

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF INSPECTOR GENERAL

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CHAPTER I

EXECUTIVE SUMMARY ANNUAL REPORT OF THE HEW INSPECTOR GENERAL FOR THE PERIOD ENDING DECEMBER 31, 1978

The first two years of the HEW Office of Inspector General have been years of growth and experimentation. Most importantly, this second Annual Report is a "lessons learned" document.

Perhaps its most important message is that Audit, Investigations, and Systems Review are each major purpose activities, each with its own work program. The Immediate Office of Inspector General is of value mainly as a leader and catalyst in assembling joint teams of mixed disciplines to attack problems or engage in new initiatives.

The Office of Inspector General Headquarters should remain lean and fit, and its operations should be highly decentralized, because discovery of problems and correcting them must occur primarily in the offices of the 50,000-plus institutional recipients of HEW funds and HEW's own internal organization. A continuing challenge is to maintain effective communications in such a highly decentralized structure.

In this year's report we make a number of recommendations to the Secretary and to the Congress. We have felt free to suggest ideas which will require further study and to recommend legislation which must yet be drafted and cleared through the normal procedures.

This Executive Summary highlights the key findings and recommendations of Chapters II through VIII.

CHAPTER II -- Putting "Losses Due To Fraud, Abuse, and Error" Into Perspective

Exceptional progress has been made since March 31, 1978, in energizing a formal cost-reduction program which builds upon -- but has gone well beyond -- the findings of the Inspector General's first Annual Report.

Savings targets of \$1.3 billion for FY 1979, and \$2.1 billion reflected in the FY 1980 budget request are admirable goals. In the years following 1980 we see \$900 million of additional waste which might be saved, using present authorities and resources. Congressional support can open avenues for further cost savings of about \$660+ million in future years (in addition to the Department's legislative program of \$2.9 billion in FY 1980).

Finally, there is a large area of uncertainty over the feasibility and timing of savings in a number of complex fields, such as unnecessary surgery, X-rays, and hospital stays, and further reductions in error rates below very low minimums.

The overall recommendation of Chapter II is to:

Establish a special fund under the direction of the Inspector General to support a "Fraud and Abuse New Initiatives Program."

CHAPTER III -- Highlights of Audit Efforts, Calendar Year 1978

In CY 1978, the Audit Agency issued 5,652 reports, of which 4,226 covered HEW-financed programs and activities. The Department's staff prepared 1,459 and public accountants and State auditors prepared 2,767.

The audits identified \$143.8 million for consideration by the POCs as not having been spent in accordance with regulations, terms, or other criteria. During the same period, the POCs agreed with Audit-recommended financial adjustments totaling \$54.8 million.

This Chapter makes two overall recommendations:

1. Audit Agency staffing needs to be steadily augmented. In-house growth for the next several years should average about 10 percent annually.
2. We urge early consideration of development of a regulation to recover the "cost of monies" borrowed from the Federal Government which are found to have been misspent by grantees. This would recover about \$17 to \$25 million annually.

CHAPTER IV -- Highlights of Activities: Office of Investigations and Other Fraud Investigation Agencies

In CY 1978, the Office of Investigations had its most successful year thus far, with 125 indictments and 105 convictions -- over twice CY 1977. A 50 percent growth in staff occurred in the last quarter of the Calendar Year -- to a new total of 136 members. Major growth still lies ahead to reach the full budgeted level of 234 staff needed to assume full responsibility for all provider criminal fraud investigations conducted by HEW and the most complex and important of the employee-conduct cases.

In the year ahead, the growth in the State Medicaid Fraud Control Units will begin to offer opportunities for multiplying the effectiveness of the office. It is essential that Federal leadership continue in this area -- in which a thousand professional staff will eventually be supported for three years by 90 percent Federal funding. We are prepared to consider whether 90 percent funding beyond a three-year term may be necessary in some cases, to assure full effectiveness.

The wisdom of Congress in enacting P. L. 95-142 (H. R. 3) is demonstrated not only by the creation of the Fraud Control Units (Section 17), but by many other provisions, including the disclosure sections which will assist us in studies of chain ownership. Four recommendations are cited in Chapter IV:

1. Establish a close working relationship within the Executive Branch among the 14 statutory Inspectors General, working cooperatively with the Department of Justice, the Office of Management and Budget, and the Office of Personnel Management.
2. Continuously assess needs and institute measures to assure the security of our computer systems.
3. Emphasize training investigators, auditors, and prosecutors, and cross-training among these skills.

4. Urge the Department of Justice to seek a general fraud statute making it a felony to defraud any Government program.

CHAPTER V -- Initiatives to Attack Fraud, Abuse, and
Error in Health Care Financing Programs

The most valuable experience during the past year has been the lessons learned with the States from Project Integrity I (physicians and pharmacists). In the coming year we will offer interested States tested computer screening aids in launching additional Project Integrity initiatives (such as the dentists and laboratories reviews now in process).

The following recommendations are offered:

1. Complete and issue HCFA's proposed regulations requiring administrative sanctions for fraud and abuse in the Medicaid program.
2. Make available to the States model legislation for fraud and abuse control in the Medicaid program.
3. Present to Congress the "Civil Money Penalty" Bill to give the Secretary authority to act if criminal penalties have not been effective or criminal prosecution is unwarranted or impractical.
4. Consider establishing by statute incentive arrangements for special financing to meet individual State needs for (a) management information systems, (b) surveillance and utilization review units, and (c) Fraud Control Units. Both provider and beneficiary fraud activities in welfare and health care programs should be included.
5. Present to Congress a statute to prevent independent laboratories from charging fees to the Medicare and Medicaid programs which exceed their charges to physicians.
6. Implement new regulations promptly to require action by the appropriate agencies when PSROs find that services are unnecessary.

7. Develop legislative measures to strengthen health care management and control:
- Legislation to permit competitive selection of fiscal agents and intermediaries (also discussed in Chapter II).
 - Statute to establish Federal criminal jurisdiction for theft or embezzlement of Federal grant and contract funds.
 - Legislation to upgrade from misdemeanor to a felony the punishment of persons who use their Medicaid cards to aid in the procurement of controlled substances to be sold on the street by drug pushers. (Amendment to 42 U.S.C. 1396h)
 - Statute to make it unlawful for a practitioner to pay a druggist to fill his prescriptions for controlled substances. (Amendment to 42 U.S.C. 1396h)
 - Termination from participation (or a very long suspension) from the Federal health care programs after being convicted of violating any provision of the Controlled Substances Act. (Amendment to 42 U.S.C. 1395y(2))
 - Propose model legislation to States providing for lifting a doctor's license to practice medicine if he supplies prescriptions for controlled substances to drug pushers. (Amendment to Title XIX)
 - Extension of the period for funding of State Fraud Control Units for a full three years after date of certification.
 - Legislation making it a Federal offense to pay a carrier, intermediary, State, or fiscal agent employee with the intent of influencing his action in either Medicare or Medicaid programs.

- Modification of the "Free Choice of Providers" provisions in the selection of laboratories and suppliers of medical supplies and equipment to permit awards based on competitive bid practices.

CHAPTER VI -- Initiatives To Attack Fraud, Abuse, and Error In Income Maintenance Programs

This Chapter reviews our experience during the past 18 months in working with the States on the matching of Welfare rolls against Federal employment rolls and against other States' Welfare rolls. In Project Match II, we will be concentrating on matches of SSI and SSA Title II rolls.

These efforts have required extended part-time participation by many OIG personnel throughout the regions and extensive interface with other Federal and State agencies. We have learned that much patience is required to administer projects of this type.

Based upon this year's experience we have four recommendations:

1. Continue to consider implementation of three recommendations made last year:

- That Congress endorse a regular program of matching State Welfare rolls against other files, including Federal military and civilian employees, State employees, Unemployment Compensation rolls, Child Support Enforcement files, mortality data, SSI files, and SSA Title II benefit files.
- That all State Welfare agencies be encouraged to acquire wage data to validate Welfare benefit application. Those which do not have quarterly wage reporting by employers to the Employment Security Agency should use an alternative source of wage data (e.g., State tax information) to report to the Welfare agencies.
- That Congress extend to the AFDC program the same funding and incentive benefits now available in the Medicaid program for design and operation of management information systems,

and for establishment of recipient Fraud Control Units.

2. Institute full support to the implementation of the National Recipient System (all AFDC recipients' information) by the Department and the Congressional committees concerned.
3. Amend the Tax Reform Act of 1976 to permit access to IRS interest and dividend income information as a means of finding unreported resources. Potential annual savings of \$45 million in the SSI program.
4. Continue full support to the Office of Management and Budget in developing Federal guidelines for computer matching to assure adherence to the letter and spirit of the Federal Privacy Act of 1974 when using computer matching to ferret out fraud and abuse.

CHAPTER VII -- Initiatives to Attack Fraud, Abuse, and Error In The Student Financial Assistance Programs

The OIG has been a partner in the development of improvements in these systems. We offer seven recommendations for Congressional consideration:

1. Retain an integrated Bureau of Student Financial Assistance if a Department of Education is formed.
2. Establish and sustain fair and equitable refund policy requirements for all Student Financial Assistance programs.
3. Give legislative approval to provide IRS address data to State Guaranty agencies prior to their submitting defaulted cases to BSFA for reinsurance payments.
4. Amend the Family Educational Rights and Privacy Act to provide that, in certain cases, prior notice to a student need not be given before the school complies with a subpoena for student records (the Buckley Amendment).

5. Clarify authority to refer default information to private credit ratings bureaus, and possibly lend legislative attention.
6. Institute an interest cost on Federal monies found to have been misspent by grantees.
7. Give legislative authorization for use of program funds to defray the cost of obtaining records needed for civil and criminal investigations (as consistent with the provisions of Title XI, Right to Financial Privacy Act of 1978).

CHAPTER VIII -- OIG Activities Related To Contracts and Discretionary Grants

During the last Calendar Year, we assisted the Secretary and his Assistant Secretary for Management and Budget in the examination of grant and contract situations involving unusual problems and questions regarding the conduct of Government and grantee officials. This experience led us to identify the need for clear policies on the award of grants when the integrity of key performers is questionable.

We likewise continued extensive audits of universities as the cognizant agency for 94 percent of the Federal audit interest in these institutions.

Growing out of our experience this year, we have made six recommendations:

1. Contracting and grant practices throughout the Department should be examined by the Assistant Secretary for Management and Budget to test the OIG conclusions that special measures and controls are needed to separate contracting operations and peer reviews from program influence.
2. The General Counsel should be sure that all new officials of the Department and others in very sensitive roles are given counsel and assistance to avoid their becoming involved in conflict-of-interest situations.
3. The proposed debarment regulation should be issued promptly to enable the Department to avoid continued awards to programs or individuals who have demonstrated fiscal irresponsibility.

4. HEW should continue to work aggressively with the Office of Management and Budget and other appropriate organizations to improve the accountability of colleges and universities for Federal contract and grant funds.
5. The double payment issue affecting Public Health Service grants should be addressed and resolved in the current year.
6. Special attention should be applied this year to improving the management of the Title XX program. An OIG report on this matter will be issued in the near future and an OHDS Technical Assistance Manual will become available in May.

In addition to this basic volume and its Appendixes, other reference materials will be available in limited quantities, depending upon the public demand for them. These are:

- The proceedings of the Secretary's First Annual Conference on Fraud, Abuse, and Error held at the Washington Hilton Hotel on December 13 and 14, 1978. All registrants for that conference will receive copies of the proceedings.
- A compilation of memoranda described as "Lessons Learned from Project Integrity I." The 51 participating jurisdictions each have been furnished a memorandum of viewpoints by the regional officials who were the developers and overseers of the project -- the Audit Agency, the Office of Investigations, and HCFA's Office of Program Integrity. A copy of this will be furnished to each State agency and Fraud Control Unit, but it may be a useful reference to others.
- In preparation at the time this report went to printing was a volume of technical memoranda describing computer screening techniques developed for Project Integrity II. These are described in Chapter V of this report and in more detail in Appendix F.

As we did last year, we wish to pay tribute to the Secretary for his unflagging and consistently high support for the independence of this office, for the maintenance of its

professional integrity, as well as for its new initiatives. He has observed at all times the letter and the spirit of the statute which confers such independence.

CHAPTER II

PUTTING "LOSSES DUE TO FRAUD, ABUSE, AND ERROR" INTO PERSPECTIVE

In our first Annual Report, we presented a compilation of dollar estimates made by various authorities -- including HEW, GAO, and Congressional Committees. This inventory had been requested by the Secretary. Its immediate purpose was to emphasize opportunities which appeared to deserve priority attention by HEW managers to achieve greater economy and efficiency -- as well as to highlight areas deserving Congressional attention. This continues to be the primary purpose of this year's report.

Overview of Findings

We have continuously monitored the results from our first Annual Report and have remained alert to any new opportunities for savings which have come to light through our own and GAO studies. Our findings lead us to four conclusions:

--First, the response of the Department to the first Annual Report has been exceptional. Last June the Secretary established targets for savings of \$1.1 billion, \$1.7 billion, and \$2.2 billion in Fiscal Years 1979, 1980, and 1981, respectively. The FY 1979 goal has already been increased by 20 percent (to \$1.3 billion). The FY 1980 projected savings are up by 25 percent (to \$2.1 billion).^{*} In addition, many new areas of savings not reported by the Inspector General have been identified and incorporated into savings plans.

--Second, the principal untapped opportunities for savings reported by the Inspector General last year lie primarily in reducing fraud, abuse, and error in the Health Care Financing programs. Realizing these saving will require several more years of intensive effort by the Inspector General

^{*}The FY 1980 budget projects savings which will be incorporated into a formal cost-reduction plan between the Secretary and his program managers.

and the Health Care Financing Administration, working closely with the States. The savings potential is about \$700 million in this area, plus \$200 million in areas other than HCFA.

--Third, in addition to the Department's legislative program, which recommends savings of \$2.9 billion in FY 1980, we are stressing longer term opportunities to save another \$660+ million. Planning for these additional actions is proceeding within HEW, but Congressional support is required.

--Finally, a number of long-range subject areas need research and development efforts to identify the feasibility of actions which may lead to future savings.

This chapter discusses these four matters in more detail.

A. The response to the first Annual Report has been exceptional.

HEW today has in operation a comprehensive and promising cost-reduction program. Last year, we reported to the Secretary that out of total "losses" of \$5.5 to \$6.5* billion due to "fraud, abuse, and waste," only \$2.7 billion could be attacked within his existing authorities and resources. This analysis, which was submitted on May 18, 1978, (subsequent to the publication of the first report), appears in full in Appendix A.

The Secretary immediately directed the establishment of cost-reduction goals by each agency concerned. The goals now established for FY 1979 total \$1.3 billion. The budget savings projected for FY 1980 are \$2.1 billion, as shown in Exhibit II-1 on the following page and explained in greater detail in Appendix B. Because operating experience with this effort is still in its infancy, we have not had the opportunity to validate actual achievement of these goals in all areas. Nevertheless, we believe that a useful process is now in place which should give significant measurable results.

*Revised downward from \$6.3 to \$7.4 billion based on later information received. A number of overlapping items were found. See Appendix A.

COST REDUCTION GOALS FOR FY 79 AND FY 80
COMPARED TO IG'S ORIGINAL SAVINGS ESTIMATE
WITHIN EXISTING AUTHORITIES AND RESOURCES
(\$ MILLIONS)

Area	IG's		Department's		FY 1980
	Original		FY 1979 Goals		Projected
	Estimate	Original	Revised		Savings
Health Care Financing	\$1,909	\$ 531	\$ 554		\$1,298
Student Financial Assistance	203	284	416		394
Income Maintenance	541	201	287		244
Elementary and Secondary Education Title I	53	22	22		34
Administrative	53	40	40		80
Total	\$2,759	\$1,078	\$1,319		\$2,050

Source for Goals: Assistant Secretary for Management and Budget

Some of the highlights of these planned improvements are as follows:

1. In Health Care Financing, the goal has been raised from \$554 million to \$1,298 million -- additional savings of \$744 million in FY 1980. The major contributions to this increase come from:
 - Reduced payments for ineligible and erroneous payments.
 - Reduced fraud and abuse in Medicaid and Medicare.
 - Limitations on routine hospital costs (Section 223).
 - Limitations on malpractice insurance premiums.
 - Limitations on home health provider and skilled nursing facilities costs.

It is notable that of these reductions, as shown in Appendix B, five represent new initiatives begun since the publication of the first Annual Report.

2. The Student Financial Assistance Program has undergone dramatic change in its cost-reduction objectives. Originally, the Inspector General's estimate of loss was \$203 million. However, the savings goals for the program are now set at \$416 million for FY 1979 and level off to \$394 million in FY 1980. This change results chiefly from the better-than-expected experience in validating the Basic Educational Opportunity Grant applications and the use of improved computer edits. It appears that 500,000 questionable applications may be screened out through these techniques.
3. In the Income Maintenance area, the Social Security Administration has improved its efforts to enforce legal requirements by eliminating benefits to students who are no longer enrolled in school full-time. It is estimated that \$100 million can be saved by this initiative in FY 1979, and \$25 million in 1980.

B. Beyond 1980, about \$900 million in additional savings appear possible under present authorities.

If the 1980 goals now established can be met or exceeded, the question arises of how much more potential there is under existing authorities and resources. As described at the outset of this Chapter, in last year's report we arrived at a benchmark of \$2.7 billion of "losses" which could be attacked by the Department under present authorities and resources. In view of the new initiatives which have been added to the program, and the experience of another year, we have restudied our analysis item-by-item, as shown in Appendix B-2, and have revised those estimates. In summary, we find that the savings figure attainable, over time, rises from \$2.7 to \$2.9 billion, as shown in Exhibit II-2 on the following page.

The chief opportunities for achieving additional savings after 1980 lie in Health Care Financing, particularly in two areas:

1. Continued progress seems possible in the reduction of erroneous payments, payments to ineligible, and improved recoveries of third-party liabilities. It appears that, over time, at least an additional \$170 million should be saved.
2. Further reductions in Medicaid and Medicare fraud, abuse, and inefficiency losses should be sought -- especially in hospitals and nursing homes. The estimated untapped potential is \$517 million.

While we are pleased with the progress made in the first two years in health care fraud and abuse initiatives (as outlined in Chapter V), we must acknowledge our inability to measure progress, and the need for continued initiatives. The Inspector General proposes to continue to assume major responsibility here, in partnership with HCFA and the States.

As noted in Exhibit II-2, Student Financial Assistance savings continue at a very high level. Income Maintenance offers a continuing challenge to reduce erroneous payments. Further opportunities for savings exist in the ESEA Title I and various administrative functions.

ESTIMATED LOSSES WHICH CAN BE ATTACKED UNDER
PRESENT AUTHORITIES
COMPARED WITH FY 1980 PROJECTIONS

Area	: Millions :			
	: Estimated Losses: FY 1980 :		: Approximate :	
	: Original :	: Revised :	: Savings :	: Added :
	: (1977 : (1978) : Projec- : Savings	: Potential		
	: (1) :	: (2) :	: (3) :	: (2-3)
Health Care Financing	\$1,909	\$2,006	\$1,298	\$ +708
Student Financial Assistance	203	394	394	-
Income Maintenance	541	370	244	+126
ESEA Title I	53	97	34	+ 63
Administrative	53	105	80	+ 25
TOTAL	\$2,759	*\$2,972	\$2,050	\$ 922

*As shown in Appendix B-2, this total has been reanalyzed item-by-item and represents both additions to and reductions from the 1977 estimate: 17 items increase, 4 items decrease.

Source for Goals: Assistant Secretary for Management and Budget

C. Other future opportunities for cost reductions require Congressional action.

Beyond the \$900 million of untapped future savings, analysis shows substantial additional savings can result from proposed Congressional actions. The largest amounts lie in the FY 1980 legislative program already submitted by the Department to the Congress, which totals \$2.9 billion in savings.* Several elements of that total program which are especially important to the OIG estimate of potential savings related to fraud, abuse, and error are discussed under item 1, below.

In addition to these proposals, our review during the last year has revealed five other prospective legislative items which could offer additional savings opportunities, beyond 1980. These savings, discussed briefly in item 2, below, could aggregate \$272 million. Several are in development now.

Finally, additional staff resources are necessary in critical program management areas to take advantage of savings opportunities of approximately \$392 million. These needs are discussed in item 3, below.

1. Several items already announced in the HEW 1980 legislative program are of special interest in reducing fraud, abuse, and error.*

Most of the following items appeared in our first report, although savings numbers were not fully available until preparation of this year's report. These are:

--A mandatory common audit of Medicaid and Medicare institutional providers is highly desirable. The total savings potential is estimated to be \$41 million. The proposed legislative program reflects a possible savings of \$34 million in the 1980 budget.

*See Appendix B-5 for a list of legislative proposals amounting to \$2.9 billion in savings. OIG is interested in six with savings estimated at \$273 million, plus the important Hospital Cost Containment legislation with an estimated savings of \$1.7 billion.

- Enactment of the Civil Money Penalty Bill will give the Secretary authority to move against defrauders of Medicaid and Medicare where criminal prosecution is unwarranted or impractical. This Bill has been under development for two years. Its passage offers potential savings in the 1980 budget of \$24 million.
- Simplification of eligibility requirements and greater automation of State AFDC information systems would offer opportunities for more substantial reductions in errors estimated at \$92 million in savings. (\$81 million is reflected in the 1980 budget.) Legislation being requested would simplify and standardize the work expense and income disregards. The Inspector General advocates greater financial assistance to the States in the development of their computerized management information systems and fraud control units.
- Reduction in excessive physician costs for hospital-based radiologists, anesthesiologists, and pathologists would produce projected savings of \$55 million in the FY 1980 budget. (This was part of last year's inventory and recommendations.)
- A new initiative in this year's legislative program is improved administration of Child Support Enforcement -- including the matching of SSA wage information against Child Support Enforcement records, collection of alimony, and relationships with the AFDC program. Such reforms could save \$35 million in the FY 1980 budget.
- With respect to excess hospital beds, the FY 1980 budget proposes a \$30 million demonstration project under which closure of 1,500 excess beds would result in an annual savings of \$78 million (\$26 million in Federal funds). This demonstration project is one step toward the long-term solution to a \$1.1 billion problem area discussed in last year's report.

The preceding items are all recommended in the Administration's legislative program, and are included in FY 1980 budget proposals.

2. Five other legislative initiatives which are being planned offer savings potentials of \$272 million in future years.

--Statutory reform to prevent excessive payments for laboratory services and to prevent such charges to Medicare and Medicaid from exceeding charges by independent laboratories to physicians. Based on our studies in California, we estimate that about \$51 million per year in excessive charges can be eliminated. A more detailed discussion appears in Chapter V.

--Competitive selection of Medicare fiscal agents, and authority (1) to combine the administration of the Medicare program, Parts A and B, and (2) to experiment with integrated administration of Medicaid and Medicare programs. Such efforts should save a minimum of \$50 million annually, starting in FY 1982, and perhaps several times that amount within five years. We, thus, strongly support action by the Department to request such authority.

--Legislation supporting recommendations of a GAO report on "Newly-Arrived Aliens" to establish stricter residence requirements, and a legally binding support agreement by the sponsor. The estimated savings is \$72.3 million. We understand that statutory amendments to the Immigration and Naturalization Laws, developed by the Social Security Administration, have been approved by OMB. FY 1980 savings of \$13 million are estimated.

--Legislation recommended by another GAO analysis to cope with the SSI/Disability overpayment problem. The estimated overexpenditure today is \$54 million. Legislation would classify all such payments as "overpayments" and allow recovery out of future OASDI benefits.

--An amendment to the Tax Reform Act of 1976, as suggested by the Social Security Administration, which would make IRS interest and dividend income records available for matching with SSI payment records to help identify unreported resources. SSA preliminary studies indicate that such matching could result in cost savings of about \$45 million per year.

