapter 5 in connection with our future initiatives in the Health Care field.

OFFICE OF INVESTIGATIONS WORKLOAD AND STAFFING

On February 28, 1977, one month prior to our establishment as an office, there were 336 cases on hand--a workload equal to 100 professional staff for one year.

Our workload has steadily increased since then--reaching 147 staff-years in February 1978--compared to an authorized staff of about 85. At the same time the demands of new project initiatives (particularly Project Integrity) are diverting a quarter to a half of our staff from regular case investigations, making this backlog totally unacceptable.

Exhibit 6 Exhibit 6

ANALYSIS OF HEALTH CARE CASES

Group	OI	OPI	Project Integrity Direct	Project Integrity Monitor	Unduplicated Total
Long-Term Care	56	21	--	--	67
Hospitals	2	25	--	--	25
Pharmacies	16	7	28	217	267
Laboratories and Clinics	8	44	--	--	48
Physicians	41	99	32	258	424
Other Practitioners	20	66	--	--	79
Equipment and Services	9	48	--	--	53
Beneficiaries	4	3	--	--	5
TOTAL	156[1/]	313[1/]	60	475	968 (Duplicated total is 1,004)

[1/] 36 cases are being jointly investigated with OI, and are duplicated in the above.

Long-Term Care	- 10
Hospitals	- 2
Pharmacy	- 1
Labs and Clinics	- 4
Physicians	- 6
Other Practitioners	- 7
Equipment	- 4
Beneficiaries	- 2
	36

We have concluded that the overall staff should be increased from 114 to 214, permitting the doubling of the professional staff, and thus enabling us to cope with the continuing high workload while freeing a number of our investigators to work on special initiatives. In the future, we intend to assess the adequacy of staffing in each HEW component to cope with problems of fraud, abuse, and waste and to make recommendations to the Secretary, where appropriate.

As we accelerate our identification and investigation of more sophisticated and complex fraud and misfeasance matters, we have determined a need for investigative teams, staffed by OI and, in many instances, Audit Agency personnel, and by attorneys with investigative and prosecutive experience. We recognize the effectiveness of having attorneys play an integral role from the incipient stages of an investigation. In order to augment the investigative-attorney assistance which is currently provided by the various U.S. Attorney Offices, we are actively considering various means by which attorneys with the requisite experience can be recruited and hired onto the staff of our Office of Investigations.

C. ANALYSIS OF CASES REFERRED TO THE DEPARTMENT OF JUSTICE IN THE HEALTH CARE FIELD:

Section 4(c) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments Act of 1977 requires that the Inspector General, as part of his annual report, provide the Congress with an analysis of the Medicare and Medicaid cases referred to the Department of Justice. Accordingly, we have attached (Appendix VIII) a list of all cases referred to the Department of Justice either by the OIG, OI, or the HCFA OPI during calendar year 1977, together with an indication of the nature of the violation, the category of provider or practitioner, and the disposition or status of each case.

In compiling the information about Medicare and Medicaid cases, it became clear that the data collection procedures employed by OI and OPI were not readily adapted to our needs. One of the collateral benefits of this reporting process, therefore, has been the impetus to create a uniform and reliable system for identifying and collating significant actions taken in criminal investigations under the jurisdiction of both offices. It is our hope that this system will also enable us to provide to the Department of Justice current information on the development of criminal cases that will permit them to monitor effectively the work of the United States Attorneys.

Because criminal investigative activities are the health insurance and medical assistance fields is now divided between OI and OPI, we thought it appropriate to analyze

separately the criminal cases referred by each organization. The principal difference between the reporting procedures used by the two offices is in the meaning of the term "referral." Typically, OI will make contact with an Assistant United States Attorney at a very early stage in an investigation to obtain guidance, and many OI cases are worked in active cooperation with the United States Attorney's offices. Formal referrals for prosecutive decision, then, are made in only a small number of cases. OPI Program Integrity, on the other hand, classifies cases as "referred" whenever there has been contact with a United States Attorney's office, whether the case is awaiting prosecutive decision or requires further investigation.

In order to treat OI and OPI cases uniformly, we have noted in the "Status" column of the OPI list whether the case is "Pending/Decision" or "Pending/Investigation." For OI cases we have prepared two separate lists--one for cases which have been referred formally, and a second for cases in which there has been some contact with the United States Attorney. These distinctions will permit a more accurate analysis of the manner in which the Department of Justice has responded to those matters in which investigation has been completed.

Office of Investigations (OI)

In 1977 OI formally referred 19 cases to the Department of Justice and had informal contact with United States Attorneys in 38 other cases. As of the date of this report, the status of these cases is as follows:

Formal referrals:

Indictments returned	6
Convictions--4 cases	
Pending Decision	7
Pending Investigation	2
Prosecution Declined-- Civil Recovery	2
Prosecution Declined	2

Informal Contact:

Pending Investigation	36
Prosecution Declined	2

The 7 cases formally referred and now pending decision were referred at the following times:

1977

January	1
February	1
March	1
September	2
November	1
December	1

The cases which had been referred by OI or in which there had been informal contact with the United States Attorneys fell into the following categories:

Physicians	22
Laboratories	8
Nursing Homes	9
Home Health Agencies	6
State Employees	5
Other (Medical equipment, pharmacies, hospitals, etc.)	7

Office of Program Integrity (OPI)

In 1977, OPI referred 83 cases to the Department of Justice. As of the date of this report, the status of these cases is as follows:

Indictments returned	20
Convictions--12 cases	
Acquittals--1 case	
Dismissals--1 case	
Pending/Decision	26
Pending/Investigation	18
Prosecution Declined	19

Of the 26 cases pending decision, 19 are in Region II (New York and New Jersey), but it should be noted that the bulk of these referrals were made in the last 3 months of 1977. The 26 cases were referred at the following times:

1977

January	2
February	1
June	1
August	3
September	4
October	7
November	2
December	6

The cases referred by OPI fell into the following general categories:

Physicians	28
Laboratories	10
Hospitals	5
Nursing Homes	8
Podiatrists	8
Beneficiaries	3
Other (Medical equipment, lab supplies, home health agencies, ambulances, etc.)	21

Analysis

At present the Department of Justice and United States Attorneys seem to be handling referrals from both OI and OPI expeditiously. In those cases in which indictments were returned, the average lapse of time between referral and indictment was approximately 2.5 months for both groups of cases. The average time between referral and declination was approximately 1.5 months for OI cases and 5 months for OPI cases. We surmise that these figures reflect the normal inclination on the part of a prosecutor to move rapidly on completed cases he views as having prosecutive merit, while being less anxious to render formal prosecutive decisions in cases on which he intends to take no action.

Certainly the ratio of convictions to acquittals in cases where indictments were returned during 1977 indicates both that the quality of investigation is high and that prosecutions are being handled effectively.

Of concern over the course of the next year will be the capacity of the Department of Justice and the United States Attorneys to absorb what can be expected to be a sharply increased number of cases--both formal referrals and joint investigations--as is reflected in the caseload statistics set out earlier. In addition, the results of Project Integrity and additional initiatives of a similar nature will fall, in part, into the hands of the United States Attorneys. There is little question that the United States Attorneys have evinced considerable interest in Medicare and Medicaid fraud prosecutions, and the stress on white-collar crime being placed by the Attorney General should ensure that that interest does not flag. It is crucial, however, that there be continued emphasis on the training of younger Assistant United States Attorneys in the investigation and prosecution of program fraud.

The Fraud Section of the Criminal Division has been extremely helpful and supportive of HEW's efforts during the past year, and recently an attorney has been formally assigned as liaison with this Office. Section attorneys have participated in training sessions for the Inspector General's staff and have provided helpful guidance in the planning of our fraud detection programs.

It should also be noted, although not directly within the scope of this report, that we have been working closely with the Fraud Section of the Civil Division to develop a system for alerting them to cases with potential for civil recovery at an early stage in the investigation. They, in turn, have agreed to take steps to increase the sensitivity of the United States Attorneys to the need to consider the civil implications of cases that are referred for prosecutive decision.

CHAPTER 4

PROJECT INTEGRITY

HEALTH CARE INITIATIVES

BACKGROUND

Immediately following establishment of the Office of Inspector General, we began preparation of a national initiative in the health care field which would involve all States who participate in the Medicaid Program. The preparatory steps were, in fact, completed in April and May, and involved computer runs in most States and the screening of 250 million transactions.

This effort was possible so quickly only because the Audit Agency had, for the preceding two years, been experimenting with computer analyses of Medicaid claims paid to doctors and pharmacists. With the advice of medical consultants, the Agency had developed computer screens designed to quickly identify doctors and pharmacists performing services which appeared aberrant when compared with "norms." An example would be a physician whose patterns showed more than 40 office visits per year for an individual recipient or the pharmacy which filled more than 25 prescriptions of valium for a single recipient in a year. Altogether, 22 different screens were used for doctors, and 26 for pharmacies.

It was decided by the Secretary to launch this as an initial effort in a continuing series of fraud and abuse initiatives in the health care field.

Project Integrity was officially launched in June 1977, in a series of meetings with State officials. We are highlighting, briefly, in this chapter, its progress since then and plans for future initiatives. Lessons learned will be noted and comments will be offered on future statutory or regulatory actions which will prove of value, as well as the status of implementation of P.L. 95-142.

A. PROJECT INTEGRITY-I: ABERRANT PHYSICIANS AND PHARMACISTS

The original concept was that the project would be limited to approximately 10 cases per State, as those most likely to warrant full field investigation (criminal prosecution potential). But we were immediately overwhelmed with the results of the computer printouts in the 49 States, the District of Columbia, and Puerto Rico. Over a quarter of

a billion transactions were screened through the computer, involving almost 275,000 providers, of whom 47,000 appeared to warrant further review. From this number, a final selection of 2,455 was made: 1,336 physicians and 1,119 pharmacist cases. The goal was 25 of each in each State--or a total of 50.

The task of selection and initial verification through record check (that is by actual examination of the original provider invoices) proved to be a massive undertaking for the Audit Agency and extended through most of the calendar year.

As of March 24, 1978, the status of the project, as shown in Exhibit 7, is as follows:

--535 cases have been chosen for a full-field investigation, meaning that criminal prosecution potential is deemed to exist. Thus far, 15 cases have been referred to prosecutors for a decision--and 6 indictments and 3 convictions have been obtained. This phase of the effort is in an early stage. The nature of these cases (290 physicians and 245 pharmacists) is illustrated by examples cited in Appendix VI.

--554 cases have been selected as meriting administrative action--recovery, reprimand, suspension or termination. Thus far, sanctions have been brought against 197 with $395,000 in recoveries recommended, and 8 suspensions effected. These actions are also in an early stage.

--387 cases have been recommended for closure, meaning that no action against the individual provider appears warranted, although many of these cases should contribute to improvements in the management system of the State agency or the provider. For example, a number of cases were identified by the computer screens of instances of multiple billings for tonsillectomies, appendectomies, hysterectomies, and other absolute types of surgery. Each of these was investigated and found to represent duplicate billings which management systems had failed to detect.

--As of March 24, 1978, there were still 979 cases awaiting classification in one of the

EXHIBIT 7

PROJECT INTEGRITY AS OF 3/24/78

Computer Screens → **Printouts** → **Visual Analysis**

- 250 million Transactions
- 275,000 Providers
- 51 Jurisdictions

47,000 Providers

- 2000+Worst Cases

Validation → **Initial Field Check** → **Full Field Investigation**

Record Check:

1,336 Physicians
1,119 Pharmacists
2,455

1,336 Physician Cases
1,119 Pharmacist Cases
2,455

290 Physicians
245 Pharmacists
535

Classified:

Full Field	- 535
Administrative	- 554
Closed	- 387
Pending	- 979
	2,455

Administrative Actions

325 Physicians
229 Pharmacists
554

- Warning, Recovery
- Suspend Payment
- Suspend or Terminate Participation

Final Report

Staff Assigned 3/24/78

State	- 309
Federal	- 163
	472

EXHIBIT 7

above categories. The work force processing the classified cases on this date consisted of 309 State personnel and 163 Federal personnel--primarily from HEW's Audit Agency, the Office of Investigations, and the Office of Program Integrity. In each of our 10 regions, a Steering Committee composed of the HEW principals (Audit, Investigations, and Program Integrity) is giving continuous oversight to the processing of these cases, the majority of which are assigned to the States for handling.

As this workload moves to a conclusion, a memorandum of lessons learned in each State will be prepared.

The most important lesson to HEW is that the States themselves should participate in national-type efforts from the very outset--so as to plan the type of effort in each State which is likely to be most productive, based on the state-of-the art and the severity of particular problems within the State. Without question, the approach used in Project Integrity-I resulted in selecting a number of unproductive cases because we chose for each State 25 physicians and 25 pharmacist cases, regardless of the degree of aberration.

Finally, the remaining universe in the original printout of 47,000 cases is still being analyzed in a variety of ways for final follow-through where other actions appear useful. As an illustration, one State has requested additional runs of the full print-out against official Certificates of Death to determine the possibility that medical claims have been submitted for services rendered to deceased persons--and also a review of drug claims paid to pharmacists when payments to hospitals revealed that the recipient was in the hospital on that date.

B. PROJECT INTEGRITY-II: OTHER PROVIDERS

In order to begin preparation for future Project Integrity initiatives, the HEW Audit Agency has undertaken a series of research efforts which are now in a test stage. Some will probably be launched on a national scale during the next few months. We plan to negotiate in each case with selected States who strongly desire to participate, using screening techniques and review approaches tailored to the needs and interests of each State. To this end, we are pleased that the State Medicaid Directors have formed a

"Program Integrity Committee" with which HCFA and ourselves can meet and plan future Project Integrity initiatives.[1/]

The provider areas now under research, in preparation for Project Integrity-II, are:

--Dental Services

--Commercial Laboratories

--Outpatient services

--Other medical practitioners

--Transportation services

--Equipment and supplies

--Physician billings for hospital visits matched against dates of actual hospitalization.

The most advanced of these are (1) dental services, where pilot work has been underway in cooperation with the State of Virginia and the District of Columbia, and (2) commercial laboratories where we are having a most successful research experience in collaboration with the State of California.

C. RELATIONSHIPS WITH HCFA

From the outset of the organization of the Office of Inspector General, a cooperative relationship with HCFA has been our goal. In fact, a blueprint of joint efforts for our first year was signed on April 29, 1977, and has been a guiding directive to both our organizations.

We believe it important to give full support to the work of HCFA's Office of Program Integrity (OPI), including participation with them in training programs, and appropriate representation from each in planning future initiatives. We particularly acknowledge the leadership of HCFA in researching institutional fraud and abuse initiatives, and in pioneering techniques to measure trends in fraud and abuse. We commend to the interested reader a review of OPI's "FIRST ANNUAL REPORT" issued on March 21, 1978.

[1/] The first such meeting was held on March 23, 1978.

One area of our realtionship which will need further clarification and delineation in the coming year is that of responsibility for criminal investigations and relationships with Federal prosecuting authorities--to be fully assumed by the OIG Office of Investigations. We recognize the importance of a gradual transfer of this full responsibility while our own personnel resources are augmented and appropriate transfers from HCFA are considered. In the meantime, the present cooperative relationship on such cases must continue unabated and a willingness to collaborate, whenever appropriate, must always be present.

D. LONGER-RANGE RESEARCH INTO HEALTH CARE INITIATIVES

In 1979 and 1980, the concentration of our new initiatives under Project Integrity will undoubtedly move to institutions. Work is now proceeding, as discussed below, in home health care agencies, nursing homes and hospitals with a heavy sharing of interest between OIG and HCFA. We are particularly pleased with HCFA's leadership in examining chain ownership.

1. Home Health Care Agencies

The last census available to us shows 2,353 such agencies, about half of which are Public Health Agencies; another 500 Visiting Nurse Associations; and a growing group of proprietary and non-profit agencies. A recent report of the Congressional Budget Office indicates a significant deficit of sheltered living arrangements, congregate housing, and home health care, with the supply of the latter equal to about one-fifth of the estimated potential need.

Problems which have begun to surface indicate opportunities for fraud or abuse, particularly in the following areas:

--Excessive salaries and fringe benefits for owners, family members, and administrators of private non-profit and proprietary agencies.

--Personal items and entertainment expenses charged to health care costs.

--Solicitation of business via kickbacks and bribes.

--Excessive rent and other costs flowing from transactions with related organizations.

--Providing more services and durable medical equipment than actually needed.

P.L. 95-142, recognizing the growing problems in this field, mandates a full study by the Secretary with a report to Congress within one year. The Office of Inspector General is participating by identifying methods for detection and investigation of fraud, abuse, and waste, as well as in directing a nationwide client-level assessment of quality, timeliness, and cost of such services.

2. Nursing Homes

Approximately 38 percent of Medicaid expenditures are devoted to long-term care. The extensive studies of the Senate Special Committee on Aging and the Moreland Act Commission in New York State have highlighted the size and importance of this area as one requiring special attention to detect and prevent fraud, abuse, and waste. Thus far, HEW's efforts have been limited, although there are now a growing number of investigations in our caseload. HCFA has sponsored the development of the Nursing Home Examiner's Guide which is still under test. Three other efforts now in process offer promise of more effective initiatives in the future:

--In accordance with Section 1905(a) of the Social Security Act, an on-site audit of each participating provider must be conducted over the next three years. The HEW Audit Agency is giving special attention to the development and testing of audit guides.

--Under the disclosure requirements of P.L. 95-142 we will begin development of a data base on ownership which should provide useful information for the future.

--The Inspector General is now conducting research audits in a selected number of nursing homes showing high cost patterns as a further means of perfecting techniques for identifying problem areas. Problems of access to these homes are discussed in Appendix IX.

We recently completed an on-site review of the work of the New York Special Prosecutor's office to observe lessons learned since his establishment in January 1975. It is

believed that these notes are of sufficient value that they appear as Appendix IV to this report.

3. Hospitals

The next largest fraction of Medicaid costs is, of course, represented by payments to hospitals. The complexity of this area is such that we have scheduled its position in the Project Integrity Program to follow other providers and institutional activities.

In preparation for the development of a national initiative, HEW has contracted for a two-year project with New York State to support the expansion of the Special Prosecutor's efforts into the hospital field. This effort, announced last October, will include a full scope investigation utilizing the Hynes team concept in at least 25 New York hospitals, and limited scope investigations in 25 additional hospitals. The project will include prosecutions where warranted, and the development of a manual of investigative techniques. This effort is off to an excellent start and the first indictment in Suffolk County has just occurred involving alleged kickbacks from suppliers and alleged theft of funds by the principal owner.

E. IMPLEMENTATION OF PUBLIC LAW 95-142

The Medicare-Medicaid Anti-Fraud and Abuse Amendments Act of 1977 (P.L. 95-142), signed by the President on October 25, 1977, contains a number of provisions which impact directly on the operation of the Office of Inspector General and enhance the effectiveness of the penalties which can be brought to bear.

Although primary responsibility for implementation of the Act lies with the Health Care Financing Administration, this Office has been actively involved in the preparation of the regulations under the Act, and in planning for new enforcement efforts made possible by the provisions requiring suspension of persons convicted of fraud in the Medicare and Medicaid programs, and disclosure of the ownership and management of providers.

1. State Fraud Control Units

Section 17 of the Act authorizes Federal payment of 90 percent of the costs of operating fraud control units certified by the Secretary as meeting the statutory requirements. The congressional intent in enacting this provision is to encourage the creation of a central organization,

distinct from the State agency actually administering the Medicaid program, with the capacity to detect, investigate and prosecute Medicaid fraud. Ninety percent funding is to be available for three years beginning October 1, 1977, with the hope that, after that period, the cost effectiveness of the units will have been so well demonstrated as to convince the States to continue funding permanently.

In order to ensure immediate implementation of this special funding, Congress directed that regulations be issued within 90 days. Accordingly, on October 31, 1977, the Secretary appointed a three-person committee, consisting of the Deputy Administrator of HCFA, the Deputy Inspector General, and the Deputy General Counsel to oversee the preparation of the regulations. After circulating draft language among all governors and attorneys general, as well as the National District Attorneys Association and other interested agencies, on January 18, 1978, the Secretary issued interim final regulations, under which certification of the units could begin.

The regulations provide three alternative placements for a State fraud control unit: (1) in the Attorney General's office with prosecutions to be conducted by that office; (2) outside the Attorney General's office, only where the Attorney General has no Statewide prosecutive authority, with prosecutions to be referred to the appropriate local prosecutor; and (3) outside the Attorney General's office of the unit has a working relationship with the Attorney General which ensures the appropriate handling of cases warranting prosecution. In addition, the regulations require that the unit have access to Medicaid patient records, and that it enter into an agreement with the single State agency under which the agency agrees to refer to it all cases in which there is evidence of fraud, to provide without charge all claims data requested by the unit, and to take appropriate action to recover sums identified as improperly paid.

The Inspector General's Office was in regular contact with the State Attorneys General, Medicaid agencies, and other officials to solicit their views concerning the application of the regulations. Under the internal procedures developed for certification of State fraud control units, all applications are reviewed by the Office of Program Integrity, HCFA, and by the Office of Inspector General; on-site visits are performed by regional staff of the Office of Program Integrity and the Office of Investigations; and the actual recommendation for certification is approved by the Inspector General before being forwarded to the HCFA Administrator for signature. Further, the Office of Investigations will have on-going responsibility for coordination of fraud investigations with each unit for the rendering of advice and

assistance, and for annual review of the unit's performance in connection with the recertification process required by the statute. This Office, together with the Office of Program Integrity, also plans to conduct training sessions for unit personnel in the investigation and prosecution of Medicaid fraud cases.

2. Disclosure of Ownership

Section 3 of P.L. 95-142 requires Medicare and Medicaid providers to disclose the identity of those holding certain management positions and ownership interests as well as, under certain circumstances, details of the ownership of subcontractors and suppliers. Information supplied under this provision will enable the Department, for the first time, to draw an accurate picture of the ownership patterns in the health care field and to study the manner in which those patterns affect costs and claims for payment. In particular, the ability to identify interlocking ownership in the nursing home industry will lead to a special audit program designed to identify patterns of fraud and abuse associated with chains and controlled suppliers. Regulations are now being drafted to implement this section, and representatives of this Office are consulting with other interested program agencies concerning the collection, maintenance and retrieval of the information.

3. Suspension of Convicted Practitioners

Section 7 of the Act provides for the automatic suspension of both Medicare and Medicaid practitioners convicted of offenses relating to either program, and Section 8 requires a provider to disclose the conviction of any of its owners or directors, with suspension of that provider to be at the discretion of the Secretary. Both sections provide that the Inspector General must be notified of actions taken or convictions disclosed, and the Office has played an active role in the preparation of the necessary regulations. We intend to encourage swift and efficient imposition of the sanctions provided for by the Act, and will work closely with HCFA to that end.

4. Professional Standards Review Organizations

Of on-going concern to this Office has been the appropriate role to be played by PSROs in the effort to combat fraud and abuse. Recognizing the need to maintain the confidentiality of the data collected by those organizations, we nonetheless view them as potentially valuable sources of information on fraudulent practices. We see as a major

step forward, therefore, the provision of Section 5(h) of the Act permitting a PSRO to give to Federal and State enforcement agencies data which may constitute evidence of fraud. We are cooperating with HCFA to draft guidelines for the PSROs and the interested Federal and State agencies under which this newly authorized cooperation can proceed.

F. NEED FOR FURTHER IMPROVEMENTS AND REGULATIONS AFFECTING HEALTH CARE FRAUD AND ABUSE

In the coming year, the primary initiatives which we believe deserve attention are as follows:

1. First the "Civil Money Penalties Bill"--a statute to permit the Secretary to assess civil money penalties against certain defrauders in Medicare and Medicaid. Specific penalties would be up to $2,000 for each fraudulent claim for reimbursement under Medicare and Medicaid Programs, and up to $25,000 for a continuous patterns of fraud in such programs. This legislation has been drafted and is now under review in the Office of Management and Budget. We hope it can be given consideration in this session of Congress.

2. Another matter which may require further statutory or regulatory clarification is the impact of the "Free Choice of Providers" provisions on the selection of laboratories and suppliers of medical appliances and equipment. The law we believe, was intended to assure that the medically needy would not be forced to use substandard or overcrowded facilities for physician care. It has been interpreted in some cases, however, to prevent the award of exclusive rights to perform tests for Medicaid patients to laboratories which submitted the lowest competitive bids and met high quality standards. This may be inflating the costs of such services without benefit to the recipient. Similar problems appear to exist in the provision of medical appliances and accessories.

CHAPTER 5

PROJECT MATCH

WELFARE PROGRAM INITIATIVES

During the spring of 1977 we reviewed the efforts being made to find Welfare cheaters on the Federal payroll in Detroit, Michigan, and Chicago, Illinois. In both cases, enterprising U. S. Attorneys had been joined by interested Federal officials (primarily from the Postal Service and the Internal Revenue Service) in cooperation with the State Welfare Agencies. Their results were impressive and, it appeared, highly cost-effective. As a consequence we decided that a pilot test should be made in the District of Columbia by matching the District's AFDC[1/] rolls against the HEW payroll. This was the starting point for Project Match, the current status of which is summarized below, together with follow-on projects now in planning.

A. PROJECT MATCH I: The Search for Federal Employees Improperly Drawing Welfare Grants.

Our initial experience in the District of Columbia produced results which indicated the utility of conducting this project on a national scale. The score card on that initial effort is as follows:

--Total number of raw matches (HEW employees on the D. C. AFDC roll)	216
--Number found totally ineligible	75
--Number found overpaid	43
--Number found underpaid	3
--Number found eligible	95
TOTAL	216

The amount of improper payments, even to this small universe, had exceeded $330,000. Based on this review, the U. S. Attorney for the District of Columbia is currently studying cases for possible prosecution. Thus far he has 31 cases under review.

[1/] Aid for Families with Dependent Children

Those not prosecuted are being referred to HEW's personnel authorities for possible disciplinary action. Fifty-six are now in this stage.

Pilot work in the District of Columbia formed the foundation for the nationwide effort which began in 21 jurisdictions and was announced in November 1977. Subsequently 5 other jurisdictions requested an opportunity to participate, bringing the total to 26, equal to 8.8 million AFDC recipients, or about 78 percent of the National AFDC population. The remaining States and Puerto Rico were sent invitations to participate in March 1978.

The first match was conducted against the Civil Service Commission's Central Personnel Data File of some 2.8 million active and about 600,000 former civilian employees.

On January 4, 1978, the Department of Defense agreed to our use of the military active duty personnel tapes, consisting of over 2 million names, for a similar match.

An updated table of 18,015 raw hits obtained for active duty military and civilian employees (plus 11,373 former civilian employees who also appeared on the Civil Service history tape) is shown in Exhibit 8.

Since the original runs, which were announced in November and February, there have been refinements in the data to exclude (1) General Assistance recipients (that is, State-funded beneficiaries who appeared on tapes in Massachusetts, Illinois and Pennsylvania); and (2) former AFDC beneficiaries which were found on tapes in Indiana and Pennsylvania.

As of March 24, 1978, 7,100 civilian employee cases were in process of delivery to State welfare agencies for eligibility review based on earnings and employment data obtained by us from the Federal employers. The remaining 16,500 civilian employee cases are in various stages of preparation for review at the State level--actions which will continue during the next several months following the procedures outlined in Exhibit 9.[1/] After the State review is completed, cases of egregious fraud will be turned over to the U. S. Attorney and FBI for possible prosecution. Those that are fully eligible will be removed immediately from the raw matches and the match record destroyed. Others will be removed from welfare rolls, or have their grants

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[1/] This entire process is governed by a memorandum of agreement between HEW, CSC and DOJ.

Exhibit 8

Exhibit 8

PROJECT MATCH

Raw Matches By State

Jurisdiction	Population	Active Federal Employees			Former Civilian Employees
		Civilian	Military	Total	
Arkansas	108,514	53	52	105	57
California	1,444,850	2,972	1,394	4,366	3,114
Colorado	99,457	69	26	95	123
Delaware	31,432	62	105	167	49
District of Columbia	102,344	1,718	50	1,768	828
Florida	250,918	176	332	508	145
Georgia	299,738	262	126	388	235
Illinois	811,042	870	212	1,082	1,043
Indiana	178,352	79	44[1/]	123	70[1/]
Kansas	77,955	146	420	566	239
Kentucky	201,411	99	187	286	162
Louisiana	231,225	70	82	152	99
Maryland	219,332	1,322	498	1,820	726
Massachusetts	361,768	335	64	399	260
Michigan	685,432	423	226	649	600
Minnesota	131,533	122	21	143	90
Missouri	274,998	485	90	575	361
New Jersey	451,508	406	258	664	400
New York City	832,397	474	163	637	445
North Carolina	191,225	147	281	428	161
Ohio	590,288	484	407	891	586
Pennsylvania	643,947	1,037	585[2/]	1,622	1,069[2/]
Rhode Island	54,811	19	8	27	16
Texas	353,274	64	22	86	81
Virginia (Northern Virginia, Norfolk)	60,817	190	51	241	195
Washington	151,631	156	71	227	219
TOTAL	8,840,199	12,240	5,775	18,015	11,373

1/ Excludes 228 civilian, and 117 military former AFDC cases.