3. Finally, there are several opportunities to obtain future savings through increased staff resources in critical functions, as follows:

<u>Function</u>	<u>Additional Staffing Needed (Positions)</u>	<u>Additional Savings Potential (Millions)</u>
HCFA's Office of Program Integrity	30	\$ 55 in new initiatives
Renal Dialysis Program	11	52
AFDC Technical Assistance Program to States	40	50
Indirect Cost Negotiations with Universities and Other Grantees	65	64
Expanded Audit Force to Obtain More Timely and Frequent Coverage of 50,000 Recipients of HEW Funds	1,000+	133 (Recommended annual growth at about 10% --100 staff -- per year)
Implementation of the Checks Paid Letter of Credit Procedure to Reduce by \$400 million Idle Funds Held by State Grantees	15+	38 (Interest Cost)
 TOTAL	 1,161	 \$ 392

D. Summary of the 1978 review of opportunities for reducing losses due to fraud, abuse, and error.

The Secretary and his principal line assistants moved effectively to act on the opportunity areas identified in last year's report. FY 1980 cost reduction goals of \$2.1 billion represent substantial progress toward attacking losses which can be reduced under present authorities and resources. The remaining untapped savings on last year's list were primarily concerned with Medicaid and Medicare fraud and abuse, and the further reduction in erroneous payments in the Medicaid program, SSI, and AFDC. The Inspector General, working with counterparts in HCFA, SSA, and the States, acknowledges a major responsibility for contributing to further improvements over the next two to three years. The untapped potential is estimated at about \$900 million annually under present authorities and resources.

Our 1978 review also reveals opportunities for additional savings by Congressional action. In addition to the Administration's \$2.9 billion 1980 legislative program, we would like to call particular attention to some \$660+ million of additional savings which could result in future years from:

- Providing more resources to critical management activities which can have an impact on reducing losses due to fraud, abuse, and error. (\$392 million annually)
- Other statutory improvements noted in recent GAO reports and in our own work for which legislation must be prepared and is now in process. (\$272 million annually)

In short, the IG review in 1978 spotlights opportunities for approximately \$1.5 billion of savings -- in the years beyond FY 1980 -- over and above the \$2.1 billion of savings which have already been targeted for the FY 1980 program.

This leaves for further attention a group of problem areas which involve acknowledged cost problems, but the solution for which depends upon further research and new knowledge. Appendix B-4 delineates these areas. Principal items involved are:

- Further research to seek reductions in the payment error rates in (1) Medicaid, (2) AFDC, (3) SSI, and (4) SSA. Potential savings will continue to be of large dollar size even after we reach the lowest feasible minimum error cost under today's technology (\$1 to \$1.5 billion annually).
- Excess hospital beds where there is an acknowledged Federal cost of \$1.1 billion but where the technology for coping with this problem may require more years of demonstration projects and research, such as proposed in this year's legislative program.
- Excess nursing home differential costs which are estimated at as much as \$185 million. However, there is much controversy and uncertainty about the nature and scope of this problem. Further study is planned.
- Unnecessary surgery, which has an estimated excess cost range of \$282 to \$600 million. There is debate over the potential and the techniques for measuring savings. Excellent progress is being made with the second opinion program.
- Unnecessary X-rays is a subject of continuous attention by Public Health Service and HCFA. One estimate of the possible long-term savings potential is \$432 million. Criteria are now being developed for skull, chest, and pelvic X-rays.

E. Recommendations.

Recommendations to implement the findings of this chapter are discussed in the remainder of this report. One general proposal that has been reached as a result of this analysis is:

A special fund should be established under the direction of the Inspector General to support a "Fraud and Abuse New Initiatives Program."

Increasingly, we are impressed with the opportunities to achieve special high payoff initiatives in collaboration with Federal, State, and local agencies. A recent experience is "Operation Crackdown." Ten States are working with Federal teams to expose and

deter fraud and abuse in controlled substances -- involving collusion between physicians, pharmacists, and drug pushers.

To conduct a project of this type, the State and local agencies at times need special financial support for computer analyses, temporary additional staff, and other unusual expenses. Also, in some cases support for a special demonstration effort may be needed. (An example in Operation Crackdown is an experiment now proceeding in California. Prior authorization is being required for certain recipients, using a computerized check on recipient eligibility similar to an airline reservation check. Perhaps this experiment should be extended to other States.)

To permit implementation of a variety of new initiatives during the course of each year, it is recommended that a special appropriation of \$5 to \$10 million be granted to the Inspector General for expenditures under his personal direction -- and for which he would be strictly accountable to the Secretary and to the Congress. These expenditures should be devoted to high payoff projects where the return on the investment will be several-fold to one. This fund should also be available for use in contracting for studies leading to increasingly sophisticated means of measuring trends in fraud, abuse, and waste, as well as HEW's success in their reduction.

CHAPTER III

HIGHLIGHTS OF AUDIT EFFORTS CALENDAR YEAR 1978

This past year, the Audit Agency issued 5,652 reports of which 4,226 covered HEW-financed programs and activities -- 1,459 were prepared by the Department's audit staff and 2,767 by public accountants and State auditors. The remainder were audits performed for other Federal agencies under an OMB system for audit cognizance. These reports covered a wide range of activities, involving thousand of diverse and geographically dispersed entities that carry out HEW's programs-State and local governments, educational institutions, nursing homes, insurance companies, many types of other non-profit organizations, as well as numerous Departmental headquarters and field installations.

Audits were concerned primarily with financial accountability for some \$19.3 billion expended by HEW grantees and contractors. Where appropriate, the audit reports also considered the efficiency and effectiveness with which these monies were spent, and they contained numerous recommendations for improved management controls and operations. The audits identified \$143.8 million for consideration by POCs as not having been spent in accordance with regulations, terms, or other criteria requiring management attention. During this same period, POCs concurred in audit recommended financial adjustments totaling \$54.8 million, many of which stemmed from reports issued in prior years. The auditors also contributed substantially to Project Integrity, Project Match, and investigations, which are discussed elsewhere in this report.

In the following parts of this Chapter, some of the more significant audit findings are highlighted under the general program categories of health, education, income maintenance and human development, and HEW administration.

A. Health

We issued 186 reports on health programs covering \$4.1 billion in expenditures. Most of the reports

dealt with the Medicaid, Medicare, maternal and child health, and community health services programs.

1. Medicaid

During FY 1979 an estimated \$21.2 billion (\$12 billion Federal share) will be spent by States on medical care for their low-income population. Audit activity on the Medicaid program in CY 1978 included work in 38 States. We continued to emphasize our reviews of payments by States to medical providers and the costs claimed by States for administering the Medicaid program.

Reports on 13 States identified various kinds of improper payments to providers, or questioned the allowability of certain State-claimed administrative costs. Payment problems usually occur when claims processing systems do not have adequate checks into eligibility factors; review of services; duplicate payments; the reasonableness of claimed costs; and third party liability. To illustrate the types of problems encountered:

- In checking into one State's payment operations, we found disbursements to providers for recipients who were no longer eligible or whose continued eligibility had not been redetermined as required. We also noted payments for durable medical equipment without evidence that its purchase had been authorized by a licensed medical practitioner, and we reported excessive amounts paid for patient transport arrangements.
- Another State's system did not identify over 12,000 aged and disabled Medicaid beneficiaries also covered by Medicare; benefits cannot be paid by Medicaid if a third party insurer such as Medicare is also liable. A second major weakness involved the accuracy of various State-produced reports intended to assist State and Federal staffs in managing Medicaid. There were serious understatements of benefits paid when compared to the State's regular expenditure report. Also, physicians had been overpaid by an estimated \$316 thousand (Federal

share \$158 thousand) during a nine month period because the State agency had not instructed its fiscal agent to impose a State-mandated reduction in certain physician fees.

- A system used by one State to detect duplicate claims filed by providers was ineffective. We found actual duplicate payments of about \$306 thousand and estimated the probability of additional duplicate payments of \$239 thousand.

Toward the end of the Calendar Year, in keeping with the Secretary's high concern and interest, we initiated special audit plans for abortion and sterilization programs funded with HEW appropriations. Audits of abortion programs in twelve States are focusing on whether HEW funds are used only for specified circumstances allowed under law (rape or incest; where the life of the mother is endangered; and severe and long-standing physical health damage to the mother would result). Audits of sterilization activities in eleven States -- to begin on-site in April 1979 -- will determine whether the rights of the individual were adequately protected, and whether required documentations was present before payment.

2. Medicare

This broad program of health insurance involves about 26.5 million beneficiaries, with estimated Federal expenditures in FY 1979 of \$29.5 billion. Each year substantial audit effort is spent to see whether Medicare claims processing systems produce timely and accurate benefit payments -- and that administrative costs claimed by Medicare's intermediaries and carriers are allowable. During Calendar Year 1978 we completed 63 reviews, covering \$1.6 billion in paid benefits and \$416 million in administrative costs.

We continue to find problems. For example, one large carrier's claimed costs were overstated because it (a) used inequitable and inappropriate methods to allocate executive salaries and certain indirect costs to Medicare (\$652 thousand);

(b) incorrectly claimed costs relating to State examining, accounting and legal fees (\$248 thousand); (c) claimed unallowable consultant and long-range systems planning costs (\$510 thousand); (d) charged for a State tax (\$494 thousand) levied on its own commercial business; and (e) improperly claimed such other unallowable costs as EDP charges and telephone expenses (\$583 thousand). Also, the carrier incorrectly computed by \$326 thousand a credit due Medicare for certain costs that also benefited the carrier's private insurance business.

Since July 1973, Medicare pays for the treatment of chronic kidney disease for most Americans. Our review of renal dialysis claims submitted by hospitals in one geographical area disclosed certain flagrant billing practices. We alerted all audit staff so they could be aware of such practices in current and future program reviews. Specifically, we found that one hospital was routinely submitting claims for renal dialysis for "no show" patients. Also, three hospitals were charging for certain lab tests whether or not they were actually performed.

Another area of special audit attention during the year related to billings for services after beneficiary's death. Medicare claims are ordinarily paid by Medicare carriers until they receive notice from HCFA of the beneficiary's death. In FY 1977, HCFA notified carriers that more than 3 million claims totaling over \$163 million, appeared to relate to medical services rendered after the beneficiary had died. We verified that about 94,500 (\$4.8 million) should not have been paid and most of these may be recovered by the carriers from the providers. We found also, though, that other claims -- paid before the deaths of these beneficiaries had become known -- were not checked to see if they also covered services after the date of death. To correct this problem, we recommended that HCFA make certain changes in its computerized and manual systems and require carriers to identify and recover claims paid for services alleged to have been provided after death.

3. Section 1864 and 1902 Audits

State agencies certify health care facilities for participation in Medicare/Medicaid. Costs incurred in certification, licensure and survey of participating providers are reimbursable. Besides reviewing the allowability of claimed costs, we check to see that certifications are timely and consistent with required scope. In 1978, 14 audit reports were issued which questioned about \$5.3 million claimed by the States.

To determine the adequacy of one State agency's survey, we initiated a resurvey of 16 nursing homes. Regional HEW nursing home specialists conducted the survey work. Results showed numerous violations of health and sanitation standards (e.g., lack of physician care, serving food under unsanitary conditions, etc.). There were also violations of Life Safety Code requirements (e.g., inadequate smoke barriers that went undetected by State inspectors).

Many deficiencies went undetected because of inadequate State inspection procedures. In other cases there was confusion in interpreting some Federal requirements; poor training of inspectors in some evaluation areas; and limited supervision of inspectors. Appropriate recommendations were made to overcome these problems.

Audits also continued to find significant overstatements of claimed administrative costs. Improper rates were used to distribute costs; costs of inspections relating to State licensure were charged to the Federal Government; and budget estimates rather than lower actual costs were used when seeking reimbursement. Also, in some States -- because of inadequate documentation -- we could not render an opinion on the allowability of some costs.

4. The Maternal and Child Health (MCH) Program

The purpose of the MCH program is to extend and improve services for reducing infant mortality and otherwise promoting the health of needy mothers and children.

In reviewing one State's program we found errors connected with costs claimed; with the adequacy and degree of State supervision of MCH projects; and with the amount determined as the State's share of program costs. We recommended that the State make appropriate procedural changes to correct identified problem areas, and also make a financial adjustment of \$7.5 million.

As a result of these disclosures, the Secretary directed that MCH program audits be made of additional States to determine if the conditions we found were widespread. At the close of the year, audits were in process at six additional States.

5. Community Health Services and Other Health Organizations

Audit coverage of community health and other health organizations was provided on a limited basis to see how well selected grantees operate, what their problems are, and to consider the need for additional financial controls.

One audit concerned a grant awarded to a City, for a Community Neighborhood Health Center program. The City, in turn, had contracted with a private firm to operate the Center. The City's responsibilities were to monitor operations and require the contractor to submit documentation supporting grant expenditures. Shortly after the grant expired, the contractor filed for bankruptcy.

The audit disclosed that neither the City nor the contractor were able to provide adequate support for claimed grant costs of \$810 thousand. Further study disclosed the contractor's petition for bankruptcy listed equipment purchased with grant funds as an asset (cost: \$349 thousand). Recommendations called for a financial adjustment of \$810 thousand if proper support was not furnished. Also, that the Trustee in Bankruptcy be advised that the property discussed is not the contractors, and may not be sold to satisfy his liabilities.

A neighborhood health center in another city had poor financial controls and was not making the

most effective use of physician time. Physicians were treating 1.5 patients per hour instead of the targeted 2.7. Efforts were minimal to obtain third party reimbursement for services furnished. Recommendations were made to improve the Center's operations in these areas.

We continued our audit coverage of professional standards review organizations (PSRO). An audit at one of these organizations revealed situations that were so serious the Department concluded the PSRO was not a responsible contractor, and its contract was not renewed. Large data service costs and physicians advisor costs were charged in excess of specific contractual limitations, there were problems with charges for equipment purchased with Federal funds, and the PSRO refused to provide us required documentation.

B. Education

Audit activities for educational programs covered student financial assistance and research funds at institutions of higher education as well as compensatory and vocational education programs at State agencies and selected local school districts.

1. Student Financial Assistance (SFA)

During Calendar Year 1978, the Audit Agency processed 983 reports on student financial aid programs. These audits continue to disclose problems -- specifically in the areas of student eligibility and grant and loan awarding procedures; refund practices; improper use of Federal funds; loan collection procedures and the computation of interest billings; the financial stability of participating schools; and advertising practices. Special attention continues to involve proprietary vocational schools -- during the past year several were cut off from Federal funding. In all, we questioned about \$9.3 million in SFA program expenditures in Calendar Year 1978.

Overall, trends identified during SFA audits led to a number of Department initiatives to strengthen program controls. Chapter VII discusses several of

these areas including the jointly sponsored Audit Agency/AICPA training program for non-Federal audits of SFA programs, improved audit guides for public accountants reviewing the basic grants and campus based programs, and Project Crosscheck and other computer matching projects designed to detect and attack abuses of SFA programs.

2. Colleges and Universities (Research Funds)

Colleges and universities annually receive about \$5.4 billion from Federal sources (HEW: \$3.9 billion) mostly for research and demonstration projects. By OMB directive, the HEW Audit Agency is responsible for auditing all Federal funds at about 94 percent of these schools.

Last year, about 20 percent of our staff years were spent on this work. In summary, about \$1.5 billion in expenditures were audited, and about \$3.5 million were reported as improperly charged for which recovery was recommended. There was an additional \$86.5 million* which the auditors had to "set-aside" for determination as to allowability by program officials. In these cases, records maintained by the schools did not comply with Federal standards and did not adequately support charges to Federal projects. Our recommendations discussed how the schools could bring their accounting and related systems into line with Federal requirements.

This is not a new problem. For years, audit reports have discussed the need for colleges and universities to improve the ways they account for staff time charged to Federal grants and contracts. Last year the Department revised its procedures for acting on such problems. (See Chapter VII of this report.) Of particular pertinence: sanctions are now called for against schools that do not implement recommended corrective measures in a timely manner. Also, there will be an early audit review service for changes schools make to their accounting systems to comply with Federal requirements. We are seeking a better "meeting of the minds" between the Federal Government and each college and university as to specific accountability requirements for Federal funds.

*This is in addition to the \$143.8 million in questioned costs discussed on page 24.

Problems also continue with the reasonableness and accuracy of overhead rates for Federal grants and contracts. These rates allow a grantee/contractor to recover a portion of such overhead expenses as depreciation, general/administrative expenses and the like. The grantees compute what they represent as reasonable overhead rates to reimburse them for such expenses. These "proposed indirect cost rates" -- expressed in terms of a percentage -- are applied against certain direct costs (e.g., salaries and wages) to arrive at amounts chargeable to grants and contracts. The Audit Agency is responsible for assisting the Department's Division of Negotiation and Grantee Assistance which reviews the proposed rates.

Last year we issued 175 reports on reviews of these proposed rates; in most cases we recommended sharp reductions. The reductions result in significant savings. For example, a review of rates proposed by one major university questioned several major overhead items. In negotiations with the school about this rate which covered a multi-year period the Department agreed with most audit conclusions, and it is estimated that actual Federal cash outlay will be \$124 million less than what would have been paid on the basis of the University's proposed rates.

3. Elementary and Secondary Education, Title I

Funds are provided local education agencies for programs designed to meet the needs of educationally deprived children in low-income areas. During 1978, audit work conducted in 7 States reviewed some \$53 million in Title I expenditures. The following examples illustrate recurring problems noted:

One State's reported expenditures were overstated by \$700 thousand in that they included amounts relating to (a) State level salaries and indirect costs that were inadequately supported; (b) services provided all students in one district, without regard to educational deprivation; (c) a project that partially supplanted the school

district's basic curriculum, and (d) funds retained by the State past the two-year period of limitation.

Similar problems were found in another State's Title I migrant program. Title I funds supplanted State funds for certain activities. Also, the State used Title I funds after the two-year period of limitation expired. Errors were also noted in the way the State allocated administrative costs between the Federal Title I and State programs. For these and other reasons, the audit report set-aside \$546 thousand for determination by the Office of Education as to allowability and proper allocation.

4. Vocational Education

Funds are provided for special educational projects to areas with youth unemployment rates of at least 12 percent, or with school dropout rates exceeding State-wide averages. Cooperative and work-study programs are also funded -- with preference given areas with high numbers of disadvantaged youths. The following examples illustrate problems noted by audit.

One State was seriously deficient in complying with program criteria. Program funds were misdirected because the State did not maintain statistics on the numbers of unemployed youths. Although dropout rates were available, they were not used in the process of awarding funds to local agencies. Some projects should not have been funded because their purposes were not consistent with program goals. In other cases, the counties in which the projects were conducted were not eligible. Projects were not always concentrated on the disadvantaged. Also, preference was not given to areas with high numbers of disadvantaged youths when \$943 thousand in cooperative and work-study program funds were awarded to local agencies.

Audit of the program in another State disclosed substantive problems in the management and expenditure of program funds, particularly in the way the State approved and allocated funding for constructing vocational high schools. Construction

funds must be awarded to local educational agencies by means of rating criteria described in the State Plan which include: manpower needs and job opportunities; differences in vocational education needs; relative ability to provide resources; and relative costs of programs, services, and activities. Applicants are to be judged competitively and ranked based on these criteria. Instead, the State was guaranteeing schools an annual ten percent reimbursement of construction costs without an adequate needs justification. Funds were provided in some cases after construction was completed. Regulations specifically prohibit the allocation of funds at a uniform percentage ratio.

Other problems noted in this State: (a) \$4.9 million was expended on projects not reviewed and approved in accordance with State plan requirements; (b) \$964 thousand in administrative costs was not documented; (c) \$677.5 thousand was used for improper grants to profit making organizations; (d) \$948 thousand had been identified by independent auditors as questionable expenditures; and \$147 thousand was used for payments involving potential conflict of interest. In addition, \$1.1 million was expended after the two year limit set by law.

Appropriate recommendations have or will be made to refund improper expenditures and to strengthen program procedures.

C. Income Maintenance and Human Development

Our audit effort in the income maintenance and human development programs consisted principally of reviews of selected aspects of aid to families with dependent children, supplementary security income, retirement and survivors insurance, social services, and Native Americans.

1. Aid to Families with Dependent Children (AFDC)

In the AFDC program we continue to identify significant amounts of incorrectly claimed administrative costs. During 1978, 10 reports were released covering \$581 million in claimed costs; of this total \$4.5 million was questioned

largely because States' claimed the same costs under more than one program; used incorrect methods to allocate costs; or claimed ineligible costs.

This problem area was covered in a special report to top HEW management issued in late 1977, which summarized and interpreted the results of 66 individual audits. It was discussed in last year's Annual Report and is further reviewed in item "2" below.

Because of the substantial sums involved, mistakes in AFDC accounting can be costly. For example, one of the things we do in reviewing AFDC is to evaluate how the State handles credits due the Federal Government. Credits are called for when recipients return AFDC funds to the State because the payments were in the wrong amount; sent to the wrong individual; and so on. We found in one State that the credit was based on an estimate, which was not adjusted to actual, resulting in an understatement of \$3.1 million over a three year period. Recoupment was recommended.

During 1978, 16 reviews looked at the AFDC Foster Care program under which the State and the Federal Government share in the cost of foster care for eligible children residing outside their own home.

In one audit we estimated that about \$1.7 million in payments had been made for ineligible children during a four year period. Cases were also found where payments had been made to providers of foster care for periods when the children were no longer in their charge. Also, children were being placed in foster homes in greater numbers than were specified by the home's license.

Review in another State also disclosed sizeable payments made for ineligible children and for costs of care that exceeded amounts established by the State. Also, the Federal account was not being credited for amounts collected from the natural parents of foster children.

Appropriate recommendations were made with respect to these deficiencies.

2. Administrative Costs in AFDC Programs -- A Problem Area Update

a. The Problem: In this and our prior report, we discussed repeated instances where auditors identified significant amounts of incorrectly claimed administrative costs:

- Our calendar year 1977 report spoke of an Audit Agency summary report revealing more than 180 instances of significant improper claims audit found over a three year period. Involved: \$78.2 million. Our principal recommendation in this summary report -- that consideration be given to establishing and imposing fiscal sanctions or other administrative motivators in case of inaccurate/excessive claims -- was not accepted.
- This current report discloses that ten audit reports released during 1978 questioned \$4.5 million in claims which were erroneous because States continued to use incorrect allocation methods; claimed the same costs under more than one program; or claimed costs that were ineligible. Thus, the problem continues.

b. Current Actions: Because of the concern and wide interest in this problem SSA's Office of Family Assistance began a national study of AFDC administrative costs in all States. The study is being made to obtain information on the breakdown of administrative costs by functions and activities, and the nature of the variations between States. Survey results are expected to provide a basis for evaluating alternative methods of Federal reimbursement and for dealing with and reducing cost allocation problems.

We will keep fully informed on the study's results and on the actions that may arise

from this work. Hopefully, the study will reaffirm our conclusion of the need to establish and impose fiscal sanctions, or other measures, when States' claims for cost reimbursement are inaccurate and excessive. We plan to appropriately assess these results.

3. Supplemental Security Income Program (SSI)

In January 1974, SSI replaced State administered programs of cash assistance to the aged, blind, and disabled. Considerable audit effort has been expended on the SSI program since its inception. Examples of audit findings in CY 1978 are:

- a. State claimed conversion costs: We audited \$5.7 million of costs claimed by 12 States in transferring records for the aged, blind, and disabled to Federal control. About 13 percent of these costs (\$740 thousand) were questioned, and SSA should make financial adjustments for this amount when settling claims with the States.
- b. SSI Quality Assurance (QA) program: Each month SSA's Office of Quality Assurance reviews a sample of about 4,500 SSI recipient cases. Data generated by these reviews is used as the basis for projecting SSI's semi-annual error rates and over/under-payment data. We concluded that, while the QA program made a strong and positive contribution towards more accurate program administration, improvements were possible.

There was a need for better compliance with existing QA procedures; further testing procedures were needed; and the exclusion of some types of cases may bias sample findings. Also, certain SSA review functions duplicate/overlap the QA process and, if these were eliminated, we believe there would be savings of \$5 million annually.

- c. Representative payees: SSI payments may be made to appointed representative payees for

recipients unable to manage their own funds. These individuals are obliged to know the recipient's situation and need; to account for the funds received; and to notify SSA of events affecting the recipient's eligibility or level of payment.

We found that SSA needs to improve its monitoring of representative payees who were:

- (a) charging SSI recipients excessive fees,
- (b) inadequately safeguarding recipients funds,
- and (c) not maintaining adequate documentation for payments made on behalf of recipients.

We recommended that SSA review the actions taken by representative payees to ensure the best interests of recipients are met; that adequate controls over funds and support for expenditures are maintained; and that fees charged are reasonable.

4. SSA Retirement and Survivors Insurance (RSI)

During the year we reviewed selected aspects of SSA's administration of the RSI program at the central office and selected program service centers and district offices. Audit findings related to payments and interest income.