2/ Excludes 1,058 civilian, and 1,887 military former AFDC cases.

Dates of Tapes: AFDC: April 1977; Military: August 1977; Civilian: March 1977

adjusted by the State agency, and will then be referred back to the Federal employer for any appropriate disciplinary action.

The processing of the active military cases is now beginning with the collection of pay data at the four military pay centers. These cases will follow essentially the same procedures as shown in Exhibit 9.

If Project Match I proves successful and cost-effective it is believed that it should be repeated periodically.

B. COMPUTER SECURITY AND PRIVACY ISSUES--A CONTINUING CONCERN:

We have been concerned from the outset of Project Match with the importance of safeguarding the privacy rights of the individuals involved, and with maintaining the security of data furnished to us on computer tapes. To accomplish this, attention has been given to the development of a detailed operating plan. Each disclosure of information among Federal and State agencies is carefully documented and has been reviewed to assure compliance with the Privacy Act, Freedom of Information and confidentiality provisions of the Social Security Act. Our objective is to build into each step of the plan, precautions to assure privacy of information on individuals, and prompt purging from the records of individual names as soon as they are found to be eligible. For example, in Project Match, the following precautions are being taken:

--All computer matches are done under the personal direction of a senior auditor at HEW Headquarters, and the tapes are maintained in a locked area and can be accessed only by special codes.

--Print-outs are delivered by hand or registered mail to designated officials in both Federal and State agencies. A senior audit official in each region serves as the conduit for receiving and transmitting documents.

--In addition, the Deputy Inspector General is a member of an ad hoc committee established by the Domestic Council, with representatives from the Departments of Justice and Defense, the Civil Service Commission, and the Office of Management and Budget, to draw guidelines for the implementation of future matching projects. We are also participating on a Federal Government

Project Match

EXHIBIT 9

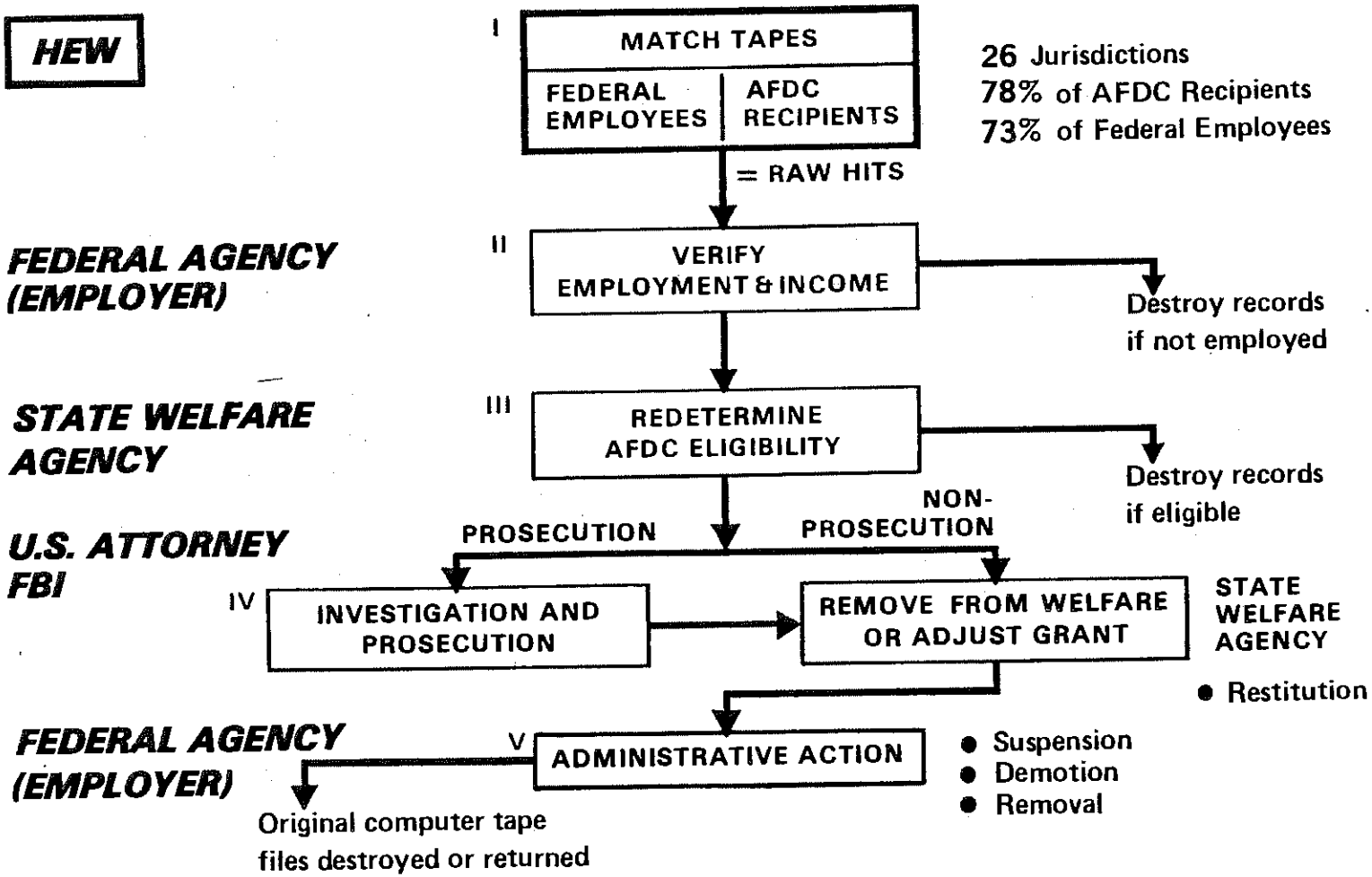

EXHIBIT 9

task force which is reviewing the report of the Privacy Protection Study Commission and developing recommendations for the President covering the entire spectrum of privacy issues. .

C. OTHER PROJECT MATCH INITIATIVES:

1. Interjurisdictional Match.

As a byproduct of Project Match we have made an inter-State match of the 26 jurisdictions with one another which found 18,319 cases where duplicate social security numbers are involved--suggesting that 9,150 individual recipients may be on two different State welfare rolls. The product of this match appears in Exhibit 10. The data are now being reported to all States concerned so they can conduct an eligibility review, take appropriate action, and advise us of their findings.

It has been determined that 62 of this group are Federal employees and that 30 are in the D.C.-Virginia - Maryland area. These cases will be processed as part of the Federal employee Project Match review and action plan.

The interjurisdictional match is an experiment, but it appears at this early point to be an effective one, worth repeating periodically on a national scale for all jurisdictions.

2. SSI/SSA/Federal Employee Match.

It is proposed to match the Federal military and civilian rolls against Supplemental Security Income and Social Security (Title II) benefit payment records. A trial match of HEW employees against these files has been completed with the identification of 707 warranting full review for eligibility. If this rate is typical of the Federal population it would suggest a universe at least as large as the Federal/AFDC match. Based on this finding permission to match the full Federal civilian master tape has been requested from the Civil Service Commission.

3. Wage Data Matches--A Future Plan Required By Congress.

Congress, in passing the Social Security amendments (P.L. 95-216) last fall mandated that the Social

Exhibit 10

ANALYSIS OF INTERJURISDICTIONAL MATCH

RAW MATCHES BY STATE

State		Number
1.	Arkansas	256
2.	California	1,607
3.	Colorado	165
4.	Delaware	800
5.	District of Columbia	600
6.	Florida	1,343
7.	Georgia	1,094
8.	Illinois	603
9.	Indiana	335
10.	Kansas	1,004
11.	Kentucky	780
12.	Louisiana	183
13.	Maryland	1,870
14.	Massachusetts	353
15.	Michigan	505
16.	Minnesota	109
17.	Missouri	473
18.	New Jersey	1,019
19.	New York City	511
20.	North Carolina	1,261
21.	Ohio	1,302
22.	Pennsylvania	1,547
23.	Rhode Island	61
24.	Texas	90
25.	Virginia (Northern Virginia, Norfolk)	245
26.	Washington	203
	TOTAL	18,319[1/]

1/ The number of individuals drawing duplicate benefits is approximately half of the figures shown here since each case is listed in more than one State.

Security Administration make available to the States wage information in SSA records which is necessary to determine an individual's eligibility for welfare. The law mandated further that by October 1, 1979, States must request and use wage information available to them from the State Unemployment Compensation agency or, if not available, from the Social Security Administration. Security safeguards and privacy arrangements are to be prescribed by the Secretary of HEW. During the period between now and October 1, 1979, these matches are permitted at the request of the State, and involve access by State welfare agencies to their own States' wage reporting systems or, if not available, to the earnings records available in the Social Security Administration.

We have determined that 37 of the States and the District of Columbia now have such wage records available within the State from the State's Unemployment Compensation agency. The remaining 13 have no State records and would thus have to depend upon the SSA records.[1/]

The Office of Family Assistance and the Office of Inspector General are conducting a joint review of State wage matching practices in order to identify best practices and to make recommendations to the States when this match becomes mandatory. Thus far, we have found:

--A wide diversity of data exchange matching practices are in use. Thus, a set of model systems would appear to be desirable and this will be the objective of the joint OIG/OFA effort this year.

--Further evidence of the value of the new statute also emerges from an experimental comparison we have made of AFDC records in 25 Project Match jurisdictions[2/] against Social Security Wage reports for the first 6 months of calendar year 1977.

Out of a total of 2.8 million AFDC families in these jurisdictions the raw matches identified 691,000 wage

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1/ New York State and Ohio have recently requested the SSA match.

2/ Minnesota was not available for this match.

earners who received earnings totalling $965 million in the 6-month period. While 99 percent had earnings of $6,000 or below, there were 5,705 above this level, as follows:

Number of AFDC Recipients
With Earnings of $6,000 and Over
25 Jurisdictions
January - June 1977

Earnings Range	Number of Raw Matches
$ 6,000 - $ 7,999	4,344
$ 8,000 - $ 9,999	1,012
$10,000 - $11,999	242
$12,000 - $13,999	62
$14,000 - $15,999	28
$16,000 - Up	17
	5,705

These numbers are sufficiently impressive to suggest that the States concerned should review these matches for eligibility. The Social Security Administration will furnish data on individual cases to the States for this purpose at their request.

F. DELAYS IN OBTAINING PERMISSION TO CONDUCT MATCHES OF HEW RECORDS AGAINST FEDERAL MILITARY AND CIVILIAN ROLLS:

We now have requests pending for permission to conduct two such matches:

1. Military/Student Loan Default File.

On January 10, 1978, we wrote the Department of Defense requesting authority to conduct a match of the 2-million member military active duty tape (now in our possession) against the Student Loan Default file. On February 16, 1978, we were advised by the Department of Defense that the Office of Management and Budget was postponing a response to our request pending the development of guidelines. We were disappointed since the match against Civil Service tapes has already been completed and since DOD, in any event, must publish a routine use for a period of 30 days prior to giving us permission to conduct the match. We had hoped that OMB would allow DOD to proceed with publishing this routine use while Government-wide guidelines for future matching projects are developed.

2. Federal Civilian Employee Match vs. SSI/SSA Files.

On February 14, 1978, we made a formal request of the Civil Service Commission for permission to use the master Federal civilian tape currently in our possession to conduct a match against the Supplemental Security Income tape and the Social Security (Title II) benefits payment files. As reported above such a match has recently been made against HEW's payroll with productive results, and Secretary Califano has testified that this match will be made Government-wide.

On March 9, 1978, the Executive Director of the Civil Service Commission advised us that he felt it essential to await permission from OMB before responding to our request.

We brought both of these delays to the attention of Secretary Califano on March 11, 1978, and are herewith reporting them to the Congress.

G. PROPOSED LEGISLATION TO AUTHORIZE FUTURE MATCHES OF THE TYPE DISCUSSED ABOVE:

1. It is our belief that the results of the above efforts should lead to a regular recurring program of matches, involving appropriate participation by the Federal and State agencies. To that end it might be desirable for Congress to establish such matching programs as a matter of national policy by authorizing the following as an expansion of the Wage Data Exchange provisions in P. L. 95-216.

--An annual match by each State of its Welfare rolls against the following files: Federal military and civilian employees, private employer wage reports, State employees, Child Support Enforcement, mortality data, SSI files and Title II benefits payments files. The statute should provide that HEW will render technical assistance in the conduct of any of these matches, perform such matches where desirable as a service to the States, and conduct an annual interjurisdictional match. In those States which do not have a quarterly wage reporting system, the law might at least provide that employers shall prepare an additional copy of the annual W-2 reports, and submit them directly to the State Welfare agencies for matching against the Welfare benefits

file. (Note: The annual report to SSA in the future will be so late as to have very low value for such matchings by the States.)

2. In addition to the above matching authority, it is urged that Congress extend to the State AFDC Programs, the same statutory funding benefits that are now available in the Medicaid program with respect to (1) supporting the cost of designing and operating management information systems, and (2) subsidizing the establishment of fraud control units.

H. RECOMMENDATIONS FOR STRENGTHENING THE OFFICE OF FAMILY ASSISTANCE:

At the request of the Secretary, the OIG has reviewed the current organization and staffing of the Office of Family Assistance in respect to reducing fraud, abuse and waste in these programs.

We conclude that this agency has been significantly understaffed in respect to its opportunities to contribute to improved management, and to support State efforts to root out fraud, abuse, and waste. We thus urge that the current initiatives recommended by the Associate Commissioner of Family Assistance be approved, with first attention to (1) the formation of a national-level clearinghouse of best practices, (2) the establishment of an AFDC Management Institute modeled along the lines of the Medicaid Management Institute, and (3) a substantially upgraded and enlarged technical assistance staff of high competence utilizing State-level expertise. A corps of such stature, along with the newly-invigorated leadership at the national level, can make huge inroads into the losses described in Chapter 1.

CHAPTER 6

STUDENT FINANCIAL ASSISTANCE

PROGRAM INITIATIVES

The pressure of problems in this area drew the immediate attention of the newly-established staff of the Office of Inspector General. These pressures arose from:

--First, the establishment of the new Bureau of Student Financial Assistance (BSFA) on March 8, 1977, to integrate the management of all Student Assistance Programs. A member of the Inspector General's staff was loaned to oversee the GSL Program while the new bureau was being formed. The computer systems support for this huge program had become highly controversial with a severe code-of-conduct problem resulting in the dismissal of a key official.

--Second, a massive workload of alleged criminal violations in the BSFA programs had accumulated in the Office of Investigations. As indicated on page 22, there are 114 potential criminal cases now on hand including those being worked by the special HEW/Department of Justice Task Force headquartered in Dallas, Texas.

--Third, the findings of audit reports over a span of several years which revealed widespread problems and inadequate follow-through.

This chapter summarizes the nature of the problems disclosed by audits and investigations, and then sketches the activities in which the OIG is engaged today with the Office of Education. We expect these programs to continue to be among the most important sources of fraud, abuse, and waste problems with which we will be concerned in the year ahead. As discussed in Chapter 1, the current annual losses are estimated at $356 million. In addition to this, there are one million loan accounts in default representing a debt to the Federal Government of approximately $1 billion.

A. PROBLEMS REVEALED IN AUDITS

Appendix V to this report includes a summary by the Audit Agency of the findings of audits conducted since 1971 in the

Guaranteed Student Loan Program and since 1974 in the other four student aid programs. This review reveals continuing problems in:

--Eligibility and award procedures.

--Internal controls, accounting systems and record maintenance.

--Interest billings and due diligence collection requirements.

--Late refund.

--Poor financial condition of schools.

--Improper use of, or accounting for, Federal funds.

--Maintenance of excessive cash balances.

The Bureau of Student Financial Assistance and its predecessors have lacked a systematic means of identifying institutions which may be committing fraud, or abusing the SFA programs in one or more of the above respects. The Bureau's Division of Compliance is correcting this deficiency, and now has pending a list of over 100 "problem schools."

In addition, the Office of Education's process for establishing school eligibility to participate in Federal aid programs does not assure that consumer protection and Federal interests are being protected. Weaknesses have been identified in each of the groups having oversight of schools: the States, the Federal Government, and the accrediting associations. OE is preparing, however, to establish separate additional criteria for those institutions which participate in the Student Financial Assistance programs. These criteria will be directed at the institution's management and fiscal capabilities for the operation of these programs. But other steps will need to be taken by OE before the situation is resolved.

B. PROBLEMS REVEALED BY OFFICE OF INVESTIGATIONS CASES

Of the SFA-related fraud and abuse cases currently being handled by the Office of Investigations, over one-half involve alleged institutional fraud in the Student Financial Assistance programs. The other half are comprised of alleged fraud or abuse by individual students, institutional financial aid officers, State agency officials, school owners or officials, or individual conflicts of interests.

A review of the institutional cases reveals that the frauds consisted largely of the conversion of the student aid funds to the use of the school's operating accounts and/or to the personal use of school officials. The frauds were found to have been accomplished by the following means:

--The schools recruited students, mostly poor, and paid sales commissions.

--The recruited students were certified eligible to receive aid in the school's Student Eligibility Reports submitted to the Office of Education, but many students were not eligible.

--Applications for grants and loans were submitted by the schools in the names of the students. In many instances students were unaware they were to receive grants or loans, for they never received checks or other documentation. In other cases students who filled out loan or grant applications at a school's request were unaware that they were applying for aid.

--Many students who supposedly received loans or grants never actually attended the schools or dropped out.

--Students in some cases naively signed over to the schools their aid funds after being advised by the schools that the grants or loans would apply to and only cover their tuition.

--Schools did not refund unearned tuition, funded by grants or loans, to student dropouts.

--Schools sold student loan notes to financial institutions at discounts. Some of the financial institutions were aware of the school's ongoing fraud in the student aid programs; some were not.

--Students who never attended school or dropped out during the term of their loan almost invariably were in default; lending institutions then claimed the principal loan balance from the Office of Education.

C. INITIATIVES LAUNCHED TO ASSIST BUREAU OF STUDENT FINANCIAL ASSISTANCE

In February 1978, Secretary Califano announced a series of management improvements to provide for stronger enforcement of the SFA programs with respect to performance of schools and repayment by student borrowers. We have been assisting in the development of implementing plans for these initiatives and, in doing so, have launched four projects which will be continuing during calendar year 1978. Their current status is as follows:

1. Accelerated Attention to Investigation of Fraud Allegations

This effort is taking two forms:

--One major effort is the management of the Dallas Task Force. This is a special mechanism established in July 1976, to provide support to the conduct of both criminal and civil investigations into fraud and abuses of SFA programs by various proprietary schools, related corporations, and other business entities in the southwest United States.

A portion of the services being performed is in support of the Civil Division of the Justice Department in connection with a multi-million dollar claim against the U.S. Government involving the GSL program. The Dallas Task Force is securing and maintaining certain documents (school transcripts, promissory notes, etc.) which otherwise might be unavailable, lost, or destroyed.

To date there have been 13 convictions, and 10 indictments are pending, involving school officials, HEW officials, collection agencies, lenders, and other entities.

--The second facet of our accelerated attack on fraud and abuse in SFA programs is to reduce, as rapidly as possible, the backlog of regular cases by a special augmentation of the OI staff during the current fiscal year, using OE financial support. Approximately 10 investigators are being assigned for this purpose. Priority will be given to cases involving institutions, large sums of money, and statute of limitations problems.

2. Identification of Student Defaulters on the Public Payrolls

The Audit Agency has developed and applied a successful technique of computer matching of the Student Loan Default file against HEW's own payroll. Out of 317 matches identified, 208 have now been resolved or otherwise settled; 61 individuals are still being sought; and 48 accounts are under negotiation.

In the light of this success, the Secretary has directed that a similar review be made of all Federal civilian and military personnel--known as "Operation Cross-Check." The matching of the Federal civilian rolls against the default file has been completed, in cooperation with the Civil Service Commission, and has revealed 6,783 employees in default with indebtedness, including interest, of $7.5 million. (The range of salaries of these individuals is shown in Exhibit 11.) A similar match with the active duty military tape will be conducted as soon as permission is granted by OMB (as discussed on page 51).

ASSISTANCE TO STATES

The success of this computer matching program at the Federal level has attracted wide attention, and HEW is now being requested to perform a matching service to assist States in the following ways:

--Match the State Guaranty Agency default files against the Federal payroll. Requests have been received thus far from California, Pennsylvania, and the District of Columbia.

--Match the State government payroll against the Federal Student Loan Default file. This match has been requested thus far by the State of Florida.

In addition to the above, the Attorney General in New York has advised that the State has matched its own payroll against the State Student Loan Default files and found 5 percent of their defaulters (822) on the State payroll. Since there are 25 State Guaranty Agencies, this indicates an effort which should be encouraged.

We intend to support these efforts and to keep Congress informed of the results. It is recognized that matches of this type may require special permission from CSC, DOD, and

Exhibit 11

SALARY DISTRIBUTION OF FEDERAL CIVILIAN EMPLOYEES FOUND IN DEFAULT ON FEDERALLY-INSURED STUDENT LOANS

Salary Range	Number of Employees (Raw Matches)[1]
Under $5,999	85
$ 6,000 - $ 7,999	664
8,000 - 9,999	1,503
10,000 - 11,999	1,011
12,000 - 14,999	2,144
15,000 - 19,999	1,140
20,000 - 24,999	141
25,000 - 29,999	64
30,000 - Over	23
	6,783

[1] This analysis is based on the matching of the CSC master file for September 1977, against the Guaranteed Student Loan file for January 1978.

OMB, and it is hoped that the guidelines now being developed will recognize and support these opportunities.

3. Development of Techniques for Identifying Industry Practices which Lead to Fraud, Abuse, and Waste

The audit studies discussed earlier revealed that 51 percent of the schools reviewed need to improve procedures and systems. It is believed that one approach to resolving these problems is to conduct studies by type of school, so as to develop knowledge in-depth of ownership, financing, and operating practices. To this end, we are beginning a special review of Schools of Cosmetology.

The plan to accomplish this initiative will include a systematic analysis of application and payment information available through the BEOG program for the beauty school industry. Indicators of impropriety will be sought and developed by the Audit Agency through its own resources, those of BSFA program staff, and through the assistance of the BEOG application contractor, American College Testing (ACT). For example, students will be contacted to verify attendance, grant and loan information maintained by BSFA, so as to uncover possible fraud or program abuse. As part of the indicator development process, BSFA and OI will provide the Audit Agency with a list of known schools that have defrauded or abused the program. Once the indicators are developed, they will be field tested. After audits have confirmed their value, regulatory changes will be recommended to prevent future occurrences.

4. Development of Audit Guides

There are currently over 8,000 institutions participating in various Student Financial Aid Programs. The Education Amendments of 1976 authorize the Commissioner to require audits of institutions participating in these programs, and he has issued regulations prescribing audits at least every two years. In preparation for this effort, which will be conducted by outside auditors, guides are being developed by the HEW Audit Agency in cooperation with BSFA, the State Societies of Certified Public Accountants (CPAs) and the American Institute of CPAs. The Audit Agency will develop the required training programs and monitoring systems to assure effective usage of these guides by the independent accountant.

D. PROPOSED LEGISLATIVE ACTIONS

1. NDSL Collection of Defaulted Loans

At present the Office of Education is able to obtain mailing address information from the IRS for the GSL and the campus-based programs, but not for the National Direct Student Loan Program (NDSL). The latter has an even larger universe of defaulted loans than the GSL Program (estimated to be in excess of $650 million).

The reason for the lack of authority is that the statute allows use of address information for debt collection only by Federal employees, whereas the NDSL collections are pursued by the educational institution which made the loan. We suggest that H.R. 8746 be enacted since it would permit disclosure of the mailing address to the Commissioner of Education and redisclosure by him to institutions for use in locating individuals in default on National Direct Student Loans.

2. Future Matches

On page 52 it was proposed that Congress consider declaring a national policy in favor of matching AFDC welfare files against Federal payrolls and other benefit files. A similar declaration may be desirable in respect to the matching of Student Financial Assistance files, both Federal and State, against public payrolls, both Federal (including military) and State.

CHAPTER 7

OTHER MAJOR AREAS ADDRESSED BY THE OFFICE OF INSPECTOR GENERAL DURING CALENDAR YEAR 1977

While the major concentration of effort during our first year has been in the areas discussed in Chapters 4, 5, and 6 we have had a significant workload in three other areas which should be noted; namely:

A. Employee cases.

B. Contracts and grants.

C. Service Delivery Assessment.

A. EMPLOYEE CASES

It is not surprising that an organization of 150,000 personnel--many of whom travel extensively, or determine client eligibility, or make payments, or negotiate and administer many thousands of contracts and grants--has problems of questionable conduct and fraud.

While we now have no way of tracking trends, we are concerned that today there are 28 cases in our active OI workload involving alleged violations by HEW employees, as well as additional cases involving former employees who are now associated with contractors, and other problems affecting internal organizational integrity.

We are pleased that the recently-established Office of Assistant Secretary for Personnel Administration is planning to establish a new unit to be devoted to "Personnel Systems Integrity," and to the conduct of investigations, training programs, and disciplinary programs. This will allow the Inspector General to concentrate on those cases that involve potential criminal activities.

The violations of a criminal nature which are found most frequently in our current caseload arise from the following:

1. Travel voucher fraud, including false claims for mileage, lodging, and moving.

2. Time card fraud, involving claims for work not performed or leave not charged.

3. Conversion of Federal property or funds to personal use, including misappropriation of refunds, overpayments, and credit cards.

4. Conflicts of interest, collusion, and bribery, usually in connection with contract awards.

We will work with the Assistant Secretary for Personnel Administration to educate employees and managers on the cause and prevention of these problems.

B. CONTRACTS AND DISCRETIONARY GRANTS

Our interest in this area has been growing not simply because of fraud and abuse, but because of its huge financial importance in HEW--over $6 billion annually--and the difficulty of assuring economy and efficiency. We have supported the Secretary's directive to all operating components to professionalize the award and administration of contracts and grants, with emphasis on competitive arrangements.

We have, and will continue to, work with the Assistant Secretary for Management and Budget toward these ends by conducting or participating in special investigations and reviews of procurement systems whenever the independence and objectivity of the Inspector General can be beneficial. Such special reviews now in process include:

--Review of contracting for consulting services in the Office of Education. A follow-on review of the discretionary grants process has been requested by the Commissioner of Education.

--An overall examination of contracting practices of the National Cancer Institute, including relationships with the Eppley Institute for Research in Cancer.

--A similar comprehensive examination of contracting practices and official conduct in the National Institute of Drug Abuse.

FOUR PROBLEM AREAS NOTED

Activities this past year have identified certain problem areas and, in some cases, have already resulted in recommendations for improved management and control. Other

issues raised will be given additional attention this coming year.

1. Contract Issuance

The problem that seems to be most prevalent in the contract process is the lack of competition. Whenever there is a sole-source contract and the justification is weak or vague or regulations appear to have been disregarded, the process is open to question.

Work statements were found to be a problem in that they failed to state in sufficiently precise terms the work to be performed. This failure makes it difficult for prospective bidders to prepare a truly responsive bid with realistic cost pricing. Because results cannot be measured against vague scope of work requirements, effective evaluation and assessment of contractor performance is precluded. Contracts are open to further abuse, as modifications beyond the original work scope are added to the contract. Such modifications should properly be awarded under a separate contract. There is also a need for project officers to understand the standards that must be maintained in preparing, issuing, and awarding contracts. Training classes for project officers were held this year and should be required of all key staff members who have contract responsibilities.

2. Contract Administration

Another failure that was noted several times in the review of problem cases was the apparent lack of monitoring of contract progress during the life of the contract. The lack of effective monitoring decreases the likelihood that the final product or service will be delivered properly and efficiently. This part of the process needs more emphasis and recognition.

In day-to-day administration there has developed a very fine line between contracts and grants. In some cases contracts, which are supposed to provide more constraint and control, are being administered like grants. This situation could be due to efforts in recent years to distribute more funds through the contract rather than the grant process. Project staffs still do not clearly distinguish between the two.

3. Grants Administration

For several years audit reports on grants have highlighted problems with time and effort reporting, improper transfers of funds and lack of adequate institutional reporting and accounting systems. Major efforts by this office to address these problems have been underway this year. The Audit Agency is currently developing a plan to assist colleges and universities as they develop or modify accounting systems so that reports and information from the systems will meet audit standards. This will provide positive "early review" assistance, instead of waiting until problems develop during an audit because of an inadequate accounting system. As these new procedures are approved and put into operation we hope to reduce the number of audit exceptions in the audit of colleges and universities. These new procedures will impact on both grantee and contractor relationships.

At the direction of the Secretary, the Office of Grants and Procurement (Assistant Secretary, Management and Budget) is assuming responsibility for resolving audit findings concerning grantee/contractor systems and record keeping deficiencies which cut across agency lines. The OGP will cooperate with audited institutions as they act to correct their deficiencies in a timely manner and monitor them to assure that the deficiencies are corrected. The OGP will recommend sanctions or other appropriate actions against an institution which fails to take timely action.

4. Peer Review Process

The peer review process and advisory councils are important components in funding decisions and technical reviews. The use of external assistance is of particular importance in the area of scientific research. It is crucial that the appearance of conflicts of interest be avoided and that Department Standards of Conduct be carefully followed by all concerned. A survey of current procedures in order to develop recommendations to improve the integrity of the peer review process will be considered this coming year.