Wives or widows may apply for SSA benefits before they reach the age of 65 under their spouse's account. When they do, benefits are reduced. However, some of these beneficiaries may be entitled to higher benefits under their own accounts on reaching age 65. We found that, although SSA was informing each applicant of this fact at the time they applied, there were no follow-up procedures to remind them to reapply for possible higher benefits when they became 65. As a result, an estimated 17,000 wives and 48,000 widows have been underpaid nearly \$99 million.

Problems with duplicate payments also surfaced. In 1975 there were 2,000 cases identified for review by SSA as potential dual payments. Our review of these cases showed nearly one-fourth had either not been further analyzed or not adequately resolved. At least \$2 million was unnecessarily disbursed as a result.

Changes were recommended that would strengthen controls over benefit payments made in these situations.

Two audit reports discussed ways that SSA could increase Trust Fund interest income earned on FICA contributions. The first centered around Social Security regulations which require that FICA contributions for State and local government employees be deposited within 45 days after the close of each quarter.

While interest at 6 percent is charged for overdue payments, SSA allows a five day penalty free tolerance on late deposits. Since 1952 SSA has used the five day tolerance rule on the premise that the interest income lost was insignificant. This is no longer true. FICA deposits have increased from \$26 million in 1952 to over \$10 billion in 1977. SSA's five day tolerance rule resulted in an estimated \$1 million in lost income over the past year. SSA agreed with our recommendation to discontinue the five day tolerance rule and will notify the States of this change.

Another audit report discussed how interest earnings can be significantly increased by a simple change in the procedure used by SSA and Treasury for investing State and local FICA contributions. Currently, SSA notifies Treasury to invest State and local contribution deposits upon receipt of deposit tickets mailed to SSA by the States and Federal Reserve Banks. Inherent in this procedure is a ten day delay due to mailing and handling. SSA agreed with our proposal to invest based on Treasury's "daily balance wire" which would result in investments within 24 hours after validation of the deposit. Implementation is pending Treasury's approval.

5. Social Services (Title XX, Social Security Act)

The purchase of social services through contracts by State and local government accounts for about half of the \$2.5 billion Title XX program. Six audits showed that States need to be more effective in contract negotiations with providers and in

monitoring provider performance to assure compliance with Federal/State regulations and contract specifications.

Specifically, we found that Federal funds were spent for services not provided for in the contract; on behalf of individuals who were not eligible for Title XX services, and in amounts which were excessive, for the service. Improvements were recommended in contracting and contract monitoring. This is discussed in Chapter VIII.

A joint audit team (comprised of staff from a State's Auditor General, the City Controller, GAO and the HEW Audit Agency) reviewed a Day Care Center administered by the City's school district. Started in 1965 with OEO funding, it is now funded by Title XX grants. Costs have risen sharply -- from \$13.3 million in 1971 to \$20 million in 1977 -- although the number of children served has declined.

The audit team noted significant weaknesses in the way the City (a) implemented the program and evaluated its results, (b) contracted for services, (c) ensured the eligibility of program participants, (d) licensed and inspected centers for compliance with health and safety standards, and (e) maintained financial control over budgeting and accounting for expenditures. The audit report noted and discussed ways in which the approximately \$61 million expended by the program during three year period ended June 30, 1977, could have been reduced by \$12.2 million -- through greater economies and efficiency -- without adversely affecting services to children. It was recommended that the school district make certain procedural and system changes to improve efficiency and economy and to refund expenditures of \$5.9 million which were unauthorized or improperly billed.

In another joint effort with State auditors, we reviewed performance of a Community Action Agency in administering Head Start and Day Care Programs. Two centers were looked at. There were serious problems in both financial and program management. The grantee improperly transferred about \$85,000

from programs and activities including about \$30,000 from the Head Start account. Because of the poor financial condition of the grantee, Federal and State funds may have to be used to pay off bank loans. The grantee also improperly paid about \$30 thousand in commissions to its employees.

Since these problems were so serious, it was recommended that other organizations in the service area be considered to provide Day Care and Head Start services. Also, that all improperly spent funds be recovered, and that technical assistance be provided and financial administration practices be more closely monitored.

6. Native American Programs

The Office of Native American Programs in HEW (in Fiscal Year 1977) spent about \$33 million to assist 600,000 Native Americans through 195 Native American grantees.

Our review of program operations showed the need to (a) increase coordination with other programs (both within and outside HEW) serving Native Americans, (b) improve methods of reporting and analyzing program achievements, and (c) better manage grants and contracts (including improvements in the grants award and contract monitoring processes). We recommended improvements in these areas, and program officials have begun corrective actions.

D. HEW Administration

In addition to audits of recipients of HEW program funds, the Audit Agency conducts or participates in a variety of internal reviews of HEW administration of its programs, functions, and activities. Some highlights of this work during CY 1978 related to contracts and grants, accounting operations, GSA self-service credit cards, and audit resolution activities.

1. Contract and Grant Activities

Audit attention continued in this major area. We developed an automated system to monitor close-out

of 839 contracts, valued at \$361 million.

But of greater significance was our work concerning contracting operations at the National Institute of Drug Abuse (NIDA) and the National Cancer Institute (NCI). These studies are discussed in detail in Chapter VIII.

2. Accounting Operations

Adequate monitoring of accounts receivable was identified as a serious problem in two areas -- audit disallowances, and advances of grantees who were delinquent in submitting expenditure reports.

a. Controls over concurred-in audit disallowances:

Effective March 1977, each POC was required to have formal procedures in place to control and monitor the collection of sustained audit-recommended disallowances. One of these POCs should have had appropriate records to show that there were 177 sustained disallowances amounting to \$4.9 million for a certain program. Our review showed, however, that only \$2.5 million of this sum was recorded. In certain other cases, where recoveries were to be made by adjustments of awards rather than by funds recoupment, serious problems were also found. As a result, action had not been taken to recover 68 disallowances totaling about \$3 million, most of which should have been recovered from 6 to 29 months earlier.

In November 1978, additional procedures were initiated to assure that POCs account fully for "concurrent in" disallowances, and track them to collection or final disposition.

b. Delinquent expenditure reports: The Departmental Federal Assistance Financing System serves as a fiscal intermediary between HEW awarding agencies and fund recipients. It provides cash to grantees in support of program needs, receives expenditure data from them, and furnishes awarding agencies transaction data for updating their accounting system.

Our review disclosed that procedures were not in place to obtain delinquent expenditure reports in order to account for funds previously advanced, recover unused funds, and alert program officials to delinquent recipients. We recommended that such procedures be established. While action was taken to reduce the number of delinquent reports from over 1,000 to 500, locating all recipients remains a problem. But definite progress is being made with 161 remaining unlocated as of February 1979.

3. Use of GSA Self-Service Store Credit Cards

A limited review disclosed numerous shortcomings in the control and use of these cards. Responsible officials were unable to identify whether there were missing cards, and measures were needed to safeguard their use. Procedures were also needed to assure that GSA was notified when cards were missing.

Although it is a Department requirement, there was no effective monitoring over the quantities and type of merchandise purchased. Lastly, accounting problems were noted in the methods used to record purchases made.

Recommendations to correct these deficiencies were made to responsible officials who have acted promptly to provide improved controls.

4. Resolution of Audit Matters

The Audit Agency issues about 5,000 audit reports each year. Misspent funds and improperly supported claims for Federal funds discussed by these reports were \$143.8 million last year. Heads of principal operating components (POCs) are responsible for resolving the matters raised in audit reports. Audit monitors the timeliness and adequacy of these actions. Our reviews have disclosed continuing problems.

- a. Timeliness of audit resolutions: The number of open audit reports over six months old remained high during the year. As of December 31, 1978, there were 920 reports in the category that questioned the validity of some \$143 million in claimed costs.

As the numbers and dollars involved indicate a serious problem, Secretary Califano asked the OIG to (a) take a close look at how POCs are handling the audit resolution process, and (b) see whether major improvements are possible.

- b. Adequacy of audit resolutions: The Audit Agency routinely reviews actions taken by Department components in response to audit recommendations using selected samples of "closed" audit reports. These reviews check whether promised corrective actions were, in fact, carried out, and whether systems in place for monitoring and controlling actions were producing the intended results.

Results of 1978 follow-up reviews were mixed. Two of HEW's five POCs had reasonable accomplishments ratios (86% and 91%). The other three were in the 40-50 percent range.

An example of an accepted recommendation that had not been implemented: Several years ago we reported on an audit of Medicare's management information system -- relating to contracted program operations -- and concluded that certain improvements were needed to enhance the system's capabilities to monitor and evaluate contractor performance. Recent follow-up showed that the Medicare Bureau still had not (a) completed development of qualitative and quantitative standards to evaluate contractor performance, (b) completed review of management information reports prepared by contractors to decide on further actions needed, or (c) provided central office summary reports to the regions in a prompt fashion.

- c. Grantee appeals: Grantees may appeal POC decisions agreeing to audit recommended financial adjustments. Until March 1978, each POC was responsible for resolving appeals concerning their programs. The effect of a March 1978 decision was to transfer jurisdiction for acting on most appeals to the

Department's Grant Appeals Board -- one major exception being the Office of Education's Title I Audit Hearing Board.

In checking into the status of appeals pending before SSA, HCFA, OE and the Grants Appeals Board, we found that more than \$200 million in sustained audit findings were under appeal. Very little progress in terms of dollars has been made to resolve open items since 1973. Cases backlogged by the Grant Appeals Board increased from 27 to 166. This may increase to over 300 when all appeal cases have been transferred from the POCs. While some additional staffing has been added to the Board, it appears to be insufficient.

Further review showed that the OE Title I Audit Hearing Board was also experiencing a backlog situation (\$40 million, some dating to 1974). OE's legal staff is giving priority to preparing regulations rather than to resolving appeal cases.

Recommendations were made to responsible officials calling for a time-phased transfer of appeals to the Board, and for a reevaluation of the Board's staffing needs -- in light of its increased workload demands. Similarly, it was urged that the questions of priorities and staffing needs of OE's Title I Audit Hearing Board be resolved.

E. Two Major Recommendations

The Audit Agency is the backbone of the Office of the Inspector General in terms of its size, versatility, and distribution of staff resources -- as well as its continuing planned coverage of every program area receiving HEW funds.

Our first recommendation discussed below is concerned with the importance of a continued incremental build-up in the staff resources over the next several years.

The second recommendation deals with an Audit Agency-conceived technique to deal with one of the most

pervasive problems encountered in audits of grantees, namely, the mispending of Federal funds where full recovery is frequently impractical but where, at a minimum, the grantee should be expected to reimburse the Federal Government for its cost of borrowing those funds.

Both of these recommendations are discussed below.

1. Audit Agency Staffing Needs To Be Steadily Augmented

The disparity between audit resources and audit workload continued to be an item of significant concern. Currently, we are authorized resources to perform approximately 72 percent of the audit effort deemed necessary. As a consequence of this shortfall in staffing, we had to cut back on the audit frequency of smaller and medium sized institutions to less than prudent cycles, and further postpone covering areas that have received little or no recent audit attention. This situation was further strained since we needed to utilize nearly a quarter of audit's in-house staff to carry out special Inspector General's initiatives during FY 1978. Currently, the Audit Agency's staffing situation is as follows:

		<u>In Staff-Years</u>
Total audit workload--determined based on several high validity studies in recent years		4,554
Less: <u>Resources</u>		3,292
Authorized in-house staff	960	
Staff-year equivalent of work performed by public accountants, States, others	2,332	
Unmet audit needs		<u>1,262</u>

We are continually looking into ways to augment our audit capability. One of the most promising is the expanded use of contracts with non-Federal audit staff. During FY 1979 we were authorized \$2.25 million for such contracts -- the equivalent of about 60 staff-years of audit effort.

The budget now before the Congress proposes an additional 30 staff-years of contract support. We must stress though that this growth needs to be complemented by some growth in-house for planning, monitoring and supervision purposes. We believe such in-house growth in succeeding years should average at least ten percent annually.

2. A Reasonable Approach is Required to Recovering the Costs of Monies Borrowed by the Federal Government -- Found To Have Been Misspent By Grantees

Other than good conscience, there is nothing to deter a grantee from misspending Federal funds. Audits turn up numerous and recurring examples. When this occurs, the grantee is merely requested to repay the funds in question.

The criminal condition of fraud, if it does exist, is difficult or impossible to prove since the typical HEW grantee is an institution and personal gain is not a factor. While the funds are recouped, the Federal Government has still suffered a financial loss, which under the current system, is not being reimbursed: the expense it incurred to borrow the funds involved. There is little to deter the grantee from again misspending Federal funds.

We believe that HEW -- as a part of its grant agreements -- should incorporate a provision requiring payment by a grantee of interest on monies it retains which are identified as misspent or misapplied under the grant.

General Counsel in researching this matter, found no provisions in law to preclude inclusion of this type of provision as a grant term. OMB staff also informally advised that Federal policy does not preclude charging interest.

Traditionally, interest is a sum paid or payable for the use or detention of money. Where a grantee misstates its grant costs or misspends funds, it is, in essence using Federal funds not due it. The Federal Government, as a result, loses the use of the money while it is held by the grantee. The Government should not be made to bear this loss; it should be recouped from the grantee. It would also provide an important deterrent to the practice of using Federal grant funds for other than the purposes intended.

Financial implications: Dollar recoveries to the Federal Government would be substantial. For example, during CY 1978 audit identified some \$144 million in HEW funds as having been misspent by grantees. Assuming that the average interest period involved was two years, and that the interest factor was 6 percent -- this would equate to \$17 million. At 9 percent the recovery would be \$25 million.

In consideration of the above factors we have recommended to the Secretary that he authorize us to begin implementation of regulations to establish a policy for inclusion of a clause in all future grant awards that an appropriate interest be charged on all funds found to have been misspent by the grantee.

We will work with responsible officials to refine the recommended grant clause with respect to (a) the specific time frame in which interest would be charged; (b) whether the interest rate should be a nominal amount of, say, 6 percent or the current, higher rate now paid for Treasury borrowings, and (c) whether there may be a necessity to permit interest waivers under certain specified conditions.

CHAPTER IV

HIGHLIGHTS OF ACTIVITIES, OFFICE OF INVESTIGATIONS AND OTHER FRAUD INVESTIGATION AGENCIES

In this year's report we will discuss in some depth the work of the Inspector General's Office of Investigations which has operational responsibility within the Department of HEW for all criminal fraud investigations.

Unfortunately, the completeness and accuracy of data on criminal fraud investigations of HEW programs by sources outside of the Department vary widely. The FBI is changing its computer system and will be able to furnish data on HEW cases in the future.* For Calendar Year 1978 data were available for the last quarter. The reporting from State agencies has also been incomplete. We are planning to devote more resources in the future to systematically gathering the best available data for purposes of analysis and identifying significant trends.

Other matters which we will cover this year include (1) experience in referral of HEW cases to the Department of Justice in the health care field, as required by statute; (2) discussion of new capability anticipated from fraud control units established by Public Law 95-142 -- and other benefits expected from P. L. 95-142; (3) the value of the OIG subpoena authority; and (4) some comments on the outlook for future progress.

A. Trends in Convictions and Workload

OI made major strides in Calendar Year 1978.

--First, its staffing has begun to improve. At the beginning of the Calendar Year, it had a total force of 87 personnel scattered thinly among the ten regional offices and the Washington Field Office. Beginning in the fourth quarter -- after

*In the past, statistical data were not separately grouped by Government agencies.

Congressional action on the budget -- the growth in staff became possible. By January 1979 the staff had expanded by 50 percent to a new level of 136, and the number of resident field locations had grown to 28. Our objective during the current Calendar Year is to further expand the staff to about 234.

This growth is essential since the work on hand at December 31, 1978, was conservatively estimated to be in excess of 12 months' work for the entire field force. Actually, this workload is much greater because of other requirements being placed upon the field staff to oversee and assist States' investigative activities, as well as the need to train and indoctrinate new staff members.

Second, OI's productivity has considerably improved, as shown by the following measures of output for the past four Calendar Years.

	<u>CY 1975</u>	<u>CY 1976</u>	<u>CY 1977</u>	<u>CY 1978 Jan.-Dec. 29</u>
Indictments	8	27	60	125
Convictions	22	40	52	105

A synopsis of each of the 105 convictions in 1978 resulting from the work of OI is presented in Appendix C. The type of convictions compared with last year is as follows:

<u>Type of Cases</u>	<u>Number of Convictions</u>	
	<u>CY 1977</u>	<u>CY 1978</u>
Employee Cases	9	8
Grantees & Contractors	7	22
Student Financial Assistance	4	34
Health Care	32	31
Other (AFDC/SSI)	--	<u>10</u>
TOTAL	52	105

The Office of Investigations is now fully responsible for the conduct of all HEW criminal investigations and the referral of cases to the U. S. Attorneys, except for Social Security Administration's routine beneficiary/recipient cases, most of which concern the Supplemental Security Income program. In addition to convictions resulting from OI's work, we have endeavored to compile conviction data from other sources in relationship to HEW programs.

--Provider Convictions Reported By Other Agencies

HCFA's Office of Program Integrity reports 39 convictions in CY 1978, 13 of which were investigated jointly with the Office of Investigations. A synopsis of these also appears in Appendix C. State agencies report 137 Medicaid convictions for the year. FBI reports 30 convictions for the October - December quarter.

--SSA Beneficiary/Recipient Cases

Social Security Administration's Office of Program Integrity reported 204 convictions in CY 1977 and 238 in CY 1978. We will continue to work with SSA to analyze these data.

--AFDC Cases

With the exception of the small number of Project Match cases -- discussed in detail in Chapter VI -- AFDC criminal cases are handled almost exclusively by the States. We have decided to conduct our own State-by-State canvass. For the 44 States who had reported by 2/7/79, the total number of convictions in 1978 was 10,424. A State-by-State breakout is shown in Exhibit IV-1. We will begin to monitor these cases systematically in the future.

--Illustrative Indictments and Convictions

Four outstanding cases last year involved a physician, a contractor, a chain of schools, and a

State	Number of Convictions	State	Number of Convictions
Region I		Region VI	
Connecticut	368 ^{2/}	Arkansas	25
Maine	1	Louisiana	79
Massachusetts	28	New Mexico	38 ^{5/} (Est.)
New Hampshire	15	Oklahoma	12
Rhode Island	79	Texas	358
Vermont	38		
Region II		Region VII	
New Jersey	381	Iowa	36
New York	1,700 (Est.)	Kansas	115 (Est.)
		Missouri	101
Region III		Region VIII	
Delaware	5 (Est.)	Colorado	7
District of Columbia	69	Montana	57
Maryland	138	North Dakota	10
Pennsylvania	369	South Dakota	49 ^{5/}
Virginia	364 ^{3/}	Utah	48
West Virginia	4		
Region IV		Region IX	
Alabama	100	Arizona	21 (Est.)
Florida	1,076	California	2,639
Georgia	282		
Kentucky	247		
Mississippi	11		
Tennessee	25		
Region V		Region X	
Illinois	181	Alaska	2
Indiana	57	Idaho	2
Michigan	322 ^{4/} (Est.)	Oregon	142
Minnesota	165	Washington	477
Wisconsin	181		
		TOTAL	10,424 (Est.)

- 1/ State Fiscal Year may be other than October to September
2/ The majority of this figure represents AFDC convictions
3/ This figure is the accumulated total over a 9 month period
4/ Number represents estimate of 35 counties
5/ Number represents estimate over 14 month period

The figures on the number of AFDC convictions represent responses given in a telephone interview with each of the respective States. It should be noted that these figures include estimates from State officials who have taken on-the-spot polls in an effort to determine the conviction numbers. There appears to be a problem in ascertaining the number of AFDC convictions in several States due to the lack of a centralized data collection unit and/or fraud unit which tracks this type of information.

Regional Commissioner. The results provide examples of well-documented investigations and teamwork that led to quality indictments and convictions. Because of their scope, cases such as those cited below have significant deterrent value.

Physician

In the fall of 1978, a physician was indicted on numerous counts involving Medicaid fraud, Medicare fraud, mail fraud, racketeering, and defrauding two States. The indictment culminated a 15-month team effort, conducted under the U. S. Attorney's supervision, by HEW Inspector General's Office of Investigations and Audit Agency, and the Postal Inspection Service, with support from two State medical assistance agencies.

According to the indictment, this doctor, billed for medical services not performed, including blood and urine tests, various surgical and diagnostic procedures and visits to hospitalized patients. In some instances, it is alleged that this provider entered false diagnoses and test results on patients' charts to give the appearance that the services were rendered.

This case illustrates a unique Federal-State investigative approach to a complex medical case which can be successful under proper direction, coordination and control. Early consultation with the U. S. Attorney resulted in the timely seizure of records under a search warrant and the creation of an effective task force whose members possessed expertise in different fields. The melding process was effected by the U. S. Attorney who vividly described the task force as a "Medifraud Strike Force". It should also be noted that the Justice Department's Fraud and Organized Crime Section participated in the investigation.

The penalties faced by this physician are staggering. If convicted under the racketeering statute, he would mandatorily forfeit to the Federal Government all interest in his medical practice, he could be fined \$25,000 and sentenced

to a 25-year term of imprisonment. The maximum punishment under the fraud counts is five years imprisonment for each count and fines totaling over \$2.3 million.

Contractor

In early 1977, information surfaced indicating misuse of funds involving a contract awarded by the Office of Education for vocational education training films. In addition, it appeared that a recipient of a portion of the misused funds had participated in the award of the contract. Initial efforts led to a major vocational educational investigation in an eastern State involving Federal and State vocational education funds, contracts and grants.

This case, as noted previously, involved State and Federal interests as well as State and Federal prosecutive jurisdiction. All parties, OI, State Investigators, HEW Audit Agency, U. S. Attorney and the State Attorney General worked together to produce 14 convictions to date -- with additional indicted persons awaiting trials.

Fines and restitution totaling over \$334,000 have been ordered to date. In addition, this effort resulted in information which led to another investigation in another State. Among those convicted are a former State Senator, an assistant to the Governor, a State Vocational Education Commissioner, and other State officials and corporate executives.

This is a fine example of a joint Federal/State investigative effort coupled with classic prosecutorial cooperation. The U. S. Attorney deferred prosecution to the State Attorney General on the major portion of the cases since past, and then present, State officials were involved. The participants in the original OE contract are being prosecuted by the U. S. Attorney.

Chain of Schools

A Department of Justice task force culminated an effort begun by OI, extending over 3 years, to

obtain evidence of misuse of student financial aid funds by a group of proprietary schools.

A corporation owned over 40 schools located in eight States. This investigation, which involved the examination of thousands of documents, hundreds of interviews and the preparation of exacting schedules, produced sound results. Ultimately, the corporation and some of its officers were indicted for such violations of Title 18 U. S. Code, as, conspiracy to make false certification to banks; submission of false statement and certification to a bank; submission of false claims to the U. S. Government for interest, and numerous other counts.

The corporation agreed to plea nolo contendere to one count of conspiracy and to 48 counts of false claims and false statements to the Federal Government. Upon payment of the \$500,000 fines, the Federal Government and the U. S. Attorney's Office agreed to drop the remaining counts in the indictment. It should be noted, however, that civil aspects of this case are continuing.

Former OE Commissioner

An HEW Audit Agency audit review revealed possible falsification of travel vouchers by a Regional Commissioner of Education. Further investigation uncovered a number of unsupported cost claims. The prosecution of the case was declined in July 1977 in favor of USOE administrative action. After receiving additional information, the U. S. Attorney's Office directed the FBI to investigate stock transfers involving the subject. It was found that the individual received approximately \$10,000 in cash from a regional USOE Consultant, and other favors from contractors and suppliers. The HEW Office of Investigations joined the FBI in the investigation. The Commissioner and the Consultant were convicted of accepting a gratuity and giving a gratuity, respectively.

Both were sentenced to two years for each of the counts, to run concurrently, with three months

to be served in custody, balance suspended, and placed on probation for three years.

Work in Process

The work on hand as of 12/31/78 -- as measured by number of cases -- remains very close to the high levels reported in the first Annual Report (which contained data as of February 28, 1978).