C. SERVICE DELIVERY ASSESSMENT-- A PIONEER INITIATIVE

In July 1977, the Secretary directed the Inspector General to give leadership in developing a plan of grass-roots factfinding to ascertain how well clients are being served by HEW programs, particularly in the social services areas.

The Secretary's objective is to obtain fresh information from a selected sample of local delivery sites throughout the United States--by first-hand observation and discussions with clients, case workers, and family members, as well as with State and local personnel who are immediately concerned with assuring effective and efficient delivery of services.

While this is an unusual mission for the Inspector General, the effort resembles the rapidly growing involvement of the General Accounting Office in "program results reviews" for the Congress.

While still experimental, it is our opinion that such fact-finding and timely reporting can lead to constructive changes in program design and execution on the one hand, while at the same time exposing potentials for fraud, abuse, and waste to which the Inspector General should give attention.

In each region a small staff of generalists has been assembled to take the lead in these assignments. The following seven Service Delivery reviews are scheduled for completion by September 30, 1978 (for next year the goal is 12 to 15 assignments):

--Head Start.
--Disability Insurance Benefit Determinations.
--Home Health Care.
--Family Planning Services for Teen-Agers.
--Multipurpose Senior Citizens' Centers.
--Foster Care.
--Education for Handicapped Children.

A brief description of each is presented in Appendix VII.

CHAPTER 8

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS TO ENHANCE THE EFFECTIVENESS OF HEW EFFORTS TO COMBAT FRAUD, ABUSE, AND WASTE

This chapter provides a summary of the conclusions and recommendations discussed in this report.

CHAPTER 1

The OIG conducted an inventory of "best estimates" of fraud, abuse, and waste in HEW programs. This inventory--the first ever taken--reveals a range of losses between $6.3 and $7.4 billion annually, equal to 4.7 to 5.4 percent of the Federal outlays concerned. These numbers are conservative. The Inspector General feels that the largest source of losses can be attributed to waste resulting from deficient management practices and systems which permit and encourage such losses.

Two recommendations are made:

1. The OIG should conduct a periodic inventory of "best estimates." Continuing efforts should be made to expand and sharpen these estimates and to seek more scientific measurement techniques (pages 7-8, and Appendix I).

2. The losses due to management and systems deficiencies appear to receive too little attention in terms of staff resources applied. A study of the implications of this and recommendations for action will be a continuing OIG objective. It is believed that tighter "front-end" controls over eligibility determination and claims payment procedures, simpler reimbursement techniques, and higher standards of integrity on the part of all concerned are essential to such improvements (page 11).

CHAPTER 2

A survey of the Audit Agency findings resulting from over 6,700 reports processed in calendar year 1977, reveals important opportunities to improve economy and efficiency, and minimize fraud and abuse in every major area of HEW's activities. A more detailed delineation of these findings is presented in Appendix II.

A key problem is the vast scope of the audit universe which must be covered--over 51,000 entities. Two recommendations are made in this chapter:

1. Ultimately, an additional 1,382 staff-years may be required to enable the Audit Agency to give timely attention to its total workload. In the meantime, augmentation by 60 staff-years of contract support, and 60 in-house personnel, will permit the present level of effort to continue, including about 120 staff-years devoted to fraud and abuse initiatives. This is presented in the FY 1979 budget (page 13).

2. Continuing attention to reducing the number of unresolved audit reports, and associated dollars, is imperative (page 18).

CHAPTER 3

This is the first Department-wide examination of criminal convictions of those who defraud HEW programs, and of current investigations. The findings (further delineated in Appendix III) further confirm the weaknesses which permit and invite fraud, abuse, and waste by employees, contractors, grantees, beneficiaries, and health care providers.

As the OIG has become established and its efforts more visible, it has attracted a much larger caseload by referrals from many sources. The key conclusions of this chapter are as follows:

1. The Office of Investigations (OIG) and the Office of Program Integrity (HCFA) witnessed a successful year of convictions resulting from their investigations--a total of 113. In addition, the States reported 129, and the FBI 23. The immediate problem is a caseload of 1,349 cases, of which OI has full responsibility for 538: OPI for 313,[1/] BSFA for 23, and the States under OI/OPI monitorship for 475 Project Integrity cases. We have concluded that OI must double its staff (from 114 to 214) to cope with this load. This is provided in the FY 1979 budget. We will assist in evaluating related staffing needs of other HEW components in the future, especially OPI and BSFA (pages 26-27).

[1/] 36 cases are being worked jointly with OI.

2. Our analysis of the handling of cases referred to the Department of Justice reveals an average of 2.5 months between referral and indictment, in those cases where indictments are returned; and an average of 1.5 months between referral and declination for OI cases and 5 months for OPI cases. It is apparent that more uniform and reliable systems of reporting and collating these data are needed for the future. However, we are pleased with the response of the U.S. Attorneys --and of headquarters officials of the Justice Department, both in the Civil and Criminal Divisions--during the past year (pages 31-32).

CHAPTER 4

The principal OIG health care initiative in calendar year 1977 was Project Integrity, devoted to exposing fraud and abuse by physicians and pharmacists. This project is now in mid-stream with 535 potential fraud cases under review, and an additional 554 being reviewed for possible administrative sanctions.

A number of additional areas are now being researched as follow-on initiatives under Project Integrity for calendar years 1978-1979-1980. The most difficult areas are those involving institutions. Four recommendations are made in this chapter:

1. OI should gradually relieve OPI of responsibility for Medicare and Medicaid fraud investigations as expansion of the OI staff permits. Joint planning of this transition is essential (page 37).

2. Project Integrity should continue as a series of national health care initiatives, conducted as a partnership between HEW and the States. The States should participate in planning future initiatives at an earlier point (page 35). The pattern of resistance by the nursing homes in permitting HEW access to records is noted and Congress will be kept informed (see Appendix IX).

3. A "Civil Money Penalties Bill" is essential to permit more effective civil sanctions against those who defraud the health care programs (page 42).

4. Congress should clarify the intent of the "Free Choice of Provider" provision in respect to competitive procurement of laboratory services, medical appliances and accessories --and perhaps of other supporting services of a non-personal nature (page 42).

CHAPTER 5

The key thrust of the OIG in the Welfare program during calendar year 1977 was "Project Match," under which potentially ineligible welfare recipients on Federal payrolls (both military and civilian) are being systematically identified and reviewed for eligibility. Care is being taken to assure protection of the privacy rights of individuals. A number of byproduct matching techniques have been explored as part of this first year's effort.

Three recommendations are made in this chapter:

1. Project Match initiatives should be expanded and conducted on a regular recurring basis. Delays now being experienced in obtaining timely permission to match Civil Service and Department of Defense tapes are noted on page 51. These may be overcome when guidelines, now in preparation, are promulgated (see page 46). The Deputy Inspector General is participating in drafting these guidelines.

2. Congress may wish to endorse a regular program of matching State Welfare rolls against other files--including Federal military and civilian employees, private employer wage reports, State employees, Child Support Enforcement, mortality data, SSI files, and SSA (Title II) benefits payments files. This would expand upon the policy established in Section 411 of P.L. 95-216 in respect to wage data exchanges (page 52).

3. The Office of Family Assistance needs a significantly larger staff to carry out an adequate program of training and technical assistance to support State programs for reducing fraud, abuse, and waste. In this connection Congress should extend to State AFDC programs the same statutory funding benefits that are now available to States under the Medicaid program for (1) developing and operating management information systems, and (2) establishing fraud control units (page 53).

CHAPTER 6

The various Student Financial Assistance programs have been reorganized and grouped under highly-qualified leadership. The OIG has participated in these efforts during the past year, including the development of new initiatives for (1) accelerating the investigation of criminal potential cases, (2) accelerating the collection of defaulted loans, (3) identifying Federal employees who are in default on their student loans, (4) a special industry study of Schools of Cosmetology, and (5) leadership in developing guides for the periodic audit of over 8,000 schools participating in these programs.

Two recommendations are made in Chapter 6:

1. To support the accelerated collection effort of the Bureau of Student Financial Assistance, authority to utilize IRS address data in the National Direct Student Loan collection effort would be highly beneficial. H.R. 8746, now pending, would permit this (page 61).

2. Congress may wish to state, as national policy, the desirability of matching Student Financial Assistance default files--Federal and State--against public payrolls, both Federal (including military) and State (page 61).

CHAPTER 7

Other initiatives in which the Office of Inspector General has been increasingly involved in the past year are the investigation of certain employee conduct and conflict-of-interest cases; reviews of contracting and grant practices,

particularly where problems of fraud or abuse have appeared to be present; and the initiation of a new pioneering effort to assess the quality, timeliness, and cost of services being rendered to beneficiaries (called "Service Delivery Assessment"). All of these are making a contribution to the Department-wide efforts to foster economy and efficiency, as well as to detect and prevent fruad, abuse, and waste.

Three recommendations are made in Chapter 7:

1. More attention is needed to the education of employees and managers on the cause and prevention of code-of-conduct violations and conflicts-of-interest. This should be a joint initiative between the Assistant Secretary for Personnel Administration and the Office of Inspector General (page 63).

2. The OIG should continue joint initiatives with the Assistant Secretary for Management and Budget in upgrading the professionalism of contracts and grants managers (page 63).

3. The OIG's new "Early Review" service to colleges and universities should improve accounting and reporting systems required to support performance under Federal research grants and contracts. Prompt penalties should be applied in those instances where institutions do not meet adequate standards (page 65).

APPENDIX I

FINAL SURVEY OF "BEST ESTIMATES" OF FRAUD, WASTE AND ABUSE IN KEY HEW PROGRAMS

Prepared by: Office of Inspector General
HEW Audit Agency
February 1978

FINAL SURVEY OF "BEST ESTIMATES" OF FRAUD, WASTE AND ABUSE IN KEY HEW PROGRAMS

This report presents the final results of our survey to determine the "best estimates" of fraud, abuse and waste in key HEW programs. It shows that as much as $6.3 to $7.4 billion, or 4.7 to 5.4 percent of the Department's fiscal year 1977 outlays for these programs, may be involved. It includes monies paid to ineligibles, wasteful expenditures due to inefficient or ineffective operations, improper charges for reimbursement of certain program costs, overcharges resulting from abusive practices, and in some cases outright fraud.

We would caution the reader that not all estimates in this survey represent monies that are potentially fully recoverable by the Department, i.e. cost savings. For example, estimates of improper payments to ineligibles in the AFDC and Medicaid programs represent the established error rates for these programs nationwide. Although the States, through improved program management, may reduce the number of ineligible payments, it is not reasonable to expect errors will be completely eliminated or all overpayments recovered. Also, we would caution that several of the estimates presented in this paper are not based on scientifically selected random samples, e.g., Medicaid fraud. Thus, the projected amounts of fraud, waste and abuse may be questioned as not scientifically valid. However, we present them here with proper qualification as the "best estimates" and in most cases the only estimates available in those programs we surveyed.

One additional qualification: - In certain programs, most notably Medicaid and other health care areas, there is the probability that estimates of fraud, waste and abuse in one segment of a program might be duplicated in another. For example, our estimate of "payments to ineligibles" in Medicaid may include some of the same payments shown under the estimate for "fraud and abuse." This latter figure is based mainly on abuses found at Medicaid mills and, for the most part, involves unnecessary services provided to Medicaid patients. It is possible that some of the patients visiting the Medicaid mills are "ineligibles" who would also be in the "payments to ineligibles" category. We have no way of knowing how prevalent this duplication might be, but our "gut" feeling is that it is a small percentage of the total. Nevertheless, where the possibility of duplication exists in our estimates, we have so indicated.

Our survey included all or portions of the following programs: AFDC, Medicaid, Medicare, Student Financial Assistance, SSI, SSA Retirement and Survivors Benefits, ESEA Title I, and Title XX of the Social Security Act (Social Services). We contacted officials of each POC involved and also certain organizations and individuals outside HEW,

including: General Accounting Office, certain Congressional committee staff members, Common Cause, the Brookings Institution, Ralph Nader's Public Citizen's Health Research Group, the National Kidney Foundation, a private renal dialysis provider, and the Allen Guttmacher Institute. Although we reviewed each estimate for reasonableness, we did not independently verify the accuracy or validity of these amounts.

The reader will note that the Medicaid and Medicare programs have the largest amounts of estimated fraud, waste and abuse. This is due in part to the fact that these programs, and indeed the entire health care field, has been subject to numerous investigations and studies in the recent past--especially by Congressional committees. Consequently, much has been written about the abuses in this area. We are not implying that the estimates are exaggerated or overstated. There is, however, a wealth of data about the problems in Medicaid and Medicare and we have obtained and incorporated much of it here.

Finally, there were a number of program areas for which potential fraud, waste and abuse estimates were not available, although it was widely accepted (and audit has shown) that problems exist. We have included discussions of these areas in this survey to show the potential for further savings, if not the actual dollars involved (see Tab K). These are large programs or program areas, involving billions of dollars. Because of our inability to obtain estimates for them and our consistent approach in selecting only figures which appeared to be from reliable sources, we are confident the $6.3 to 7.4 billion is a conservative estimate of fraud, waste and abuse in key programs. Further refinements of current estimates (such as HCFA's Program Integrity efforts in Medicaid/Medicare) and new studies in heretofore untested program areas are likely to result in findings of greater amounts misspent. For now, however, shown in the following schedule, by program surveyed, are the current best estimates of fraud, waste and abuse. Additional narrative is provided in tabs which more fully describe the source and make up of each estimate presented.

SCHEDULE OF "BEST ESTIMATES" OF FRAUD, WASTE AND ABUSE IN KEY HEW PROGRAMS FOR FY 1977

Program	Federal Outlays (In Billions)	Fraud, Waste & Abuse (In Millions)	Tab
Medicaid	$ 9.8	($2,310-2,640)	A&C
Medicare	21.9	2,217	B&C
AFDC	6.3	669	D
SSI	5.4	334	E
Social Services	2.7	88	F
Student Financial Aid	3.6	356	G
Income Security (SSA)	84.3	(160-867)	H
Indirect Costs	1/	102	I
ESEA Title I	2.1	97	J
Other Problem Areas	2/	2/	K
Total	$136.1	($6,333-7370)	

1/ Funds are not appropriated separately for indirect costs. They are included as part of the appropriation of each applicable program.

2/ Includes programs where problems are suspected or known to exist but no overall estimate of fraud, waste and abuse is available.

The accompanying tabs should be considered an integral part of this schedule.

Tab A

Medicaid ($2,310-2,640 million)

Expenditures under the Medicaid program approximated $9.8 billion in Federal Funds during FY 1977. Of this amount we found estimates that as much as $2.3-2.6 billion might be misdirected because of fraud, waste and abuse.

General Description	Amount (Millions)	
Payments to Ineligible Recipients	330-660	1/
Fraud and Abuse	468	2/
Third Party Liability Losses	330	3/
Erroneous Payments	110	4/
Common Audit	50	5/
Quarterly Expenditure Report Reviews	17	6/
Audit Exceptions	18	7/
Other Excessive Health Care Costs	987	(See Tab C)
Total	$2,310-2640	

1/ Payments to Ineligible Recipients ($330-660 million) - Ineligible payments are based on a review of a sample of paid claims and information submitted by 47 States and jurisdictions for the period from April-September 1976 and projected to FY 1977 dollars. HCFA's Medicaid Eligibility Quality Control (MEQC) staff reviewed this information and found that about $1.2 billion of Medicaid expenditures were for services received by recipients who were ineligible under the State plan at the time the service was provided. We have reduced this estimate to exclude State contributions (Federal share 55%). Also for reasons discussed in the note below this estimate may range from a low of $330 million to a high of $660 million.

(NOTE: GAO advised us of a problem with HCFA's estimate of payments to ineligibles, $1.2 billion, which they believe to be overstated. In a recent review in Ohio, GAO looked at cases sampled by the State Quality Control (QC) staff. They found that most errors causing ineligibility involved institutionalized patients and the problem usually involved personal resources exceeding the maximum allowable by State rules. They also noted that when QC reviewers discovered that patients' accounts exceeded the limit, the patients were considered ineligible and the entire claim for the time period covered for those patients was questioned. This, in GAO's opinion, is where the overstatement occurs. Their contention is that the most that could have been questioned is the amount by which personal resources exceeded the limit. Even then, this amount may not be ineligible since the patient may spend-down to reach the established limits.

GAO estimates that in Ohio the amount of ineligible payments were actually about $15.2 million (disregarding spend-down provisions), about 44% of the HEW estimate of $34.4 million. GAO also sampled cases in five other States and found that ineligibility amounts were overstated in the same way at approximately the same rate of frequency. Therefore, we have shown the amount of ineligible payments for Medicaid as ranging from a possible low of $330 million (reducing HCFA's estimate by 50%) to a high of $660 million. GAO plans to discuss this matter in a draft report which they hope to issue in March 1978.

2/ Fraud and Abuse ($468 million) - The Subcommittee on Long-Term Care of the Senate Special Committee on Aging, reports that Medicaid fraud and abuse exists on a massive scale.* This conclusion is based on their study of Medicaid providers in five** States involving 100 "Medicaid Mills" (mostly in New York City), 60 physicians and $15 billion in Medicaid expenditures (55% of 1975 Medicaid expenditures in the U.S.). Also, involved, a separate subcommittee study of 21 medical labs, 50 medical clinics and 50 or more physicians in the State of Illinois. This latter review included information on fraud and abuse investigations of clinical labs in other States. They report that all parties in the program, i.e., Providers, Clinical Laboratories, Pharmacies, Nursing Homes, and recipients have been affected.

$423 million of the $468 million applies to providers - The subcommittee staff report entitled "Fraud and Abuse Among Practitioners Participating in the Medicaid Program" states that, of the $2.2 billion that flows through Medicaid mills, roughly 35 percent ($770 million) is pocketed by entrepreneurs "who essentially provide no services." Of this amount, they estimate $220 million is involved in outright fraud. Another $550 million results from overutilization of services. The Federal portion of these payments in the States reviewed averages roughly 55%--thus our estimate of $423 million (55% x 770 million). As noted in the introduction to this report, there may be some duplication in the above figures in that certain fraud and abuse cases may also fall under the categroy of "payments to ineligibles." However, it is our feeling this would involve a small percentage of the totals. The fraud and abuse figures concern mainly overutilization of services to recipients in Medicaid Mills - their eligibility was not the main issue. We recognize, however, that some of these recipients may have been ineligible.

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* Staff Reports - Fraud and Abuse Among Practitioners Participating in the Medicaid Program, August 1976; and, Fraud and Abuse Among Clinical Laboratories, June 15, 1976.

** New York, New Jersey, California, Michigan, and Illinois.

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The abuses most frequently found in Medicaid Mills are referred to as: ping-ponging, ganging, upgrading, steering and billing for services not rendered. The following briefly describes these practices which were actually found during an investigation by the Special Committee Staff. (The study did not provide a breakdown of the $423 million by each of the following practices.)

- "Ping-ponging" is the term applied to the most common mill abuse, the referral of patients from one practitioner to another within the facility, even though medically there is no reason for the referral.

- "Ganging" refers to the practice of billing for multiple service to members of the same family on the same day when, in fact, only one person needs treatment.

- "Upgrading" is the practice of billing for a service more extensive than that actually provided. A physician may treat a suspected cold, for example, and bill for treating acute bronchitis.

- "Steering" involves direction of a patient to a particular pharmacy by a physician or anyone else in the medical center. It is a violation of the patients' freedom of choice.

- "Billing for services not rendered" consists either of adding services not performed on to an invoice carrying legitimate billings, or submitting a totally fraudulent billing for a patient the doctor has never seen and/or an ailment he has not treated.

$45 million of the $468 million applies to clinical laboratories - The full dimensions of Medicare and Medicaid fraud and abuse with respect to clinical labs is unknown. However, the Special Committee on Aging estimated that $45 million* in Medicare and Medicaid billings is either fraudulent or unnecessary. This estimate results from an investigation which uncovered the following types of fraudulent and abusive practices.

-Billing Practices: Reviews of bills submitted for payment by clinical laboratories disclosed a number of significant problems, including:

1. Labs charging Medicaid for tests not ordered by the physicians.

* The Senate study did not indicate what portion of $45 million involved Medicaid; thus we could not determine the amount of, and remove, State funds from this figure.

2. Labs charging Medicaid for questionable tests, i.e., tests inappropriate for the disease diagnosed by the physicians.

3. Charging Medicaid patients more than private patients.

4. Billing Medicaid for component parts of automated profile tests.

5. The use of billing forms supplied by the laboratory which encourages overutilization by making it impossible for the physicians to order certain lab tests without also ordering related tests.

-Brokering: Another significant problem area involves brokering--the practice of subcontracting laboratory tests. With the rapid development of new technology, the use of reference laboratories has become more common. It is necessary to send certain complicated lab tests to establishments that are qualified to perform them. However, abuse can occur when a lab represents itself as having capabilities which it does not have. A storefront lab can acquire Medicaid accounts and subcontract tests to other independent laboratories, at half the cost of billing these services to Medicaid.

-Fee Schedules: Many problems relating to lab services have to do with fee schedules established by Medicare and Medicaid. The number of schedules is a problem. There is variability in prices from city to city and from county to county. Another problem appears to be that most of these rates were established 8 to 10 years ago - prior to the development and widespread availability of sophisticated analytical equipment. Now, the cost of performing most tests is a fraction of what it once was. However, much of this cost savings has not been passed on to consumers. Instead, much of it has apparently resulted in higher profits to labs and in kickbacks to the providers.

-Kickbacks: Enormous amounts of profits can be made by a lab performing tests for Medicare and Medicaid providers. Because of these high profits a number of labs have resorted to various kickback schemes to get and keep the public aid business. The Special Senate Committee found that kickbacks average about 30 percent of the Medicaid and Medicare business. They can take several forms including cash, long-term credit arrangements, gifts, supplies, and the furnishing of various types of equipment. Most commonly, it involved the supposed rental of a small space in a medical clinic (sometimes a closet), and payment of salaries for a doctor's (providers) staff and assistants.

3/ Third Party Liability ($330 million) - After reviewing data from four States (California, Michigan, Minnesota and Wisconsin) MEQC estimated that State Medicaid expenditures are 4-10 percent greater than they would be if accurate determination and recovery were made of Third Pary (private health insurance) Liability (TPL). As a result, about $600 million (Federal share $330 million) is lost each year due to uncollected TPL.

4/ Erroneous Payments ($110 million) - Based on a review of data from Michigan and Minnesota, MEQC estimated that approximately $200 million (Federal share $110 million) is lost nationwide in erroneous payments to providers. The data showed that State agencies processed Medicaid payments for duplicate claims, uncovered services and to ineligible providers.

5/ Common Audit ($50 million) - See 5/ under Medicare. (Tab B)

6/ Quarterly Expenditure Report Reviews ($17 million) - State agencies submit quarterly expenditure reports to recover costs incurred in administering the Medicaid Program. Before payment is made, HCFA's Regional Financial Management Staff review these reports. These reviews oftentimes pick up overpayments to providers, AFDC payments improperly charged to Medicaid, and payments to providers without valid agreements. As a result $17 million was disallowed during fiscal year 1977.

7/ Audit Exceptions ($18 million) - Represents recommended financial adjustments in Medicaid audit reports that were resolved during fiscal year 1977.

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Tab B

Medicare ($2,217 million)

During FY 1977 an estimated $21.9 billion was spent providing medical services to the 26 million aged and disabled Americans eligible under Medicare. Our survey has identified $2.2 billion in estimated losses due to fraud, waste and abuse in this program.

General Description	Amount (Millions)	
Excessive Nursing Differential	$ 185	1/
Renal Dialysis	153	2/
Provider Overpayments	141	3/
Cost Report Reviews	16	4/
Common Audit	8	5/
Audit Exceptions	3	6/
Other Excessive Health Care Costs	1,711	(See Tab C)
Total	$2,217	

1/ Excessive Nursing Differential ($185 million) - Medicare presently pays 108.5 percent of hospital nursing care costs allocable to Medicare patients. The 8.5 percent plus factor was included, by regulation, in recognition of a claim that Medicare patients required more nursing care than other patients. This claim resulted from a study performed by the American Hospital Association (AHA). We were told by members of the staff of the Senate Committee on Finance that this study was indiscriminate, inexact, and no longer applicable. They pointed out that the statistical sample used for the study was flawed. For example, of the 55 hospitals surveyed many were selected because they were near to the homes of researchers performing the study. This lack of randomness is especially significant since there was a wide variance in nursing costs for older people in the 55 surveyed hospitals. Most did not show the need for the 8-1/2 percent differential and, in fact, some reported lower nursing costs for their older patients. A few very high cost hospitals brought the average up.

Nevertheless, the 8.5% differential was added by regulation in 1969. The Department sought to withdraw it in 1975, claiming lack of justification. The AHA brought suit and the Department was enjoined from withdrawing the 8.5 percent premium until it had undertaken and completed studies showing support for such a withdrawal. To date these studies have not been performed. Medicare is paying an estimated $185 million to cover this nursing differential cost in fiscal year 1977.

2/ Renal Dialysis ($153 million) - The Social Security Amendments of 1972 provide Medicare coverage for eligible people under 65 for the cost of services and supplies furnished in connection with the treatment of end-stage renal (kidney) disease. Under this law, Medicare benefits for individuals with chronic renal disease include coverage of dialysis services in all settings - hospitals, outpatient hospital facilities, free standing renal dialysis facilities, and in the home of patients who are undergoing self-dialysis. The cost of providing coverage to the 36,000 renal disease patients in FY 1977 was $750 million. Our estimates show that about $153 million may be saved in this program. A brief discussion follows:

(a) Decrease in Home Dialysis ($90 million) - Although dialysis can be performed in either the home or in an institutional setting, the cost of home dialysis is, over the long run, considerably less than institutional dialysis. Studies indicate that the current annual cost of home dialysis is about $10,000 while the annual cost of institutional dialysis is $22,500, more than double.

Since July 1973 when the renal dialysis program started, there has been a steady decline in the percentage of patients on home dialysis. According to the National Dialysis Register, over 40 percent of the total patients on dialysis were dialyzing at home in 1972. By the beginning of 1975, the percentage on home dialysis had declined to 25 percent. According to data just released by HEW less than 10 percent of dialysis patients were on home dialysis for 1977. Why this sudden shift away from home dialysis?

We noted several reasons for this, including: professional disinterest in encouraging home dialysis and increased access to institutional facilities. However, we believe there is another reason which is basically financial--the way facilities are owned and operated and the advent of the Federal renal program which now pays for most treatments. Most free standing dialysis facilities are not affiliated with any hospital and are usually owned and operated by physicians who specialize in renal dialysis. Physicians caring for dialysis patients in facilities they own have no incentive to encourage a patient to dialyze at home; in fact, the physician stands to lose income and profit by doing so. And it doesn't make much difference to the patient if he receives a more expensive treatment since the Medicare program will pay.

If this trend could be reversed and just 30 percent of renal dialysis patients could be encouraged to use home dialysis, we estimate that $90 million in Medicare funds could be saved each year - based on 1977 figures.

(b) Renal Dialysis Costs ($63 million) - When the Congress enacted the renal disease program in 1972, it did so in full recognition of the fact that substantial difficulties would be encountered in development of equitable reimbursement policies. Little data was then available either on treatment costs or on prevailing charges. Moreover, there was a great variety of arrangements through which services in the relatively new field of renal dialysis were rendered. As a result, the Congress authorized the Secretary of HEW to develop and apply reimbursement policies and procedures on the basis of evolving experience.

Two criticisms most often made of the present "reasonable charges" method for reimbursing renal dialysis facilities are (1) it does not permit the program to effectively adjust payment limits as prices and circumstances vary; and (2) it allows facilities to receive reimbursement based on their own charges regardless of the relationship to cost. Although the congressional intent at the time of enactment was to provide for the development of a "charges related to reasonable cost" method, this intent was not sufficiently clarified in congressional reports, and efforts by the Secretary to obtain appropriate cost data from some facilities in accordance with this intent have been challenged. Therefore, there was no guarantee that charges "related to costs" are reasonable and, in fact, there is some feeling they are excessive in some cases.

As pointed out previously, the average yearly cost for institutional dialysis is $22,500. We learned from discussions with program officials and a physician who is a director of a well-known dialysis facility that institutional dialysis could easily be done for an average yearly cost of $20,000. Institutions could provide adequate care and still make a reasonable profit at this rate we were told. Based on this rate and current average charges, we estimate that payments for institutional dialysis could have been reduced by as much as $63 million in Medicare funds in 1977.

(NOTE: On December 30, 1977, HCFA published regulations in the Federal Register, which become effective immediately, requiring free standing renal dialysis facilities to furnish information about their costs to HCFA. These regs formally restate HCFA's authority to obtain such costs. We were told by a HCFA official that this formal issuance now makes the books and records of all renal dialysis facilities open to audit. He stated that it was the ruling in a recent court case that once the regs were formalized access would be granted. With this, the books and records of all facilities will now be open for review to determine the reasonableness of charges.)

3/ Provider Overpayments ($141 million) - Represents overpayments to providers, principally hospitals, under the Medicare Program as of September 30, 1976 - the most recent date for which this data is available. Responsibility for Medicare was transferred to HCFA from SSA in the recent Departmental reorganization. HCFA expects most of the $141 million will be recovered through refund and/or offset of current payments due hospitals.