<u>Program Area</u>	<u>Investigating Agency</u>	<u>Number of Cases</u>	
		<u>2/28/78</u>	<u>12/31/78</u>
Employees	OI	40	31
Contractors and Grantees	OI	76	74
Student Financial Assistance	OI	114	135
	BSFA	23	67
Social Security	OI	38	23
	SSA	*668	*645
AFDC Beneficiaries	OI	54	20
Health Care Cases (Other than Project Integrity)	OI	156	152
	OPI	313	157
Project Integrity Cases	OI	60	63
	States monitored by OI/OPI	475	502
TOTAL	OI.....	1,013	1,000
	Other.....	1,004	869
	Grand Total....	2,017	1,869

*Represents referrals to Department of Justice still pending. Total pending workload is 7,100 matters at 12/31/78 and 6,761 at 12/31/77.

One other workload indicator in the case of OI is matters pending in our "zero file" where raw allegations are undergoing preliminary verification. It is estimated that 50 percent of these matters will be found to have merit warranting their placement into active investigation. The Office of Investigations' "zero file" grew from 205 at the end of 1977 to 488 at the end of 1978. A major part of this growth is the assumption by OI of referrals from HCFA. The FBI reports that as of 12/31/78, there were a total of 799 HEW criminal matters under investigation by them.

The consistent level of workload found in the major program categories holds true in the Health Care Provider fields as shown in Exhibit IV-2.

It should be noted that cases being monitored under Project Integrity constitute a significant levy on the professional staff of the Office of Investigations. About 20 members of the field professional staff have been assigned at least part-time to this effort during the past year -- and we expect this rate of participation to continue, at least through the first 6 months of CY 1979.

We are pleased with the quality of cases under investigation which, we believe, have high prosecutorial potential. The following paragraphs synopsizes several ongoing investigations:

- One OI Field Office is conducting an investigation of 15-20 Guaranteed Student Loan applications which were prepared by persons unknown using real student names and forging their signatures. This appears to be an organized attempt by several persons to defraud the program. The total fraud may be in excess of \$100,000. The U. S. Attorney's Office and the District Attorney's Office are co-operating in the direction of the investigation.
- Seven individuals were recently indicted by a Federal Grand Jury in New Jersey for obtaining Guaranteed Student Loans in excess of \$100,000 by using fictitious identities. The seven individuals used the identities of at least 60 students at various colleges in the State of New Jersey.

ANALYSIS OF HEALTH CARE CASES
DECEMBER 31, 1978

Provider Groups	: : OI	: : OPI*	: Project Integrity : : Direct Monitor	: 1978 : : Total	: 1977 : : Total	
Long-Term Care	21	24	1	--	46	67
Hospitals	3	17	1	--	21	25
Pharmacies	10	--	23	289	322	267
Laboratories and Clinics	6	31	2	5	44	48
Physicians	44	40	33	262	379	424
Other Practitioners	3	19	--	--	22	79
Equipment and Services	22	26	3	2	53	53
Beneficiaries	<u>19</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>19</u>	<u>5</u>
TOTALS	<u>128</u>	<u>157</u>	<u>63</u>	<u>558</u>	<u>906</u>	<u>968</u>

*Information as of 11-22-78

- OI New York is currently investigating travel agencies based upon allegations of bribery of Social Security Administration employees for falsely obtaining Social Security cards for use by illegal aliens in obtaining employment, claiming unemployment benefits, and a myriad of other federally funded benefits.
- A Nursing Home is under investigation for false and inflated cost figures under Medicare claims. Kickbacks from a linen supply company, a paper product company and food companies have been uncovered. Billings to Medicare allegedly included costs of landscaping, travel, appliances and alarm systems.
- Several Pharmacies are under investigation for alleged kickbacks to nursing homes in exchange for the pharmacy business from the nursing homes. It is believed that the kickbacks are recovered by the pharmacies through inflated billings to Medicaid for the prescriptions filled.
- An Oxygen and Medical Equipment Supply Company is alleged to have submitted false claims to Medicare. Investigation has developed information that the company may have made false statements in obtaining a Small Business Administration loan. It appears that the company billed Medicare for oxygen services already paid by the Veterans Administration. Initial estimates indicate that Medicare must have been billed for as much as \$80,000 for supplies and services not rendered.

Finally, it should be noted that the Office of Inspector General is experiencing a growth in cases that have multi-State significance due to the increasing trend toward chain ownership of organizations in the health care field. These cases are much more complex than the cases under investigation in the past.

By some estimates there are about 25 percent of American hospitals and more than one-third of skilled nursing homes that are owned by organizations operating other health care institutions.

This poses new problems in our oversight of these industries. Special studies of these developments are underway. (See Chapter V)

B. The Growing Importance of State Medicaid Fraud Control Units

Congress, in P.L. 95-142 provided 90 percent funding for a 3-year period ending September 1980 to encourage States to establish and operate Medicaid fraud control units having a mixed team of auditors, attorneys, and investigators. The Inspector General views these new units as a potentially rich resource -- currently planned to have 737 professionals (attorneys, investigators, and auditors). Training sessions have been held for 250 members of these organizations; 23 units are now certified as shown in Exhibit IV-3. Their cases on hand now total about 1,500. Working with HCFA we will seek to optimize the effectiveness of these units and are prepared to support a full 3-year funding period from date of certification for each. The need for funding beyond the initial 3-year period will be kept under study. We are pleased that the units themselves have formed their own joint steering committee and clearinghouse.

C. Other Provisions of P. L. 95-142 Which Are Proving of Significant Value

In addition to the Fraud Control Units, this Bill is providing many opportunities to improve management of the Medicaid/Medicare programs.

In the near-term, we are building on the disclosure provisions to support our growing interest in ownership patterns and the phenomena of chain ownership mentioned earlier.

We are urging the PSRO's National Council to create an advisory group to assist HCFA and OIG in planning future initiatives.

We are observing with interest HCFA's actions to suspend practitioners who have been convicted of fraud against either program (40 in 1978)*. This

*Period covered is November 1977 - December 1978.

MEDICAID FRAUD CONTROL UNITS
CERTIFIED AS OF FEBRUARY 23, 1979

State	Number of Professionals Authorized				First Year
	Attorneys	Investi- gators	Auditors	Total	Budget
Region I					
Connecticut	3	6	3	12	\$ 337,008
Massachusetts	11	21	21	53	1,492,954
Rhode Island	3	4	3	10	286,898
Vermont	2	2	2	6	227,240
Region II					
New Jersey	7	20	13	40	1,075,140
New York	71	104	133	308	10,844,214
Region III					
Maryland	4	6	5	15	561,298
Pennsylvania	10	19	12	41	705,823
Region IV					
Alabama	3	8	2	13	388,708
North Carolina	2	3	2	7	243,008
Region V					
Michigan	7	20	10	37	1,483,121
Ohio	11	16	6	33	833,903
Wisconsin	7	10	12	29	960,617
Region VI					
Arkansas	1	3	1	5	192,939
Louisiana	3	5	3	11	307,020
New Mexico	3	5	3	11	400,738
Texas	4	12	3	19	459,879
Region VII					
Nebraska	1	2	1	4	122,760
Region VIII					
Colorado	4	5	5	14	500,198
Region IX					
California	7	29	6	42	2,366,188
Hawaii	2	2	2	6	356,127
Region X					
Idaho	1	3	2	6	222,452
Washington	2	10	3	15	491,464
TOTALS	<u>169</u>	<u>315</u>	<u>253</u>	<u>737</u>	<u>\$24,859,697</u>

authority is in addition to the exclusion and termination authorities which have existed in the Medicare program -- for which there were 35 actions (in 1978)*.

We find of great value the special report on the home health industry prepared by HCFA as required by P. L. 95-142, and have participated in the special HEW study on contracting with intermediaries and carriers, on which the Comptroller General must also report. At longer range, implementation of uniform cost reporting systems should prove of value to both audit and investigations activities.

D. Experience with Subpoena Power Granted to the Inspector General by Statute

Thus far, the Inspector General has had occasion to issue eleven subpoenas. The status of each to date is presented in Appendix P. In general, compliance has been gratifying; only one case at this time is a problem.

E. 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 (as Appendix D) a list of all cases referred to the Department of Justice either by the OIG, OI, or the HCFA, OPI, during Calendar Year 1978, together with an indication of the nature of the violation, the category of provider or practitioner, and the disposition or status of each case.

During 1977, following the establishment of the Inspector General's Office and the Health Care Financing Administration, it became clear that in the area of criminal fraud investigations, both the Office of Investigations (OI) of the Inspector General's staff and the Office of Program Integrity

*Period covered is November 1977 - December 1978.

(OPI), HCFA, had been carrying out many similar functions. In August of 1977, an operating statement was entered into between OI and OPI which reflected the situation as it then existed by providing for a sharing by OI and OPI of criminal investigative responsibility in health care matters. In early 1978 and in light of a full year's experience, we reassessed the roles and relationships of OI and OPI in the conduct of Medicare and Medicaid investigations -- both those where evidence of fraud exists and those where administrative and civil action may be warranted.

A decision was made in March 1978, to develop and implement a plan for transferring to OI operational responsibility for all criminal investigations involving the Medicare and Medicaid programs. Our goals were to ensure that both the Department's criminal investigative and its program integrity functions were performed in the most effective manner and to preserve the integrity of both those functions.

Most of 1978 witnessed a transition period during which:

1. Cases already referred to U. S. Attorneys by OPI were to be completed by OPI.
2. Cases undergoing active criminal field investigation by OPI were to be completed by OPI in those cases where OPI had conducted substantial investigation and where continued OPI handling of the cases would result in the most effective disposition of the cases.
3. Cases in which the potential for fraud was established by preliminary review and where no substantial field investigation had yet commenced, would be referred by OPI to OI.

The transition has been substantially completed. Under current procedures, all matters, in which the potential for fraud is identified after preliminary review, are referred to OI by OPI. The responsibility for the development of civil fraud matters

remains with OPI except in those cases where the civil fraud case is predicated upon essentially the same facts as the criminal case which was developed by OI. In such instances, OI, with the assistance of OPI, will have the lead responsibility. Because criminal investigative responsibilities for health care cases were shared by OI and OPI during 1978, we consider it appropriate to analyze separately (as we did in last year's Annual Report) the criminal cases referred by each organization. In our report last year, we noted that the principal difference between the reporting procedures used by OI and OPI was in the meaning of the term "referral".^{1/} Throughout the 1978 transition period, OPI decreased the number of cases in which it had informal contact with U. S. Attorneys at the early stage of an investigation since most of those matters were referred by OPI to OI for further handling. Matters in which OPI had expended substantial investigative effort and which had progressed to a point at which a decision could be made regarding prosecutive merit were formally referred by OPI to the U. S. Attorneys. If further investigation was required in these cases, OPI would retain investigative responsibility. Accordingly, we are able this year to report in a uniform manner on formal referrals by OI and OPI to the Justice Department.^{2/}

^{1/} We stated that, "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 Attorneys' offices. Formal referrals for prosecutive decision, then are made only where investigations are completed or nearly completed. OPI, 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." See Inspector General's Annual Report dated March 31, 1978 at page 29.

^{2/} During 1978, OI had informal contact with U. S. Attorneys at a very early stage in 48 investigations, all of which are in a pending active investigative status.

Office of Investigations (OI)

In 1978, OI formally referred 29 cases to the Department of Justice (as compared with 19 during 1977). As of December 31, 1978, the status of these cases is as follows:

Indictments Returned.....	16
Convictions.....	7
Pending Trial....	7
Dismissal.....	1
Acquittal.....	1
 Pending Decision.....	0
 Pending Investigation.....	3
 Prosecution Declined.....	10

The foregoing cases fell into the following categories:

Physicians and Clinics.....	16
 Nursing Homes.....	2
 Pharmacies.....	7
 Other Practitioners.....	3
(e.g., podiatrists, optometrists, chiropractors, dentists, etc.)	
 Other.....	1
(e.g., therapists, suppliers of equipment, purchasing agents, etc.)	

As of March 31, 1978, 9 of the 19 cases formally referred by OI in 1977 were either pending decision or investigation. As of December 31, 1979, the status of these cases is as follows:

Indictments Returned.....	1
Convictions.....	1
 Pending Decision.....	1

Pending Investigation.....4

Prosecution Declined.....3

Office of Program Integrity

In 1978, OPI, formally referred 54 cases to the Department of Justice (as compared to a total of 83 formal and informal referrals in 1977). As of December 31, 1979, the status of these cases is as follows:

Indictments Returned.....9

Convictions.....7

(resulting from
5 indictments)

Pending Trial
or other
disposition.....5

Pending Decision.....13

Pending Investigation.....10

Pending Grand Jury
Investigation.....12

Other Adjudication.....3
(e.g., pretrial diversion;
plea negotiation)

Prosecution Declined.....7

Of the 13 cases pending decision, the majority are in Region II (New York - 4) and Region V (Ohio - 6)*.

*It should be noted that these cases are, for the most part, pending in judicial districts where caseloads are heavy and backlogs not uncommon. We have been assured by the Justice Department that these cases will be reviewed to determine those which have the most prosecutive merit and, consequently, warrant priority disposition. Where feasible, administrative or other appropriate civil action will be considered in those cases which lack criminal prosecutive merit.

The 13 cases were referred at the following times:

First Quarter.....	3
Second Quarter.....	4
Third Quarter.....	3
Fourth Quarter.....	3

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

Physicians and Clinics.....	13
Laboratories.....	5
Nursing Homes.....	9
Hospitals.....	5
Home Health Agencies.....	7
Other Practitioner.....	11
(e.g., podiatrists, optometrists, chiropractors, dentists, etc.)	
Other.....	4
(e.g., therapists, suppliers of equipment, purchasing agents, etc.)	

As of March 31, 1978, 46 of the 83 cases formally and informally referred by OPI in 1977 were either pending decision or investigation. As of December 31, 1978, the status of these cases is as follows:

Indictments Returned.....	10
Convictions.....	6
Pending trial or other disposition.....	3
Acquittal.....	1

Pending Decision <u>1</u> /	6
Pending Grand Jury Investigation...	1
Pending Investigation.....	8
Prosecution Declined.....	13
Transferred to OI <u>2</u> /	8

Analysis

During 1978, we witnessed a significant increase in positive responses by the Department of Justice and United States Attorneys to referrals from both OI and OPI. Indictments and active investigations to perfect cases referred have resulted from 64% of our 1978 referrals (as compared with 45% in 1977). Only 16% of the referrals in 1978 remained pending decision (as compared with 32% in 1977). We attribute this trend to several factors. First, the quality of investigative and prosecutive efforts has increased as we gain experience in the more complex Medicare and Medicaid schemes to defraud. Second, the stress which has been placed by the Attorney General on white collar crime, in general, and on program fraud, in particular, is reflected by a marked increase in prosecutive resources devoted by United States Attorneys to program fraud matters. Once again, the ratio of convictions to acquittals (21 convictions; 2 acquittals) in cases where indictments were returned in 1978 indicates that the quality of investigation continues to be high and that prosecutions continue to be handled effectively.

-
- 1/ One of these cases resulted in an indictment and subsequent conviction during 1979. Another resulted in a conviction in State court and is being reviewed to determine whether a Federal trial is appropriate.
 - 2/ Most of these are cases in which OPI had done preliminary investigation, had informal contact with the U. S. Attorney and which, after review, have been determined by OI as warranting further investigation.

Referrals during 1978 were handled even more expeditiously than during the previous year. In all cases which were referred by OI and declined, the declination occurred in the same month as the referral (as compared with an average 1.5 month lapse the previous year). The average time between referral and declination for OPI cases was 2.7 months (as compared with an average 5 months lapse in the previous year). The average time lapse between referral and declination for both groups of cases, therefore, was 1.1 months. We consider this prompt decision making pattern to be indicative of an increase in the number of prosecutors who have acquired more experience and sophistication in dealing with these cases and who, consequently, can more rapidly identify weak cases and devote their limited resources to cases with merit. The average lapse of time between referral and indictment increased slightly for both groups of cases (3.2 months for 1978 referrals as compared with 2.5 months in 1977) which we attribute, in part, to the increasing complexity of the cases referred.

The Fraud Section of the Criminal Division has continued to be extremely supportive of HEW's efforts during the past year. Of special significance has been the active role of the Section in task force and other efforts requiring central coordination. Their role has been most helpful in the growing number of investigations which are national in scope or which involve novel issues of law and fact. Department and Assistant United States Attorneys who have developed particular expertise and skills in the development and prosecution of Medicaid and Medicare cases have assisted us as lecturers during training conferences held for the staffs of the 23 certified State Medicaid Fraud Control Units.

F. Some Issues For the Future

1. New Inspectors General Offices

Perhaps the most important single development which will impact upon the work of HEW Inspector General's Office in the coming year, and beyond, is passage of "The Inspector General

Act of 1978" (P. L. 95-452). President Carter signed this Act on October 12, 1978, and issued a directive to the Office of Management and Budget, the Department of Justice, and the Office of Personnel Management to give leadership to the 14 statutory Inspectors General Offices.

These central agencies have moved to create a forum in which the Inspectors General and their key associates can meet to share experiences, develop uniform policies covering the conduct of audits and investigations, and identify opportunities for joint efforts. From HEW's point of view, this can be very helpful due to our common interests with other agencies, on university audits as well as interfacing programs in Housing, Agriculture, Labor, and VA.

It is recommended that the newly-established forum address common concerns and issues which the Inspectors General Offices will face. Several possibilities warranting early attention are:

- The proper roles of general investigators (1810) and criminal investigators (1811) in the conduct of investigations.
- Type of training and career opportunities which should be afforded to those in each of these series.
- Whether criminal investigators should be authorized to carry firearms and have arrest authority -- and under what circumstances.
- The use of electronics surveillance and undercover techniques.
- The use of subpoena authority.
- The referral of cases to the Department of Justice.
- Use of attorneys in the Inspector General's functions:

- With Criminal prosecution expertise as well as Civil prosecution expertise.
- Development of optimal relationships with merit system investigators and reviewers in connection with employee conduct and conflict of interest matters.
- Development of appropriate relationships with agency legal staff on civil fraud matters.
- Sanctions to be applied to beneficiary/recipient fraud cases (SSA/SSI/AFDC, etc.) which are being declined for prosecution.

2. Need For Greater Emphasis on Training

One of the keys to the continued success of our program fraud control efforts is a greater emphasis on the training of investigators, auditors and prosecutors. The Criminal Division's Fraud Section has developed "mini-courses" to supplement agency training programs. These courses are designed to provide agency investigators and auditors with a basic knowledge of the proof necessary to prove a criminal fraud case involving their particular programs as well as the methods and techniques for obtaining the necessary evidence.

On a broader scale, and in response to a Presidential directive, an ad hoc group of policy-level Government officials was formed by the Office of Personnel Management to develop recommendations for the improvement of the training of auditors and investigators assigned to the Inspector General function. The recommendations of this group were set forth in a report issued on February 26, 1979, and are summarized below:

- a. The proposed National Council should play a leadership role in planning, coordinating and evaluating audit/investigative training in the Executive Branch.
- b. The Treasury Department's Federal Law Enforcement Training Center (FLETC) and the

Interagency Auditor Training Program (IATP) should serve as focal points for audit and investigative training.

- c. In addition to using strengthened inter-agency training, agencies should continue to conduct their own courses.
- d. All currently unprogrammed interagency training should be conducted on a reimbursable basis.
- e. Where capacities and capabilities exist in the Executive Branch to provide support to audit and investigative training the Council's influence should be brought to bear.
- f. Specific improvements should be made in existing training.
- g. The National Council should continue work on determining training needs.

We concur fully with the foregoing recommendations. We would also recommend that more formal programs for the training of younger Assistant U. S. Attorneys in the prosecution of program fraud be developed.

3. Computer Security Issues

A matter which is likely to be of concern to most Inspectors General Offices is the maintenance of security over computer hardware and software -- particularly those installations concerned with maintaining client records, establishing eligibility for benefits, and payment of benefits. In HEW we anticipate that problems of this type will regularly be among our major interests. No major aspect of our mission can be or is accomplished without automated data processing. At the direction of Secretary Califano, the OIG is working with the Social Security Administration in the development and execution of an action plan to upgrade the security aspects of SSA ADP activities.

It is the Inspector General's view that the Computer Crime Bill (S-240) is a significant legislative initiative which should be encouraged.

4. The Desirability of a General Fraud Statute

Throughout the remaining chapters of this report, specific recommendations will be made for Congressional action to strengthen individual statutes and authorities. However, there is one overall proposal which our investigators believe would be especially valuable -- that is, a general fraud statute which would make it a felony to defraud any Government program. This would extend the authority now established by P. L. 95-142 in the Medicare/Medicaid program to all Government programs. The Criminal Division of the Department of Justice has assumed leadership in this area and has drafted proposed legislation.

CHAPTER V

INITIATIVES TO ATTACK FRAUD, ABUSE AND ERROR IN HEALTH CARE FINANCING PROGRAMS

Introduction

The first national initiative by the Office of Inspector General after its establishment on March 29, 1977, was aimed at developing techniques which could be widely employed at the State level to detect and prevent fraud and abuse in the health care field. The initiatives which will be described in this Chapter are based primarily on the Medicaid program but, where possible, are correlated with abuses or fraudulent actions against the Medicare program. These are joint efforts with HCFA in every case*.

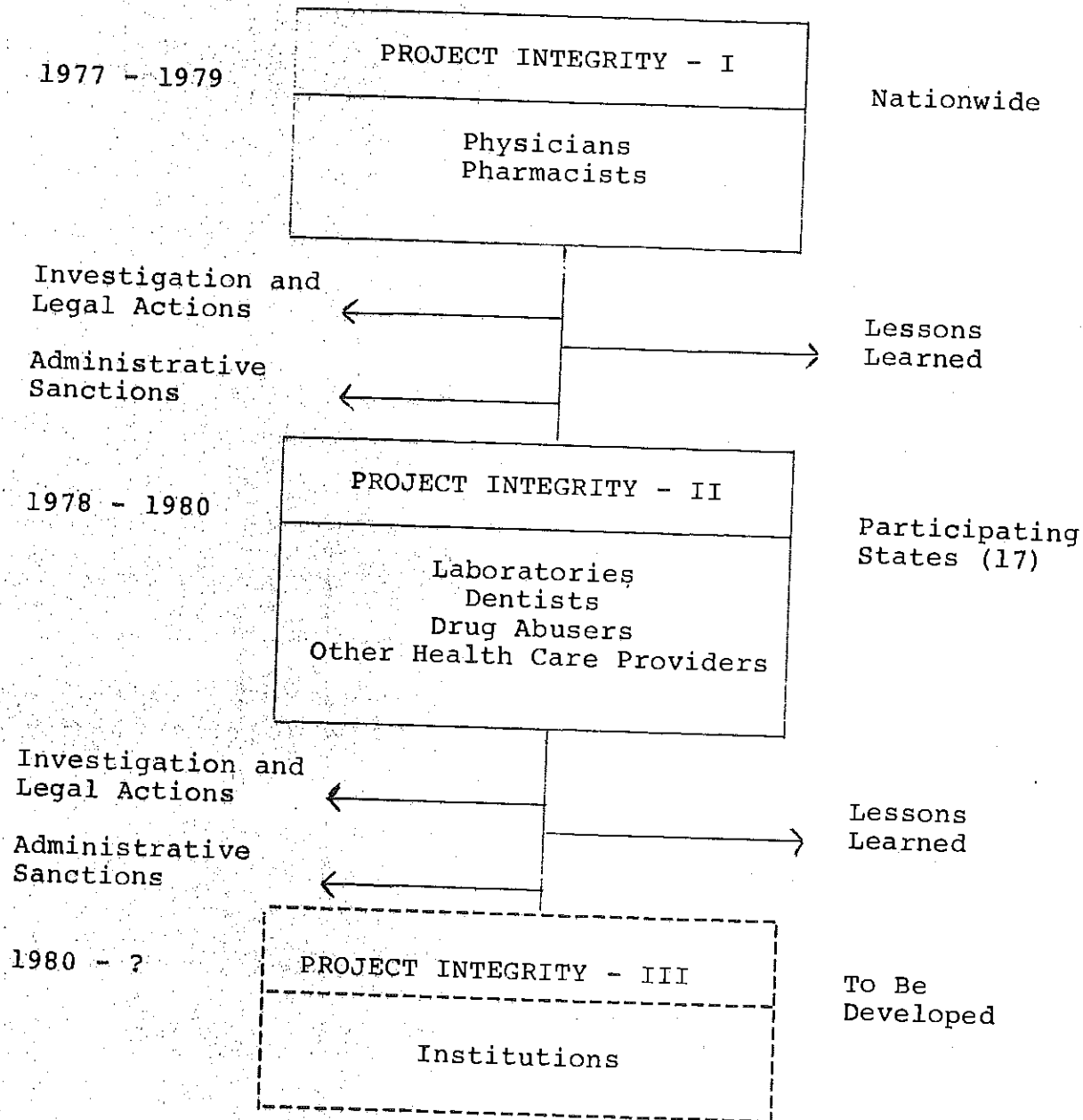
Project Integrity, the name given the project, has taken the form of three distinct initiatives, as illustrated in Exhibit V-1 on the next page:

- Project Integrity I covers physicians and pharmacists nationwide. It began in 1977 and will be substantially completed in Calendar Year 1979.
- Project Integrity II is a direct outgrowth of the early findings of Project Integrity I and currently is concentrating on laboratories, dentists and drug abusers. A number of other health care provider fraud or abuse problems, now under study, will be described later in this Chapter. State participation is optional in this project.
- Project Integrity III, a longer range effort envisioned to begin in 1980, will concentrate on the institutional field -- including nursing homes, hospitals and home health agencies. Techniques are in a research and demonstration stage.