4/ Cost Report Reviews ($16 million) - Medicare institutional providers use established cost rates when determining the amounts to bill for services provided to Medicare recipients. Rates are established based on reports of Providers actual costs, audited by the Intermediary for accuracy and allowability. To determine the adequacy of these rates, BHI central office staff reviewed a number of cost reports and noted that some rates were overstated. Based on these reviews BHI estimates that $16 million is wasted annually because the rates of certain Providers were overstated.

5/ Common Audit ($8 million) - Intermediaries perform audits on a rotating basis at Hospitals, Skilled Nursing Homes and Health Maintenance Organizations to determine the allowability of amounts claimed for operating the Medicare program (see 4/ above). In addition to these audits, Federal and State auditors review other Federal and State programs administered by these same providers. HCFA estimates that $8 million in Medicare and $50 million in Medicaid costs could be saved if only one common audit was performed of all programs administered by the Provider.

6/ Audit Exceptions ($3 million) - Represents recommended financial adjustments in Medicare audit reports that were resolved during fiscal year 1977.

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Tab C

Other Excessive Health Care Costs ($2,698 million)

This tab describes estimates of waste and abuse amounting to $2.698 million in general health areas for which a portion of the costs are borne by the Medicaid and Medicare programs, $987 million for Medicaid (Tab A) and $1,711 million for Medicare (Tab B), in the following areas: hospital inpatient services ($1,982 million), X-ray procedures ($516 million), and nursing homes ($200 million).

We would caution that these estimates may be duplicated to some extent. For example, in the area of hospital inpatient services, the estimate of losses for unnecessary surgery may be partly duplicated in the estimate for unnecessary hospital procedures. Also, some estimates previously presented under Medicaid (Tab A) may be duplicated. As noted in the introduction to this report, we could not always tell how prevalent this situation might be.

Although we have only included estimates of fraud, waste and abuse related to direct Medicaid and Medicare payments, there are other indirect ways HEW absorbs increased health care costs. Two examples: (i) wasteful or abusive practices increase health care costs and as a result cause increases in premiums charged by private health insurance organizations. As do other employers, HEW picks up about half the total premium of many of its thousands of employees. So, as health care costs go up, so do HEW payroll costs; (ii) HEW sponsors research in many health care areas, usually at university medical schools which often operate teaching hospitals. These activities are also subject to in efficiencies and wasteful practices, as are other hospitals or clinics, and increased costs may be absorbed by HEW grants for research projects. Although aware of these additional problem areas, we were not able to obtain or develop estimates of actual HEW dollars wasted or lost. Following, a brief discussion of problems and questionable expenditures in health care areas:

Hospital Inpatient Services ($1,982 million)

During Congressional hearings on the Hospital Cost Containment Act of 1977 it was noted that the single largest cost item under health care is the operation of the nation's hospitals ($64 billion in FY 1977). This holds true also for Medicare and Medicaid where 34% of program expenditures go for general hospital inpatient services. We identified four cost centers related to hospital inpatient services* where we believe about $2.0 billion in Federal funds may have been lost due to fraud, waste and abuse. A brief description of each follows:

*See footnote page 14

a) Excessive Hospital Beds ($1,130 million) - Section 2 of Public Law 93-641 entitled "Findings and Purpose," states that uncontrollable and inflationary increases in the cost of health care, particularly of hospital stays, are due in part to an estimated 100,000 surplus hospital beds. Hospitals must maintain enough staff, equipment and auxiliary facilities to be able to care for patients at an annual occupancy rate of 80 percent. Beds in a hospital are considered surplus when the annual occupancy rate falls below 80 percent.

Nationally, the cost of maintaining empty surplus beds may run into the billions. The costs are borne not only by hospital patients but by everyone who pays hospital insurance premiums and tax dollars for health care. We estimate that as much as $753 million of Medicare funds and $377 million of Medicaid funds may have been spent during fiscal year 1977** to maintain surplus hospital beds.

b) Unnecessary Surgery ($655 million) - The Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce performed an in-depth examination into the area of unnecessary surgery and concluded, in a report dated January 1976, that an estimated 17 percent of all procedures funded by Medicare and Medicaid during fiscal year 1974 were unnecessary.

Making the same assumptions as above - namely that 17 percent of the procedures are unnecessary - and applying this same percentage to FY 1977 costs, we estimate $468 million of Medicare funds and $187 million of Medicaid funds were spent on unnecessary surgery that year.

c) Unnecessary Hospital Stays ($124 million) - The Subcommittee on Oversight and Investigations, in a report dated January 1976, entitled "Cost and Quality of Health Care: Unnecessary Surgery," presented evidence that 20 to 40 percent of surgical procedures performed on inpatients were simple enough to be completed on an outpatient basis. A major factor contributing to this misutilization of hospital facilities is that about 90 percent of all hospital bills in the United States are reimbursed by third-party payers. Thus, neither physician nor patient tends to be overly concerned with the cost of treatment at the time it is rendered. This can lead to situations where physicians, when there is some doubt, decide in favor of using more expensive short-term hospital stays instead of the lower cost out-of-hospital treatment. The

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* Where estimates for the Medicaid and Medicare share of total costs of hospital services nationwide were not available, we applied the 34% figure in our projections. Also, where necessary, we split this amount between Medicare and Medicaid by a 2/3 to 1/3 ratio. This is the approximate ratio of the total cost of these programs to one another.

** Based on an average hospital bed cost of $100 per day (34 percent or $34 for Medicaid and Medicare) and a surplus hospital bed figure of 100,000.

patient is not "hurt" financially nor will he object since he is covered by hospital insurance.

There appears to be enormous potential for cost savings in this area. For example, there were at least 3.8 million surgical procedures financed by Medicare and Medicaid during 1977. If approximately 750,000 (20 percent) of the procedures could have been performed on an outpatient basis, and if as little as $165* could have been saved per procedure, the overall savings in this area alone would approximate $124 million. (Medicare - $83 million and Medicaid - $41 million).

d) Excessive Physicians Costs ($73 million) - A study funded by HCFA entitled "Study of Reimbursement and Practice Arrangements of Provider Based Physicians," dated October 1977, shows that physicians on a percentage system of reimbursement make more money than salaried doctors doing the same type work. For example, pathologists - the MDs who specialize in laboratory tests and diagnoses - averaged $124,000 a year on a percentage basis compared to $50,000 per year on salary.

The message in these statistics, according to the Ralph Nader-backed Public Citizens Health Research Group, is that consumers and taxpayers are being overcharged by as much as $215 million a year because doctors are making "exorbitant" profits from percentage contracts with hospitals. These "exorbitant" profits result, they say, because the percentage system encourages physicians to promote the use of unnecessary or questionable lab tests, X-rays and other hospital procedures because they receive a share of the income these services help to bring in.

In FY 1977 the Medicare and Medicaid programs picked up about 34% of all hospital costs. Therefore, to compute the Federal share of excess physician fees, as discussed above, we multiplied $215 million by 34 percent and arrived at a figure of about $73 million ($48 million for Medicare and $25 million for Medicaid).

X-Rays ($516 million)

Over the last few years the use of X-rays as a diagnostic aid has grown tremendously. In fiscal year 1977, 241 million X-rays were taken at a cost of about $6.3 billion. We noted that FDA has identified a number of areas where the inefficient and improper use of X-rays has caused an unnecessary increase in health care costs, part of which has been absorbed by the Federal Government. A brief description follows:

*Federal portion of estimated savings per procedure per Senate Subcommittee Report.

a) Unneeded X-rays ($400 million) - Concern about the consequences, both professional and legal, of failing to make an adequate patient diagnosis may often pressure physicians into prescribing X-ray procedures of questionable need. An FDA report states that other factors leading to unnecessary X-rays include monetary incentives and lack of scientific data on when they are needed. FDA estimates that for these and other reasons 30 percent of all X-rays in FY 1977 were unneeded. It has also been estimated by FDA that this has increased health care costs unnecessarily by about $2 billion, of which we estimate $400 million was paid by Medicare ($266 million) and Medicaid ($134 million).

b) Genetic Defects ($84 million) - Errors or omissions at any stage in the design or manufacture of diagnostic X-ray equipment, or its improper use, can result in unnecessary radiation exposure to the public. Current FDA testing indicates that new X-ray systems, supposedly manufactured and installed in compliance with Federal performance standards, fail to comply with one or more of the requirements at a rate approaching 20 percent. Noncompliance with this requirement results in X-ray beam sizes which are too large, leading to unnecessary patient exposure. The exposure to high doses of X-rays can cause damage to the reproductive organs, resulting in future genetic defects. Many current day cases dealing with birth defects and illnesses of the reproductive organs have been directly linked to past exposure to excessive X-ray beams. If X-ray equipment had been designed within acceptable standards, X-ray beam size limited, and gonad shields used, FDA estimates that about $400 million (Federal share $84 million) of health care costs needed to treat these patients could have been avoided. Of the Federal share, we estimate Medicare paid $56 million and Medicaid paid $28 million. Although some improvements have been made over the years, there is still potential for reducing health hazards and related costs in this area.

c) Repeat X-Rays ($32 million) - FDA's Bureau of Radiological Health is responsible for reducing unnecessary radiation exposure to the general population. Part of the Bureau's responsibilities deals with determining the number of X-rays that are repeated because of poor quality or the use of improper techniques. During fiscal year 1977, the Bureau estimated that approximately 10 percent of the medical radiographs produced in the U.S. had to be repeated for these reasons. The cost of these repeated X-rays in extra film and materials is estimated at $150 million, of which we estimate $32 million was paid by Medicare ($22 million) and Medicaid ($10 million). (Estimates of additional costs for processing and diagnosis by technicians and physicians were not available.)

(NOTE: The Food and Drug Administration has been involved in a program to reduce unnecessary patient exposure from diagnostic X-rays. They hope to do this by improving the safety of X-ray equipment and regulating performance and X-ray usage practices through voluntary educational and quality assurance programs for physicians, dentists and technicians. In a memo to the Secretary in August 1977 the Commissioner of FDA, in discussing cost containment considerations in the area of unnecessary X-rays, now running at an estimated 30%, noted that if these were eliminated, "...the potential saving in radiology costs alone would be over $2 billion annually." (This includes both Federal and private dollars.))

Nursing Homes ($200 million)

The term "nursing home" is used to identify a wide range of institutions and facilities which provide varying levels of care and services to aged individuals with health problems ranging from minimal to very serious.

In 1976 there were about 20,000 nursing homes in the United States containing about 1.4 million beds and providing care to about 1.3 million residents. During fiscal year 1977, expenditures for nursing home care reached $11.5 billion or 7.4 percent of total expenditures for health care. HEW provides $3.8 billion (33 percent) of all monies used to purchase nursing home care, most under the Medicaid program.

Several investigations (e.g. see footnote 1/) into nursing homes have documented evidence of fraudulent activities and abuses including undisclosed ownership interests, deceptive real estate practices, kickbacks/false and misleading cost reports, and patient mistreatment and neglect. A conservative estimate by HEW officials is that at least $200 million of Medicare ($15 million) and Medicaid ($185 million) funds spent for nursing home care were lost due to fraud and program abuse during fiscal year 1977.

1/ -- "Nursing Home Care in the United States: Failure in Public Policy," Report of the Subcommittee on Long-Term Care, Special Committee on Aging, 93rd Cong., 94th Cong.
-- "Improvements Needed in Medicaid Program Management Including Investigations of Suspected Fraud and Abuse," Report of the Comptroller General of the United States, April 14, 1975.

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Tab D

AFDC Programs ($669 million)

The program of aid to families with dependent children (AFDC) assists States and localities in providing public assistance benefits to the needy. Outlays for these grants are estimated at $6.3 billion in FY 1977. Our analysis indicated that an estimated $745 million of AFDC payments involve fraud, waste or abuse.

General Description	Amount (Millions)	
*Payments to Ineligibles and Overpayments to Eligibles	$ 490	1/
*Fraud and Abuse	145	2/
Quarterly Expenditure Report Reviews	13	3/
Audit Exceptions	21	4/
Total	$ 669	

*(AFDC Comments: Some overlap may be present. Some errors if corrected--WIN registration--do not reduce costs.)

1/ Payments to Ineligibles and Overpayments to Eligibles ($490 million) - As in the Medicaid and SSI programs, a quality control review is performed to determine AFDC recipients eligiblity. The State agencies administering the program are required to review a sample of approximately 45,000 recipients every six months. Results of the most current reviews (January-June 1977) indicate that $490 million of AFDC payments are made to ineligible recipients or as overpayments to eligible recipients.

2/ Fraud and Abuse ($145 million) - State agencies reported that there were 166,342 AFDC cases which involved questions of fraud and/or abuse disposed of by administrative action during fiscal year 1976. It was determined that 40,721 of the cases had sufficient facts to support a question of fraud and were referred to law enforcement officials for action (18,475 actually prosecuted). Of the remaining 125,621 cases; 16,838 are still under review; reimbursement was arranged in 16,943; and for 91,840, although there is some question as to propriety, the facts were deemed insufficient to support the question of fraud. Based on these statistics, we estimate that $145 million is involved in fraud and abuse in the AFDC program. We arrived at this figure by multiplying the estimated average amount of AFDC cases ($2,000) by the 40,721 cases referred to law enforcement officials (fraud) and 91,840 cases not prosecuted but where there was an indication of impropriety (abuse) and by 55%, the average Federal share of national AFDC payments.

3/ Quarterly Expenditure Report Reviews ($13 million) - Reviews by SSA staff of quarterly expenditure reports submitted by the State agencies during FY 1977 showed that $13 million of claimed expenditures were not allowable under the AFDC program.

4/ Audit Exceptions ($21 million) - Represents recommended financial adjustments in AFDC audit reports that were resolved during fiscal year 1977.

Tab E

Supplemental Security Income ($334 million)

The supplemental security income (SSI) program, which replaced federally aided State assistance programs for the aged, the blind and disabled, provided an estimated $5.4 billion in Federal benefit payments to 3.9 million recipients in FY 1977. Of this amount we could find estimates of approximately $334 million lost due to waste and abuse.

General Description	Amount (Millions)	
Overpayments and Payments to Ineligible Recipients	$ 310	1/
Overpayments to Medicaid Nursing Home Residents	23	2/
Audit Exceptions	1	3/
Total	$ 334	

1/ Overpayments and Payments to Ineligible Recipients ($310 million) - SSA's Office of Quality Assurance performs in-depth reviews of more than 20,000 SSI recipients every six months. The reviews are to determine if SSI recipients were eligible for the program, remained eligible during the period they received benefits, and were paid the correct amount. As of November 30, 1977, the date of the latest reviews, an estimated $310 million* represented overpayments and payments to ineligible recipients.

2/ Overpayments to Medicaid Nursing Home Residents ($23 million) - Under the SSI program the amount of payment to a recipient is dependent on living arrangements which are generally classified as independent (in own household), in the household of another, and in a nursing home. When a recipient becomes a nursing home resident his or her payments should be reduced to not more than $25 for each calendar month of residence. GAO in a report entitled, "SSI Overpayments to Medicaid Nursing Home Residents Can Be Reduced," dated August 23, 1977, points out that SSA's failure to reduce payments to SSI recipients entering nursing homes on a timely basis results in about $23 million annually in overpayments.

3/ Audit Exceptions ($1 million) - Represents recommended financial adjustments in SSI audit reports that were resolved during fiscal year 1977.

* This figure represents net overpayments and Payments to Ineligibles, less the amount SSA has established for losses under this program.

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Tab F

Social Services ($88 million)

Under Title XX of the Social Security Act, assistance is provided to States and localities for the delivery of services to eligible individuals and families in order to promote their independence and overall well-being. States and localities, which are responsible for delivering the kinds and levels of services to be delivered within Federal regulations, provide a broad array of services ranging from family planning and child care to transportation and services to senior citizens. Federal outlays for this program were estimated to be $2.7 billion in fiscal year 1977. Our current estimate is that at least $88 million of these funds were lost due to fraud, waste and abuse.*

General Description	Amount (Millions)	
Quarterly Expenditure Report Reviews	$ 82	1/
Audit Exceptions	6	2/
Total	$ 88	

1/ Quarterly Expenditure Report Reviews ($82 million) - This amount represents disallowances made by Office of Human Development Services staff when reviewing quarterly expenditure reports submitted by the States for Title XX services. Disallowances represent improper expenditures during FY 1977 (overpayments, unallowable costs, costs for services provided to ineligibles, etc.).

2/ Audit Exceptions ($6 million) - Represents recommended financial adjustments in Title XX audit reports resolved during fiscal year 1977.

*See Tab K for further discussion of this program area.

Tab G

Student Financial Aid (SFA) Programs ($356 million)

The Office of Education sponsors five major student aid programs -

-- Basic Educational Opportunity Grants (BEOG)
-- Supplemental Educational Opportunity Grants (SEOG)
-- College Work Study (CWS)
-- National Direct Student Loan (NDSL)
-- Guaranteed Student Loans (GSL)

Federal contributions for these five programs amounted to approximately $3.6 billion during FY 1977. Funds are distributed on the basis of need to students enrolled in a wide range of postsecondary institutions including colleges; universities; community and junior colleges; vocational, technical and business schools; and hospital schools of nursing.

We found estimates of $356 million in losses due to fraud, waste and abuse in SFA programs.

Program	Amount (Millions)	
Basic Educational Opportunity Grant	$ 109	1/
Campus Based Programs	49	2/
Guaranteed Student Loans	187	3/
Audit Exceptions	11	4/
Total	$ 356	

1/ Basic Educational Opportunity Grant ($109 million) - The BEOG program involving about $1.5 billion is designed to assist students in continuing their postsecondary education and is intended to be the "foundation" or starting point for needy students. We found estimates of waste and potential abuse in two areas of this grant program.

a) Excessive Payments ($70 million) - Students, when applying for BEOG grants, must provide information concerning their financial need. Part of the required information is an estimation of family income. Studies by OE and private contractors have indicated that estimated income is generally understated, resulting in BEOG grants being overstated by approximately $65 million. Further, OE estimated that an additional $5 million is lost because other eligibility data on the application is not verified.

b) Poor Management ($39 million) - OE, after reviewing 150 HEW Audit Agency and CPA audit reports, estimated that $39 million of the $1.5 billion expended during fiscal year 1977 was lost due to poor management of the program by various educational institutions.

Findings by the GAO tend to corroborate the OE studies, which may be conservative. In a report entitled, "OE Basic Grant Program Can Be Improved," dated September 21, 1977, GAO stated that review of 19 selected schools showed about $24 million of $356 million of BEOG funds awarded by these schools during fiscal years 1974 and 1975 may have been awarded to ineligible students. Other BEOG grants of as much as $118 million were awarded without resolving discrepancies in eligibility information, GAO reports.

2/ Campus Based Programs ($49 million) - Three student loan programs--Supplemental Educational Opportunity Grants, College Work Study, and the National Direct Student Loans--are referred to collectively as the campus-based programs because they are administered by postsecondary schools. SEOG grants are intended to assist students who demonstrate exceptional financial need. The College Work Study program is intended to promote part-time employment of students needing funds to continue attending postsecondary institutions. The NDSL program makes low interest, long-term loans available to qualified students needing financial assistance. It is estimated that about $1 billion was dispensed to needy students under these three programs during fiscal year 1977.

During our survey we were unable to obtain estimates of fraud, waste and abuse in the SEOG and CWS programs. For a description of problems related to these two programs, see Tab K.

For the NDSL program we were able to identify estimates of $49 million in losses due to defaulted loans and maintenance of excessive cash balances by lender institutions in FY 1977.

a) Defaulted Loans ($46 million) - Under the NDSL program students are required to repay their loans plus interest over a maximum period of ten years generally starting after a grace period (9 to 12 months) after leaving school. If a student fails to repay his loan after this period the loan is considered defaulted. Lending institutions are required to exercise reasonable care and diligence in collecting student loans. If lenders have exercised "due diligence" in seeking repayment of loans and are still unsuccessful, they may then seek recovery from OE. In fiscal year 1977, OE paid an estimated $49 million to institutions for defaulted loans. They estimate they will collect only about 5% of these defaulted loans, or $2.5 million, from the student borrowers. Thus, the

remaining $46 million in FY 1977 defaulted loans will ultimately be written off as uncollectible.* (During the life of this program OE has paid an estimated $502 million to institutions for defaulted loans.)

b) Excessive Cash Balances ($3 million) - Schools administering the NDSL program are provided funds for the loans they plan to make each year. Educational institutions that don't make the number of loans they anticipated are allowed to maintain a minimal cash balance that is to be carried over to the next year.

OE noted that as much as $3 million in cash balances, which they considered excessive, are being maintained by certain schools.

3/ Guaranteed Student Loan ($187 million) - The Guaranteed Student Loan program enabled eligible students to obtain about $1 billion in loans during fiscal year 1977 to finance part of their educational costs. Students obtain long-term loans directly from banks or certain other participating lenders. Guaranteed loans are insured by either the Federal Government or a State or private nonprofit guaranty agency.

Fraudulent, wasteful and abusive activities related to the GSL program accounted for approximately $187 million in losses in FY 1977. These losses involved two types of situations - defaulted loans and fraudulent and abusive activities. More specifics follow:

a) Defaulted Loans ($137 million) - OE has encountered the same types of problems with defaulted loans in this program as in the NDSL program. During FY 1977 the amount of defaulted loans under the GSL program was $151 million. Of this amount OE estimates they will collect only about 9% or about $13.6 million. Thus an estimated $137 million of insured loans assumed by OE during FY 1977 will eventually be written off as uncollectible.* (The cumulative amount of defaulted loans under this program through fiscal year 1977 is $752 million.)

* Our estimates of losses in the NDSL and GSL areas may be slightly overstated. A loan program of this type should expect a certain amount of defaults. We attempted to obtain from OE a percentage which could be considered reasonable or acceptable for these programs. They could not provide us with one. Therefore, rather than making an uneducated guess at what it should be (and then reporting the difference between it and the actual as excessive) we have shown the entire amount expected to be written off as uncollectible.

b) Fraud and Abuse ($50 million) - Reviews performed by OE's Program Compliance staff found inappropriate loans of approximately $50 million disbursed at the school level during fiscal year 1977. They involved unpaid refunds, excessive interest benefits and criminal and civil violations by schools in the preparation of loans that are subsequently approved by lenders.

4/ Audit Exceptions ($11 million) - Represents recommended financial adjustments in Student Financial Aid audit reports that were resolved during fiscal year 1977.

Tab H

Income Security (SSA) ($160-$867 million)

Included in this category are benefits of about $84 billion paid out under the social security trust funds for retirement and disability, and special benefits for disabled coal miners in fiscal year 1977. The largest part of the $160-$867 million in losses involve overpayments and payments to ineligible recipients. As noted in the footnotes to the following schedule, SSA officials caution that a part of this figure is estimated and not verifiable in SSA records.

General Description	Amount (Millions)	
Retirement and Survivors Benefits	(85-$723)	1/
Disability Insurance and Black Lung	(74- 143)	1/
Audit Exceptions	(1- 1)	2/
Total	$(160-$867)	

1/ Retirement and Survivors Benefits, Etc. ($866 million) - Of the $723 and $143 million overpayments to beneficiaries shown for Retirement and Survivors Insurance (RSI) and Disability and Black Lung Programs, only $85 and $74 million, respectively, can be verified in SSA records. These latter figures* represent overpayment cases controlled through SSA's partially implemented ROAR System, a computer process that identifies overpayments. However, control totals are produced for less than 20% of all overpayments cases - only those terminated or ineligible for some reason. The remainder can only be estimated. Latest estimates by SSA are $638 million for RSI and $69 million for disability insurance and black lung. SSA officials caution, however, that these latter figures should only be used for informational purposes and not in formal written reports as they are considered "ball park" figures and their reliability is questionable.

2/ Audit Exceptions ($1 million) - Represents recommended financial adjustments in audit reports that were resolved during fiscal year 1977.

* Net overpayments less amounts SSA has established for losses under this program.

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Tab I

Indirect Costs ($102 million)

To recover indirect costs incurred while administering Federal programs, colleges and universities, hospitals and other health providers, non-profit institutions and State/local governments establish indirect cost rates. The entities submit indirect cost proposals for review by the Divisions of Negotiation and Grantee Assistance (DNGA) of the Office of Principal Regional Officials. DNGA negotiates overhead rates after desk audits, field reviews and participation in HEW or other Federal agency audits of the indirect cost proposals. These reviews and negotiations resulted in approximately $102 million of indirect cost disallowances during fiscal year 1977.

Tab J

ESEA Title I ($97 million)

Title I of the Elementary and Secondary Education Act (ESEA) authorizes Federal financial assistance through the States to local educational agencies (LEA) for programs designed to meet the special educational needs of educationally disadvantaged children. Federal outlays for this program were estimated to be $2.1 billion in fiscal year 1977.

During fiscal year 1977, we performed 15 audits of State Title I programs and recommended financial adjustments totaling $22 million, or 4.6 percent of the $474 million we reviewed. For the most part the recommended financial adjustments related to the following three areas:

... Supplanting of Funds - Occurs when the State or LEA use Title I funds (1) to pay for programs that are not designed to help educationally deprived children or (2) to pay for activities that previously were paid for from State or local funds.

... General Aid - This happens when all students in a class are permitted to participate in a special project that was originally designed for only educationally deprived students.

... Comparability - When LEAs apply for Title I funds they are required to certify that they are presently providing services in targeted Title I schools that are comparable to non-targeted schools. We found that a number of LEAs who were approved for participation, based on their application, did not meet this requirement and therefore should not have participated in the program.

We believe that these types of problems are not limited to the States and LEAs covered by these 15 audits but exist throughout the national Title I program. Numerous prior audits have borne this out. Projecting the results of our 15 audits nationwide, we estimate that in FY 1977 about 4.6 percent or $97 million of Title I program funds may have been improperly expended because of the above discussed problems, i.e. supplanting, general aid, and comparability.

However, the Office of Education has not always sustained our recommendations and in many cases has not pursued recoveries. Nevertheless, we believe that our estimate of waste or abuse--while admittedly controversial--is not unreasonable for this huge Title I program.

(NOTE: The President's FY 1979 budget submission to the Congress has earmarked ESEA Title I for an increase of about $644 million up to about $2.8 billion.)

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Tab K

Other Potential Problem Areas

While developing the "best estimates" of fraud, waste and abuse we noted four program areas where known or potential problems exist but where estimates of amounts were not readily available. A brief discussion of these areas follows:

College Work Study and Supplemental Educational Opportunity Grants - As mentioned earlier the National Direct Student Loan (NDSL), College Work Study (CWS) and Supplemental Educational Opportunity Grants (SEOG) form the three student aid programs often referred to as the campus-based programs. Our report includes a discussion of NDSL in Tab G. As for the general purpose of the latter two, CWS is intended to promote part-time employment of students needing funds to continue their postsecondary education while SEOG grants are intended to assist students who demonstrate exceptional financial need. We were unable to develop a figure for funds lost due to fraud, waste and abuse in these two programs. OE officials informed us that they had little information on this aspect of these programs. The problems that they are aware of, they said, such as: students getting paid under the CWS program but not actually working; students providing inaccurate information of family income for SEOG grants; and poor management of both programs; were surfaced mainly as a result of Audit Agency and CPA audits of the programs. The dollar effect of those problems, however, is not included in this report.

Drugs - We noted two areas related to drug purchases where funds may have been lost due to fraud, waste and abuse. They were (1) the use of brand name drugs instead of lower cost generic drugs; and (2) the problem of kickbacks given by pharmacists to doctors, hospitals and nursing homes (and related cost increases). We found that even though there has been much written about these two problem areas, no firm estimates have been made as to the amounts actually being lost. This, in our opinion, is an important area not only because of the publicity given the above noted problems but also because the Federal Government spent about $2.7 billion for drugs in fiscal year 1977.

Respiratory Therapy - The health care practitioners discipline--currently entitled respiratory (also called inhalation) therapy--has greatly increased the cost of health care over the last ten years. Respiratory therapy has evolved from a procedure costing $175 million in fiscal year 1968, and usually administered by nursing personnel under specific physician's orders, to a sophisticated medical treatment employing 55,000 registered therapists costing $800 million (Federal share $272 million) in fiscal year 1977.

Over the last few years a growing number of physicians and other medical experts have pointed out that respiratory therapy procedures are often inappropriate or useless. However, we have been unable to obtain estimates of how much money is actually being wasted because the procedures may be over priced and/or unnecessary. (We were informed by members of the Senate Committee on Aging that it was their opinion that huge "rip-offs" were occurring in this area.)

Social Services (Title XX of Social Security Act) - We have included an estimate of $88 million in fraud, waste and abuse in this program (see schedule page 3 and Tab F). This amount relates only to questioned costs as a result of quarterly expenditure report reviews by staff of Human Development and from audit reviews. We are of the opinion, however, that the amounts wasted or lost to fraud and abuse in this program could be much higher. For example, a recent review found that social workers submitted claims for social services for recipients who were deceased, took possession of the checks and, in some cases, forged signatures to cash them. Also, prior audits have revealed overcharges by private contractors for homemaker/chore services provided recipients. Because our audit effort in this area has so far been limited, we have no way of knowing how widespread these abuses may be or how much money is involved.