*An overview of the Office of Program Integrity appears in Appendix Q. The HCFA Administrator's review of his total efforts to combat fraud, abuse, and waste appears in Appendix R.

INSPECTOR GENERAL'S HEALTH CARE INITIATIVES

Present and Planned



This Chapter will discuss each of these matters briefly, but will give particular attention to the lessons learned in Project Integrity I. We believe these illustrate the real values that an Office of the Inspector General can contribute in providing leadership to complex program areas susceptible to widespread fraud and abuse.

A. Status of Project Integrity I: Physicians and Pharmacists

As illustrated in Exhibit V-2, on the following page, this project began with the computer screening of physician and pharmacist claims paid in Calendar Year 1976. Fifty-one States and Federal jurisdictions are participating in the project (all except Arizona, the Virgin Islands and Guam). A few of the 51 jurisdictions lacked complete data for computer analysis but all are represented in some measure.

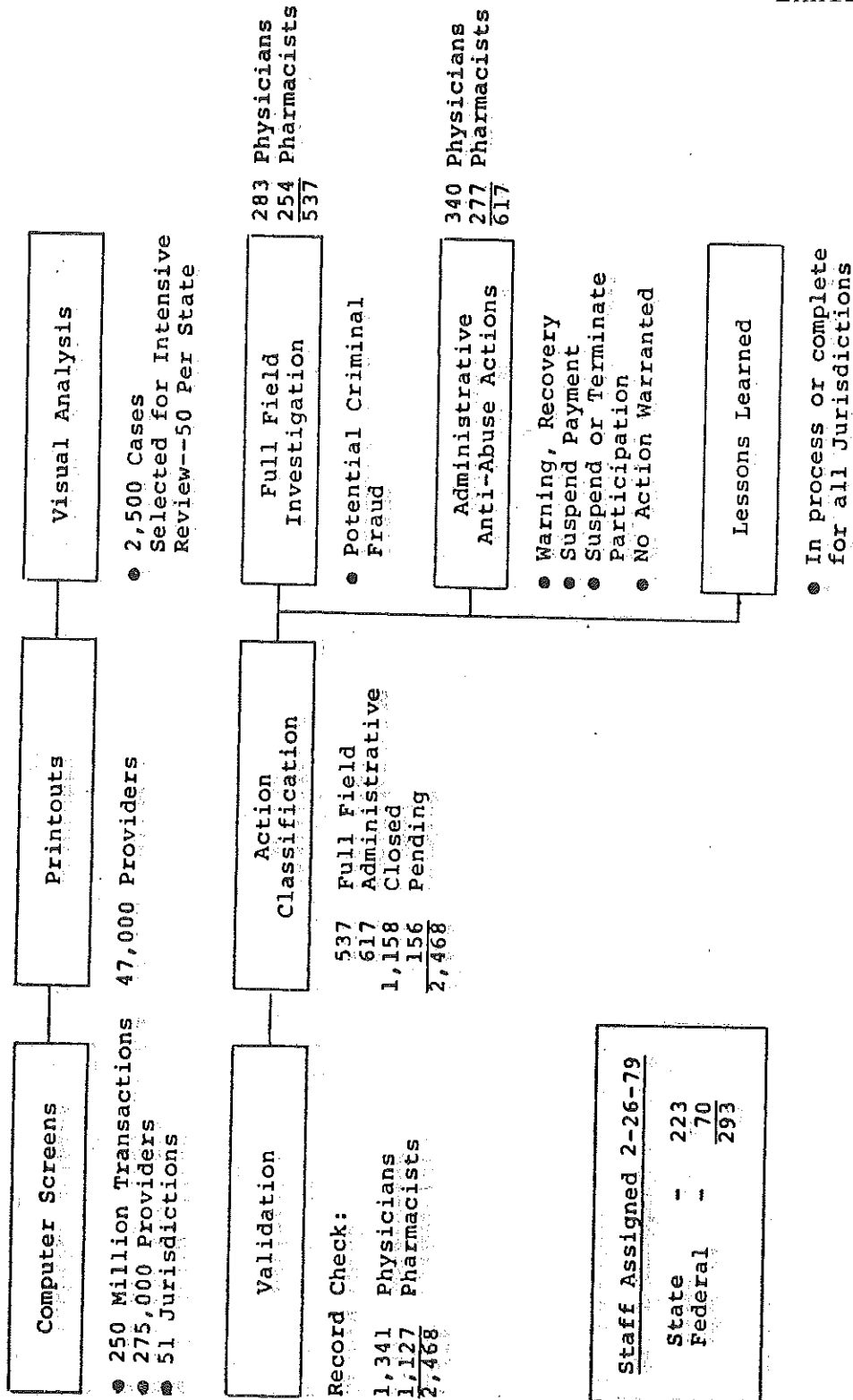
Using computer screens which had been previously developed by the HEW Audit Staff, with the assistance of professional medical and pharmaceutical consultants, we first identified 47,000 providers whose billing practices in 1976 appeared to be unusual. Then, visually, we narrowed down the list to about 50 cases per State so as to have nationwide coverage as a learning experience. The final list consists of 2,468 cases -- 1,341 physicians and 1,127 druggists.

The Audit Agency in each region conducted a preliminary validation of the selected cases against basic records to delete those that were inappropriately selected due to clerical mistakes or other obvious justifiable explanations.

Cases began to be forwarded for work by the State Medicaid agencies, or other investigative bodies, in the late fall of 1977 and we have now had about one year's investigative experience. HEW has retained some of the cases for direct work, but the majority are being worked by the States themselves. In many cases we are working on these cases together.

As of February 26, 1979, there were 1,154 active cases divided between potential criminal fraud (537)

PROJECT INTEGRITY I AS OF 2-26-79 COVERING 51 JURISDICTIONS



cases and those warranting administrative sanctions (617). The most frequent sanction is recovery of overpayments. Amounts being sought totalled over \$4.0 million.

In addition, system changes are being made in many States based on Project Integrity findings. To date, the potential annual savings from these system changes is \$6.8 million, but we believe that this is a conservative estimate. Examples are cited in Appendix E.

To date there have been 30 indictments involving 39 individuals. Another 188 cases are now pending a decision from the prosecuting authorities.

We estimate that the major part of the work on Project Integrity I cases will be substantially completed by June 30, 1979.

B. What Key Lessons Have Been Learned from Project Integrity I?

A Steering Committee in each Region has been established for this project composed of OIG auditors and investigators and the HCFA Program Integrity staffs. The Committees are preparing memoranda reports on lessons learned from the project in each of the 51 jurisdictions.

In most jurisdictions the project has had value of lasting significance, in addition to the immediate recoveries and criminal indictments. Some illustrations follow:

- For a State in the midwest, the report finds that the State "feels that Project Integrity has resulted in a more exacting case control system which should enhance their efforts in defining levels of fraud and abuse, and their investigations. The increased coordination between the Medicaid State Agency and the intermediary is one of the demonstrable achievements of Project Integrity."
- For a State in the west, the report finds "Project Integrity I has resulted in improved channels of communication, strengthened working relationships, and instilled a deeper commitment toward the

elimination of Medicaid fraud and abuse, not only within the State but also within the Federal Government.

--For a State in the south, the report states, "The cooperation of the State during the project has been excellent. Both the State and the Federal personnel involved in the process agree that this effort has contributed much toward the prevention of fraud and abuse in the Medicaid program."

These quotations underscore some of the most important values of efforts of this type: increased mutual understanding of problems faced at State and Federal levels, and an on-the-job training experience which makes each of us more effective. At the same time the Federal investment, (which we estimate will be about \$8 million in total*) will be substantially repaid by savings already identified, with additional savings continuing to accrue annually. See discussion in Appendix E.

Illustrations of some of the lessons learned and corrective action techniques evolved in the physician and pharmacist areas are summarized below:

1. Problems Exposed in Physician Billing Practices:

- a. Medicare and Medicaid reimbursement rules allow higher fees for initial visits and for noncomplicated procedures.

One of the most often mentioned problems is the tendency to bill at the highest procedure code whether warranted or not. This problem was mentioned by several regions and occurred in at least 8 States.

In one State there are 20 different codes for office visits alone, and a rather vague distinction among them. For example -- an intermediate examination is described as "a complete history and physical examination

*A rough estimate of the additional costs by the States is \$3.0 million.

of one or more organ systems, but not requiring a comprehensive evaluation of the patient as a whole." The next higher value code, called an extended examination, is defined as "one requiring an unusual amount of time, skill, or judgment, but not necessitating a complete examination or reexamination of the patient as a whole." Little wonder that physicians faced with this choice would choose the higher code and the greater reimbursement!

- b. Frequently found was the duplicate billing problem. Many causes were identified, starting with the fact that some claims payment systems fail to catch such errors. The errors themselves appear to result from poor record keeping by some providers. The practice of allowing physicians to bill under more than one provider code was a problem in several States. Another source of duplicate billings was found in partnership or group practice situations.

The report on one State found "There were 3,902 instances where two physicians of the same speciality provided the same type service/s to the same recipient on the same day, or overlapping dates. Reimbursements totaled about \$55,000."

- c. Another problem is a lack of documentation on claims. The report said: "Services billed to the program were not recorded in patient medical records. Laboratory tests, hospital visits, and office visits were the services most frequently not supported by patient medical records. While the number of unsupported services varied substantially among the physicians, it appeared to be a general problem."
- d. The fourth group of billing problems noted is charging for full office visits which might not be justified, as indicated by the following examples from one State:

"--Office visits were charged for injections, usually administered by a nurse, and the patient was not seen by the physician.

"--Office visits were charged for simple prescription renewals. In these cases, the patients were not seen by the physicians.

"--Office visits were charged for services provided by other than the physician, such as social workers, nurses, midwives."

- e. There were a variety of apparent abuses in the hospital field. One was billing for daily hospital visits whether such visits were performed or not. Another was billing for more than one service per visit, such as the physician in one State "billing separately for psychiatric care and daily hospital visits," when regulations allow the physician to bill for only one of the two. Another abuse is the billing for after-surgery office visits when the fee for the surgery covers after-care.
- f. In the nursing home area we found the problem of multiple billings where a doctor sees a number of recipients and charges the prime rate for each one, when that is not permitted under State regulations. In one State we developed a special computer analysis to expose the extent of this problem and State agency staff determined the overpayment to be at least \$40,000. The State is in the process of recovering this overbilling.
- g. Another recurring problem is the medical value or necessity of the services rendered. In one jurisdiction we found a physician who gave virtually every patient an EKG on every visit. In another jurisdiction there were several thousand cases of multiple visits billed at the prime rate when the rule is that there will be one prime consultation at the prime rate and follow-up visits at a reduced rate.
- h. Finally, a cluster of problems involved laboratories and their relationship to the physician. It was out of these findings that Project Integrity II was born. Among the most frequent abuses may be billing for individual tests

which are part of a panel of tests. Many States reported this problem. In another situation, we found a lab and physician billing for the same service. A very troublesome problem involves physicians billing the Medicaid program a larger fee than the lab bills to them. Some charges were two to three times as much.

A variety of corrective actions are being applied to cope with the above problems. Perhaps the most frequently mentioned improvement is better computer edits at the prepayment stage, supported by peer group comparisons. Other techniques on which favorable experience was reported in several States include (1) on-site review of physicians' records, and (2) the interviewing of recipients to verify services rendered. We found that Explanation of Benefit mailings were widely used as required by P. L. 95-142, we also found that Congress' removal of mandatory and universal EOBs was wise in light of many questions regarding the value of this technique as compared with personal interviews.

Various ideas are being tried to cope with the problems resulting from the multiple procedure codes and the multiple provider codes. Some problems are being attacked by putting limitations on reimbursements -- such as the number of complete physical examinations, or the number of nursing home visits per month, or the number of office visits per month, etc.

In a separate volume -- to be available to the States and other interested parties -- we will publish the Lessons Learned memoranda for all 51 jurisdictions. They should be useful sources of ideas for some time to come.

2. Lessons Learned About Pharmacy Abuses Were Equally Productive.

The most frequent of all abuses reported in Project Integrity I is described as "prescription splitting," -- a problem in at least 20 jurisdictions. The following is a summary of problems cited by one jurisdiction. It touches on practically every type of problem encountered:

Services billed but not rendered. This included duplicate billing; billing for the same drug under the code numbers for both generic and brand name; billing for greater quantities than ordered and dispensed;

Prescription splitting causing undue additional dispensing fees;

Billing for refills not authorized by prescribing physician, nor supported by provider's records;

Billing for prescription drugs when over-the-counter items were prescribed and dispensed.

Billing for services with no documentation.

Billing for greater drug strength than prescribed.

Use of outdated prescriptions.

Filling and refilling prescriptions without properly documented written or verbal orders.

Almost none of the pharmacies reviewed maintained patient profiles. As a result, there was no monitoring of the number of prescriptions in use for the same drug at the same time by one or more physicians. The reviews of virtually all pharmacies which did not maintain patient profiles disclosed frequent instances where two or more prescriptions for the same drug for the same patient were filled during the same time period. In some cases, the prescriptions were written by the same physician, in other cases by different physicians.

Prescriptions on telephone orders lacked vital information such as prescription number, date, strength, dosage, refill limitations.

Substituting the highest priced drug when a lower priced drug could have been used. This was not precluded by State Agency regulations, but caused excessive payments to be made.

Two pharmacies charged the recipients as well as Medicaid for the same service.

Three instances were noted where the provider billed for services to non-eligible family members under the identification number of an eligible family member. In addition, three recipients obtained controlled drugs at the same time under their own identification number and under the identification number of one of their children. The physician had prescribed the drug for both the adult and child, and both prescriptions were for the adult dosages. They were filled at the same pharmacy.

Many actions to cope with these problems have been initiated during Project Integrity I, with significant savings anticipated. One of the most frequent techniques is to institute a 30-day supply requirement for maintenance-type drugs -- particularly for nursing home patients -- and to impose strict reauthorization limits for refills of controlled drugs.

The abuse of telephone prescriptions is a widespread concern. One preventive technique is to require signatures of both the doctor and the patient before honoring a claim. Another is to require that the claim identify the prescribing physician who telephones the prescription. One State is using a combination prescription/invoice form and we found all cases examined in that State to be "clean."

Recipient interviews and on-site surveys of pharmacists were widely advocated, as were audits on a regular basis.

C. Why A Different Approach To Project Integrity II?

First, we concluded that a national mandatory effort on the scale of Project Integrity I has tremendous learning value but that it cannot be equally efficient in every State or in every area of health care. It assumes that each State has an equal need, interest and staff capability to attack problems in a given health field. This, of course, is not true.

Growing out of the experience with Project Integrity I we concluded that new techniques developed for fraud

and abuse detection should be tested by HEW, using a pilot State as a partner. Successful techniques would then be made available through HCFA on an optional basis to other States. We have now reached this point on three projects which have been launched as Project Integrity II. These are described in Appendixes F and G. The operational projects cover laboratories, dentists and drug abusers:

--Laboratories. Seven States are now participating, and we expect a total of about 10. In many cases we are finding discriminatory billing of the Medicaid program. For example, a laboratory charged the Medicaid program \$10.80 for a pap smear but billed physicians at \$2.80 for the same test. Another lab billed Medicaid \$117.50 for a series of tests for which it charged physicians only \$13.50. Another lab had its biopsy test done for it by a cooperating lab at a cost of \$10 and billed the Medicaid program \$15.00 for the test.

The pilot work in this project is being done in collaboration with the State of California.

--A similar effort is designed to expose abuse of dental services. Techniques designed by the HEW Philadelphia Audit Office are currently being applied in nine States or jurisdictions. Several other States are giving the project consideration. Ideas here come primarily from pilot work in Virginia and the District of Columbia, and feature an in-mouth examination to determine whether the services billed were actually rendered. HCFA's dental consultant is very active in assisting the States which are participating in this project.

--A third special effort, known as "Operation Crackdown," is now operational in ten localities. It is an organized attack on the abusers of drugs -- usually representing collusion between physicians, pharmacists and drug pushers. This has become a matter of high public concern and more recently of Congressional interest, including a GAO review. The problem surfaced in Philadelphia last summer with a series of expose's written by a reporter who went undercover and posed as a pusher. Further discussion of this effort, which

is still in its beginning phases, will be found in Appendix G.

These three efforts are being directly administered by HCFA's Office of Program Integrity based upon the research and tests performed by the Office of the Inspector General, which continues to support the HCFA operation.

Lessons Learned conferences covering the three projects, to be held in February and March, will be open both to participating States and to others who may wish to learn from these experiences.

Project Integrity II Research:

Project Integrity II consists of more than the three efforts just described. Currently there are several additional research projects summarized in Exhibit V-3 and described in Appendix F. In the next several months we will publish a handbook of computer-based techniques, based on this research, for interested States. The subjects are:

- A dates-of-service match of hospital inpatient billings and physician billings. A mismatch indicates a problem.
- Billings at higher procedure codes than justified -- to inflate physician charges.
- Billings for outpatient hospital services, in search of duplicate or excessive charges.
- Billings for medical supplies and equipment, in search of excessive charges and billings for services after death.
- Billings for transportation services, in search of unnecessary or excessive trips.
- Billing by other medical practitioners -- including podiatrists, optometrists, and chiropractors -- in search of excessive or questionable charges.

PROJECT INTEGRITY II
RESEARCH AND DEVELOPMENT PROJECTS

As of December 31, 1978

Lead Region	Subject	No. of Specific Computer Applications	Total States Involved
Boston (I)	Hospital Inpatient - Physician Billing Match	1	4
Boston (I)	Procedure Codes	1	2
New York (II)	Outpatient Hospital Services	10	2
Philadelphia (III)	*Dental Services	2	9
Atlanta (IV)	Medical Supplies and Equipment	4	2
Chicago (V)	Transportation Codes	5	2
Dallas (VI)	Other Medical Practitioners	2	2
San Francisco (IX)	*Laboratories	5	7
TOTALS		<u>30</u>	<u>30^{1/}</u>

*Projects now operational (See Appendix F)

^{1/} Includes 17 different States

E. What Is the Status of Project Integrity III: The Institutional Providers?

The most complex and costly of the health care components are hospitals, nursing homes, and home health agencies. Altogether they represent about 70 percent of the Medicaid dollar. Research and testing will be continuing throughout the Calendar Year of 1979 and the early part of 1980. A brief status report is as follows:

- Nursing Homes. A new nursing home audit guide being developed by the HEW Audit Agency will provide additional guidance to help auditors detect fraud and abuse. Also, we have designed and conducted test audits in three States utilizing computer cost analysis for health-care provider selection. We are looking forward to working with the Medicaid Fraud Control Units in selected States to test detection and investigative methods. As a related interest we are examining State decertification activities as a means of eradicating serious deficiencies in nursing homes.
- Chain Ownership of Nursing Homes. We have noted the rapid growth in chain ownership arrangements in the health care field generally and particularly among nursing homes, hospitals and related vendors. These ownership arrangements pose new challenges to our audit program and open possibilities for abuses such as pyramiding of profits, inflation of equity value by transfers of ownership, inflated prices through lack of arms-length negotiations, abuse of sale and lease-back arrangements, and potential for kickbacks. Working with HCFA we are now gathering extensive data on ownership practices -- utilizing the authority of H.R. 95-142 concerning disclosure of ownership in the Medicare and Medicaid programs. We expect to exploit this new authority to develop a data base for the future. A full-time staff team will be engaged in these studies throughout the 1979 Calendar Year.
- Special Hospital Project. We are keeping abreast of work being done in improving hospital management and cost reduction, and anticipate fresh

insights from the HEW-funded project in New York State under the direction of Special Prosecutor Charles J. Hynes. This project involves a review and investigation of at least 50 hospitals containing about 12,000 beds in the State. The study design calls for 25 hospitals to have full scale investigations, including complete review of costs. The Hynes technique of using mixed teams of attorneys, investigators and accountants is expected to produce fruitful guidance for HEW and the State Medicaid Fraud Control Units. The Hynes staff devoted to this effort is approximately 100 members with additional resources to be added in 1979 as the caseload matures.

--Medicaid Management Information Systems Project.

During 1978 the Office of the Inspector General conducted an on-site study of the Medicaid program, including management information systems and other control devices employed in 10 States which account for two-thirds of the Medicaid expenditures. Our findings were reinforced by a General Accounting Office report in September 1978 which highlighted inadequacies encountered in its studies of the Medicaid Management Information Systems in three States. As a consequence of these findings, a joint task force of HCFA/OIG experts are now working with the States on action plans to upgrade computer management systems and Surveillance and Utilization Review Units (SURs), and their relationship to Medicaid Fraud Control Units (FCUs). The work of this task force will contribute significantly to our efforts in both Project Integrity II and Project Integrity III.

--Home Health Agencies. The other principal institutional area in which research is underway, looking toward Project Integrity III, is Home Health Agencies. There are 2,200 organizations now certified under the Medicare program. Altogether, expenditures under Medicare, Medicaid, and Title XX programs have reached a level in excess of \$1 billion. We will be focusing on problems of billing for services not rendered, misrepresentation of services, altering or falsifying bills and records, duplicate billings, payroll and expense account padding, and improper allocation of costs.

F. Recommendations For Detection and Prevention of Fraud and Abuse In the Health Care Program

Throughout the year we have been seeking ideas as to how to strengthen statutes and regulations, to enhance detection and prevention. Six major ideas have evolved on which we are making recommendations in this year's report. A seventh recommendation lists various legislative initiatives which may be worthy of consideration by the Congress. These are:

1. Complete and issue HCFA's proposed Administrative Sanctions concerned with fraud and abuse in the Medicaid program.

These regulations have been under development for many months and have been reviewed in guideline form* by the States. State Medicaid officials concurred with the value of issuing these regulations, and the majority have stated that such a Federal issuance is important to applying an adequate spectrum of sanctions within their State. The proposed sanctions will be similar to those currently utilized in the Medicare program, and will require each State (a) to have administrative mechanisms to identify, investigate and recover funds improperly or erroneously paid to providers; and (b) to take actions against providers of services who defraud or abuse the program -- including authority to suspend or exclude the provider from participation. Our experience with the States, and more recently with Operation Crackdown, clearly shows the need for affirmative policies of this type.

2. Make available to the States model legislation for fraud and abuse control in the Medicaid program. Good work has been done on this by HCFA in the past year. We feel the product is ready for widespread dissemination, as guidance to the States. We recommend that the Administrator of HCFA proceed expeditiously to issue this document.

*Published as HCFA, AT-77-105, November 7, 1977

3. We strongly urge the Congress to act upon the proposal for a "Civil Money Penalty Bill." This legislation would permit the Secretary, (where criminal penalties have not been effective or where criminal prosecution is unwarranted or impractical) to apply a penalty of up to \$2,000 for each fraudulent claim submitted to the Medicaid or Medicare program, and to impose a fine equal to twice the amount of such claim.

In order to make this same civil penalty effective in dealing with the abuse of controlled substances, it is recommended that the civil penalties for false claims which would be provided in the Bill also be made applicable to certain abusive prescription practices.

Specifically, we suggest having available administrative penalties in cases where a physician regularly prescribes controlled substances for certain patients in excessive quantities, far beyond any test of medical necessity or reasonableness; which practice has persisted for a significant period of time; and which practice is deemed to be excessive or unreasonable or medically unnecessary by a qualified peer group.