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AUDIT OVERVIEW

During calendar year 1977 the Audit Agency processed 6,716 audit reports, 2,453 prepared by its own staff and 4,263 prepared on behalf of HEW by independent public accountants and State auditors. These reports contained monetary findings totaling $190.3 million, and during the year the POCs concurred in audit-recommended financial adjustments totaling $65.3 million.

The Audit reports dealt with a wide range of HEW activities. While many were concerned with individual contracts, grants, or other transactions of a local nature, others were of broader scope and identified opportunities for important improvements in operations of HEW programs. In the following parts of this Chapter, some of those more important findings are highlighted under the general program categories of health, education, income maintenance and human development, and HEW administration.

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HEALTH

MEDICARE

Medicare payments systems: Considerable audit effort was expended on seeing whether Medicare claims processing systems were producing accurate and timely benefit payments. Auditors worked at the program's central office, at ten intermediaries and at six carriers.

Part A: In calendar year 1976 intermediaries were paid $170.5 million to process 30.2 million bills totaling $14 billion. The auditors found that while the systems generally performed satisfactorily, improvements were possible to improve economy and efficiency. For example: (i) of the 30 million bills processed annually, about two percent could not be fully processed by Medicare program staff because of billing errors, (ii) beneficiaries were overcharged about $2.9 million because charges were billed separately for outpatient services that should have been included in a related bill for inpatient stay, (iii) bills for multiple services were erroneously rejected as duplicate bills, while other potentially duplicate bills went undetected, (iv) about 7.5 million of 14.3 million queries made to Medicare program staff for benefit status information were not necessary, and (v) about 549,000 of 646,000 minor dollar adjustments were processed unnecessarily. A number of other minor deficiencies, although not widespread, also reduced the efficiency and increased the cost of bill processing procedures.

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Part B: In calendar year 1976 carriers were paid $290.2 million to process 92 million claims totaling $3.7 billion. The auditors found that (i) an estimated 19,000 claims for 10,000 beneficiaries amounting to almost $2.2 million nationwide were incorrectly denied, (ii) certain processing and program costs of about $2.3 million at six carriers could have been avoided, and (iii) certain payments were not based on properly computed reasonable charges or were incorrect because of coding errors. Also, numerous claims were improperly denied because SSA did not inform carriers that beneficiaries who previously dropped from the program were reinstated, or because carriers failed to pick up reinstatement information. These incorrect denials also caused about 173,000 avoidable inquiries to SSA about eligibility status.

Program staff concurred with the Audit Agency's recommendations aimed at improving the claims processing systems.

Medicare Administrative Costs: Medicare's 128 intermediaries and carriers are estimated to incur $589.1 million in administrative costs for FY 1978. Audits of administrative cost proposals provide verified cost information for negotiating final settlements. Significant cost disallowances were recommended in several areas:

Electronic Data Processing Costs: Seven audits found problems with electronic data processing costs. For example, not all subcontracts were let on a competitive basis, several were not approved by Medicare as contractually required, and in one case there was a lack of Federal access to records supporting the reasonableness of costs claimed. Other errors resulted in overclaims of $300 thousand.

Premium Taxes: The auditors have questioned whether a State-enacted tax on gross insurance premiums collected from subscribers is an allowable charge. Some State laws call this a "franchise" tax, ordinarily an allowable cost. The Audit Agency believes it is actually a gross receipts tax, applicable entirely to the contractor's commercial business. Contractors do not agree. In one case, the Secretary disallowed the cost--the contractor had recovered the total tax from premium rates charged commercial subscribers. His decision was upheld by the Armed Services Board of Contract Appeals, and the U.S. Court of Claims. Seven current reports call for over $1 million in adjustments. The item continues in dispute.

Other sizeable sums recommended for disallowance concerned excessive or ineligible costs claimed for (i) building space, (ii) cost of investment, (iii) indirect costs, (iv) personal service costs, (v) travel, and (vi) complementary insurance.

MEDICAID

Claims Processing Systems: Adequate controls are needed in a claims processing system to ensure that Medicaid expenditures are proper (annual Federal and State expenditures - $19 billion). An effective provider claims system includes checks and controls over eligibility, review of services, duplicate payments, reasonableness of cost, and third-party liability and reimbursement.

Reviews in several States identified problems in each of these areas. As a result, the systems were not fully effective in controlling the program costs, and the audits identified about $30 million of improper payments made by States to Medicaid providers. This amount is being repaid and/or adjustments made to the Federal account. Corrective actions based on Audit Agency recommendations have been initiated to eliminate the deficiencies.

Medicaid-Management Information System (MMIS): These computerized information systems process claims for medical care and services, and produce medical services utilization and other management information. If approved by HEW, Federal matching to defray operating costs is available at 75%.

Audits of procurement activities dealing with MMIS design, development and installation in five States disclosed weaknesses including: (i) instances where maximum free and open competition was lacking; (ii) problems with the preparation of invitation for bids; (iii) inadequate price analyses; and (iv) inadequate monitoring of contractor performance. Recommendations call for States to provide the Federal Government with assurance of compliance with Federal and State procurement standards.

Fraud and Abuse in Medicaid Claims: Reviews of State agency policies and procedures for preventing, identifying, investigating, and reporting suspected fraudulent claims at six jurisdictions disclosed areas in need of attention: (i) verifying with recipients that services paid for were actually received, (ii) improving written policies and procedures, and assuring that identified fraudulent/abusive practices are investigated, and (iii) improving the bases upon which investigations would result in suspension of benefits or criminal prosecution.

Reviews of HEW regional office procedures for assisting States in establishing effective fraud and abuse controls showed that actions were needed to strengthen regional administration of the Medicaid fraud and abuse program. Such steps are being taken.

SECTION 1864 AND 1902 AUDITS

Under these sections, State agencies certify health care facilities for participation in Medicare and Medicaid on a reimbursable cost basis.

Twelve audit reports questioned about $5 million claimed by State agencies. The audits also identified problems in State agency administration of the certification program.

Overstated Costs: The most significant cost overstatements were caused by the use of improper or unsubstantiated rates to distribute costs ($2.2 million), charging costs applicable to inspections of facilities for purposes of State licensure to the Federal Government ($2 million), charging costs of surveys at non-participating facilities to the Federal Government ($.2 million), and using budget estimates rather than actual costs incurred when requesting payment for administrative costs ($.3 million). The State agencies concurred with audit findings pertaining to $472 thousand, disagreed with $30 thousand, and have not yet responded to findings pertaining to $4.6 million.

Operational Deficiencies: Audits disclosed instances of waivers of serious deficiencies at health care facilities, incomplete survey reports, delays in reporting deficiencies to the facilities and other parties, inadequate or untimely follow-up on reported deficiencies, and inadequate records. With only one exception, the State agencies concurred with these findings.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSROs)

Limited reviews of 39 PSROs, with about $100 million in funding, identified problems in management practices. Of the 39 PSROs reviewed 34 had inadequate accounting systems and poor methods of controlling budgets, 29 lacked controls necessary to prevent potentially excessive expenditures, and 14 could not demonstrate they had an adequate system for evaluating program progress.

As a result of Audit Agency recommendations, HCFA is taking a number of corrective actions including: (1) the hiring of a management consulting firm to help solve PSRO fiscal and administrative system problems, (2) improved guidance to PSROs by updating financial management and accounting systems manuals and through training in financial areas, (3) more intense monitoring and guidance concerning the propriety of expenditures and (4) development of a system of program management and monitoring.

EDUCATION

VOCATIONAL EDUCATION

Allocation of Funds: Audits of vocational education programs in seven States that receive almost one-third of total program funding (over $400 million in FY 1978) revealed significant variances between the funding allocations shown in their State Plan, as approved by HEW, and actual

allocations made. While the plans complied with program criteria, actual practices did not. As a result, there was no assurance that funds were being furnished to appropriate agencies and training programs. OE officials agreed to act on increasing guidance, monitoring and evaluation.

Program Impact: In seven other States it was observed that vocational education programs may not be responsive to employment opportunities. State plans provided for training more individuals than could be absorbed by certain occupations. Thus, funds were expended for training programs where there was little assurance that job opportunities existed. Recommendations will call for OE to strengthen monitoring and evaluation of these programs.

ELEMENTARY AND SECONDARY EDUCATION, TITLE I

Educationally Deprived Children: Thirteen audit reports, covering Title I, ESEA program funds of about $500 million, called for recommended financial adjustments of over $21 million. Title I funds were found to have been used to supplant rather than supplement State and local funds, and local education agencies were not providing Title I schools with State and local funds for services comparable to those provided non-participating schools.

Handicapped Children Programs: Six audit reports, covering handicapped children program funds of about $25 million called for recommended financial adjustments of over $7 million. One major reason was that States included attendance data for children in institutions not meeting Federally mandated eligibility criteria. For example, one State was allocated about $2 million based on attendance totals that improperly included children in schools which neither received substantial State support nor provided a program meeting State standards for elementary and secondary education. Recommendations called for strengthening State program management and assuring compliance with these requirements.

COLLEGES AND UNIVERSITIES (RESEARCH FUNDS)

Colleges and universities annually receive about $4.5 billion from Federal sources (HEW: $3.2 billion) for various research and demonstration projects. HEW Audit Agency has been assigned responsibility for audit of all Federal funds at about 94% of the schools. About 20% of the Agency's resources are allocated for these audits.

Reviews of $1.2 billion in expenditures showed that $13.2 million were not properly charged. Recommendations were made that this amount be recovered. Also, because of inadequate accounting and workload distribution systems and poor internal controls, the auditors could not determine whether another $419.7 million had been properly charged. This amount was set aside for consideration by program officials as to

allowability. Audit reports recommended that schools review and revise their workload distribution and other reporting and accounting systems to bring them into line with Federal requirements.

Audits at colleges and universities have consistently shown major problems in the way they account for salaries and wages of faculty and other staff charged to Federal Projects. The Department has recently revised its procedures for resolving audit reports showing major system deficiencies. The revised procedures include an early audit review service for schools on proposed changes in their accounting systems, and sanctions against institutions and individuals when corrective actions are not taken in a reasonable time period.

STUDENT FINANCIAL AID

During FY 1977, the Audit Agency processed 1,111 audit reports on student financial aid programs: the Guaranteed Student Loan Program (GSL), National Direct Student Loan Program, College Work Study Program, Supplemental Educational Opportunity Grants, and Basic Educational Opportunity Grants. About half of these reports commented on one or more administrative weaknesses the most serious relating to student eligibility determinations and awarding procedures, refund practices, the financial stability of participating schools, improper use of Federal funds, loans collection procedures, and problems with the computation of interest billings in the GSL program.

Vocational Schools: Because of indications of irregularities in the use of Student Financial Aid funds, a major audit initiative was begun in FY 1976 and carried through to FY 1977 to review proprietary vocational schools participating in Federal student aid programs. Twenty-five schools in 15 States were reviewed, including several correspondence schools. The audit scope included recruitment practices, job placement activities, refund practices, and other financial matters.

At 16 schools, over $30 million in refunds to students, GSL lenders or OE were found to be late, incorrectly computed, or not made. As a result, the GSL program was billed for excessive interest of $10.3 million. An additional $1.8 million in additional interest overbillings was also identified, attributable mainly to unsupported estimates of loan balances and delayed graduation of students. Over 80% of these overbillings were caused by correspondence schools.

Seven schools were found to be using misleading or inaccurate information about job placements, class sizes and other recruiting data. Four schools did not exercise due care and diligence in their GSL collection activities. Other problems: schools did not graduate or terminate students, request OE pre-claims assistance, or file GSL defaulted claims in a timely manner.

The Audit Agency made numerous recommendations, including that OE give high priority to vocational schools in their compliance and program review activities, and to issuing new regulations to correct the practices noted. OE generally concurred and has numerous corrective actions in process.

The Basic Educational Opportunity Grant Program: OE's use of a computerized fund allocation and monitoring system for this program was found ineffective. This system is intended to alert program staff to discrepancies in data reported by grant recipients, but certain internal checks were not being performed and expenditure data of grant funds by schools were not being verified. Because of inaccurate data, program staff lacked a sound basis for monitoring the schools, accounting for program funds, or having current and accurate program activity information. Internal controls to safeguard transaction tapes and student eligibility forms were deemed inadequate.

OE concurred in these findings. A contract has been awarded to work on improving the information and monitoring system.

INCOME MAINTENANCE AND HUMAN DEVELOPMENT

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Administrative Costs: A report summarizing 66 individual audit reports issued over the past three years on the costs to administer the AFDC program (FY 1977 Federal expenditures $6.2 billion), illustrated nationwide problems in State overclaims for administrative costs. There were 182 instances of significant improper claims for administrative costs, 168 were reported for the first time and 14 were repeats. Over $78.2 million was involved. Findings dealt with non-compliance with Federal criteria, incorrect rates of Federal financial participation, claiming the same costs under more than one program, incorrect methods of cost allocation, and claiming ineligible costs.

In response to the audit recommendations, the States as of December 1977 had reimbursed $44 million. The balance of $34 million represented adjustments for which (i) final action had not yet been taken by program officials, or (ii) States had filed for reconsideration. The Audit Agency has recommended that responsible Federal officials more aggressively review and monitor State agencies' claims for reimbursement, and consider establishing and imposing fiscal sanctions or other administrative motivators in cases of inaccurate/excessive claims.

Foster Care: Eighteen audit reports issued in 13 States have pointed out that significant program management weaknesses with adverse affects on the types of care and services provided to foster children.

There were at least 47 instances of procedural weaknesses or noncompliance with substantive program requirements: (1) eleven instances involving problems with the licensing of foster care facilities, (2) two involving mixing foster children with delinquent children, (3) eight on problems with preparing plans of individual care, and (4) twelve involving the eligibility of children for the program. There were at least 14 other conditions identified as detrimental to the children and the program as a whole.

The Audit Agency is considering recommendations for establishing uniform minimum Federal standards for licensing and inspection of foster care facilities and for Federal program officials to provide improved monitoring of State and local agencies involved in licensing and inspection of foster care facilities.

SUPPLEMENTAL SECURITY INCOME PROGRAM (SSI)

Effective January 1, 1974, this Federally administered cash assistance program replaced the former State-administered programs of Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled. The program is intended to provide a minimum income for eligible persons using nationally uniform eligibility requirements and benefit criteria. Problems relating to program administration identified by the Audit Agency related to:

State Claimed Conversion Costs: Approximately $11.8 million of costs claimed by 15 States for transferring aged, blind, and disabled records to Federal control were audited--recommended financial adjustments totalled $1.7 million. Overclaims generally resulted from lack of controls to insure that amounts claimed were accurate and supportable by required documentation. SSA has settled with eight States and settlements for the balance are in process. Audit recommended disallowances of $274,436 were sustained by SSA in the settlements.

One-Time Payments: The issuance of manually processed one-time payments under SSI was not properly controlled, and most payments were not being recorded on the recipients master records. Recommendations that the manual pay process be automated, and all one-time payments be computer generated and properly recorded, were agreed to by SSA. They plan to have a fully automated system by the end of 1978. In the interim, more effective controls over the manual one-time payment system are being implemented.

Interim Assistance Payments: For the first eight months of FY 1977, interim assistance payments under SSI--made to participating States--totalled $22.8 million. Review of State reports disclosed cases where States did not adhere to established reporting requirements and that SSA

took little, if any, action to obtain compliance. SSA also lacked sufficient assurance that States withheld proper amounts of reimbursement for interim assistance payments, or that recipients received the correct balance of the SSI payment they were due. SSA agreed and advised corrective action is being taken.

VOCATIONAL REHABILITATION PROGRAM (VR)

The VR program's basic purpose is to prepare handicapped persons for gainful employment--1973 amendments to the VR Act require priority to be given to individuals with most severe disabilities, also, that each client receive an individualized written rehabilitation plan.

The results of a broad-based five State audit, show mixed program results: States have increased the numbers of severely disabled clients accepted for services but improvement is needed in the outcomes for all vocational rehabilitation clients. Half of the reported successful clients had full-time competitive employment, 20% of which were unemployed five months of leaving the program, and 11% of the reported employed actually were not employed when their cases were closed.

Marginal economic gains were realized for most successful clients. Half of the clients did not feel the services received were useful in getting a job--and they used little or none of their training on the job. Requirements for an individualized written rehabilitation plan were often not observed. Those clients with plans had a greater likelihood of being placed in competitive employment than those without.

Audit recommendations call for counselors to do more in providing job placement services and to be better trained in requirements for individualized written rehabilitation plans. Also, counselor caseloads needed to be reasonably limited, and supervisors needed to review client cases for completeness, particularly during critical points. Lastly, responsible HEW program staff needed to periodically check the accuracy of State agency reported data. These recommendations were under consideration by program staff.

SOCIAL SERVICES

Purchase of social services (Title XX, Social Security Act) by State and local governments accounts for over half of the $2.5 billion Federal allotment. Ten reports on contracting procedures in seven States identified significant weaknesses in: (i) contract monitoring, (ii) rates of payments to providers, and (iii) methods for charging costs to the contracts. One audit of State purchased Homemaker/Chore services disclosed improprieties on the part of private entrepreneurs. The Audit Agency recommended increased Federal monitoring. Program officials advised that corrective measures were being taken.

RETIREMENT AND SURVIVORS INSURANCE

Benefit Payments: Audits of the retirement and survivors insurance benefit payments process showed that SSA needed to develop an automated system to identify potential underpayment conditions that affect selected beneficiaries (i.e. those who have not met filing requirements for all benefits for which they may be eligible). Further that SSA's district offices ought to inform such beneficiaries of their potential right to higher benefit payments. The need for automation was also called for in certain cases involving benefit recomputations (those involving prior periods of disability, and where the beneficiary is due an increase in benefits). Some two-thirds of these recomputation cases still require manual processing in the Program Service Centers--a timely and expensive process.

SSA indicated general agreement with these recommendations for corrective action.

DISABILITY DETERMINATIONS

State agencies making disability determinations on behalf of SSA continue to experience problems in (1) implementing effective quality assurance procedures, and (2) submitting accurate claims for reimbursement of administrative costs.

Quality Assurance Procedures: SSA's Bureau of Disability Insurance has prescribed minimum requirements for the types of reviews considered essential for effective program monitoring. Four of the thirteen State agencies reviewed however, had not fully implemented these requirements. Auditors recommended the State agencies establish necessary procedures and controls and that SSA monitor their implementation.

Administrative Costs: Reviews of administrative costs claimed by 14 States noted that about $1.2 million--out of $124 million claimed--was either unallowable or unsupported by accounting records. To preclude recurrence of this problem, auditors recommended improvements in the State agency procedures for fiscal controls over the disability program.

Actions to implement the audit recommendations have been or are being taken.

HEW ADMINISTRATION

COMPUTER SYSTEMS SECURITY

Protecting Access to SSA's Data Bank: The Advance Records System--a telecommunications system maintained by the General Services Administration (GSA) for Federal Agencies--is used by SSA offices, State

agencies, and private insurance companies for SSA program and administrative purposes, and by 33 other Federal agencies. Auditors reviewed the systems' security to see whether a user of the system outside SSA could gain unauthorized access to SSA's central office data bank. It was concluded that security of the system could be compromised when certain specific conditions were met.

SSA agreed and promptly initiated meetings with GSA to jointly develop necessary corrective action. Pending permanent installation of needed safeguards, interim security measures were implemented.

Data Acquisition and Response System-Security Controls: Controls over the Social Security Administration's Data Acquisition and Response System (SADARS) were reviewed to evaluate the security of the system including its terminal facilities at SSA's headquarters in Baltimore. SADARS is used to process claim's data such as applications and eligibility changes for all SSA programs. Improvements were needed in (1) management guidance and emphasis on systems security, (2) security over terminal access and use, and (3) effectiveness of programmed security clearance system.

SSA generally agreed with the Audit Agency's findings and recommendations. They took prompt action to correct an identified systems control deficiency and subsequent tests showed that SSA's action to correct this problem was effective. In addition, security measures to correct other weaknesses were being considered or in process.

ADP SYSTEMS DEVELOPMENT POLICY

Certain personnel, contract, and grant information systems at the National Institutes of Health (NIH) were found to contain information duplicated in other management information systems within NIH and at the Department level. In these cases, data was being independently input into each system from basic source documents. Further study showed that this duplication occurred because of inadequacies in the Department's policies and procedures governing development and use of ADP systems. New ADP systems were not always adequately justified--monitoring of systems development was ineffective--evaluations of ongoing systems were not being made.

Auditors recommended strengthening of procedures over approval of new systems and periodic evaluations of operational systems to identify and eliminate duplication. Departmental policies dealing with these areas have been strengthened.

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ACCOUNTING OPERATIONS

Federal Assistance Financing System (DFAFS): Under DFAFS, recipients are provided cash in support of program needs, expenditure reports are received, and HEW's principal operating components are furnished with transaction data for their accounting systems. An audit found that poor accounting practices resulted in at least $43 million in payments made during 1975 and 1976 being unrecorded. and that another $15 million was recorded more than once or at incorrect amounts.

Recommendations for appropriate controls were accepted by Department officials who stated that significant improvements had been made to improve system integrity.

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SUMMARY OF OFFICE OF INVESTIGATIONS
CONVICTIONS REPORTED IN
CALENDAR YEAR 1977
(Includes Medicare/Medicaid)

1. School officials can and do take advantage of Student Financial Assistance Programs. The HEW Audit Agency reviewed the records of a Beauty School and discovered apparent misuse of Basic Eligibility Opportunity Grant (BEOG) and Federally Insured Student Loan (FISL) funds. The matter was then referred to the Office of Investigations.

   The investigation established that some students allegedly receiving loans and grants had never attended the school. Others had dropped out after short periods. Federal loan and grant funds were in fact diverted and were used by a school official to defray corporate expenses and for personal use.

   The school official was indicted on 30 counts of embezzlement, 9 counts of mail fraud, and 3 counts of false statements in February 1977; the school corporation was indicted similarly. In June 1977, the official and the corporation entered guilty pleas to 9 counts on all 3 types of violations; the remaining counts were dismissed. The official was sentenced in August 1977 to five years, suspended, placed on 5 years' probation, and ordered to make restitution of $74,000. The corporation's penalty (civil) has yet to be detemined.

2. The HEW Audit Agency referred another case involving a school which ultimately involved over a million dollars of student assistance funds. This was a long complex investigation necessitating the review of voluminous records, countless interviews, and numerous court appearances. It demonstrates clearly the cooperative efforts of the Audit Agency, the Federal Bureau of Investigation, the U. S. Attorney and OI.

   This enterprising "educator" diverted over $450,000 from BEOG, FISL, and the College Work Study (CWS) programs to his own use. Needless to say, it was a tedious task to piece together the financial manipulations pertinent to this diversion of funds to establish a total.

   It is interesting to note that this owner could have utilized an additional $400,000 of grant funds. This amount, however, was deobligated and the school owner did not get the opportunity to divert these funds.

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The subject was convicted and sentenced to four years' imprisonment and five years' probation. In August 1977, HEW obtained a civil judgment against the individual for $634,144.

3. Some Student Financial Assistance cases are relatively simple as previously noted. For example, a student employee of a school stole, forged, and cashed two BEOG checks totalling $1,200.

   An information charging violation of Title 18 U.S.C. 1003 (Issuance of a forged instrument) was filed in May 1977. Subject was convicted and sentenced to four years' imprisonment in June 1977.

4. One investigation centered on a doctoral candidate who falsified his income and received both BEOG and National Defense Student Loan funds. OI investigation confirmed the facts. The individual pleaded guilty to furnish false statements to the Government and was sentenced to 2 years' probation and ordered to make restitution of $5,500.

5. Schemes to bill the Federal Government constantly surface. Recently the United States Public Health Service (USPHS) advised that information had been received from a county health service agency which stated that its former purchasing agent had embezzled $87,619 in HEW grant funds.

   OI investigation and a private company audit disclosed that the purchasing agent had established a dummy corporation and ordered non-existent supplies from it. Payments to the company were deposited by the purchasing agent to an account he maintained under another name.

   A six-count indictment charging violation of Title 18 U.S.C. Section 1001 was returned against the subject by a Federal Grand Jury in November 1977. He was subsequently convicted on all counts and sentenced to four years' imprisonment.

6. The HEW Audit Agency advised that review of travel vouchers of two Regional employees indicated that they were altered and false claims were filed.

   OI investigation reflected that the two employees had each submitted three false lodging claims in 1975-76. Investigation included interviews of employees and contacts with hotels where employees allegedly were lodged.

   Both employees pled guilty to Title 18 U.S.C. Section 287 (fraudulent claims) and each was sentenced in April 1977 to one year's probation plus $900 fine.

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7. The SSA advised that they had received an anonymous allegation which indicated a Norwalk, California, SSA Field representative had issued benefit checks fraudulently.

   OI investigation disclosed that the Field representative had caused a benefit check to be issued to her mother who was ineligible for benefits. The employee admitted her guilt and was indicted on one count of violation of Title 18 U.S.C. Section 641 (unlawful conversion of funds) on April 20, 1977. She entered a guilty plea the same date and was sentenced on May 10, 1977, to five years' probation and ordered to make restitution of $7,800.

8. An HEW Regional Official requested OI aid in investigating the activities of a former employee. OI, along with Postal authorities, U.S. Secret Service, and local police, determined that the former employee had stolen, forged, and cashed five Supplemental Security Income (SSI) recipient benefit checks in late 1976.

   The individual was indicted by a Federal Grand Jury in April 1977, pleaded guilty, and was sentenced to three months' incarceration and placed on three months' probation.

9. An Assistant Regional Director for Management and Finance, DHEW, requested that OI investigate the travel voucher claims of a retired employee.

   It was determined that the former employee had falsely claimed over $1,300 in expenses for an inter-regional transfer.

   The former employee was indicted on three counts of false statements in July 1977. He was allowed to enter a guilty plea to two misdemeanor counts in August 1977, and sentenced to two years' probation, plus a $1,500 fine. Civil recovery actions may be undertaken.

10. A Special Project Officer of the SSA requested OI investigation into the procurement activities of a Regional SSA official.

    OI and Local investigation disclosed that the official had contracted with a builder for services to an SSA office and had accepted rebates and refunds from the builder. The official had also forged six purchase order forms for construction which, when checked, was not done on the premises described on the forms nor was it described correctly.

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The official was indicted on three felony counts in June 1977, and pleaded guilty to one count of violation of Title 18 U.S.C. Section 1001 (false statement) in December 1977. He was sentenced to five years' probation and fined $5,993.85.

11. The Social Security Administration requested that OI investigate the activities of a Regional employee. It was determined through interview and documentation review that the employee had converted three SSA overpayment returns to her own use. The employee admitted it.

    The employee pleaded guilty in June 1977, to an information charging two counts violation of Title 18 U.S.C. Section 641 (embezzlement). She was sentenced to four years' imprisonment, suspended, and four years' probation in July 1977. Conditions of probation include the restitution of $2,031.06.

12. Region IX advised that a Fiscal Services Officer had resigned when her activities were questioned. OI investigation disclosed that the ex-employee had converted to her own use monies from supposed advances to other employees.

    The individual was indicted for fraud against the Government in July 1976, and convicted of same in early 1977. Sentencing was deferred; defendant was placed on undeterminate probation, and ordered to make restitution of $693.50.

13. HEW Audit Agency review of Project Head Start grantee reflected unaccounted expenditures of grant monies. OI investigation disclosed that Project Director had embezzled $8,300+ and had converted these funds to his own use.

    A Project Director was indicted in July 1976, and pled guilty to two counts of embezzlement in December 1976. He was sentenced to three years' imprisonment and fined $500.

14. An HEW Audit Agency review of Project Head Start grantee disclosed missing records and an incomplete audit conducted by a private firm. Attempts to locate independent auditors indicated they were non-existent. OI investigation disclosed no private firm audit was conducted; checks made out to the audit firm were forged by Director of the project and pocketed.

    The Project Director admitted guilt, was indicted on two counts of obtaining monies of U.S. by fraud in October

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1976; he was convicted of two counts of embezzlement in January 1977; and received a suspended sentence, three years' probation, and ordered to make restitution of $4,800.

15. The HEW Audit Agency advised that officials of a Community Action Agency had misued OHD grants. OI investigation reflected that officials of the agency used grant funds for personal expenditures such as household items, repair to homes, etc.

Indictment returned in August 1976, led to a guilty plea from one official in March 1977, to a charge of embezzlement. Three other officials were indicted in January 1977, for making false statements, and each pled guilty to one count in May 1977. Sentences are pending.

16. One nursing home case is of particular interest because it shows the time-span involved. This case first received attention in 1971 by the Bureau of Health Insurance. It was referred to the U. S. Attorney in 1974. In 1975 a Grand Jury investigation began. In 1976 indictments were returned against three defendants and in November 1976 the owner and two of his corporations pleaded guilty to a criminal information. In 1977 the owner and two corporations were fined a total of $22,000. This case, investigated by OI in cooperation with the U. S. Attorney, HEW Audit Agency, and OPI is still an open matter. Over $100,000 in over-payments is involved and currently, civil fraud action is planned.

This is a significant case. It was successfully accomplished because of team action which, conservatively estimated, has taken at least five man years to date, and more time will be required for planned civil fraud activity.