4. The Inspector General urges that the incentive arrangements, under which special financing of Medicaid Management Information Systems and Fraud Control Units are subsidized, be modified to provide a more flexible subsidy to meet individual State needs.

One of the most significant findings of Project Integrity I is that the States vary widely in the extent to which they have developed balanced fraud and abuse control programs. Exhibit V-4 shows the components of a total fraud and abuse control system for a State. A complete system must encompass both beneficiary and provider fraud and abuse matters, for both Welfare and Medicaid programs. There must be an adequate computer information system, for each, to cope

COMPONENTS OF TOTAL MANAGEMENT SYSTEMS
NEEDED TO COPE WITH FRAUD, ABUSE AND ERROR

Type of Fraud	:	:
Abuse or Error	:	Management
	Program	Systems Needed
Recipient Fraud	AFDC	-Computer
		-Utilization Review
		-Fraud Investigation
	Medicaid	-Computer
		-Utilization Review
		-Fraud Investigation
Provider Fraud	Medicaid	-Computer*
		-Utilization Review
		-Fraud Investigation*

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Computer: 90% for Development
75% for Operation

Fraud Control Units: 90% for Three Years
Ending September 1980

with the high volume of recipients and transactions, and to meet the need for analytical data which can only be obtained by computer. There then need to be Surveillance and Utilization Review Units (SURs) capable of analyzing the computer printouts to detect cases for administrative sanctions or referral to Fraud Control Units of those cases having potential criminal fraud.

The problem in many States is that some of these units are being overbuilt compared to others, and an imbalance occurs. This is particularly true of the MMIS and Fraud Control Units -- because of the 90 percent Federal funding which is made available for specified uses or periods as an incentive to their development. Unfortunately, this may result in building capabilities of these types without balanced support for the other components of a total fraud-and-abuse management system.

For example, a logical staffing of a SUR Unit and a Fraud Control Unit would in most States provide a larger number of professional personnel in the SUR Unit since it is the principal source of referrals to the FCU. But in twelve States which now have FCUs, the FCU is larger than the SUR staff, by as much as two to one.

While a more flexible concept will be difficult to implement, it is felt that the time has now arrived when HEW should examine with each State its total organization, staffing and computer capability, to define the strengths and weaknesses which exist and to determine the extent to which the State can overcome the weaknesses within its available financial resources. HEW should then have statutory authority to work out an incentive arrangement with each State, as needed, to bolster inadequately staffed units for a period sufficient for them to prove their cost effectiveness. This would cover both recipient and provider fraud and abuse. Properly approached, this might be the most powerful single action that can be taken from

the Federal level to assist the States during the next several years.

5. Medicare and Medicaid payments for independent laboratory services exceed charges to physicians. This should be corrected by statute. Independent laboratories are charging Medicare higher amounts than they charge physicians for the same clinical services. This conclusion is based principally on audit work under Project Integrity II in California.

Medicare carriers develop lists of the customary charges (profiles) for services rendered by the physicians and suppliers in their service areas and develop prevailing charges based on these customary charges. In California, and we suspect in other jurisdictions, these profiles do not reflect billings by laboratories to physicians, which are considerably lower than the charges reported to the carriers. Price lists of several independent laboratories reviewed included charges for Medicare patients which averaged 30 percent above charges to physicians.

This problem also exists in the Medicaid program. Legislation to correct the effect of discriminatory billing practices in Medicaid was considered by Congress (H.R. 10909) last year but not voted. It would have limited payments for laboratory services to the lowest charge to any person or entity. However, the proposed legislation did not contain similar restrictions for Medicare.

We propose that this legislation be given further consideration and that it include Medicare (with due regard to beneficiaries' liability for co-insurances and deductibles).

6. New regulations should be implemented promptly to require action when PSROs find that services are unnecessary.

There have been instances where payments have been made for services which were ruled unnecessary by a local Professional Standards Review Organization (PSRO).

On October 13, 1978, a Notice of Proposed Rule-making was issued concerning the imposition of sanctions on health care practitioners resulting from PSRO sanction reports. This proposed rule provides procedures for the processing of PSRO sanction reports and details actions that HCFA will take when such sanction reports are received. We urge prompt implementation to replace the interim procedures now being followed by the Office of Program Integrity.

7. Other legislative suggestions are proposed to strengthen health care management control.

Appendix H presents other items for legislative consideration. The most important, which has been proposed to Secretary Califano in a recent HCFA report, is legislation to permit a combined and fully integrated Part A and Part B structure for the administration of the Medicare program, and for the selection of fiscal agents on a competitive basis. Several other suggestions are made for new authorities to help attack the drug abuse problem (Operation Crackdown).

CHAPTER VI

INITIATIVES TO ATTACK FRAUD, ABUSE, AND ERROR IN INCOME MAINTENANCE PROGRAMS

In the first Annual Report, we discussed several newly launched computer matching initiatives designed to detect fraud, abuse, and error in income maintenance programs under the general caption of "Project Match." In this year's report, we are summarizing results to date and lessons learned through expanded matching program efforts in the areas depicted in Exhibit VI-1 on the following page:

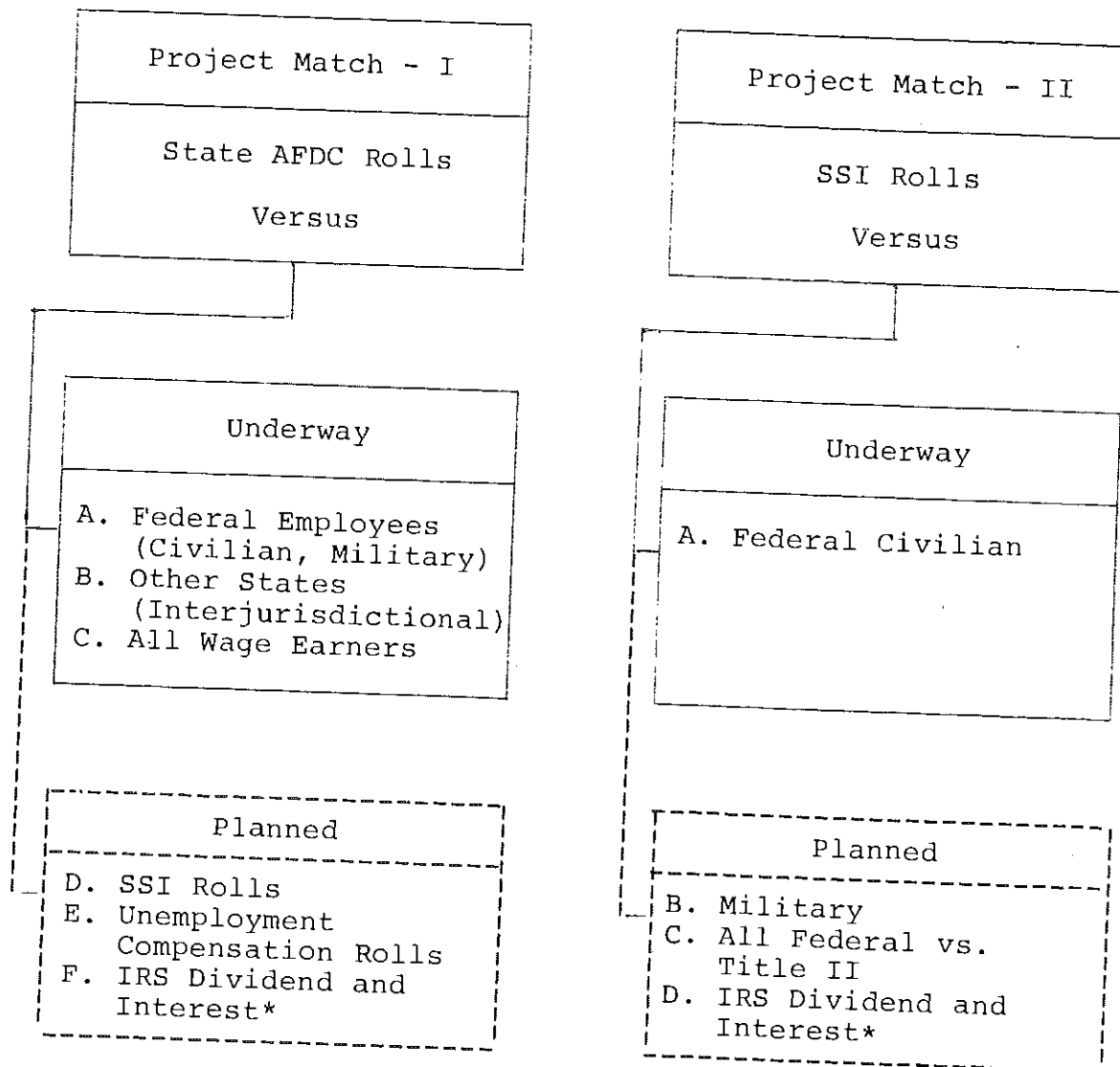
- Project Match-I, the match of Federal military and civilian rolls against State AFDC rolls.
- Interjurisdictional Matches, the comparison of State AFDC rolls against each other.
- The "Private Employee" Earnings Match, the match of wage data files against AFDC recipient rolls as mandated by Public Law 95-216.
- Project Match-II, the new initiative in matching the Supplemental Security Income (Federal program for aged, blind, and disabled) against Federal employee rolls.
- Future match projects now in research or planning stages.

In concluding this Chapter, we will discuss recommendations to facilitate the future conduct of such projects while assuring proper controls over privacy rights of individuals.

A. Project Match-I Federal Employees Versus AFDC Rolls

There is wide agreement that the Federal employee population--4.8 million strong--must be a model of good practice and a paragon of good behavior. Especially, we cannot tolerate Federal employees who are fraudulently or improperly on the recipient rolls of the very programs which the Federal Government funds and monitors.

PROJECT MATCH
 DETECTING RECIPIENT FRAUD, ABUSE, AND ERROR
 IN INCOME MAINTENANCE PROGRAMS



FUTURE

- Multiple Fraud Detection Techniques
- Mortality Tapes vs. AFDC, SSI, Title II
- Other Related Federal Benefit Programs vs. AFDC, SSI, Title II

*Will require statutory authorization

Early in our planning of fraud and abuse initiatives the President endorsed these concepts, and Civil Service Commission Chairman Campbell joined Attorney General Bell and Secretary Califano in approving our first major initiative in this area described as "Project Match-I."

As our first effort, we matched the Federal military and civilian employee rosters against the AFDC rolls. Initially, 26 States submitted tapes for this match, and later most of the remaining States responded to our invitation to participate.* Out of approximately 4.8 million Federal employees' records (civilian and active duty military) matched against these rolls, we found over 33,000 apparent matches which were forwarded to the Federal agencies for submission of payroll data. We eliminated those cases with low earnings or where the individuals were no longer employed by the Federal Government and narrowed the list down to about 18,900 cases warranting full eligibility review by the State Welfare agencies. As of March 15, 1979, States had completed an initial review of 14,352 cases and found that 33 percent were overpaid or ineligible as follows:

<u>Status</u>	<u>Number</u>	<u>Percentage</u>
Eligible	9,607	67%
Overpaid	3,066	21%
Ineligible	1,644	12%
Underpaid	<u>35</u>	<u> </u>
Total	14,352	100%

We wish to commend the States for their willingness to participate with us in this and our other matching programs.

*The matches were made against welfare rolls for the month of August 1977; Federal civilian rolls as of March 31, 1977; and Federal military rolls as of October 31, 1977.

What Have Been the Benefits to Date?

From a narrow cost-benefit perspective, the Federal savings from this effort have already repaid Federal costs several times over, as noted later in this Chapter.

In addition to the direct savings achieved by reducing overpayments and eliminating ineligible welfare rolls, there are, in many cases, restitutions being made voluntarily by the individual involved or as required by Court Order. (Thus far we have been able to identify over \$4.1 million of potential restitution although the exact amount being sought is not known.)

The most egregious cases--employees with earnings of \$10,000 or more who have accepted improper welfare payments in excess of \$2,000--are being referred to the U.S. Attorneys to consider prosecution with investigative support from the FBI, Postal Service, and Internal Revenue Service. Prosecutions at the local level are also strongly encouraged.

As of March 15, 1979, the following actions have occurred:

--Federal indictments in New York (16), New Jersey (21), and Washington, D.C. (15).....	52
--State and County Complaints in Virginia (1); Missouri (3); California (16); Georgia (2).....	22
--Pre-trial Diversions in New York (19) and Washington, D.C. (1); Georgia (2).. Total	22
	96*

*In addition, we assisted the FBI in the City of Philadelphia in developing cases covering 29 county employees who have been indicted for welfare fraud.

As of March 1979, there were about 1,000 cases in the hands of FBI, Postal Service, Internal Revenue Service, and State or County investigators for review as to possible prosecution. While most of these may not be selected for prosecution, the deterrent effect of such intensive scrutiny is valuable. A number of additional indictments are anticipated throughout the United States. We have been particularly pleased with the cooperation of the Department of Justice and its willingness to encourage U.S. Attorneys to take an interest in welfare fraud cases which heretofore have not been considered high priority cases.

B. Project Match-I
Interjurisdictional Match Cases

As an additional step of these matches of State welfare rolls against Federal employee rolls, we matched the tapes furnished us by the participating States against each other in search of instances where individuals might be drawing grants from two or more jurisdictions ("double-dipping"). This program covers all welfare recipients, not just Federal employees.

Out of the first 26 States and jurisdictions which were matched as of August 31, 1977, we identified 9,000 individuals who may be receiving duplicate welfare payments which warrant further screening by the State Welfare agencies. The 18,000 raw matches (two matches for each individual identified) are being reviewed by the States involved. The status of this effort with partial results thus far reported by 23 States, is as follows:

Eligible..... 6,488

Double-Dipping..... 1,284

TOTAL 7,772

These States are finding even a small number of inter-jurisdictional cases more "productive" than originally anticipated in ferreting out State and local welfare agency employee fraud as shown by actual examples cited in Appendix I.

We ran a second interjurisdictional match of 50 State tapes as of December 31, 1977, and identified another 8,000 individuals (16,000 duplicate names) not previously identified in the August 1977 run. These names have only recently been sent to the States for review.

Federal Savings from Project Match-I and Interjurisdictional Matching Programs

Combining the results to date of the Federal employee match and the interjurisdictional match, we calculate that the Federal share of savings (i.e., overpayments eliminated) for the first 12 months after the welfare payments are reduced exceeds \$7.9 million. Since the AFDC program is funded jointly by the Federal Government and the States, States should realize similar savings. As shown below, savings are achieved not only in the direct welfare program payment but in the Medicaid and Food program payments as well*:

<u>Program</u>	<u>Ineligibles</u>	<u>Eligible but Overpaid</u>	<u>Total</u>
AFDC	\$4,079,319	\$1,210,602	\$5,289,921
Medicaid	<u>1,728,737</u>	<u> </u>	<u>1,728,737</u>
Sub Total	\$5,808,056	\$1,210,602	\$7,018,658
Food Stamps	<u>934,700</u>	<u> </u>	<u>934,700</u>
Total	\$6,742,756	\$1,210,602	\$7,953,358

The Federal cost of this entire project, upon completion, is estimated to be \$2.2 million.

C. The "Private Employee"
Earnings Match (AFDC Versus SSA's Summary
Earnings Record)

Section 403 of P.L. 95-216 enacted in November 1977 requires that State Welfare agencies use wage information in State Employment Security agency files (if available) or from Social Security Administration

*As of March 15, 1979

records to validate AFDC eligibility. This becomes mandatory on October 1, 1979. The purpose is to make earnings data of all individuals covered by the Social Security Retirement System fully available for matching. This data exchange has become increasingly important due to the growing percentage of AFDC recipients having earned income.

SSA responded immediately to the new statute by making its Summary Earnings Records (SER) for 1977 available for State matching. During CY 1978, 19 States or jurisdictions requested Social Security Administration assistance in conducting this match, and several other States are in the process of requesting this data. The cost-benefit in using this data to verify information provided by Welfare recipients in the Welfare application and redetermination process is believed to be substantial. New York City has reported an estimated savings of \$9.6 million resulting from the match; and Franklin County, Ohio, \$2 million. These two States, as well as several others, were not able to gain access to this wage data previously.

Approximately 40 States will be able to match with records from their own State Employment Security files. Some States (particularly New York and Massachusetts) have recently enacted legislation to mandate the provision of quarterly wage data to the Welfare agency from the State Tax agency.

A problem for the future will be posed for those ten States in which the State Employment Security agencies do not maintain quarterly wage data. Since wage data will only be reported to the Social Security Administration on an annual basis, it may be as much as 18-months old at the time of match with the States. Last year we recommended that Congress consider requiring that an additional copy of each W-2 report be submitted by the employers in these ten States, directly to the State Welfare agency for matching against its Welfare Benefits file.* We would prefer to see all these States

*See page 52 of IG's Annual Report dated March 31, 1978.

require that wage data maintained by State agencies (i.e., the taxing authority) be made available for use by the State Welfare agencies.

Lessons Learned in Project Match-I and Plans for the Future

Experience of the past two years has confirmed the rich opportunities which exist to combat fraud, abuse, and error in the AFDC program--a program which serves 3.5 million needy families and over 10.5 million recipients, at a Federal cost of \$6.7 billion.

We are delighted at the action of the Social Security Administration in creating a Welfare Management Institute to assist the States. Further, the SSA has launched a number of new initiatives, including:

- A concentrated corrective action effort to make rapid and significant reductions in erroneous payments in a selected group of six high error States. (Estimated savings are \$145 million per year when fully implemented in FY 1981.)
- A variety of improvements in data exchange techniques including the development of the National Recipient System (NRS) discussed below, and the implementation of P.L. 95-216, requiring States to match quarterly earnings data, where available, to help determine eligibility for AFDC payments.
- The implementation of sanctions and incentives to encourage reductions in payment errors (incentives are required by P.L. 95-216).
- Expanded technical assistance to the States in the form of improved management methods and computer analysis techniques, such as the error-prone profiles.
- An expanded Program Integrity staff.

The Inspector General's conclusions based on Project Match-I are:

1. The Interjurisdictional Match has high appeal to the States and significant savings potential.

This underscores the importance of the National Recipient System under which a central data base will be kept current for all AFDC recipients, nationwide. When this system becomes fully operational in 1981, it will be possible for a State Welfare agency to ascertain that an applicant for AFDC is not receiving welfare payments from another jurisdiction, is using the correct Social Security number, and has reported receipt of other Federal benefits accurately. The annual savings envisioned once the system becomes fully operational exceed \$60 million--at least six times the estimated annual operating costs. This is indeed cost-effective.

Implementation of this system should proceed with urgency. In the interim, the Office of Inspector General will work with SSA's Office of Family Assistance to perform a periodic service for the States--by gathering AFDC tapes for matching and referral of apparent problem cases (i.e., double dippers, Federal employees, etc.) to the States for investigation. A third such match is now planned for June 1979, based on active AFDC cases as of March 31, 1979.

2. Periodic matching of Federal civilian rolls is desirable. Beginning in 1980, this should be conducted as a match against the SSA "Summary Earnings Record" (SER).

It is our understanding that beginning with earnings for Calendar Year 1978, all Federal employee earnings will be reported, along with employee earnings from private employers and from other public jurisdictions, to the Social Security Administration. Thus, a central master file will be available for an annual match against State AFDC records. This match will have the advantage of showing full earnings for all employees--public and private--for the calendar year and may be the most effective method of accomplishing a computer matching program with Federal, State, and local public employees not included in State Employment

Security wage files. Ultimately, this expanded SER could be matched against the National Recipient System to detect all those who mis-report earned income to Welfare agencies.

3. The other key lessons learned from Project Match are the characteristics of Federal employee abusers.

- a. Active duty military members pose only a minor problem of fraud and abuse with respect to the AFDC program. Out of the 3,502 military cases analyzed through March 1979, only one in eight involved ineligibility or overpayments. In most cases, the military member was not the primary recipient in the welfare case but was a dependent before enlisting. The overpayment was typically caused by the slow reporting to the Welfare agency of the enlistment of the former dependent.
- b. Among the Federal civilian employees, the incidence of Welfare cheating encountered indicates that about 25 percent of the cases identified may involve improper payments. In general, the problem occurs where there are large concentrations of workers with relatively low income residing in large metropolitan areas. Thus, wherever selectivity is desired in running future matches in order to isolate the worst cases, we conclude that the kind of efforts earlier undertaken as a joint effort by the U.S. Attorney and State Welfare Department in Cooke County, Illinois, and in Detroit, Michigan, as well as HEW's payroll match with the District of Columbia will produce the most cost-effective results.

Further, only a small number of agencies (including some Federal, State, and local) need to be covered for maximum effectiveness. For the next year while the expanded SER/NRS Systems are being developed, we recommend that selective matches of this type be pursued with interested States.

The HEW role will be that of providing technical assistance and helping to obtain data from the Federal employers.

4. Finally, we have conferred with the Department of Justice officials regarding their perspective on the lessons learned from Project Match-I. They conclude, and we concur, that in cases involving Welfare recipient fraud, the use of State or local investigators and prosecutors is highly desirable. However, the Department of Justice should assist in the investigation and prosecution of interjurisdictional cases which may be difficult to handle at individual State or local levels. As suggested in Chapter V, it is the Inspector General's hope that financial incentives can be given to the States to improve their detection and investigative capabilities in the areas of recipient and Welfare fraud. These incentives should also include increased support for improved computer systems. Congressional action will be necessary to accomplish this.

D. Project Match-II
Social Security Benefit Rolls

When Secretary Califano reported the first results of Project Match-I to the Congress early in Calendar Year 1978, interest was expressed in extending the match of the Federal rolls against the Supplemental Security Income recipient file, and later to the entire Social Security Beneficiary file.

A detailed operating plan for conducting this matching program has been developed in consultation with the Office of Personnel Management (formerly the U.S. Civil Service Commission) and the Office of Management and Budget. This plan, which is a model for future such initiatives, is enclosed as Appendix J.

The first initiative in Project Match-II has been a match of Federal civilian rolls of 2.8 million names against the current SSI recipients rolls of 4.9 million. This match was conducted in December 1978 and resulted in a total of 10,105 raw matches

requiring evaluation. During January 1979, data on cases were furnished to the 52 Federal agencies who will provide validated employment and earnings information. We hope this step will be completed by the end of March 1979. Thereafter, the Social Security Program Integrity staff and the District Office staffs will assume responsibility for conducting field investigations and referring potential fraud cases to the U. S. Attorneys for investigation and prosecution. As in the case of Project Match-I, all cases where fraud has been determined, whether prosecuted or not, will be referred to the Federal employing agency for appropriate administrative action.

E. Future Match Projects Planned
for Exploration in CY 1979

Based upon the experience of the past two years, we believe the Office of Inspector General can perform a useful service, in collaboration with SSA's Office of Family Assistance, by testing the value of various matching techniques, and making them available for operational application if warranted.

Looking ahead we are considering the following:

1. Additional AFDC matches:

--Against SSI rolls.

--Against Unemployment Compensation rolls,
in cooperation with the Department of
Labor.

In both instances, the objective will be to identify individuals receiving both benefits and to ascertain eligibility and accuracy of reporting.

2. Additional matches against Social Security
Beneficiary Rolls.

--Match of Federal civilian employees against
Title II beneficiaries (retirement, survivors,
and disability insurance programs).

--Match of active duty military against both SSI and Title II rolls.

The objective in both cases will be to identify those collecting both benefits in order to validate eligibility and accuracy of reporting. The pilot run of HEW employee rolls against SSI revealed 158 raw matches, of which 55 cases warrant further investigation. A similar match of HEW employees against Title II rolls revealed 549 raw matches, of which 337 cases warrant further investigation.

3. Other research and experimental match efforts.

In all of the match projects conducted to date, the presumption has been that correct names, addresses, birth dates, and social security numbers have been employed. In our next generation of studies, we plan to develop and test techniques to detect the individuals who falsify one or more elements of identification in order to receive a benefit payment or multiple payments. Many States have expressed an interest in a system of this type and early experiments show promise.

--Mortality data matches. Limited experimental matches are being made in three States comparing the State file of persons who have died against SSI rolls. The purpose is to ascertain whether payments are being made after the death of the beneficiaries. Investigations are proceeding to ascertain the value of this technique.