17. Generally speaking, fraud in the Medicaid/Medicare area involves in large part, billing for services not rendered. OI in cooperation with OPI conducted a joint investigation regarding a physician. A State health finance monitoring agency and Medicaid carrier advised that reviews reflected that a physician had billed Medicaid for services not performed. The total false claims against the Federal Government were in excess of $200,000.

OI investigation reflected that the physician had billed for operations and lab tests that he had not performed, hospital visits not made, and other services not rendered. Records, reviews, and patient interviews were

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utilized to prove the case.

a 47-count indictment was returned by a Federal Grand Jury, charging false statements, against the physician in March 1977. He was convicted of 20 counts in May 1977, sentenced to 8 years' imprisonment, and fined $50,000. The sentence is now under appeal.

18. Another OI investigation in cooperation with OPI involved a Florida-based Home Health Care agency. Allegedly its officers had submitted inflated semi-annual cost reports to a Medicare carrier.

Investigation reflected that the officers had used Medicare funds for vacations, for non-existent attorneys' fees, had used Medicare funds to provide treatment to non-Medicare patients, had used Medicare funds to pay consultants, and had used Medicare funds as "kickbacks" to physicians for referral of patients. The agency was overpaid by $273,000 in FY 1975.

Three officers were convicted, two in March 1977, and one in July 1977, on charges that included mail fraud, conspiracy, and embezzlement. A total of seven years' imprisonment was imposed and civil recovery procedures initiated.

19. In another case a review of Medicare claims of a chiropractor reflected possible false claims. OI investigation reflected through review of claims and interviews of recipients that the chiropractor and his wife had made false claim statements to a Medicare carrier on over 300 occasions.

A six-count indictment charging violation of 18 U.S.C. Section 1001 (false statements) and 18 U.S.C. Section 371 (conspiracy) was returned in August 1977. Both were found guilty of a total of five counts in October 1977. The chiropractor was sentenced to one year imprisonment and three years' probation; his wife was sentenced to two years' probation.

20. OI and OPI cooperated in another investigation prompted by a review of Medicare claims of a physician which reflected possible false claims. OI investigation established through review of claims and recipient interviews that the physician and his wife had made false claim statements to a Medicare carrier on over 58 occasions.

A 20-count indictment charging violation Title 18 U.S.C. Sections 286 and 2 (conspiracy and fraud) was returned

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against them in June 1977. Both pled guilty to a total of three counts in August 1977. In October the physician was sentenced to three years' imprisonment and five years' probation; his wife was sentenced to three years' probation.

21. A review by a State Social Service Agency reflected that a dentist had submitted false claims to the Medicaid program. The matter was referred for investigation.

OI investigation indicated that the dentist wrote unnecessary prescriptions for Medicaid recipients, billed Medicaid for tooth extractions he didn't perform or that someone else had performed, and he also billed Medicaid for services he had previously billed for privately.

A 75-count indictment charging false statements was returned against the dentist in September 1976, by a Federal Grand Jury. He pleaded guilty to two counts in February 1977, and was subsequently sentenced to two years on the first count and one year on the second to run consecutively. The excess Medicaid payments received were over $250,000; civil recovery action is being considered.

22. A U. S. Attorney requested that OI participate in an investigation being conducted by Postal authorities and State officials in which it was ultimately determined that a number of physicians were billing Medicaid/Medicare for services not rendered and were receiving kickbacks from a medical laboratory which handled their unnecessary tests.

Sixteen indictments were returned in October 1976, and eleven convictions were obtained in June 1977 (against eleven physicians) resulting in fines of over $30,000 and a total of eight years' imprisonment.

23. Price-fixing, a cost-related matter, is also of interest to HEW. OI assistance was requested by a U. S. Attorney to assist local investigators in developing evidence of a violation of the Sherman Act, 15 U.S.C. Section 1, against hearing aid distributors in a large metropolitan area.

The investigation established that the distributors had conspired to fix prices artificially high for hearing aids and to stifle competition. Thirteen defendants were indicted in June 1976, and nine were convicted or pled guilty in April 1977, to conspiracy and mail fraud. Sentences are pending.

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MEDICARE CONVICTIONS IN CALENDAR YEAR 1977 REPORTED BY OFFICE OF PROGRAM INTEGRITY

OPI provided the IG with case summaries on all Medicare convictions in calendar year 1977. As noted previously, OPI's investigative effort covered a wide spectrum. Following is a description of each Medicare case investigated by OPI:

1. A case was opened as a result of a complaint by the fiscal intermediary, Prudential Insurance Company, that a laboratory was billing for services not rendered. The complaint was received in the New York Regional Office in April of 1976. Prudential reviewed 89 Medicare claims and found that on each one the laboratory was either misrepresenting services or altering bills by adding on tests which were not ordered by the physician. In June of 1976, the case was referred to the U. S. Attorney's office for prosecution.

   The corporation and one individual entered pleas of guilty in September to Federal conspiracy charges in U. S. District Court. The individual involved is currently serving a 6 to 9 year sentence imposed as a result of his conviction.

2. The New York Regional Office started an investigation of a New York dermatologist, in November 1975, after receiving a complaint from the carrier that the doctor was misrepresenting services rendered. On April 25, 1977, he was charged with 48 counts of filing false claims and 43 counts of mail fraud. He pleaded guilty and was found guilty in November 1977, to one count of submitting a false claim and is currently awaiting sentence.

3. A routine Regional Office investigation revealed that a physician's secretary, was billing for nonrendered services. She was billing Medicare for EKGs and X-rays which the physician did not perform, and forging the doctor's signature on the billing. The billings were primarily for services rendered nonassigned relatives. She pleaded in April 1977, to one count of mail fraud and was found guilty. She has not as yet been sentenced.

4. An investigation was initiated as a result of a beneficiary complaint to the Poughkeepsie Social

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Security Office that a physician had billed Medicare for services he did not render. In the course of the initial investigation, contacts were made with 15 beneficiaries, in addition to the children of 2 other beneficiaries, relative to 495 claims filed by the doctor from about October 1968 through March 1973. These claims represented a total of 4,280 billed services of which only 942 were verified as having been rendered. There were additional indications that a number of claims bearing the beneficiaries' signatures were forgeries.

On November 10, 1976, in United States District Court, Southern District of New York, this physician was found guilty of 53 felony counts (Title 18 U.S.C. Section 1341, 287, and 2) of willfully and knowingly making or causing to be made false statements or representations of material facts for the purpose of causing payments to be made under Title XVIII of the Social Security Act, as amended. As a result of the conviction, he was given a 2 year sentence of which 18 months was suspended provided he be confined to jail for 6 months. He was placed on probation for 18 months.

5. This case was opened on January 26, 1973, as a result of a beneficiary complaint to the New York Bureau of Health Insurance Regional Office that the physician had billed for in-hospital services he did not render. In the course of the initial BHI investigation, contacts were made with 13 beneficiaries, 10 of whom indicated their care by the doctor was in his office, although the billings were for home visits. It was subsequently established that he had submitted 410 claims for 64 beneficiaries; on these claims, he billed for home visits when, in fact, the services were rendered in his office.

The case was referred to the U. S. Attorney's office on January 8, 1976, with a recommendation for criminal prosecution. The doctor pleaded guilty to one count of unlawfully, willfully, and knowingly combining, conspiring, confederating, and agreeing with others to defraud the United States by obstructing and hindering the Department of Health, Education, and Welfare in administering the Medicare program. In 1977, he was given

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a 2-year suspended sentence, placed on probation for 6 months, and fined $2,500. Exclusion action is pending.

6. On October 28, 1975, the New York Regional Office received a complaint from a New York area carrier, Blue Shield, regarding alleged improper issuance of checks by one of their employees. An investigation was conducted by the NYRO and the Office of the United States Attorney, Southern District of New York. This led to a March 1976 indictment and the employee was charged with 18 felony counts. He was convicted after pleading guilty and was sentenced to four months in prison and 32 months on probation for embezzling more than $100,000 in Medicare funds. He also faces two Federal civil suits to recover more than $100,000 in total damages. The employee had manipulated claims data between 1971 and 1975 and caused a computer to issue checks to ineligible recipients who shared the proceeds with him.

7. The NYRO received a complaint from the Medical fiscal intermediary alleging falsification of records by the business manager of a nursing home. After investigation he was indicted in the Southern District of New York on 12 felony counts. The primary count being filing false Medicare and Medicaid statements. The false statements enabled him to pay for personal expenses when the money should have been used for the care of patients at the nursing home. He was convicted on two felony counts (conspiracy and false claims) and was sentenced on January 11, 1977, to five months imprisonment and fined $5,000. He was also sentenced on a related charge of inflating his employee withholding taxes to the IRS. He was placed on one year probation and ordered to pay a fine of $2,100.

8. In March 1976, New York Blue Cross/Blue Shield complained that a laboratory was submitting duplicate bills. After extensive investigation a part-owner of the laboratory was charged with 165 counts of conspiracy and submitting fraudulent invoices for Medicare and Medicaid claims. He was also charged with 65 counts of mail fraud and conducting an enterprise by a pattern of racketeering based on mail fraud. The laboratory was also charged with conspiring with the part-owner to defraud HEW and New York State. On

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December 9, 1977, both were found guilty by a jury on 30 counts of mail fraud, 77 counts of filing false claims.

9. The Prudential Insurance Company reported to the NYRO in March 1976, that a Convalescent Center was billing for services not rendered. After an investigation by the NYRO and the Department of Justice in Newark, New Jersey, a Grand Jury indicted the Convalescent Center and its administrator. Both defendants were charged on 16 counts, which included tax evasion and submitting fictitious and fraudulent statements to HEW. He pleaded guilty and was sentenced April 19, 1977, to 6 months in jail, 5 years' probation, and a $5,000 fine. The Convalescent Center was also fined $5,000.

10. The New York Blue Shield complained to the New York Regional Office that a Medical Therapy provider was generating duplicate billings at a rate of approximately 10 percent of their total billings for the first 6 months of 1975.

The owner and the Company were investigated by the Regional Office and on July 18, 1977, the case was referred to the U. S. Attorney. He was indicted September 12, 1977, for conspiracy, false claims, false statements, racketeering, and perjury, a total of 189 counts. He was tried by a jury, convicted in December 1977, on 57 counts of false claims, 34 counts of mail fraud, one count of perjury, and one count of conspiring to defraud the United States Government. On January 6, 1978, he was sentenced to 6 months in jail and fined $10,000. The Company was fined $15,000.

11. In May of 1975, the Chicago Regional Office began an investigation of a chiropractor as a result of beneficiary complaints that he was billing the Medicare program (through Blue Shield of Michigan) for services not rendered while operating a Clinic. The Regional Office interviewed 60 beneficiaries or their relatives and found additional allegations that spinal adjustment services had not been rendered although he billed for them. In addition, he received full payment both from the beneficiaries and from Medicare for those same services.

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He was indicted on December 16, 1976, in the Western District of Michigan on eight felony counts. He requested and received a change of venue to Oklahoma, having moved to the Tulsa area following his indictment. On February 15, 1977, in the U. S. District Court, Northern District of Oklahoma he was found guilty of two felony counts (Title 18, U.S.C. Section 1001) of willfully and knowingly making or causing to be made false statements or representations of material facts for the purpose of causing payments to be made under Title XVIII. As a result of the conviction, the doctor was sentenced to probation for a period of two (2) years on each count, to be served concurrently. In addition, as a special condition of probation, he was required to make full restitution of the $5,900 fraudulently obtained from Medicare.

12. In late 1974, the Chicago Regional Office began an investigation of an ophthalmologist as a result of a beneficiary complaint that he billed the program for the dispensing of a pair of contact lenses which were not received. Investigation determined that 14 of 25 beneficiaries interviewed by the RO and for whom Medicare claims had been submitted for the dispensing of contacts denied receiving any contact lenses.

    On January 19, 1977, in United States District Court, Eastern District of Michigan, the doctor pleaded guilty to one misdemeanor count (Title 42 U.S.C. Section 1395) of knowingly and willfully making or causing to be made false statements or representations of material facts in application for a Medicare benefit or payment. As a result of the conviction he was fined $2,500. The defendant was placed on probation for a period of 2 years during which he must donate 1 day per week of his professional services to the Greater Detroit Society for the Blind. The defendant must also make restitution of the actual money falsely claimed from the Department of Health, Education, and Welfare. Civil settlement is still pending.

13. An individual owned and operated five (5) nursing homes in California and Utah with another party from November 1972 to June 1974. In December 1974, Blue Cross of Utah received information

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that they were involved in falsifying various expenses relating to the operations of three Title XVIII facilities. An investigation conducted by the Program Integrity Branch, BHI, disclosed that the partners engaged in a scheme to receive kickbacks from physical therapists and pharmacies, and that they had received over $32,000 which they failed to disclose on the Medicare cost reports of three Title XVIII facilities for the fiscal years ending 12-31-72, 12-31-73, and 6-30-74.

On March 18, 1977, $40,000 was paid to the Bureau of Health Insurance in full settlement of all civil fraud liability. On May 2, 1977, one partner pled guilty to one misdemeanor count under 42 U.S.C. Section 1395 nn, of knowingly and willfully making and causing to be made a false statement and representations of material facts in an application for benefits from the Bureau. The U. S. District Court of California, Southern District (after transfer from the District Court in Utah) fined him $5,000 and sentenced him to 1 year in prison. The remaining seven counts were dismissed.

14. Investigation of podiatrist began January 1976. The case was brought to light through the investigation of an unrelated case. During an interview with a program specialist, a beneficiary mentioned a problem with a recent EOMB he had received.

A beneficiary alleged that the charges claimed by a podiatrist for an incision and drainage were in excess of services actually performed. The Regional Office surveyed over 400 beneficiaries and found 104 further allegations of fraud. The majority of these allegations involved misrepresentations of services: incision and drainage had been claimed when routine trimming of toe nails was the service performed. The number of counts involved was dropped to 24 at the time of the trial due to beneficiary deaths, inability to testify, etc.

On November 17, 1977, in United States District Court, Colorado, the podiatrist was found guilty on 22 of 24 counts (Title 42, U.S.C. Section 1395 nn (A) (1) of knowingly and willfully making or causing to be made false statements or

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representations of material facts in an application for a Medicare benefit or payment. He was fined $10,000 and received 2 years probation at his sentencing on November 30, 1977. The civil aspects of this case are still pending.

15. An investigation into the billing practices of the subject began 8-11-75, following the receipt of information from the carrier that he was billing for services not rendered. The investigation confirmed that the physician, in addition to billing for services not rendered, was collecting payments from his patients, and from Medicare and Medicaid. He was indicted on 4-12-77, on 10 counts of violating 18 U.S.C. 1001, 42 U.S.C. 408, 42 U.S.C. 1395 nn, and 31 U.S.C. 231. On May 31, 1977, he pled guilty to 2 misdemeanor counts and was sentenced July 13, 1977, to 3 months in prison, 21 months' probation following incarceration during which period he must work 2 days per week at a free clinic for 48 weeks per year. He was also fined $500. No civil action has been filed nor has administrative sanction been imposed.

16. An investigation into the billing practices of the subject began 3-13-75, at the suggestion of the Medicare carrier, Travelers Insurance Company, that he was billing for services not rendered. The investigation confirmed that the subject was billing Medicare for services which were in fact being rendered by his nurse and which were not under his personal direction or supervision.

    On January 19, 1977, the subject was indicted in U. S. District Court, Richmond, Virginia, on 18 counts involving the mail fraud statutes, 2 felony and 5 misdemeanor counts for submitting fraudulent claims to Medicare (and Medicaid).

    He was found guilty on 3-30-77, on the 18 counts of mail fraud (18 U.S.C. 1341). On April 25, 1977, the subject was sentenced to a 6-year prison term and fined $8,000. He will also be placed on 5 years' probation following his incarceration. Civil action is pending, and no administrative sanction has been levied.

17. An investigation into the billing practices of the subject was prompted 7-31-75, upon receipt of information from the carrier that he could

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be misrepresenting services. The investigation uncovered a billing scheme which involved billing Medicare for (1) excessive laboratory tests; (2) diagnostic tests that the laboratory did not or could not perform; and (3) automated tests as if they were done manually.

The subject was indicted on 10 counts of mail fraud and was convicted on April 13, 1977, for one felony count (18 U.S.C. 1431 and 2). He was sentenced to 2 years' incarceration in Federal prison. Civil action and a proposed termination for Medicare participation, are pending the subject's appeal of his conviction.

18. This investigation began February 17, 1976, following a complaint that the subjects. owners, stockholders, and employees of an Ambulance Association were misrepresenting services on Medicare claims. The development revealed that the subjects had indeed been submitting Medicare claims for ambulance service which their clients did not need and were misrepresenting the client's condition.

The three subjects were indicted 1-19-77, in U. S. District Court for Eastern Pennsylvania on 15 counts of violating 18 U.S.C. Section 1001 for making false statements on their Medicare claims. On March 13, 1977, the three subjects pled guilty on all 15 counts and on 5-19-77, were sentenced to a 3-year suspended sentence, a 6-month suspended sentence and the Ambulance Association was fined $1,000.

In addition, as part of a plea bargaining agreement, the subjects agreed to make restitution of $16,500 in Medicare payments. OPI recommended that the subjects be terminated from participating in Medicare program, and the association was notified of the proposed termination on 8-23-77. It requested and was granted a hearing on the proposed termination on November 30, 1977. The hearing officer has not rendered a decision to date.

19. In August 1973, the son of a beneficiary complained to a county (PA) medical society and the Medicare carrier, Pennsylvania Blue Shield, that a doctor was billing Medicare for services he had not rendered. An investigation of the

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claims submitted by the physician with respect to 35 beneficiaries was conducted, and discrepancies were found concerning 29 of these beneficiaries. On November 24, 1976, a criminal information was filed against him in the Eastern District of Pennsylvania citing 5 misdemeanor counts of submitting false Medicare claims (42 U.S.C. 1395 nn). On February 11, 1977, he entered a plea of guilty to all counts, and that same day was sentenced to 2 years' probation and was fined $500. A civil suit was filed against him in February 1977, claiming $10,000 in damages, but a compromise settlement of $2,000 was effected in March 1977. No administrative sanction has been imposed.

20. In April 1977, the SSA District Office in Petersburg, Virginia, advised the Philadelphia Regional Office (BHI) that they had reports of three attempts by an Ambulance Service to defraud the Medicare program. An investigation by the Regional Office revealed 36 instances of billing for ambulance services not rendered involving 14 beneficiaries. The owner pleaded guilty to one felony count and on October 17, 1977, was sentenced to 5 years' probation and ordered to make restitution of all Medicare/ Medicaid monies fraudulently obtained.

    OPI is preparing a recommendation to exclude subject from participation in the Medicare program.

21. In February 1974, a former employee advised the Philadelphia Regional Office (Bureau of Health Insurance) that two physicians were involved in questionable Medicare billing practices. An investigation of these practices revealed a high percentage of the services were not rendered. Because of these findings, criminal informations were filed against the two doctors and their nurse in the Eastern District of Virginia. On February 14, 1977, one doctor pled nolo contendere to seven misdemeanor counts of willfully making false statements on requests for Medicare payments, and was fined $5,250; the other pleaded nolo contendere to four counts of the information and was fined $3,000; the nurse pleaded guilty to 2 counts, and was fined $600. Both of the physicians continue to participate in the

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Medicare program as the result of decisions in their favor at termination/exclusion hearings held in September and October 1977.

22. On March 3, 1977, in U. S. District Court, Providence, two owners of a nursing home were indicted for eight felony counts under 18 U.S.C. 1001 and 2 and 11 misdemeanor counts under Medicare Title XIX in violation of Title 42 U.S.C. Section 1396 h (a) (1). The counts cite specific instances where owners knowingly and willfully make false statements of material facts on the cost reports filed with the Medicare intermediary, Blue Cross of Rhode Island. The false statements involved the inclusion of costs that had nothing to do with patient care.

On September 7, 1977, one owner plead guilty to one Medicare felony count in violation of Title 18 U.S.C. Sections 1001 and 2. The nursing home plead guilty to one Medicare felony count in violation of the same provision and also pled guilty to one Medicaid misdemeanor count in violation of Title 42 U.S.C. Section 1396 h (a) (1).

The subjects were sentenced on October 21, 1977, as follows:

1 year confinement (10 Months suspended)
$5,000 fine.

Nursing Home - $15,000 fine

OPI is preparing a recommendation for termination of subjects from participation in both the Medicare and Medicaid programs. This case was the subject of considerable press coverage.

23. Investigation of this case began September 7, 1976, following the receipt of information indicating that the subject may have presented false credentials in connection with the Medicare certification of the clinical laboratory at which she was employed. The investigation confirmed the suspicion by revealing she had misrepresented her qualifications on numerous occasions in order to meet the requirements as a laboratory supervisor thereby facilitating the certification of the laboratories for Medicare participation. The case was sent to

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the U. S. Attorney for Massachusetts on October 15, 1976, and a criminal indictment was obtained February 9, 1977, charging the subject with four violations of Title 18 U.S.C. Section 1001. The subject pled guilty to the four violations on June 28, 1977. The judge suspended the imposition of a sentence, however, he placed the subject on 1 year's probation and levied a fine of $500 payable during the probationary period. No civil action was instituted because the subject was not a provider, nor were the laboratories at which she was employed involved in the violations. Administrative sanction was not applicable.

24. On the basis of a July 1973 complaint from the daughter of a Medicare beneficiary, OPI began an investigation which ultimately established that principals of a Home Oxygen Supply Company had been billing Medicare for services they had not in fact rendered. On April 14, 1977, the Grand Jury in the U. S. District Court in Massachusetts returned a 55-count indictment of these defendants, for billing for more oxygen tanks than were delivered, in violation of Title 18 U.S.C. Section 1001 and Section 2.

    On September 9, 1977, one brother pled guilty to 30 counts of the indictment and the other pled guilty to 15 counts. They were sentenced on October 20, 1977 as follows:

    One brother was sentenced to 2 years' imprisonment (all but 6 months suspended); 2 years' probation; and a $10,000 fine.

    The other brother received a 1 year suspended sentence; 2 years' probation; and a $5,000 fine.

    A civil complaint was filed (July 8, 1977) against the subjects seeking damages, totaling $1.7 million. In addition, OPI will recommend termination from participation in the Medicare program.

25. An investigation was begun on this case on May 13, 1976, following the receipt of information indicating that the subject may have falsified her qualification of an independent clinical laboratory for participating in the Medicare program. The investigation established that she had in fact presented false credentials in connection with the certification of the laboratory. The case was presented to the U. S. Attorney for Massachusetts

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on July 21, 1976. On February 2, 1977, the subject signed a Statement of Acceptance of the Benefits of the Pre-trial Diversion Program and was placed on probation for 12 months with special conditions.

In view of the Pre-trial Diversion agreement, no civil action was contemplated nor was termination contemplated since she was merely an employee of the laboratory.

26. In July 1975, Blue Shield of Rhode Island (a Medicare carrier) informed the Boston Regional BHI Office that a Medical Laboratory may have been submitting Medicare claims for services that were not rendered. Subsequent investigation by the carrier revealed that nearly one-third of the services claimed for reimbursement were either not ordered by a physician or not performed. It was further determined that the owner and operator of the Medical Laboratory signed all Medicare claim forms.

After further case development, the U. S. Attorney for Rhode Island obtained a 3-count indictment against the owner for making false statements to obtain Medicare reimbursement (18 U.S.C. 1001, 1002). On February 2, 1977, the owner pled guilty to two of these counts, and on April 1, 1977, he was given a 1-year suspended sentence, a $4,000 fine and 1-year's probation. The terms of the probation required the subject to make full restitution of $40,000 and no further civil action is planned by the U. S. Attorney.

In a letter of December 27, 1977, the owner was notified that OPI intended to exclude services provided by him or the Medical Laboratory from coverage under the Medicare program. He was given 30 days to appeal this decision and asked for a hearing on the proposal to exclude. He has not yet responded.

27. In May 1973, a beneficiary reported to Blue Shield of Massachusetts (the Medicare carrier) that a doctor had billed for services that were not rendered. Subsequent investigation confirmed that the physician billed extensively for services not rendered. The case was referred to the U. S. Attorney on August 27, 1974, with a recommendation for prosecution.

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On September 24, 1976, this osteopath was indicted on 50 felony counts of filing false Medicare claims (18 U.S.C. 1001, 42 U.S.C. 1395). Six months later, on March 30, 1977, the defendant pled no contest to 15 counts, and the remaining 35 counts were dropped. She was sentenced on April 20, 1977, to a 6-month suspended sentence, a $4,000 fine, and 2 years' probation, during which she must contribute 5 hours of charity work per week.

On October 20, 1977, the doctor agreed to a $6,000 civil settlement, so that her total monetary loss (criminal fine plus civil settlement) was $10,000.

28. Culminating a two year investigation by the Program Integrity staff in Miami, and the United States Attorney's Office, a Federal Grand Jury in Fort Lauderdale, on June 16, 1977, returned two indictments charging 13 doctors and 3 laboratory officials with over 200 counts of conspiracy (18 U.S.C. 371), mail fraud (18 U.S.C. 1341) and Medicare fraud by the receipt of kickbacks (42 U.S.C. 1395).

The investigation began when a laboratory official contacted Blue Shield of Florida to inquire about the legality of third party handling fees. A scheme was discovered which involved kickbacks, or bribes, to the doctors by the three labs in return for their submission of blood specimens on Medicare patients. Typically, these physicians would receive $35 rebate for each blood sample sent to the labs for a comprehensive profile. Medical Administrative Services, a corporation conceived by two of the individuals involved in the scheme, functioned solely as a conduit of funds from the laboratories to the doctors. These labs billed Medicare for these tests at rates of 500 percent or more over what such tests would have cost at other labs. Medicare reimbursement was higher because these labs billed for the manual method of testing blood which is much more costly and time consuming than the newer automated method. Medicare approves of both forms of testing at remarkably different reimbursement rates. The doctors received automated lab tests on their non-Medicare patients to avoid the high charge to the patients.

In order to prevent complaints from Medicare patients, the labs did not bill for the deductible

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or co-insurance amounts. Furthermore, one lab operator falsified his records to make it appear that such billings were made.

During the 2-year period in which the scheme was in operation, the labs received approximately $600,000 in Medicare payments. The 13 doctors received kickbacks totaling over $120,000. To date, 9 have been convicted and the remaining doctors are awaiting trial.

Civil fraud action on all of the above individuals is pending. No recommendations for termination from the Medicare program under Section 229 have been initiated. However, one physician was excluded from Medicare participation on August 19, 1977, due to a previous conviction (11-12-76) for submitting false Medicare claims.

The remaining principals are scheduled for trial at a later date.

29. On September 22, 1976, and December 17, 1976, the Atlanta Office of Program Integrity received complaints alleging that a doctor was billing for services not rendered. The investigation disclosed that he and his wife were conspiring to fraudulently obtain funds by submitting false Medicare and Medicaid claims. His wife, a licensed practical nurse, worked as an assistant to him and was responsible for completion of the claims. The falsified services included office visits, injections, and lab work.

The couple was indicted on June 21, 1977, in Columbia, South Carolina. They were charged with nineteen counts of submitting false Medicare and Medicaid claims in violation of 18 U.S.C. 287 and 2, and were also charged with one count of conspiring to fraudulently obtain funds in violation of 18 U.S.C. 286 and 2.

On August 1, 1977, the doctor entered a plea of guilty on two of the false claims counts and was convicted in November 1977. He was sentenced to 3 years in prison beginning December 1, 1977, on the first count and five years probation to run consecutively with the prison sentence on the second count. His wife plead guilty at the same time to one count for submitting false claims. She was sentenced to three years probation.

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Civil fraud action is pending on this case. Termination action has been recommended.

30. Complaints were received in the Atlanta Office of Program Integrity on December 4, 1975 and January 26, 1976, which alleged that a physician was billing for services not rendered. The investigation confirmed that several beneficiaries did not receive all services that the doctor had claimed in his submittals for Medicare payment. It was also discovered that the doctor's wife who was also his secretary, had participated in submittals for Medicare payment.

On August 23, 1977, the doctor was indicted in Savannah, Georgia on six counts for knowingly and willfully making false statements in violation of 18 U.S.C. 1001. His wife was indicted on one count for knowingly and willfully preparing and submitting false statements in violation of the same statute. In addition, both were charged with conspiracy to commit offenses against the United States in connection with two of the counts in violation of 18 U.S.C. 371.

They were convicted on October 21, 1977. The doctor was found guilty on three counts of 18 U.S.C. 371. He was sentenced to one year in prison, and on November 14, 1977, he surrendered to the U. S. Marshal to begin serving sentence at Elgin Air Force Base, Florida. His wife was found guilty on one count of 18 U.S.C. 371 and received two years' probation.

Civil fraud action is pending.

31. The Atlanta Office of Program Integrity received a complaint on January 27, 1969, which alleged that a doctor was billing for services not rendered. The investigation disclosed that the doctor had, in fact, submitted Medicare claims for more services than were actually rendered to several beneficiaries. He was indicted on May 7, 1971, on four counts of 42 U.S.C. 408 (c) and four counts of 18 U.S.C. 1001. Both statutes concern making false statements.