--Matches of HEW beneficiary rolls against other Federal populations such as Federal retirees (military and civilian) and beneficiaries of other Federal programs such as Food Stamps, Unemployment Compensation, and Housing.

Of significance to our plans for the future is the establishment by the Congress of statutory Inspector General offices in 14 agencies,

followed by the President's directive requiring all agencies to establish programs designed to achieve similar purposes. With the leadership which has been taken by the Office of Management and Budget, the Department of Justice, and the Office of Personnel Management, it is anticipated that efforts of the type outlined above will be greatly facilitated.

F. Other Initiatives Planned by the Commissioner of Social Security to Enhance Program Integrity Efforts

The Associate Commissioner for Management and Administration of the Social Security Administration has furnished the Inspector General a comprehensive review of efforts concerned with Program Integrity and SSA's future plans, including those in which we may have joint participation as related above. We commend the Commissioner for a program of high professional content. The document is of such value, in our opinion, that it is included as Appendix K to this report.

Of particular interest to the Inspector General is the proposal to make Internal Revenue Service's (IRS) interest and dividend income records available for matching with SSI and AFDC payment records, in search of unreported resources. SSA reports that preliminary studies indicate that such an interface could result in SSI cost-savings of up to \$45 million per year. Savings in the AFDC program have not been estimated at this time. The IRS view is that the Tax Reform Act of 1976 prohibits the use of taxpayer information, and, hence, legislation is needed to pursue this initiative.

Further, we suggest that when Congress enacts this proposal, it indicate its intent that Federal and State agencies should make disclosures to IRS where recipients of Federal program benefits have a tax liability as a result of fraud or abuse.

G. Summary of Recommendations to Enhance Detection and Prevention of Recipient Fraud, Abuse, and Error in Income Maintenance Programs

1. We reiterate three recommendations made last year for Congressional action (these appeared on pages 52 and 53 of last year's Annual Report):
 - a. 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 and local employees, unemployment compensation rolls, Child Support Enforcement files, mortality data, SSI files, and SSA (Title II) benefit files.
 - b. With respect to the private employer earnings match, it is suggested that all States which do not have regular wage reporting to the State unemployment income agency, make annual wage data (such as tax return data) available to the State Welfare agencies to match against the State Welfare files to assist in determining initial or continuing eligibility.
 - c. It is urged that Congress extend to the AFDC program the same statutory funding benefits that are now available in the Medicaid program with respect to (1) supporting at increased funding levels the cost of designing and operating management information systems, and (2) subsidizing the establishment of recipient (a) abuse review, and (b) fraud control units.
2. The Congress should join the Secretary in vigorously supporting the implementation of the National Recipient System, discussed in this Chapter. It holds high promise for substantial future savings in detecting Welfare

cheating which extends across State lines; or which involves the use of fraudulent social security numbers; or which results from the illegal receipt of other Federal benefits--as well as providing the system for future Federal employee matches against Welfare rolls.

3. The Congress should enact the Social Security Administration proposal to amend Tax Reform Act of 1976 to permit access for the SSI and AFDC programs to interest and dividend income information which would produce estimated savings of up to \$45 million annually in SSI and savings would also be realized in the AFDC program.
4. The Office of Management and Budget has assumed the responsibility for developing Federal Guidelines to assure that the letter and spirit of the Federal Privacy Act of 1974 are adhered to when computer matching is used by Federal agencies. We at HEW have been working closely with OMB to assure that the guidelines which are developed by OMB are workable and do not unnecessarily retard the effective use of computer processing. We believe that we have demonstrated in Project Match-I and -II (described above) that protection of personal privacy rights can be combined with the effective and efficient application of modern computer processing in the administration of Federal benefit programs.

Draft Federal guidelines were published in the Federal Register on August 4, 1978. Federal guidelines are expected to be published by OMB in the near future. We recommend that Congress keep this development under review to assure that the guidelines are issued in a timely manner and that they facilitate desirable projects such as those discussed in this Chapter.

CHAPTER VII

INITIATIVES TO ATTACK FRAUD, ABUSE, AND ERROR IN THE STUDENT FINANCIAL ASSISTANCE PROGRAMS

Prior to the establishment of the Office of Inspector General in April 1977, many problems began to surface involving the management of the Student Financial Assistance programs which involve loans and grants totaling about \$6.4 billion in FY 1979, and resulting in over 5-1/2 million awards to students. Engaged in these activities are an estimated 8,000 educational institutions -- ranging from the major universities to several thousand vocational and technical schools offering short courses. In addition, there are approximately 14,000 lending institutions participating in the Guaranteed Student Loan Program.

The OIG has had a major involvement in overseeing the Student Financial Assistance programs. They constitute the second largest source of criminal cases for the Office of Investigations, and represent a large continuing workload for the Audit Agency. Both of these activities will be described in greater depth in this Chapter.

The transformation in the management effectiveness of the Student Financial Assistance programs during the past two years has been comprehensive and cost-effective, although far more remains to be done. Secretary Califano's testimony of July 27, 1978, before the House Subcommittee on Intergovernmental Relations and Human Resources, recounted the problems encountered and the actions taken up to that point. It is the purpose of this Chapter to deal only briefly with an update that will look at past efforts and sketch the opportunities which lie ahead. To facilitate a reading of this summary, we will deal with the following principal areas:

- The importance of the reorganization which created a Bureau of Student Financial Assistance (BSFA).
- Expanded and accelerated mechanisms to monitor fraud, abuse, and error by institutions.

--A new validation process which has been the principal source of improvement and savings in the Basic Educational Opportunity Grant (BEOG) Program.

--A containment and reduction in defaulted loans under the Guaranteed Student Loan (GSL) Program. A similar effort is being launched against the defaulted loans under the National Direct Student Loan Program.

--A tuition refund policy for the student financial assistance program is being reviewed by the Department. It is expected that a resolution to the problem will be obtained in the near future.

A. Reorganization Was the Essential First Step

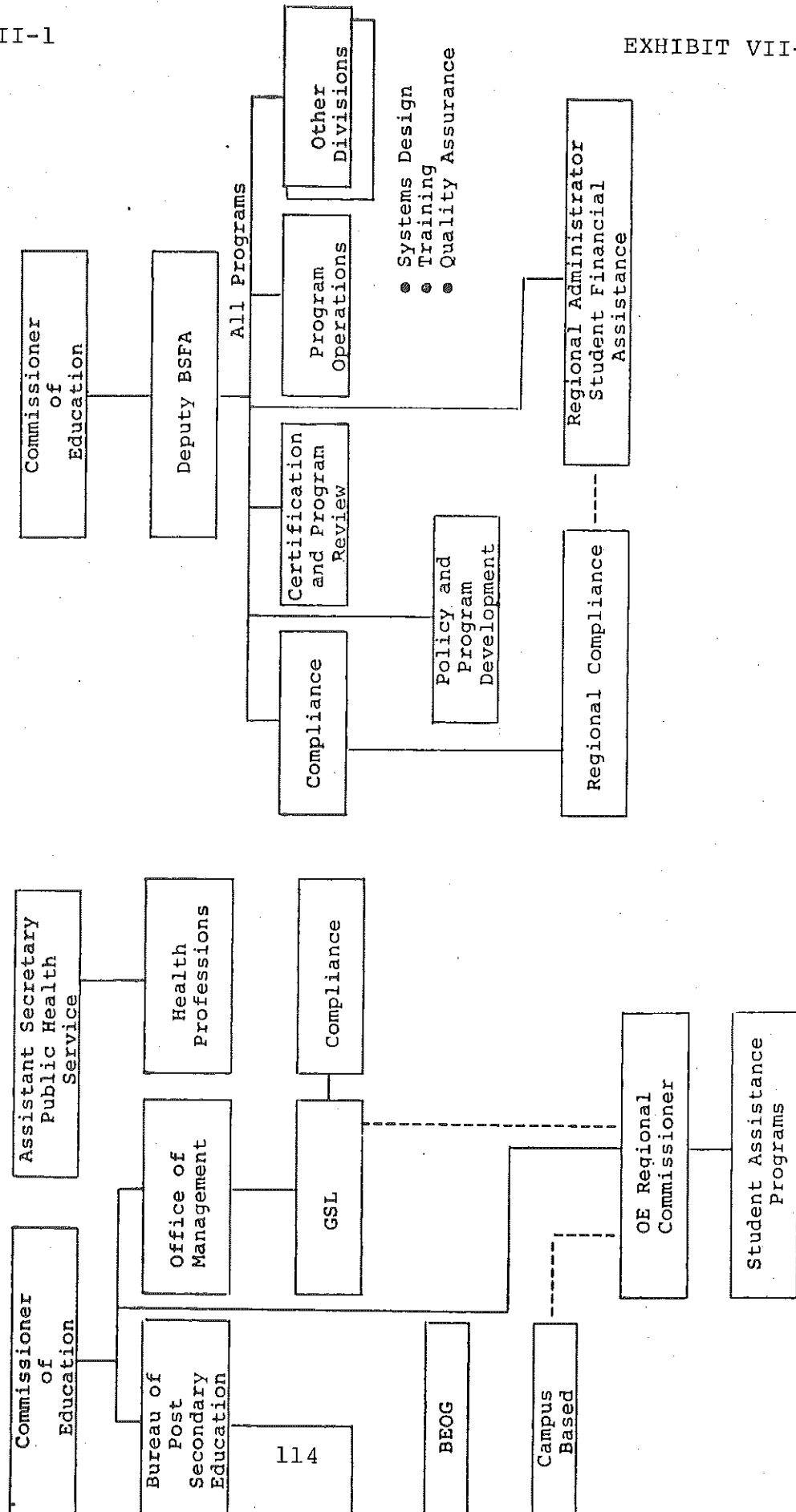
Four independent divisions for student financial aid existed in January 1977. None had a skilled management executive conversant with large-scale loan and grant systems, which are more akin to commercial banking practice than the normal Federal processes. Exhibit VII-1 illustrates the former organizational structure and shows the arrangement which was instituted in September 1977, and has been progressively improved since then. The significant elements of this structure are as follows:

1. One Deputy Commissioner now has full "command authority" over all the programs at headquarters and through his own direct regional organization. Previously the headquarters functions were split among separate divisions, and the ten regions were similarly disjointed with divided responsibility for the programs in the regional offices. The headquarters divisions had only a "dotted-line" relationship to this morass. This was indeed an impossible arrangement.
2. The new structure makes it possible to integrate the oversight of all of the programs, so that there is one division responsible for policy and program development; another for quality assurance; a third for

ORGANIZATION OF STUDENT FINANCIAL ASSISTANCE PROGRAMS

Before Reorganization

After Reorganization



operations; a fourth for certification and program review; and a fifth for compliance -- which is the principal interface with the IG's Office of Investigations (OI). The Compliance Division serves as the BSFA base of operations for monitoring and reducing fraud and abuse in its programs, and it assists OI where appropriate in the conduct of criminal investigations. OI/BSFA Compliance working relationships were formalized through a Memorandum of Understanding entered into by the OIG and BSFA in September 1977. We are currently engaged in an examination with the Director of Compliance of our working relationships in order to assure the most effective utilization of resources.

B. Accelerated and Expanded Mechanisms to Reduce Fraud, Abuse, and Error in the Management of Student Financial Assistance Programs

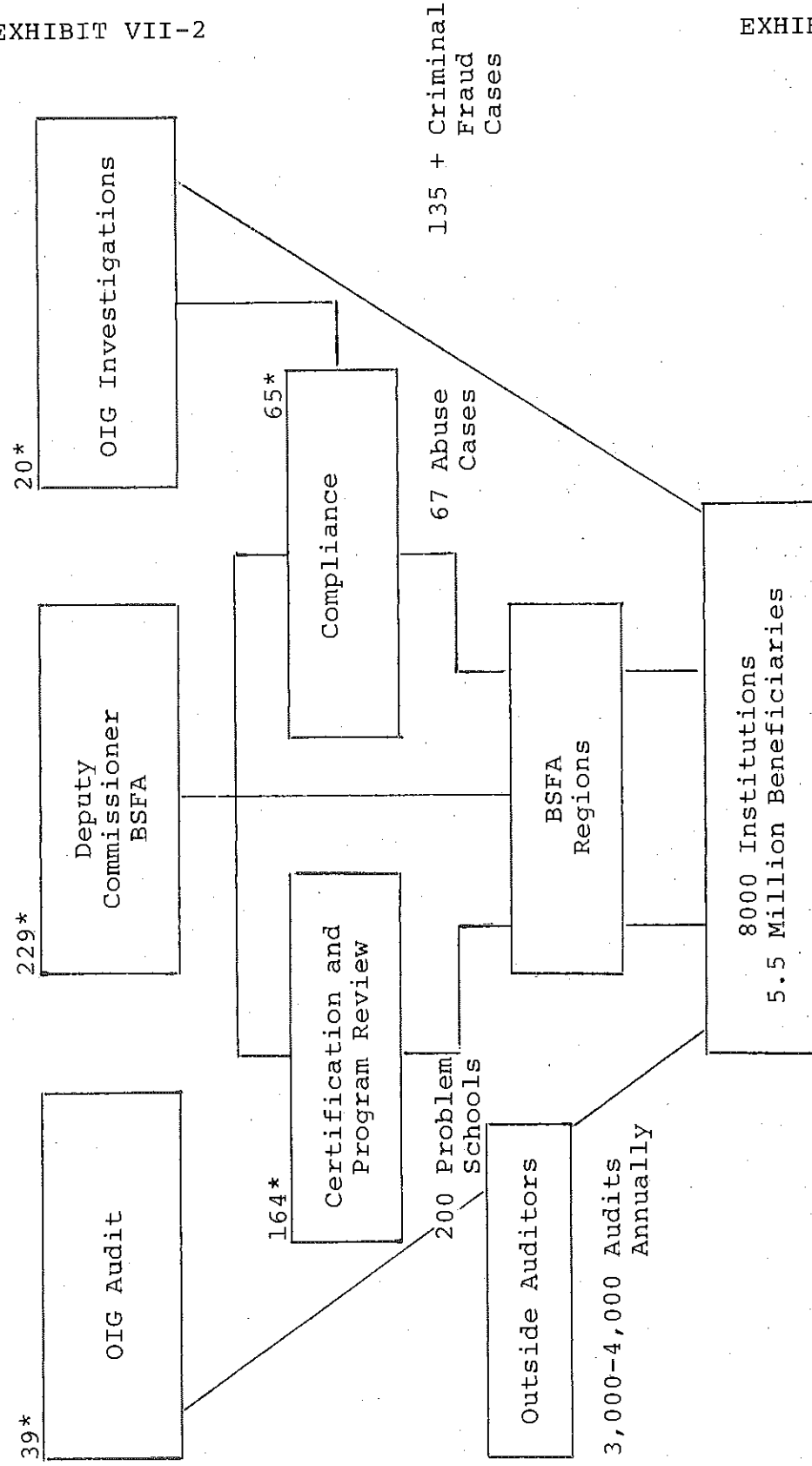
The scope and attention now being given to all programs in all types of institutions is illustrated in Exhibit VII-2 on the following page:

--At the heart of the new approach is the improved oversight provided by the Deputy Commissioner and his national staff. This consists first of a Division of Certification and Program Review which conducts regular inspections of problem schools among other duties. As a result of this Division's activities, institutional liabilities of nearly \$9 million have been established to date. Out of their findings flow matters for attention by the HEW Audit Agency, BSFA's Division of Compliance, or, in the case of criminal fraud, by the OIG's Office of Investigations. Further, this effort is being bolstered by a nationwide training program designed to upgrade the performance of financial aid officers at the institutions.

1. Division of Compliance

--Next, the Division of Compliance, BSFA, has come into its own in Calendar Year 1978 with

MECHANISMS TO REDUCE FRAUD ABUSE, AND ERROR
IN STUDENT FINANCIAL ASSISTANCE PROGRAMS



*Professional Staff

the establishment of a nationwide staff of 51 investigators and 14 technicians skilled in civil fraud and administrative sanctions. An account of the work of this Division -- whose caseload has more than tripled in its first year -- is contained in Appendix L. This appendix also reviews the highlights of 17 illustrative cases. The complexity of these matters is revealed by the following example of a current Compliance review:

--A nationwide chain of schools which trains students in computer technology was found to have made false certifications, withheld funds due to students by the lenders, disbursed loans to students not in attendance, and charged excessive interest in billings to the Federal Government. The school was forced to immediately repay certain interest and tuition refunds exceeding \$1 million, and its eligibility was terminated to prevent future damages. The matter continues to be an open case under investigation by OI and the FBI.

2. OIG Audit Agency

--The Audit Agency processed 983 audit reports in 1978 on institutions administering student financial aid programs. Sixty percent of the reports disclosed one or more deficiencies -- ranging from minor internal control weaknesses or problems of poor financial practice, to major areas of non-compliance with Federal regulations.

--The student financial assistance programs now require an independent audit biennially of each educational institution participating in their programs. The HEW Audit Agency is preparing standardized guides for the conduct of such audits by independent auditors, subject to quality control reviews by HEW's Audit staff. Audit Guides have been issued for the BEOG and campus-based programs, (NDSL, SEOG, and CWS), and one is in development for the GSL program.

--A training program has been developed in cooperation with the American Institute of Certified Public Accountants. Three seminars were held in October and November of 1978 and six are planned for 1979.

--Examples of audits completed in 1978 are cited in Appendix M. These have become the basis in several cases for action under the new "limit, suspend, and terminate" procedures authorized by the 1976 amendments.

3. OIG Office of Investigations

--An analysis of 103 cases under criminal investigation is presented in Appendix N. One of the most interesting areas is proprietary schools where the work in process involves 29 cases with the following problems:

--Suspected misappropriation and misuse of student financial aid funds appear to exist in one-third of these cases.

--Embezzlement accounts for an additional one-third, including evidence of bribery and kickbacks to school personnel, school officials, and collection agencies.

--The remainder of the cases involve a variety of schemes to defraud and misrepresent. The most typical are fraudulent applications with forged student names, or cases where students are induced to file false applications.

Altogether 34 convictions in the Student Financial Aid area resulting from the work of the Office of Investigations and U. S. Attorneys were obtained in 1978. A brief synopsis of these appears in Appendix C.

4. Industry Studies

Another oversight initiative being tested by the Inspector General is a series of industry

studies designed to examine specific types of schools and to develop criteria for detection of problems needing attention. The initial effort is directed at proprietary schools, with the focus on some 900 in the cosmetology field. This initiative, known as the "Beauty School Project," holds great promise as a technique that can be progressively extended to a number of categories of schools in the future. A description of the approach being used, and early results, appears as Appendix O. Three principal techniques are being employed:

--Computer analysis of the BEOG applications submitted by students for a 3-year period to identify deviations from norms, which indicate possible fraud and abuse, suggesting that applications are being prepared by the school itself and not by the applicant.

--Questioning students to verify whether they received the grant award and under what conditions.

--Intensive audits of selected institutions pinpointed by the foregoing factors.

5. Future Oversight Initiatives

The Inspector General plans, during the coming year, to give special attention to assisting BSFA in planning additional industry studies of the type described above.

At longer range, we expect to continue review of the design of management information systems for all BSFA programs and to achieve the benefits of integration where possible.

C. The Success of Efforts to Validate Applications in the Basic Educational Opportunity Grant Program (BEOG)

The BEOG program is the largest of the financial assistance programs with awards in FY 1979 to 2.7 million students of up to \$1,600 each. As a result of initiatives undertaken by the Deputy Commissioner, in the 1978-1979 academic year, some \$300 million is being saved.

This achievement is a result of two new techniques:

--The first is a computer edit check applied to the applications at the time of receipt to test for completeness or inconsistent information. About 40 percent of the applications in 1978-1979 were returned to students for additional information. Most of the applications were returned due to problems with income, taxes paid, missing social security numbers, or other data critical to making an award.

Of the 1.4 million applications returned to students so far approximately 500,000 have not been resubmitted for correction. Applications may not be resubmitted for a variety of reasons not related to fraud and abuse. In this context, OE is continuing to simplify and improve the application form and procedures to reduce the risk of excluding otherwise eligible applicants.

--The second technique is to select a large number of applicants (who submitted new information which drastically changed their eligibility, or who submitted inconsistent data) and to return the application to the student for a 100 percent validation review by the institution of the facts presented, including a check of income tax return. This year, approximately 120,000 applications have been flagged for the validation review.

In accordance with the plans discussed by Secretary Califano in his testimony last July, several other "front end" validation checks are being incorporated, as fully as practical, in this year's processing cycle. It must be stressed that this will be the first year that such validation checks will have been attempted and we anticipate varying degrees of success. They are planned to include the following:

- A computer cross check of beneficiaries of student assistance under Social Security with BEOG applicants to assure that SSA benefits are counted in determining the BEOG award. A test run in the summer of 1978 indicated the possibility that as many as 113,833 applicants had failed to report their SSA student benefits.
- A computer cross check of BEOG applicants with students receiving Veterans Administration (VA) educational benefits to assure that VA benefits are included in determining the BEOG award. A test run, made last summer, revealed the possibility of some 19,000 cases where VA benefits had not been reported.
- A third computer match which the Inspector General feels should be attempted (even though its cost-benefit has not been established) is between BEOG applicants and AFDC rolls. A test run last summer revealed the possibility of 19,704 applicants not reporting such benefits. The Inspector General feels that this check should be made so that information can be furnished both to the States and to the Office of Education to assist them in making their respective decisions on the size of the grant entitlement.

Looking ahead it is felt that important lessons can be learned in the coming year, particularly in relation to the most effective ways of conducting validation checks including the use of IRS data for this purpose.

D. Reduction in Defaulted Student Loans

Two student loan programs whose default problems have tested the mettle of the Department include: the Guaranteed Student Loan Program* and the

*The Guaranteed Student Loan program consists of (1) the Federal Insured Student Loan Program (FISL) totally administered by the Federal Government and (2) the State Guaranty Agency program, where the Federal Government places an 80 to 100 percent guaranty behind the State insured loans.

National Direct Student Loan Program (NDSL). A major management break-through has been achieved with the containment of the defaults (number and rate) in the federally insured program.

With this effort well in hand, the Department is now beginning to be able to apply the lessons learned against the default problems in NDSL.

1. Federal Insured Student Loan Program

--The FISL program had, in 1977, accumulated defaulted loans involving 300,000 students and totaling more than \$300 million. This number increased steadily and reached a peak of 393,000 students owing \$400 million in March 1978. At that time, the program had a default rate of approximately 13 percent. As a result of initiatives begun by the new Deputy Commissioner, the backlog was contained for the first time in the 10-year history of the program, and by September 1978, it had dropped to 357,000 and by February 1, 1979, to 336,000. Of these accounts, about 33,000 are now under investigation or are in litigation, resulting in a "hold" being placed on collection actions until the cases are resolved.

The improvement in the FISL program is attributed to a variety of special initiatives. The Inspector General's Office has collaborated in several of them and will continue to do so.

--Establishment of a computerized billing system. Prior to November 1977, virtually no student who had defaulted had been regularly billed by the Federal Government. Now a regular billing procedure is in operation.

--An agreement with IRS to obtain current defaulters' addresses.

--The institution of a systematic cross check of the default file with Federal

active duty civilian and military employees. This check conducted by the Inspector General, revealed 16,500 employees in default, with indebtedness (including principal and interest) of \$15.8 million.

An additional 317 HEW employees had been identified previously in a pilot test, and all of these accounts for individuals still working in the Department have been resolved, or have been referred for litigation. As to the remaining Federal civilian employees -- 6,600 in number -- excellent progress is being made as shown in Exhibit VII-3. This is due in large measure to the cooperation received from the Federal agency personnel divisions.

The remaining 9,930 military employees were only identified in November 1978 and the Defense Department is cooperating with HEW in locating these individuals at their work addresses.

- Greatly accelerated referral of civil cases to U. S. Attorneys. In FY 1978 we referred 3,000 civil cases compared to a total in the preceding 5 years of only 500.
- A variety of additional initiatives are being planned. Contracts have been awarded in two regions as an experiment to determine whether private agencies can be effective in collecting defaulted loans. In the meantime, as of February 1979, 684 temporary and part-time employees had been hired to launch a massive collection effort -- an additional 519 are to be hired in the months ahead. This represents a major increase of collection employees over the 100 some collectors that were in place in 1977.