The doctor fled to Canada in 1971 before litigation could take place. He returned to the U.S. in 1976. He pled guilty on March 15, 1977, to two counts of 42 U.S.C. 408 (c) and received two years' suspended sentence, a $1,500 fine, and

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two years' probation.

Civil fraud action is currently pending.

32. A husband and wife were the operators of a Home Health Agency. On February 2, 1976, a complaint was received from a former employee alleging that the two individuals were submitting personal items on cost reports. After investigation by the Atlanta Office of Program Integrity, the case was turned over to the Office of Investigations which is currently continuing the investigation.

The couple was indicted, however, on June 9, 1976, for perjuring testimony given before a Federal Grand Jury. They were prosecuted under 18 U.S.C. 1623. The husband was convicted on three counts on December 10, 1976, and was sentenced on February 4, 1977, to two years imprisonment on each count to run concurrently. His wife was convicted on one count on the same date and was also sentenced to two years imprisonment. All but six months of her sentence was suspended. She also was placed on three years probation.

In addition, the President of a Home Health Agency was indicted under 18 U.S.C. 1623 for perjury during the same Grand Jury proceedings. He had given false information relating to a contract between himself, as the President of the Home Health Agency, and the couple who operated it. He was convicted on two counts on February 10, 1977, and was sentenced to two years imprisonment on each count with all but six months suspended. He also was placed on two years probation.

33. An anonymous complaint was received in the Kansas City Regional Office on September 30, 1975, alleging that the doctor was billing Medicare for services not rendered. This was confirmed by the Regional Office and the case was referred to the U. S. Attorney on March 26, 1976. On June 9, 1977, the doctor and an employee were indicted in Kansas City, Missouri. They were charged with 49 counts of violating Section 1001 and Section 2, Title 18 U.S.C. The indictment alleged that the two made statements claiming Medicare payment for treatment of patients when they knew that some of the patient visits were not made and treatment was not given. The doctor pleaded nolo contendere to one misdemeanor count on October 21, 1977. On

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November 23, 1977, he was fined $2,500 and his employee was fined $500.

34. In December 1973, the daughter of a Medicare beneficiary filed a complaint that a doctor had billed Medicare for podiatric services which had not, in fact, been rendered. The subsequent investigation into services not rendered to other beneficiaries revealed that he was billing Medicare for treatment of mycotic toenails or for the complete excision of toenails when he was actually providing routine footcare which is noncovered by Medicare. On October 14, 1976, a Grand Jury in the Northern District of Texas indicted this podiatrist on 19 felony counts (18 U.S.C. 1341). On May 19, 1977, he was convicted on 4 counts of the indictment of causing fraudulent Medicare claims to be delivered by the U. S. Postal Service to the Medicare insurance carrier. The sentencing, originally scheduled for June 10, 1977, has not as yet been rescheduled because of a presentencing investigation. He has been notified of Medicare's intention to exclude him from the program, and he has requested a hearing on the matter.

35. An investigation of the billing practices of the subject began 2-7-75, based on the Texas DPW referral of a complaint that the subject was billing for services not provided. The investigation revealed the subject had in fact been submitting claims which were fraudulent. The subject was indicted on 10-14-76, in U. S. District Court for Eastern Texas on 5 felony counts under 18 U.S.C. 1001. He pled guilty to 1 count of the indictment, was subsequently fined $1,000 on 5-6-77.

No civil action was filed nor has any administrative sanction been imposed.

36. This investigation began December 6, 1976, following the referral of a complaint received in a district office that the subject may be billing for services not rendered. A joint investigative effort by OPI, the Office of Investigations, and the Texas Department of Public Welfare established that the subject had been billing Medicare and Medicaid for services (primarily, cystoscopics) never actually rendered. On March 22, 1977, the subject was indicted in U. S. Western District

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Court, Texas, on 43 counts in violation of 18 U.S.C. 1001. He was convicted of 20 counts of the indictment on 5-21-77, and sentenced to 8 years' inprisonment and fined $50,000. The subject has appealed his conviction to the Fifth Circuit Court of the U. S. Court of Appeals, New Orleans, Louisiana, and the proposed exclusion of the subject from the Medicare program is being abated pending the outcome of the appeal.

37. On July 13, 1977, the U. S. Attorney for the Northern District of Texas obtained a 36-count indictment against two Dallas podiatrists for filing false Medicare claims (42 U.S.C. 1395). On November 2, 1977, during their trial, each defendant pled guilty to one misdemeanor count under 42 U.S.C. 1395 nn (a) (1). As part of this plea-bargaining, the defendants were guaranteed probation. On November 23, 1977, each defendant was fined $10,000 and sentenced to 5 years' supervised probation.

As part of the civil settlement, each defendant forfeited $2,000 and suit costs.

38. In December 1976, a Grand Jury in San Antonio, Texas, indicted a doctor on 36 counts of filing false Medicare claims (18 U.S.C. 1001). On March 28, 1977, the defendant pled no contest to one of the felony counts, and the remaining 35 counts were dismissed. As a result, the physician was sentenced to 5 years' imprisonment and a $10,000 fine. Additionally, as part of the civil settlement, he agreed to refund approximately $10,000 in overpayments to the Medicare program.

However, the unexpected severity of the sentence led the doctor to obtain new counsel and request that his plea be withdrawn. The request was granted, and the defendant is now scheduled for a jury trial later this year. Program termination action is being held in abeyance until the results of the trial are known.

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ON-SITE ANALYSIS OF NEW YORK SPECIAL PROSECUTOR'S OFFICE

LESSONS LEARNED IN NURSING HOME INVESTIGATIONS

The Office of the Inspector General is in the process of developing special techniques to provide for selection and indepth review of nursing homes. In pursuit of this initiative a senior member of the Health Care Systems Review staff recently spent a substantial period onsite at the office of the special prosecutor, State of New York, in an extended analysis of that operation designed to determine effective methods for use by other jurisdictions. A detailed report of this analysis is being prepared, but some of the more significant findings will be summarized here:

1. Use of Subpoena Power - based on the New York experience, any jurisdiction undertaking a vigorous nursing home investigative program can expect to be required to issue subpoenas to obtain access to nursing home records and to have the validity of its subpoena power tested in the courts. Such legal challenges can also be expected to last for extended periods of time as appeals are taken from lower court decisions.

2. Need for Third Party Contacts - most illegal acts in New York State Nursing Homes have been found to fall into the categories of (a) kickback arrangements between nursing homes and vendors and (b) personal expenses added to nursing home costs. Essential to investigation of both of these categories is evidence provided by the third parties. Securing such information from third parties in the case of personal expense additions is generally less difficult than in kickback arrangements since in the former instances the vendor is generally not a party to the illegal act. Even in kickbacks, however, success may be obtained by indicating to the vendor that the prime area of concern is nursing home costs. In some cases, however, the use of subpoenas will be necessary to obtain desired records.

3. Need for Vendor Analysis in Areas with Concentration of Nursing Homes - the New York experience is that there is a direct correlation between a concentration of nursing homes and the likelihood of kickback arrangements. This relation would seem to be explained by the fact that where there are such concentrations there also are vendors which have a high volume of business with nursing homes so that

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"bidding" for such business through kickbacks is economically valuable. This possibility suggests the need for identification of areas with a high concentration of nursing homes and an analysis of the vendors in such areas who are engaged in supplying significant numbers of these homes; these provider-vendor constellations can then be targeted for close examination.

4. Need for National Coordination for Examination of Multi-State Chain Operations - the New York Special Prosecutor has encountered a number of situations where owners of providers under investigation in New York State also own facilities in other States. Through the cooperation of other States, it has in some cases proved possible to conduct joint investigations of such providers. However, a clear need exists to coordinate such multi-state investigations at a national level.

5. Sentencing of White Collar Criminals - the New York Special Prosecutor's office appears to have had greater success in securing convictions of their subjects than in securing sentences commensurate with the magnitude of the illegal acts. The national experience in this respect needs to be examined for a concerted national effort.

6. Coordination of Criminal Prosecutions with Civil Recovery - through arrangements with the New York Departments of Health and Social Welfare, the New York Special Prosecutor's office has assumed jurisdiction for civil recovery of overpayments to audited providers as well as criminal prosecution of such providers. This combination of possible avenues of correction of incorrect and/or improper payments to providers provides additional flexibilities in monitoring the provider population and its implications are being studied nationally.

7. Problem Costs - the New York Special Prosecutor's office has identified a number of expense areas on providers' cost reports which appear most often to contain improper costs. The applicability of this experience to other jurisdictions is under consideration.

8. Account Certifications - the New York State Department of Health Regulations require that an accountant's certification be submitted with each cost report submitted by a provider. The special

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prosecutor's office has recently moved for professional disciplinary action against certifying accountants in cases where the investigation has disclosed that such a certification violates professional standards; in at least one case an accountant's license has been suspended as a result of his failure to meet professional standards. The applicability of this approach on a national level is under consideration.

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Synopsis of Audit Reports on Student Financial Aid Programs Guaranteed Student Loan Program, Campus Based (CWS, NDSL and SEOG) and Basic Educational Opportunity Grant Programs

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Synopsis of Audit Reports on Student Financial Aid Programs

Guaranteed Student Loan Program (GSL), Campus Based (CWS, SEOG and NDSL) and Basic Educational Opportunity Grant Program (BEOG).

INTRODUCTION

This synopsis of audit reports covers all of the reports issued on the GSL program for the period 1971 through November 1977 and a select sample of 77 audits on the student financial aid programs performed by the Audit Agency on participating institutions during the period July 1974 through November 1977.

The majority of the audits of the Campus Based (NDSL, SEOG, and CWS) and BEOG programs are done by independent accountants (Certified Public Accountants, State auditors, or other licensed public accountants). The Audit Agency performed all of the audits of the Guaranteed Student Loan Program. The HEW Audit Agency performs audits of the student aid programs at institutions normally whenever we have knowledge of problems or receive a special request from the Office of Education, Office of Investigations, DHEW, or other Department officials.

The responsibility for safeguarding the use of Federal funds does not belong to the Federal Government alone. Recipients of Federal funds such as colleges, universities, and vocational schools--proprietary as well as non-profit--have a responsibility for proper financial management and accountability of the funds. Institutions participating in DHEW Student Aid programs must exercise a full measure of financial management, which includes both internal and independent audit, as a part of the its system of controls. The Audit Agency's role is seen as one of overview which utilizes as fully as possible the work performed by others and encourages adequate coverage by them of adherence to Federal requirements.

Based on these concepts, the HEW Audit Agency and the Office of Education started in 1967 a joint effort to encourage institutions to utilize independent auditors for audits of the National Direct Student Loan, College Work Study and the Supplemental Educational Opportunity Grants Programs. The effort was successful in that approximately 1,100 of the 3,000 participating institutions were utilizing the services of their independent auditors. Beginning with the program year ended June 30, 1977, the

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institutions are required by law to have an audit of the programs at least once every two years.

Audits of student aid programs are to be performed in accordance with the audit requirements set forth in audit guides prepared by the HEW Audit Agency, with the assistance of representatives from the American Institute of Certified Public Accountants and the Office of Education. Upon completion of the audits, copies of the audit report are submitted to the HEW Audit Agency for review, approval and transmittal to the Deputy Commissioner, Bureau of Student Financial Assistance. On a selective basis and as the need dictates, the HEW Audit Agency reviews the working papers prepared by the independent accountants and visits certain institutions to evaluate the management of these programs.

BACKGROUND

Background program information follows:

The Guaranteed Student Loan program is authorized by Title IV, Part B of the Higher Education Act of 1965, (P.L. 89-329) as amended.

The primary purpose of the Guaranteed Student Loan program is to make low interest loans available to students to help them meet their postsecondary educational expenses. The program itself provides benefits under loan guarantee programs of state and private non-profit agencies and, in limited circumstances, under a program of Federal loan insurance. The objective of the program is to provide loans to students attending eligible institutions of higher education, vocational, technical, business and trade schools, and eligible foreign institutions. The program is designed to utilize private loan capital supplied primarily by commerical lenders, but also by some state agencies and educational institutions acting as lenders. These loans are guaranteed either by individual state agencies (reinsured by the Federal Government) or directly by the Office of Education.

Through December 1976, about 9.4 million loans totaling over $10.9 billion have been made by about 19,000 lenders participating in the program. About 8,120 institutions are eligible to provide the educational services for student recipients of loans under the program, of which 3,500 are vocational, technical, business and trade schools, proprietary as well as public and private non-profit institutions.

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The National Direct Student Loan program was established under Title II of the National Defense Education Act of 1958 (P.L. 85-864). The Education Amendments of 1972 transferred the program to Title IV, Part E, of the Higher Education Act of 1965 and changed its name from the National Defense Student Loan program to the National Direct Student Loan program. The program provides for the establishment of an NDSL fund at each participating educational institution for the purpose of making long-term, low-interest loans to qualified students who need financial assistance to pursue a course of study on at least a half time basis. Contributions to the loan fund are made by OE and the school in a 9 to 1 ratio. In academic year 1976-77 the appropriation for the NDSL program was $317.1 million. About 825,000 students received loans from the 2,867 institutions participating in the program during that period.

The Supplemental Educational Opportunity Grants (SEOG) program provides financial assistance to undergraduate students of exceptional financial need who otherwise could not afford to attend the institutions. About 442,000 students, attending 3,517 different institutions received SEOG awards during academic year 1976-77. The appropriation for that period was $238.5 million.

The Basic Educational Opportunity Grant (BEOG) program, the newest of the OE student financial aid programs, provided funds for the first time in 1973. Basic grants are awarded to all financially needy students enrolled in eligible programs at eligible institutions of post-secondary education to help defray the costs of their education. During the 1976-77 academic year about 1.9 million students in over 5,200 institutions received grants from the program's appropriation of $1.5 billion.

The College Work-Study program provides funding for part-time employment opportunities for students who need the earnings to pursue their course of study at institutions of higher education. In academic year 1976-77 over 893,000 students benefitted from jobs under the CWS program. The Federal funds available to pay 80 percent of the wages for these students totalled $387.9 million.

RESULTS OF AUDITS

This section contains a summary of findings from several centrally coordinated reviews under which top management reports were issued, and results from individual reports issued on participating institutions.

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Guaranteed Student Loan Program

The Audit Agency has expended approximately 82 man-years of direct effort on the GSL program through FY 1977. We have performed audits at OE and the regional offices, State guarantee agencies, lending institutions and eligible schools. To date we have issued about 90 audit reports.

FY 71 Audit of OE and State Agencies

Audits of the Guaranteed Student Loan program began in January 1970 with a "Review of the Administration of the Guaranteed Student Loan Program by the Office of Education." This audit, covered OE operations, banks and State guarantee agencies in Massachusetts, Pennsylvania, Illinois, New York, and Wisconsin.

The audit of a State agency included reviewing their policies and procedures for approving loan applications, collection of insurance premiums, monitoring the enrollment status of students, monitoring the claims and collection practices of lending institutions, and the collection of default claims purchased from lenders.

This audit disclosed serious weaknesses in several areas. We found that interest subsidies were being improperly computed by many lenders and OE's GSL system did not have the capability to verify lender's subsidy billings. Claims were being paid by OE without requiring certain essential supporting data, i.e., date student withdrew from school; copies of final demand letters evidencing due diligence; and death certificates for claims based on death of a borrower. We also found that the system was deficient with respect to internal controls over claims and collections. (ACN 12-20006, April 17, 1972)

Consolidated Review of Lenders

Because of the inability of OE's system to verify interest subsidy billings, the Audit Agency made a special review of a statistically selected sample of lenders to determine the overall reliability of lender interest billings and the extent of compliance with the "due diligence" requirement. This review, started in June 1972, covered 108 lending institutions and resulted in a report to OE dated September 7, 1973. Ninety-six of the 108 lenders had erroneously computed their interest entitlements. We estimated that, out of the $167.5 million of interest benefits paid by OE to the 22,000 lenders participating

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in the program for the period April 1, 1971 to March 31, 1972, overbillings totalled $6.1 million (4 percent). We also found that 14 (13 percent) of the 108 lenders were not complying with the due diligence requirements in their collection activities.

As a result of our alerting OE of our preliminary audit findings, they promptly issued advice to lenders of the problem areas disclosed by our review and also issued instructions which we felt would eliminate some of the causes for errors.

In addition to these actions, our principal recommendations were to assign priority for on-site visits by OE employees to the larger lending institutions where the magnitude of errors and program impact was greatest and to recover the $1.2 million in overbillings by the lenders included in our review, of which $1.1 million was by the 18 largest lenders. Other recommendations included alerting all lenders to the causes we found for errors in computing special allowances and following up on the weaknesses in due diligence at the 14 lenders identified in our review.

Follow-up - First Voc-Tech Audits

Our audit work for 1973 and 1974 included follow-up reviews of 14 lenders and another 5 State guarantee agencies. In addition to finding that most of the lenders had settled with OE, we also found that more overbillings had occurred in the subsequent period at 13 of the lenders. During these fiscal years we had, on our own initiative or by special request, performed about a dozen vocational-technical school audits. These resulted from Congressional requests, bankruptcies, school closings, private party allegations or press exposes. These audits, coupled with information coming to light from OE program reviews and other sources, disclosed a disturbing pattern of program abuses by all types of participants but particularly by proprietary schools, especially those which were lenders, and to a lesser extent by the financial organizations which bought their paper or made loans to their students.

In August 1974, the Secretary was provided with information from the Audit Agency and others. Our analysis suggested the following as some of the underlying causes of high default rates and overstated interest charges associated with loans to students of proprietary schools.

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--False advertising, unkept promises, and inequitable and ignored refund policies contribute to a student's decision not to repay his loan.

--Allowing a school to be a lender and allowing a lender to sell its paper, thus generating capital, tempts schools to emphasize sales to the detriment of due diligence, to engage in prohibited practices to sell paper, and in general to overextend themselves.

--Lack of notification by schools to lenders about changes in student status causes loss of contact with the borrower and increases the changes for default.

--HEW reliance on the accreditation agencies for school eligibility purposes.

This information was transmitted by the Secretary to Commissioner of OE on August 12, 1974. The information provided by the Audit Agency was useful to OE in developing the new regulations issued in February 1975.

Audit of Claims and Collections

Another review entitled "Controls Over Defaulted Claim Files and Collections - FISLP - GSLP" (ACN 12-63010, October 15, 1975) was started in FY 1975. This review, which followed up some of the results of the FY 71/72 audit, covered OE headquarters and each of the regional offices. We reviewed procedures for controlling claim files and for collecting, depositing, recording, and reconciling receipts. We tested collection receipts, examined default case files and verified transactions of claims between regions.

We found that serious problems persisted in OE's controls over default claims under the FISLP. Specifically, (1) the Office of Guaranteed Student Loans did not have accurate records of the location of claim files for the estimated 190,000 default claims on hand at headquarters and in the regional offices; (2) except for Region VIII, the regions did not maintain accounting control over loans receivable and the headquarter's control account did not agree with subsidiary records; and (3) internal control, both at headquarters and in the regions, over repayments on defaulted loans was extremely weak. These conditions make it relatively easy for collections to be diverted to personal use, claims to be lost and errors in borrower's accounts to remain undetected. OE is designing a new system, which they believe will correct the problems

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disclosed by our audit.

Consolidated Voc-Tech Audit

The Audit Agency work for FY 76 and 77 included a review of 25 proprietary vocational schools located in 15 States throughout the country. Three of the schools were correspondence, twenty-one were residential, and one provided both types. We reviewed school operations,including recruiting practices, job placement activities, quality of instruction, student attendance, refund practices, enrollment standards, financial stability, and the composition of factors influencing tuition charges, as well as the accuracy of interest billings and the compliance with due diligence requirements.

The selection of schools audited was based on several criteria. First, if possible they were to be lenders as well as eligible schools under the GSLP. Second, we tried to select schools with which OE had some reason for concern. We, therefore, asked OE to identify those schools which they had reason to believe might be problem cases.

At 16 of the 25 schools we estimate that over $30 million of refunds to students, GSL lenders or OE program accounts were late, incorrectly computed, or not made at all. As a result, the GSL program was billed for excessive interest of $10.3 million and its contingent liability for defaults was significantly overstated. We also found $1.8 million of additional interest overbillings mainly attributable to unsupported estimates of loan balances and delayed graduation of students. Over 80 percent of these overbillings were attributable to correspondence schools.

In addition, expenditures for the other OE student financial aid programs were overstated and a number of needy students were denied access to postsecondary education. We are recommending regulation changes as well as close monitoring of the recovery of interest overbillings and the correction of the deficiencies which caused them.

The financial condition of eight of the schools was such that it was doubtful that they would be able to continue operations. In fact, six of them have already closed or filed for bankruptcy. School closings are particularly hard on the affected students who are frequently unable to complete their education or obtain refunds and are often left with loans to repay. Although not all of the school closings or bankruptcies could have been prevented, we are recommending extension of the GSL regulations on financial condition to all of the student aid programs

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and establishment of a monitoring system which would provide early warning signals. This would give OE a chance to help avoid those situations which currently allow only costly, frustrating, and often futile salvage operations.

Seven schools were using misleading or inaccurate information about job placements, class sizes, training materials, and equipment for "hands-on" training to attract students. The schools' failure to provide the end products and services promised was a major contributing factor to many students' feelings that they had been deceived. We found that many of these same students later dropped out of school and, in some cases, defaulted on their loans. In our opinion, one of the major reasons behind the schools' practices was the intense competition among proprietary vocational schools to attract large numbers of new students. Elimination of these misrepresentations will require not only the issuance of regulations compatible with those being proposed by the Federal Trade Commission, but also a cooperative enforcement program with the Commission.

Four schools did not exercise due care and diligence in their GSL collection activities. This adversely affected their right to be reimbursed under OE's guarantee of the loans and the ultimate collection of more than 20,000 loans totaling over $9 million. In addition to inadequate collection practices we found that the schools did not graduate or terminate students, request OE pre-claims assistance or file GSL default claims in a timely manner. We are recommending that OE remind all school lenders of the necessity for due diligence and deny payment of all defaults which do not evidence it.

In recognition of the fact that problems were found at 21 of the 25 schools, we are recommending that OE:

--give high priority to proprietary vocational schools in its compliance and program review activities,

--focus such activities on the institution rather than individual programs,

--place high priority on issuing the currently proposed regulations and making the needed changes to current regulations, and

--reemphasize to all proprietary vocational schools, their responsibilities under the student financial aid programs.

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This report has been staffed with BSFA and their written comments have been received. BSFA concurs with our findings and all but two of the recommendations. We are recommending that OE reconsider its position on these two recommendations. We plan to issue the final report within the next 60 days (ACN 14-81350).

Campus Based (CWS, SEOG, and NDSL) Programs and Basic Educational Opportunity Grant Program (BEOG)

A total of 4,148 audit reports were issued during the 40 month period between July 1, 1974 through November 30, 1977 (3,927 by non-Federal staff -- 221 by HEW staff). We estimate that about 50 percent of the audit reports contain findings. These reports contained 4,894 findings totaling $36.7 million. Most findings noted were of a procedural type, dealing with such items as weaknesses in the institutions' accounting systems, internal controls, payroll practices and financial reporting. The more serious problems were noted in HEW performed audits and tended to be in the area of the institutions' financial stability, improper use of Federal funds, student eligibility determinations, awarding procedures and refund practices. The 221 reports issued by the HEW Audit Agency account for 72 percent of the total funds questioned during the 40 month period ($26.5 million out of $36.7 million). As of November 1977, the Office of Education has cleared $2.9 million of the $26.5 million and has concurred with the Audit Agency on $2.2 million.

Following is a summarization of the audit results contained in 77 of the 221 reports. The criteria for selection of the audit reports was the use of 50 man-days or more to complete the assignment. Included in the sample of 77 are 20 - 4 year institutions, 7 - 2 year institutions and 50 - proprietary vocational schools. The following schedule, "Summary of Audit Results" shows that the types of deficiencies noted in the reports except for refund policies and practices are applicable to all types of institutions. Even though weaknesses in refund practices were not noted at the 4 year and 2 year institutions we believe a potential problem exists at those institutions. The significant findings pertaining to refund practices were developed largely under the Guaranteed Student Loan Program and at proprietary vocational schools. This was greatly influenced by the facts that: these schools have been eligible to participate in the other student aid programs for a much shorter period of time than the GSL program; more HEW resources were devoted to proprietary vocational schools; and regulations on refund practices and procedures were not as well defined during this period for the campus based and BEOG programs. Consequently, this area received little or no coverage in the audits at the 4 year and 2 year institutions.

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Summary of Audit Results on
77 Audit Reports Issued During
July 1974 through November 1977

Type of Deficiency	4 Year Institution	2 year Institution	Proprietary Vocational Schools	Total Occurrences	Percentage of Occurrences
Number of Institutions	20	7	50	77	
Eligibility and Awarding Procedures	14	7	18	39	51%
Internal Controls, Accounting Systems and Record Maintenance	15	5	15	35	45%
Refund Policies and Procedures	-	-	34	34	44%
Due Diligence	12	4	14	30	39%
Institutional Matching	8	5	9	22	29%
Financial Stability in Question or Institution Closed	2	-	20	22	29%
Federal Funds Improperly Used/Unaccounted For	5	1	11	17	22%
Federal Cash Balance - Excessive	4	2	8	14	18%
Ineligible work Projects and/or Questionable College Work Study Payments	7	2	3	12	16%
Students in Ineligible Programs	-	-	7	7	9%
Recruiting Practices	-	-	7	7	9%
Inducements to Lending Institutions	-	-	5	5	6%

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Eligibility and Awarding Procedures

We found that 39 of 77 institutions needed to improve eligibility and awarding procedures to assure that funds are being awarded only to eligible students and in the proper amounts. The reports identified over 8,500 student cases totaling about $4 million which was awarded improperly. In the 39 institutions, we found 90 instances of weaknesses.

--27 awarded amounts in excess of computed financial need

--17 awarded funds to ineligible students

--12 did not have adequate documentation to support awards

-- 9 had not prepared any needs analysis or analysis was incomplete

-- 9 had not maintained student files or files were incomplete

-- 7 had no evidence that students attended classes after enrollment or continued in attendance after reporting to classes

-- 6 had not determined eligibility of students before making awards

-- 3 had not maintained on file the required affidavit of educational intent.

Internal Controls, Accounting Systems and Record Maintenance

We found that 35 of 77 institutions could not demonstrate that they had an adequate accounting system to provide accurate financial data or effective control over Federal funds. In the 35 institutions, we found 68 instances of weakness.

--17 had inadequate or significant weaknesses in their accounting system used to account for Federal funds

--13 could not support their financial statements with their books and records

-- 7 needed to safeguard NDSL records and promissory notes

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-- 7 needed to segregate duties and responsibilities among the staff

-- 6 had accounting record deficiencies on the NDSL program

-- 5 had not performed monthly bank reconciliations

-- 5 had not established formal written accounting policies and procedures

-- 4 had payroll record/procedure deficiencies - CWS program

-- 4 needed to improve coordination between Student Financial Aid Office and Business Office

Refund Policies and Practices

We found that 34 of 77 institutions had not made timely and correct refunds totaling about $15.7 million to students, banks, other lenders and OE program accounts. As a result, the GSL program was billed for excessive interest charges totaling about $10 million and its contingent liability for defaults was significantly overstated. Due to the condition of the records at some of the schools, we could not determine the exact amount of these refunds.

Due Diligence

Thirty of the seventy-seven schools had not exercised due care and diligence in administering the NDSL or GSL loan programs. In the 30 institutions we found 82 instances of weakness.

-- 14 needed to establish collection procedures

-- 14 had a high percentage (15 percent or more) of loans in past due/default status

-- 10 had not held exit interviews with students

-- 6 had notes not signed or dated by students, missing or not properly executed

-- 6 had incorrect or undocumented information in loan files

-- 4 had not followed OE requirements on frequency and time frames for making initial contact with the

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student, mailing follow-up collection letters, final demand letters and requesting preclaim assistance; GSL program

-- 4 GSL lenders did not promptly notify OE when a student borrower defaults in his payments

-- 3 made incorrect interest computations

-- 3 retained excess accumulation of cash in NDSL loan fund totaling $639,877

The delinquency rate on the NDSL loans has been a problem at the institutions. Therefore, in April 1973, we issued an audit report to the U.S. Commissioner of Education, disclosing the significance of this problem. The report disclosed that about 25 percent of the participating institutions (2200) had been experiencing loan delinquency rates in excess of 10 percent, even though OE had prescribed what seem to be appropriate collection procedures for the institutions to follow.

We recommended that OE (1) determine the status of implementation of OE collection procedures at all institutions and assist those experiencing implementation problems, (2) provide priority in program reviews to new institutions and those experiencing high loan collection delinquency rates, and (3) strengthen certain aspects of regulations, terms of agreements, and OE directives. On the basis of this report, the Secretary of HEW directed OE to develop an action plan to reduce the delinquency rate at the institutions.

Financial Condition of Schools

We found that 22--2 institutions of higher education and 20 proprietary vocational schools-- had serious financial problems, closed or filed for bankruptcy.

-- 11 schools closed

-- 5 filed for bankruptcy

-- 4 schools financial stability in question

-- 2 schools had change of ownership after experiencing financial difficulties.

Institutions which have closed or lost their eligibility to participate in Federally-funded student aid programs are a matter of special concern. Therefore, on November 24,

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1976, the Audit Agency issued a report to the Commissioner of OE which dealt with the adequacy of controls established by OE to assure that funds were not provided to these institutions and that unexpended grant funds and promissory notes are recovered when institutions close (ACN 12-73025). Highlights of this report follow:

More than 500 institutions have closed or lost eligiblity during the last five years. We reviewed OE records for 75 and found that:

--Fifty-one of these institutions had undisbursed authorizations from OE programs totaling $2.2 million on record with the Department Federal Assistance Financing System (DFAFS). Under existing procedures, DFAFS would continue to honor requests for funds until advised to stop payment.

--OE made awards totaling over $1 million to 14 of the 51 institutions after they had closed or become ineligible. As of September 30, 1976, OE had cancelled only $591,000 of these awards.

--DFAFS made payments totaling $747,000 to ten schools after the date the schools closed or became ineligible. Although these schools may have been entitled to some payments, at least two ineligible schools were overpaid a total of $149,600. As of September 30, 1976, no determination had been made as to the propriety of payments made to the other schools.

--For 10 of 29 closed institutions which had participated in the National Direct Student Loan (NDSL) program, as of September 30, 1976, OE had not made arrangements for continued servicing of loans due under the program or taken action to account for unexpended NDSL funds. The 10 institutions had received allocations of about $764,000 from the NDSL program.

In Region VI, at least 11 proprietary schools participating in the NDSL program closed during fiscal year 1976. These schools had NDSL program loans outstanding totaling $1.9 million. Among these schools' records were original promissory notes which constitute the basis for collecting amounts owed to the NDSL program by former students. OE had not taken action to obtain the notes nor made arrangements for continuation of collection services. Services needed include monthly billings, processing of checks, maintenance of loan repayment records, and responding to

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student inquiries.

At OE headquarters, about 2,000 NDSL promissory notes totaling about $1.5 million from 18 closed schools were on hand in May 1976. These notes were not being serviced and there were no current plans to do so. Prior to October 31, 1975, the Office of Guaranteed Student Loans (OGSL) was servicing these notes; however, on that date, OGSL turned the notes over to the NDSL program office. According to the NDSL staff, 7,000 more notes totaling about $5 million were expected to be received during fiscal year 1977 as more schools close. Despite the fact that the loans were not being serviced, some loan payments were being received. However, appropriate accounting procedures had not been established to control the amount of outstanding loans or collections received. Also, the promissory notes had not been properly safeguarded against theft, loss or damage.

OE officials concurred with our findings and told us they would initiate action to:

--Cancel undisbursed authorization balances of all identifiable institutions which have closed or lost their eligibility to participate in student aid programs;

--Establish procedures to assure that program managers and DFAFS are notified promptly of closings and loss of eligibility;

--Recover and account for unexpended grant funds and promissory notes held by closed institutions;

--Establish accounting control over NDSL loans receivable and collections, arrange for the continued servicing of loans acquired from the closed institutions, and safeguard notes on hand.

Federal Funds Improperly Used or Unaccounted For

We found that 17--6 higher educational institutions and 11 proprietary vocational schools-- of 77 institutions had improperly used or could not account for over $5 million of Federal student aid funds. A major problem with the institutions participating in the Campus Based and BEOG programs is the ability of the institutions to draw Federal funds in excess of need from the Department's Federal Assistance Financing System (DFAFS) Identified use of the funds follows:

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$3.8 million - payment of general operating expenses

$670,000 - embezzled by an employee of college

$216,310 - used to obtain short term financing for operational needs

$355,065 - payment of college's matching requirements

$ 19,500 - disbursed to owner of school

$ 17,776 - to cover a bank overdraft of college

$ 10,968 - unable to account for

$5.2 million total

Federal Cash Balance - Excessive

We found that 14 of the 77 schools had withdrawn funds totaling about $4 million in excess of cash needs from the Department's Federal Assistance Financing System (DFAFS). Included in the 14 schools are five schools which improperly used or cannot account for funds totaling about $2.1 million. The five schools are included in the above finding. The excess cash balances at the 14 schools follows:

North Eastern Illinois	$59,536
Career Academy	29,881
Flamingo Beauty College	101,881
University of Arkansas	700,000
Northeastern Oklahoma A&M	230,000
American Beauty Academy	110,077
Lincoln College of Commerce	25,584
Arizona Automotive Institute	126,330
Shaw College of Detroit	303,039
Milwaukee Career Academy	2,829
Salem Community College	22,000
Grambling State University	1,748,899
Midwest Business College	193,000
ITT Technical Services and Institute	317,699
Total	$3,970,755

$4.0 million

The audit reports did not compute the imputed interest lost by the Federal Government as a result of the institutions

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drawing funds in excess of need. However, even at a rate of 8 percent the amount of interest lost annually based on $4 million is substantial. We recommended in the individual reports that the institutions improve their cash management systems to ensure that funds are only drawn as needed to administer the programs.

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ILLUSTRATIVE PROJECT INTEGRITY CASES SELECTED FOR FULL FIELD (CRIMINAL POTENTIAL) INVESTIGATION

Type of Provider	Reason for Selection
Pharmacy	31 instances of duplicate billing for the same prescription over an 18-month period.
Physician	Double billing for 321 office visits.
Physician	Billing for patient office visits which did not occur in 54 instances. Also, billing for 169 visits when services were rendered by an auxiliary staff member who was not licensed.
Physician	Apparent duplicate billings for psychotherapy sessions. 110 sessions resulted in 220 Medicaid claims. 5 were billed 3 times. Psychotherapist holds frequent family group sessions and bills each member.
Physician	29 recipients billed for 1,466 claims in 6 months--an average of 50 visits per person. Some claims for dates when recipients were out of town. Individual billings for one-hour sessions when group sessions were held.
Physician	Billing for hospital visits when instructions were given to hospital personnel by a telephone call--in 115 cases.
Pharmacy	Drugs dispensed without a physician's prescription or authorization, and billings submitted for drugs not received.
Pharmacy	Billing for unit doses when deliveries were made in bulk.
Pharmacy	Billed for drugs dispensed after patient had died.

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Type of Provider	Reason for Selection
Physician	75 percent of families serviced during 12-month period were seen as a group, thus escalating billings. There were 7 separate physician cases of similar type in this region.
Physician	3 different physicians submitting invoices for same recipient. Recipients were contacted and did not know 2 of the 3 physicians. Appears to involve fraudulent billing.
Physician	Former nurse's assistant testified that she was instructed to forge recipient's signature on Medicare and Medicaid cliams, and to submit falsified blood test claims to Medicaid.
Physician	Billed $40 for test panels costing $9.50.
Physician	Billed 12 beneficiaries for examinations not performed.
Physician	26 percent of families treated as a group on numerous occasions and also engaged in ping-ponging. Three other similar cases identified in this region.
Pharmacy	Drugs billed to Medicaid were not dispensed or were substituted with less expensive products.
Pharmacy	Charging substantially more to Medicaid than non-Medicaid patients, and charging for more pills than authorized by physician. Two other similar violations in this region.
Pharmacist	Excessive narcotic prescriptions for a number of recipients. Documented instances of drug splitting and duplicate charges.
Pharmacist	Excessive narcotic prescriptions for 20 recipients, including as many as 50 for one and over 20 for a number.

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Type of Provider	Reason for Selection
Physician	Excessive numbers of hospital visits for patients, including dates following discharge.
Physician	Excessive number of X-rays, laboratory tests, and blood tests to 281 Medicaid patients. Generally, averaged twice as many tests as given to other patients by his peers.
Physician	Billing both Medicare and Medicaid for common services provided to the same recipients, as well as billing for services not rendered. Far exceeded average of his peers in number of injections and laboratory tests.
Physician Team	Billed for services not provided and double billing for patient visits in 45 instances during a 12-month period. Also billed for full examination when patient was attended only by a technician in connection with laboratory testing.
Pharmacist	Furnished drugs to nursing homes in bulk but billed for unit dosage so as to collect dispensing fee for each.
Physician	Saw 338 families one or more times as a group in a 12-month period--far exceeding average of other physicians in the State.

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SERVICE DELIVERY ASSESSMENT WORK PLAN: FY 1978

The FY 1978 Service Delivery Assessment Work Plan is based principally on direct assignments by the Secretary and the Under Secretary. Activities during the initial year of operation will emphasize experimentation with methods and techniques, continuous training, critiques of individual assessment projects and feedback from initiators on the utility of each project.

1. HEADSTART--Requested by the Secretary

Lead Region: Region III with support by Region IV

Projected Completion: March, 1978

The assessment will examine how the Head Start program overall and its core service areas (education, nutrition, health, social services and parent involvement) are viewed by parents, teachers and staff. The assessment will attempt to identify the program's strengths, weaknesses and general operations as perceived and experienced by those groups involved in the program. A limited amount of objective and descriptive program information, including record documentation and classroom observations, will be collected and cross-referenced with qualitative information. In addition, opinions will be solicited from program staff and parent members of policy councils regarding the utility of the Comprehensive Management Review Process.

Regions I, VII and X will participate.

2. DISABILITY INSURANCE BENEFIT DETERMINATIONS--Requested by the Under Secretary

Lead Region: Region VI

Projected Completion: April, 1978

The assessment will gather information from those most closely involved in the disability determination process--clients, local SSA staff, state disability determination units, rehabilitation services staff and administrative law judges. The Under Secretary's review of the Disability program with SSA and ASPE to identify desirable legislative and/or management changes has determined the assessment objectives, which include: identifying perceptions of factors

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that affect the uniformity and quality of decisions; ascertaining views of major incentives, inducements and accountability in the system; obtaining reactions to administrative and legislative options under consideration; considering operational relationships between organizational units involved in the determination process; and sampling clients perceptions regarding the decision system and program services.

Regions I, III, VIII and X will participate.

3. HOME HEALTH CARE--Requested by the Secretary

Lead Region: Region IV

Projected Completion: May, 1978

Based on a pre-assessment of major home health issues in Florida, and on advice from ASPE, HCFA and ASH, the assessment will examine: uneven patterns in the supply of home health care (factors leading to geographic concentration, proliferation of private agencies and implications for staff quality); how reimbursement patterns in Titles XVIII, XIX and XX encourage delivery of excessive or unnecessary services to clients while denying needed services to others; how clients enter the home health care system; and incentives to provide clients with the best services and plan of treatment. Clients, all types of home health service providers and state agencies will be contacted in the assessment.

Regions II, V, VI and IX will participate.

4. FAMILY PLANNING SERVICES FOR TEENAGERS--Requested by the Secretary

Lead Region: Region II with support by Region V

Projected Completion: June, 1978

The assessment will describe the roles, activities and effects of Federally-funded family planning projects on teenagers. The assessment will examine: counselling; issues related to the wide range of public and voluntary clinic settings; how outreach and education are handled in various settings (schools, adult/adolescent community organizations) and perceived constraints associated with

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community attitudes, federal program and fiscal policies, state laws and availability of staff resources; client attitudes toward staff characteristics and mandated services; how clinics measure their effectiveness; role of the male; general ambiance of clinics and staff/client interaction; relationship to other agencies; and role of state and local governments in providing services to teenagers. Special attention will be devoted to describing the wide regional variations in services and methods of delivery.

Regions III, VI, VII and IX will participate.

5. MULTIPURPOSE SENIORS' CENTERS--Requested by the Secretary

Lead Regions: Regions I and IX

Projected Completion: July, 1978

The assessment will examine to what degree centers serve as community focal points for developing and delivering social, health, education, nutrition and recreation services for older persons. Special emphasis will be given to identifying client motivations in seeking and using these services and this mode of service delivery, client perceptions of the adequacy and quality of center services and whether services delivered in the center are available elsewhere in the community.

Regions II, III, IV and VIII will participate.

6. FOSTER CARE--Requested by the Secretary

Lead Regions: Regions VII and X

Projected Completion: August, 1978

The assessment will stress the actual problems facing caseworkers and clients when there is the posssibility that children may be removed from their natural parents (emphasis will be placed on whether there are adequate criteria to guide caseworkers in making decisions), services to natural parents during the early stages of foster placement and services to facilitate adoption where services to natural parents are unable to overcome obstacles to reuniting the family. Attention will be devoted to describing the wide variations in policies and practices throughout the participating regions.

Regions II and V will participate.

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7. EDUCATION FOR THE HANDICAPPED--Requested by the Secretary

Lead Regions: Regions VIII and X

Projected Completion: September, 1978

The assessment will examine to what extent handicapped children who need services are being identified and served in local school systems. Special attention will be given to factors at the parent, teacher and school system level that account for difficulties in identifying and serving handicapped children and how these factors differ in a mix of school systems.

Regions I, IV, V, VI and IX will participate.

OFFICE OF INVESTIGATIONS (OIG)
CASES REFERRED TO THE U.S. ATTORNEYS
CALENDAR YEAR 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status (Pending) (Further Invest.)
1	N - Texas	HHA	Billing for services not rendered	6/77	6/77			Pending
2	S - Georgia	MD	Billing for services not rendered	5/77	9/77			Pending
3	S - Florida	LAB	Bribery; kickbacks to providers	6/77	6/77	10/77		Pending/Investigation
4	M - Florida	SNF	Billing for services not rendered	6/76		2/77		Pending/Investigation
5	Idaho	HOSP	Billing for services not rendered	2/77			2/77	Closed
6 1/	E - Michigan	DME	Excessive payments	3/77				Closed
7	South Carolina	MD	Billing for services not rendered	6/77	6/77	8/77		Closed
8	W - Texas	MD	Billing for services not rendered	1/77	3/77	5/77		Closed

1/ Civil recovery of $40,441.46

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Judicial Districts

S - Southern District
N - Northern District
M - Middle District
W - Western District
E - Eastern District
C - Central District

Class

HHA: Home Health Agency
MD: Doctor of Medicine
LAB: Laboratory
SNF: Skilled Nursing Facility
HOSP: Hospital
DME: Durable Medical Equipment
CL: Clinic
PHAR: Pharmacy
DO: Doctor of Osteopathy

Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status (Pending) (Further Invest.)
9	E - California	State	Falsifying records re certification for participation in Medicare program	9/77				Pending Decision
10	N - Illinois	State	Falsifying Medicare recipient claims	9/77				Pending Decision
11	Maryland	SNF		11/77				Pending Decision
12	Connecticut	MD	Billing for services not rendered	3/77				Pending Decision
13	S - New York	MD	Billing for services not rendered	1/77				Pending Decision
14	W - Michigan	IHA	Billing for services not rendered; duplicate billing	12/77				Pending Decision
15	S - Ohio	SNF		2/77				Pending Decision
16 [2/]	N - Indiana	SNF	Falsifying records/ documents	5/77			7/77	Closed

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2/ Civil recovery of $8,900

Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status (Pending) (Further Invest.)
17	N - West Virginia	SNF	Bribery	6/77			8/77	Closed
18	M - Florida	MD	Billing for services not rendered	9/77				Pending
19	South Carolina	MD	Billing for services not rendered	10/77				Pending
20	N - West Virginia	MD	Billing for services not rendered	2/77				Pending/Investigation
21	S - West Virginia	MD	Billing for services not rendered	2/77				Pending/Investigation
22	W - Pennsylvania	CL	Duplicate billing; billing for services not rendered; kickbacks	3/77				Pending/Investigation
23	W - New York	LAB	Falsifying documents	9/77				Pending/Investigation
24	District of Columbia	MD	Billing for services not rendered	1/77				Pending/Investigation
25	W - New York	MD	Duplicate billing	5/77			7/77	Closed

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Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status (Pending) (Further Invest.)
26	S - New York	CL	Billing for services not rendered	1/77				Pending/Investigation
27	S - New York	MD	Billing for services not rendered	2/77				Pending/Investigation
28	Oregon	SNF	Falsifying documents/ records	7/77				Pending/Investigation
29	E - Washington	Employee of MD	Billing for services not rendered	2/77				Pending/Investigation
30	N - Texas	SNF	Billing for services not rendered	8/77				Closed
31	S - Texas	MD	Billing for services not rendered	5/77				Pending/Investigation
32	E - Texas	IHA	Billing for services not rendered	10/77				Pending/Investigation
33	C - California S - California	IHA	Falsifying documents/ records	1/77				Pending/Investigation
34	N - California	IHA	Billing for services not rendered	1/77				Pending/Investigation

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Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status (Pending) (Further Invest.)
35	E - California	CL	Falsifying documents/ records	3/77				Pending/Investigation
36	E - California	State	False certification of facility in order to be eligible for Medicaid	8/77				Pending/Investigation
37	C - California	LAB	Billing for services not rendered	10/77				Pending/Investigation
38	New Jersey	SNF	Receiving kickbacks from Lab; falsifying documents/records	10/77				Pending/Investigation
39	New Jersey	MD	Duplicate claims in both Medicare and Medicaid	8/77				Pending/Investigation
40	S - New York	MD	Billing for services not rendered	7/77				Pending/Investigation
41	New Jersey	SNF	Receiving kickbacks from Lab	2/77				Pending/Investigation
42	New Jersey	LAB	Billing for services not rendered	2/77				Pending/Investigation
43	New Jersey	LAB	Duplicate billings; billing for services not rendered	2/77				Pending/Investigation
44	New Jersey	LAB	Duplicate billings; billing for services not rendered	2/77				Pending/Investigation

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Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status (Pending) (Further Invest.)
45	S - West Virginia	DO	Double billings; billing for services not rendered	3/77				Pending/Investigation
46	W - Pennsylvania	LAB	Billing for services not rendered	3/77				Pending/Investigation
47	Maryland	MD SNF	Embezzling from Medicaid	11/77				Pending/Investigation
48	Rhode Island	SNF	Falsifying documents/ records	1/77				Pending/Investigation
49	Rhode Island	MD	Falisfying documents/ records	12/77				Pending/Investigation
50	Maine	PHAR	Billing for services not rendered	11/77				Pending/Investigation
51	Oregon	MD	Billing for services not rendered	3/77				Pending/Investigation
52	W - Washington	LAB	Falsifying diagnosis to make Medicare claims	3/77				Pending/Investigation
53	W - Washington	MD	Kickback from Labs	2/77				Pending/Investigation

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Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status (Pending) (Further Invest.)
54	W - Washington	PHAR	Billing for services not rendered	5/77				Pending/Investigation
55	S - Florida	MD	Billing for services not rendered	3/77				Pending/Investigation
5[illegible]	M - Florida	MD	Billing for services not rendered	5/77				Pending/Investigation
57	S - California	IHA	Falsifying documents/ records	1/77				Pending/Investigation

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OFFICE OF PROGRAM INTEGRITY (HCFA)
CASES REFERRED TO THE U.S. ATTORNEYS
CALENDAR YEAR 1977

REGION I (Boston)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
1	Vermont	SNF	Falsifying records/ documents	1/18/77	9/22/77			
2	Maine	DME/ AMB	Billing for services not rendered	1/21/77				Pending/Decision
3	Maine	LAB	Billing for services not rendered	12/14/77				Pending/Decision
4	Rhode Island	MD	Billing for services not rendered	12/1/77				Pending/Decision
5	Rhode Island	MD	Billing for services not rendered	10/6/77			1/27/78	
6	Vermont	MD	Billing for services not rendered	1/27/77			8/8/77	
7	Rhode Island	SNF	Misrepresenting services	2/7/77			10/25/77	

Judicial Districts

S - Southern District
N - Northern District
M - Middle District
W - Western District
E - Eastern District

Class

HHA: Home Health Agency
MD: Doctor of Medicine
LAB: Laboratory
SNF: Skilled Nursing Facility
HOSP: Hospital
DME: Durable Medical Equipment
CL: Clinic
PHAR: Pharmacy
POD: Podiatrist
DO: Doctor of Osteopathy

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REGION II (New York)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
8	E - New York	MD	Billing for services not rendered	1/4/77				Pending/Decision
9	E - New York	MD	Billing for services not rendered	1/25/77				Pending/ Investigation
10	S - New York	HOSP	Kickbacks	2/28/77				Pending/Decision
11	Puerto Rico	HOSP	Falsifying records	3/16/77				Pending/ Investigation
12	New Jersey	SNF	Falsifying records	3/23/77				Pending Investigation
13	S - New York	LAB	Billing for services not rendered	3/23/77				Pending/ Investigation
14	S - New York	LAB	Billing for services not rendered and kickbacks	3/23/77				Pending/ Investigation
15	S - New York	DME	Duplicate billing	6/6/77	9/12/77	11/7/77		
16	S - New York	MD	Billing for services not rendered	8/4/77				Pending/ Investigation
17	S - New York	LAB	Kickback	8/7/77				Pending/Decision

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REGION II (New York)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
18	S - New York	LAB	Duplicate billing	8/7/77	9/12/77	12/5/77		
19	New Jersey	Ther-apist	Billing for services not rendered	8/11/77				Pending/Decision
20	S - New York	Admin. CL	Conspiracy to defraud	9/1/77				Pending/Decision
21	New Jersey	MD	Billing for services not rendered	9/9/77				Pending/Decision
22	New Jersey	POD	Billing for services not rendered	10/3/77				Pending/Decision
23	E - New York	LAB	Kickback	10/20/77				Pending/Decision
24	S - New York	MD	Billing for services not rendered	10/25/77				Pending/Decision
25	N - New York	MD	Misrepresenting services	10/25/77				Pending/Decision
26	E - New York	MD	Billing for services not rendered	10/27/77				Pending/Decision
27	N - New York	MD	Billing for services	10/31/77				Pending/Decision

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REGION II (New York)
Calendar Year 1977

	Name	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
28		S - New York	POD	Billing for services not rendered	11/22/77				Pending/Decision
29		N - New York	LAB	Misrepresenting services	12/1/77				Pending/Decision
30		S - New York	MD	Billing for services not rendered	12/9/77			3/78	
31		E - New York	LAB	Billing for services not rendered	12/19/77				Pending/Decision
32		E - New York	Lab Supplier	Falsifying documents	12/27/77				Pending/Decision
33		E - New York	MD	Misrepresenting services	4/12/77	4/25/77	11/14/77		
34	1/	S - New York	Respiratory X-Ray Spec.	Misrepresenting services	6/6/77	9/12/77	12/6/77		
35		N - New York	POD	Billing for services not rendered	12/14/77				Pending/Decision
36		New Jersey	NH	Falsifying documents	3/23/77				Pending/Decision
37		New Jersey	NH	Kickback	3/23/77				

1/ Concerns two separate matters--presentation made to U. S. Attorney in Connecticut and New York. U. S. Attorney in Connecticut turned over matter to SDNY who had a stronger case--hence, successful prosecution resulted in SDNY. (Counted as one case.)

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REGION III (Philadelphia)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
38	M - Pennsylvania	MD	Billing for services not rendered	2/22/77 to OI			11/11/77	
39	E - Pennsylvania	DC	Billing for services not rendered	3/4/77 to OI				Pending/ Investigation
40	E - Pennsylvania	BENE	Altering records	3/21/77			7/26/77	
41	M - Pennsylvania	DO	Practicing while license suspended	4/11/77 to OI			9/15/77	
42	E - Pennsylvania	DME	Billing for services not rendered	4/20/77 to OI			10/15/77	
43	E - Pennsylvania	BENE	Altering records	5/23/77				Pending/ Investigation
44	E - Pennsylvania	MD	Billing for services not rendered	6/3/77				Pending/Decision
45	E - Pennsylvania	LAB	Misrepresenting services	9/27/77				Pending/ Investigation
46	W - Pennsylvania	DME	Billing for services not rendered	1/19/77			3/17/77	
47	E - Pennsylvania	AMB	Misrepresenting services	1/19/77	1/19/77	3/13/77		

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REGION III (Philadelphia)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
48	E - Pennsylvania	AMB	Billing for services not rendered	7/7/77	9/28/77			

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REGION IV (Atlanta)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
49	S - Florida	MD	Billing for services not rendered	1/20/77				Pending/ Investigation
50	N - Georgia	HOSP	Falsifying records	5/77	7/14/77			Indictment Dismissed
51	S - Florida	DO	Billing for services not rendered	8/1/77	9/1/77			
52	W - Tennessee	MD	Billing for services not rendered	9/3/77				Pending/ Investigation
53	S - Georgia	CHIRO and Other	Billing for services not rendered	3/3/77	8/23/77	10/21/77		
54	South Carolina	MD and LPN	Billing for services not rendered	5/77	6/21/77	8/1/77		
55	M - Florida	MD	Billing for services not rendered	11/6/77	11/14/77 & 2/22/78			

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REGION V (Chicago)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
56	N - Illinois	POD	Billing for services not rendered	1/7/77	4/12/77	2/10/78		
57	S - Ohio	AMB	Billing for services not rendered	6/27/77				Pending/Investigation
58	N - Ohio	MD	Billing for services not rendered	11/17/77				Pending/Investigation
59	N - Illinois	POD	Billing for services not rendered	1/7/77			2/14/78	
60	S - Indiana	Water Supplier	Billing for services not rendered and falsifying records	2/11/77			8/11/77	

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REGION VI (Dallas)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending (Further Invest.)
61	S - Texas	MD	Billing for services not rendered	1/21/77	6/30/77			
62	N - Texas	DPM	Billing for services not rendered	6/7/77	7/13/77	10/25/77		
63	W - Texas	AMB	Billing for services not rendered	11/3/77				Pending/Decision
64	W - Louisiana	RN	Falsifying records	2/25/77	4/14/77	5/20/77		
65	N - Texas	HHA	Falsifying records	1977	6/24/77	2/21/78		

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REGION VII (Kansas City)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
66	E - Missouri	MD	Billing for services not rendered	1/27/77			1/78	
67	W - Missouri	BENE	Misuse of Medicare card	3/25/77	6/20/77		9/12/77	Acquitted
68	E - Missouri	DO	Billing for services not rendered	12/11/77				Pending/Investigation
69	S - Iowa	Blood Supply	Medicare discrimination	2/18/77			3/77	

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REGION VIII (Denver)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
70	Colorado	MD	Billing for services not rendered	8/26/77				Pending/Investigation
71	Colorado	DPM	Billing for services not rendered	6/2/77	9/16/77	11/16/77		
72	Colorado	MD	Billing for services not rendered	1/77			1/77	
73	Colorado	NH	Falsifying records and documents	8/77	11/2/77			
74	Colorado	LAB	Kickback	6/77			10/28/77	
75	Colorado	MD	False billing	8/77				Pending/Investigation
76	Colorado	MD	False billing	8/77				Pending/Investigation
77	Colorado	MD	Billing for services not rendered	3/3/77			3/4/77	

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REGION IX (San Francisco)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date of Conviction	Declined Date	Status (Pending) (Further Invest.)
78	N - California	MD	Billing for services not rendered	8/25/77				Pending/Decision
79	E - California	DPM	Billing for services not rendered	5/19/77			5/19/77	

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REGION X (Seattle)
Calendar Year 1977

Name	Judicial District	Class	Nature of Offense	Date Referred to U. S. Attorney	Date of Indictment	Date Conviction	Declined Date	Status (Pending) (Further Invest.)
80	Idaho	HOSP	Billing for services not rendered	10/21/77				Pending/Decision
81	Oregon	HOSP	Falsifying records	10/27/77				Pending/Investigation
82	W - Washington	NH	Billing for services not rendered	1/25/77			2/9/77	
83	E - Washington	NH	Misrepresenting services	2/3/77			10/11/77 (Thompson and 2)	

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PROBLEM CASES -- ACCESS TO NURSING HOME RECORDS

1. Florida Nursing Home Association v. Page

Early in 1977, the Department, in cooperation with the Florida Department of Health and Rehabilitation Services (DHRS), initiated plans for a review of sixty nursing homes in Florida. The homes, all Medicaid providers, were selected largely because of the amount of their Medicaid reimbursements. In March, 1977, the Florida Nursing Home Association, together with several individual nursing homes, filed suit against DHRS and HEW for injunctive relief against the planned audits.

HEW moved to dismiss the complaint, and the litigation is now pending in the Southern District of Florida. Meanwhile, HEW representatives have been excluded from the nursing homes and, thus, prevented from completing their financial reviews. With the passage of P.L. 95-142, specifically authorizing HEW access to the records of Medicaid providers, HCFA and the Office of Inspector General have consulted with the Department of Justice to determine how best to implement this authority.

2. Other Access Problems

Drawing on the experience of the New York Special Prosecutor and others who have analyzed the nursing home industry, the Inspector General began a project to develop auditing and investigative guides that could be used to identify those homes whose practices reflect waste, abuse and fraud. Homes in three states were selected on the basis of an analysis of cost reports filed with the Medicaid agencies as the subjects of in-depth audits.

The audit of one home began in October, 1977 but was cut short when the HEW auditors were refused further access to the home's records. Again, the Inspector General is consulting with the Department of Justice in order to determine what action may be most appropriate to vindicate his statutory right of access.

A second audit of a nursing home in the same state was begun in February, 1978, and once more, some ten days after the auditors started their review, they were excluded from the home. After seeking unsuccessfully to negotiate a settlement to this dispute, the Inspector General decided to make use of the subpoena power conferred on him by Section 205(a)(3) of P.L. 94-505. Accordingly, a subpoena calling for the relevant books and records of the nursing home was served on the home's administrator on March 24, 1978, and we are now awaiting compliance with that demand.