Work has also begun with selected State Guaranty Agencies to develop match projects

STATISTICS OF GUARANTEED STUDENT LOAN FEDERAL DEFAULTERS

	: : Secretary : Testimony	: : Period : Ending : : 12-24-78 :	: : Period : Ending : : 12-31-78 :	: : Period : Ending : : 1-7-79 :	: : Period : Ending : : 1-14-79 :	: : Period : Ending : : 1-21-79 :	: : Period : Ending : : 1-28-79 :	: : Period : Ending : : 2-3-79 :	: : Period : Ending : : 2-10-79 :
Paid-in-Full	172	452	457	462	480	517	528	543	545
Death, Disability and Bankruptcy	69	102	103	104	106	106	108	110	112
Write Off	181	302	303	305	308	312	311	311	310
In Repayment/Promise To Pay	540	2,815	2,823	2,835	2,842	2,859	2,875	2,885	2,890
Litigation	32	67	68	68	69	68	69	69	69
Problem School Related	0	0	0	0	0	0	0	0	0
Data Problems	0	0	0	0	0	0	0	0	0
No Longer Government	0	1,531	1,588	1,603	1,638	1,638	1,638	1,638	1,638
Losses/Never Paid	5,606	1,331	1,258	1,223	1,157	1,100	1,076	1,044	1,036
Total Federal Defaulters	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600

in order to expose Federal employee defaulters. A contract has been made to acquire credit reports on student loan defaulters (prior to a referral to litigation), and to provide current address information on defaulters.

Among other actions being planned are:

- An assessment of the feasibility of matching State Government payrolls against the default files.
- Access to employee address data for defaulters from Social Security Administration records to assist in locating defaulters.
- Legislative authorization for releasing IRS address data to State Guaranty Agencies prior to their submitting the case to BSFA for reinsurance payments.
- Consider using credit bureaus for skip-tracing of defaulters, as recently proposed by the General Accounting Office.
- Consider furnishing default data to IRS on accounts written off as uncollectibles, so as to permit the taxation of these funds as income.

2. National Direct Student Loan Program

--NDSL has been operating at an average default rate of almost 20 percent -- equal to 830,000 students with unpaid principal of nearly \$700 million as of June 30, 1978. This program is administered by the institutions themselves, but with a 90 percent capital contribution by the Federal Government. The idea is to create a revolving fund out of which future loans can be made to needy students at a very low interest rate.

In order to reduce the default problem in NDSL, BSFA is encouraging institutions to turn over

their defaulted NDSL loans for Federal handling. We are working with the Attorneys General for individual states (where State law may prohibit a school from turning over its defaulted notes to BSFA for collection) to seek a resolution to the problem. We are also streamlining the paperwork required for the assigning of the notes to BSFA by the schools. This is expected to increase collections in 1980 by \$94 million. In addition, cash on hand in these institutions is being reduced to a 30-day level. This will return to Federal control some \$10 million in otherwise idle funds.

BSFA has established a savings target through the increased recovery of loans in default in the amount of \$70 million in 1980 for the FISL program, and \$94 million for the NDSL program -- a total of \$164 million -- in addition to the savings cited earlier for the BEOG validation.

E. The Need for Rational Refund Policies

A problem was encountered in 1978 with preserving a policy of requiring institutions participating in the GSL programs to have a "fair and equitable" refund policy for students who drop out or who are unable to complete their courses. The Inspector General wrote the Secretary urging that he reinstate and reaffirm this policy for GSL. Backing up his recommendation was the finding of the HEW Audit Agency, based on a review of 25 vocational and technical schools, which concluded:

"At 16 of the 25 schools 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."

Further evidence of the need for a clear policy has been found in a study released by GAO on January 17, 1979 titled: "What Assurance Does

Office of Education's Eligibility Process Provide?". Substantial differences in refund policies were cited for a number of schools visited by GAO. They found that some schools provided no refund after the first week while others gave a substantial refund well into the term. To illustrate, the following compares the practices of four schools in granting refunds for a hypothetical student who paid \$1,000 in tuition and withdrew after completing three weeks of class.

<u>School</u>	<u>Applicable Refund Provision</u>	<u>Amount of Refund</u>
A	No refund due after 3 weeks	\$ 0
B	No refund beyond first week	0
C	70 percent refund allowed	700
D	School retain 25 percent of tuition plus \$100 withdrawal fee	650

The Secretary accepted our recommendation to preserve the GSL refund policy, and on July 19, 1978, HEW published a regulation requiring continuance of the "fair and equitable" refund policy in the GSL program.

Two other developments in the refund policy area should be noted. On December 28, 1978, the Federal Trade Commission published a rule, effective January 1, 1980, that requires proprietary vocational and home study schools to provide pro rata refunds to students who withdraw from their courses. Recently, the American Council on Education has submitted draft rules to the Department for comment, enunciating a much more logical refund policy than that which has existed for universities.

These two developments are very encouraging, and we will continue to work closely with the Office of Education to sustain the principle of a fair and equitable refund policy for students forced to an early withdrawal or unable to complete their studies.

F. Summary of Conclusions and Recommendations

Student Financial Assistance programs rank among the most difficult in the Department from the viewpoint of detecting and preventing fraud, abuse and error -- and fostering economy and efficiency. The record of management improvements and savings which has been compiled in FY 1978 is excellent. The goal of \$394 million in savings for FY 1980 is praiseworthy.

Several matters warrant Congressional attention:

1. The integrated Bureau of Student Financial Assistance should be retained intact if a Department of Education is formed, perhaps under the direction of specifically qualified leadership.
2. Fair and equitable refund policy requirements should be established and sustained for all of the Student Financial Assistance programs. Some variation in the specific application of this policy as between vocational and technical schools on the one hand, versus the major universities on the other, is probably justified.
3. It is recommended that legislative approval be given to providing IRS address data to State guaranty agencies prior to their submitting defaulted cases to BSFA for reinsurance payments.
4. It is recommended that the Family Educational Rights and Privacy Act (FERPA) be amended to provide that in certain cases prior notice to a student need not be given before a school complies with subpoena for student records. *The present act leaves in doubt the question of whether a subpoena of the Inspector General or the U. S. Attorney can be honored by a school without either obtaining the consent of the student, or unless

*This is known as The Buckley Amendment.

the educational institution makes a reasonable attempt to notify the student prior to disclosure. Such prior notification could seriously interfere with a criminal investigation.

5. The authority to refer default information to private credit bureaus requires clarification. The General Accounting Office has recommended the referral of student loan information, both for new loans and defaulted loans, to the private credit bureau network. We are now endeavoring to ascertain whether this is consistent with the Privacy Act and, if not, to recommend legislation to afford us this authority. We understand that the General Counsel at GAO feels that no legislative amendment is needed.
6. A continuing problem is the practice of some institutions of retaining excessive Federal cash and improperly using these funds without an imputed interest cost. HEW is now moving to limit NDSL funds on hand to a 30 day requirement. As discussed in Chapter III, we believe that a regulation is desirable to assess an interest charge against any organization which misapplies Federal funds. We believe that the specific instances which have been encountered among institutions in the Student Financial Aid programs confirm that such a regulation should also cover educational institutions.
7. It is recommended that legislative authorization be provided for use of program funds to defray the cost of obtaining records needed for civil and criminal investigations consistent with the provisions of Title XI, Right to Financial Privacy Act of 1978.

CHAPTER VIII

OIG ACTIVITIES RELATED TO CONTRACTS AND DISCRETIONARY GRANTS

In 1978 we conducted or participated in seven special investigations or reviews of procurement and grant systems five of which were initiated in 1977. Four of these special investigations or reviews are described below to illustrate the kinds of problems found. In addition, we discuss other specialized problem areas and provide our assessment, plans and recommendations.

A. Special Investigations and Reviews

1. Contracting Practices of the National Cancer Institute (NCI)

At the request of the Secretary and the Director we reviewed NCI's contracting function to assess the adequacy of operations and business practices. The review was intended to highlight procedural weaknesses in need of prompt attention.

We found that sharp increases in financial resources available to NCI over the years generated heavy pressures to convert dollars into research quickly, but the system was not able to cope fully with the strain.

We recommended the following:

- Centralization of administration of contracting operations and separation of them from program influences.
- Centralization of administration of peer review and separation of it from program influence.
- That NCI take steps to ensure that:
 - Project Officers prepare better defined work scopes and assist the contracting

officers by providing necessary technical input and surveillance.

--Contract Officers award contracts with more precise performance requirements under financial arrangements favorable to the Department and use the competitive process to the fullest extent. Close surveillance procedures should be adopted to ensure financial and technical progress and compliance with contract terms; unsatisfactory performance should be corrected or contracts terminated.

--Peer review group members are encouraged to prepare recommendations consistent with their observations. Better use should be made by contract and project officers of peer observations and recommendations.

- The Office of the Assistant Secretary for Management and Budget, the Public Health Service (PHS) and the National Institutes of Health (NIH) should assist NCI.
- Closer surveillance of staff relationships should be provided to minimize the possibility of conflicts of interest.

Before we made our formal report NCI began to take actions commensurate with some of the recommendations. On May 12, 1978, PHS submitted to the Assistant Secretary its correction plan addressing all but one (inadequate Departmental stewardship) of the 15 areas in which the deficiencies fell. PHS stated that the remaining one would be discussed in a coming plan dealing with other NIH contracting activities. On October 20, 1978, PHS made a report indicating very substantial progress in executing the plan with almost all of the actions either completed or on schedule.

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2. Relationships of the National Cancer Institute with the Eppley Institute for Research in Cancer

In February 1978 GAO issued a report on a contract with the University of Nebraska's Eppley

Institute for Research in Cancer. The contract, for carcinogen testing and carcinogenesis research, had been originally negotiated, and subsequently renewed, noncompetitively.

GAO criticized NCI actions resulting in a 1973 renewal, the administration of the contract and the limited degree of utilization of contract research reports. GAO also said that Eppley had used contract funds for projects lacking initial formal NCI approval, charged some noncontract expenses to the contract and used some contract equipment for noncontract work.

Further, GAO said, Federal regulations for certifying personnel services charged to the contract were not being followed, controls for recording employees' leave were inadequate and Eppley had received approval to refurbish its breeding facility which was breeding many more animals than it needed for research purposes.

GAO noted actions taken by NCI and Eppley to correct a number of the criticized situations.

We performed an audit covering the period from May 16, 1973 through August 31, 1977. Our review generally confirmed the conditions cited in GAO's draft report and we recommended that Eppley refund about \$1.1 million. Because of inadequacies in labor distribution records we were unable to express an opinion on the validity of \$7.1 million of costs. Under HEW procedures, NCI must determine how much of the \$7.1 million is a proper charge to the contract.

At the request of the Secretary, the OIG reviewed the activities of the Director of the Eppley Institute and members of his staff while they served on various HEW advisory organizations. Based on our review of this case, we concluded that the variety of roles assumed by an HEW consultant (i.e. principal investigator on HEW contracts or grants, consultant

to private industry, and consultant to HEW) could result in, at a minimum, the appearance of impropriety. We recommended that careful study be made of acceptable standards of conduct for NIH consultants and that financial interest disclosure forms filed by NIH consultants be given wider dissemination to assist NIH officials in determining whether there are any conflicts which might affect the scientific judgment of the consultants.

Acting on our report, the Secretary directed that (a) a review be made to determine if additions or amendments to HEW conflict of interest regulations are necessary, (b) the practicality of prohibiting HEW consultants from representing third parties before HEW be assessed, (c) consideration be given to prohibiting any HEW consultant from accepting employment by any for-profit entity, the activities of which involve matters under the jurisdiction of the committee on which the HEW consultant serves, (d) immediate action be taken to ensure that the financial disclosure forms are distributed to those agency officials whose duties require them to deal with the consultants, and (e) that a directive be issued immediately to all committee members reiterating the importance of filing complete and accurate disclosure forms and stressing that amended forms must be filed as a member accepts new employment or obtains a new financial interest.

Certain information obtained during the HEW audit has been turned over to the Office of Investigations for further review.

3. Contracting Practices and Official Conduct in the National Institute on Drug Abuse (NIDA)

We made a review of allegations of improper conduct by the staff, management, grantees and contractors of NIDA. We found loose management practices and evidence of cronyism. We recommended to the Secretary on May 26, 1978 that (a) NIDA contract proposal technical review committees be selected from outside the

contracting NIDA division and, where possible, outside the Government, (b) where few responses to requests for contract proposals are received, potential contractors' reasons for not proposing be ascertained and the request reissued if circumstances warrant, (c) an official outside the contracting NIDA division monitor the award process, (d) an independent group periodically reassess the continued need for long term contracted projects, and (e) Departmental standards governing travel by key officials be reviewed to make certain that they are sufficiently vigorous to preclude excesses. We also recommended immediate reassessment of a pending project on which the current contractor was personally related to NIDA staff.

The Secretary on June 2, 1978 approved these recommendations and directed that the following actions be taken immediately:

- The Assistant Secretary for Management and Budget assure that the contract and grant practices of NIDA are impeccable, free from favoritism or cronyism, and that competition is obtained whenever feasible.
- The Assistant Secretary for Personnel Administration review the personnel matters cited and advise the Secretary whether any steps should be taken.
- An examination be made of standards governing travel by top officials with the objective of assuring that those standards are sufficiently vigorous to preclude excesses.
- General Counsel take the findings of our report into account in his review of conflicts-of-interests policies in respect to HEW contract and grant programs.

The above matters were the subject of a hearing on July 31, 1978 before the House Committee on Interstate and Foreign Commerce Subcommittee on

Oversight and Investigations. Certain additional matters are still undergoing review as discussed with that Committee.

The Assistant Secretary for Health, in reporting on the actions taken in response to our recommendations, has described a new contract management system, which, in our judgment, is both unique and praiseworthy for readers of this report. The system is as follows:

"e. Contract Management System

"During the past several months, the Inspector General has detected a number of instances in the award and administration of departmental contracts which leave the appearance of favoritism and cronyism. These involved instances in which the spouses of departmental officials received remuneration under HEW contracts, as well as instances in which key contractor staff had close personal relationships with departmental awarding officials. Our assessment of these circumstances revealed that we do not have adequate management controls since neither contractors nor HEW staff are required to reveal 'special relationships' of this type.

"As a consequence, we are implementing in ADAMHA a management system whereby contractors will be required to certify in their proposals whether or not they have knowledge of circumstances which give the appearance of conflict of interest. Likewise, ADAMHA staff will be required to disclose any such relationship for each procurement in which they are involved.

"This management system will provide information at a point in time in which the Department can take action to assure the integrity of the contracting process.

This new process, which to our knowledge is unique in the Executive Branch of the Government, will be tested in ADAMHA for 1 year and then after any necessary modifications, will be extended Department-wide."

4. Office of Education Discretionary Grants

At the request of the Office of Education (OE) a small team of OIG and ASMB staff have made a preliminary review of the management of several OE discretionary programs.

Four problem areas have tentatively been identified:

- a. The OE Grants and Procurement Management Division is not as effective as it should be in its oversight and administrative management of grants.
- b. The peer review system does not serve as an effective check on excessive program discretion.
- c. There is evidence of inadequate enforcement of conflict-of-interest procedures.
- d. There is uneven implementation of Departmental and OE Grants Administration Policies among OE grant programs.

In the next year, we will be examining these broad problem areas and related weaknesses in greater detail. We expect to work with OE to devise a number of short and long term remedies for these problems.

5. Problems of Official Conduct in the Contract and Grant Awards

A range of problems were investigated during CY 1978 ranging from criminal behavior in the case of a Regional Commissioner of OE -- who accepted kickbacks and other favors from contractors and suppliers -- to situations where

the individual was careless in failing to avoid an unintended conflict-of-interest situation, or the appearance of a conflict-of-interest.

The Ethics in Government Act introduces disclosure requirements and reviews that will go far toward avoiding such problems in the future. However, it is urged that the HEW General Counsel institute procedures under which key officials and consultants who have sensitive roles which can be construed as having an influence on the award of a contract and grant to an organization in which the individual has a financial or other personal interest, will be given special advice.

B. Audits of Contracts and Grants at Colleges and Universities

OMB has designated this Department as the cognizant audit agency responsible for providing all needed Federal audit services to about 94% of the nation's 2,500 colleges and universities. Audits have consistently disclosed major problems in nine areas which suggest that adequate record keeping and cost controls are a widespread problem at colleges and universities -- and hence, we do not have a sufficient degree of assurance that all Federal funds are used for the purposes that they were provided.

The nine problem areas are:

- Lack of Salary and Wage Documentation
- Improper, Late or Undocumented Cost Transfers
- Cost Sharing Requirements Not Met, or Undocumented
- Fringe Benefits Overcharged
- Improper Payments - Summer Salaries, Excess of Regular Base, Vacation Leave Charges
- Tax-Exempt Stipends Charged as Salaries

--Consultant Costs Undocumented

--Cash Management System Needs Improvement

--Acquisition, Control, and Accountability
Procedures on Equipment and Supplies Need
Improvement

Because the largest portion of the funds provided under cost reimbursable agreements is expended on the salaries and wages of institutional personnel, related fringe benefits and indirect costs; review of systems of accounting for salaries and wages have received the thrust of the Audit Agency's efforts. The most outstanding problem revealed by our audits has been lack of reliable documentation to support salary and wage charges to Federal grants and contracts.

1. Results and Recommendations

During CY 1978 we issued audit reports covering reviews of \$1.5 billion of expenditures under HEW Grants and Contracts. Due to major systems deficiencies, we were unable to determine whether approximately \$86.5 million of these expenditures were properly chargeable to the HEW projects involved. This does not mean that these costs were illegal or improper, but rather that they could not be audited under existing regulations and must be adjudicated by program managers. We further identified about \$3.5 million of expenditures which were not properly chargeable to the HEW projects. Most of the \$86.5 million and a large part of the \$3.5 million were caused by deficiencies in the institutions' salary and wage systems or by inadequately supported or improper cost transfers.

Recommendations are included in the individual reports issued on each educational institution audited. These recommendations are directed to the educational institution and/or to the Principal Operating Component (POC) of HEW which provided the preponderance of HEW funds to that institution. The audit reports typically recommend that:

- The institution implement or revise its certification or review procedures to bring them into compliance with the requirements of FMC 73-8;
- The institution refund any unallowable expenditures which we were able to identify;
- The institution review the reasonableness and acceptability of salary costs and expenditure transfers whose allowability/unallowability we could not determine and make any necessary additional financial adjustments; and
- The cognizant POC determine the allowability of the substantial amounts of charges on which we were not able to express an opinion.

2. Actions in Process to Resolve Problems

The causes of the problems can be traced to both the Government and the institutions. Problems on the Government side appear to be unrealistic regulations, and lack of consistent actions to correct problems encountered by all Federal agencies concerned. From the standpoint of the faculty members, there has never been, in fact, a meeting of the minds on what reasonable Federal record keeping requirements should be. The requirements are unclear and subject to differing interpretations.

All concerned -- both the college and university administrators and HEW and other Federal agencies -- have been dissatisfied with this state of affairs and have started aggressive efforts to improve the situation. Major steps are:

- HEW submitted detailed proposals to OMB for revisions in the regulations. OMB has collected views from about 100 organizations and is preparing to promulgate revisions. The current target date is October 1979. Included in these revisions will be a new method (Monitored Workload System) of accounting for salaries and wages.

--The Secretary on February 14, 1978 issued a wide range of reforms which highlights the need for greater involvement and direction from the Department in resolving the audit findings and in working with the institutions to correct their deficiencies in a positive timely fashion. The reforms are:

--An HEW "Early Review" service that will offer advance consultation to colleges and universities on their proposed changes in accounting systems, where changes are necessary to meet revised Federal accounting standards.

--Assignment to HEW's Office of the Assistant Secretary for Management and Budget of a new responsibility for working with institutions to correct accounting system and reporting deficiencies.

--Sanctions by HEW against institutions or individuals that willfully violate regulations and policies or fail to correct system deficiencies after they had full opportunity to do so. Such sanctions could include disqualifying the institution or individual from receiving Federal grants.

--A new high level HEW board will be established to review recommendations from the Office of Grants and Procurement for sanctions or other action against a non-complying institution. The board will be composed of the Inspector General, the Assistant Secretary for Management and Budget, the General Counsel and the heads of the Department's Principal Operating Components.

--Departmental oversight of progress by the major HEW components in acting upon audit report recommendations. The oversight will be carried out by the Office of Grants and Procurement, as well as by the Inspector

General who will make periodic on-site reviews of a deficient institution's progress in revising its procedures.

--A new rule limiting retroactivity of Federal audit claims against an institution to three years except when fraud or deliberate misrepresentation is involved. This rule will result in fairer and more consistent audit settlements.

--The Office of General Counsel will develop Departmental regulations providing for the disqualification and/or debarment of individuals and organizations as eligible applicants for grant and other assistance awards, where necessary, to protect the public interest from willful and material violation of regulations and policies, criminal acts, or other causes which seriously reflect negatively on the individual or organization's integrity, or ability to act responsibly.

--HEW will also continue to work with the grantee-contractor community, the Office of Management and Budget and the other Federal departments in clarifying and simplifying the Federal Government's record keeping requirements and bringing about needed reforms to the Federal cost principles.

C. Public Health Service (PHS) Grants - Double Payment Issue

The Department's Maternal and Child Health, Medicare, Medicaid, and Social Services programs are paying PHS grantees (such as Community Mental Health Centers) for services rendered to eligible individuals when, in fact, the same services were grant supported. Present procedures and policy are inadequate to prevent double payment.

We will conduct a review of the reimbursement policy, procedures and audit areas, and propose issuance of directives which will result in program savings.

D. Social Services (Title XX) -- Purchase of Services

The first Annual Report discussed the problems involved in the purchase of service by State agencies under Title XX. Contracting or purchasing of services has become the prevailing method of service delivery -- more than 65% of all Title XX dollars are expended through purchases from public (including other State agencies) or private agencies.

We have identified three significant weaknesses:

1. Contracting methods and procedures;
2. Cost allocation and rates of payments to providers;
3. Staff monitoring.

A management review presently being undertaken by OIG of 10 States with the largest Title XX expenditures indicates that they have made progress in addressing their inadequacies. Most of the States included in the management review have developed standardized procedures and manuals which specify what is required in order to be in compliance with Federal contractual and procurement standards and their own State administrative procedures. Some of the improved methods and procedures include:

- Standardization of contracts, reduces ambiguous language and facilitates more efficient execution and monitoring of contractual arrangements.
- Preliminary review of potential providers to ensure fiscal capability to carry out required bookkeeping, accounting, and recording requirements as specified in the contracts.
- Development of error-and-abuse-prone profiles for use in the contracting process.

In spite of this progress, however, problems still exist with regard to the State agencies' ability to provide technical assistance (TA) to small providers, and the providers need to develop simple

accounting and budgeting techniques to meet contractual requirements. Two problems slow this process: (1) lack of staffing on the State level and (2) Title XX training funds cannot be used to train other than direct delivery staff in provider agencies. Modification of the Title XX statute and Federal TA rules (e.g., supplementation of State staff efforts, regional conferences) would alleviate this problem. Equally important, however, is the need for the Federal Government to help the States develop procedures to handle fraud and abuse in social services. Our review indicated only three States have specific procedures.

Another major problem was the weakness in methods of cost allocation by the provider agency and thus in the development of reasonable rates. States have made some progress in developing uniform rates, based on the prevailing rate in a particular geographic area. Little examination has been made (except at the time of an audit) of what activities have been included in the rate and it is unclear how indirect costs should affect the establishment of "reasonable" rates. This is the area where the greatest amount of abuse has been found. When there are multiple funding sources with overlapping criteria for a particular service, such as family planning, indirect costs are often inappropriately allocated.

The third problem in which some progress has been made is in the quality and quantity of monitoring staffs. States have reorganized and redeployed staff to monitor purchase of service agreements; however, units remain understaffed and untrained. Several organizational patterns have emerged:

1. Generalized Unit

These units are usually centrally or regionally based; staff monitor all procurement agreements or contracts. They are usually responsible to the financial/comptroller division of the State agency and therefore monitor all contracts funded through that agency.

2. Specialized Unit

These units are usually at the bureau rather than the operational level and are attached as staff to a program division (e.g., Adult Services, Children and Youth). These units monitor contracts in a particular program area, only. Their focus is program, rather than fiscal requirements.

3. Generalized/Crisis

These are probably the least effective. They are generally centralized units whose staff perform procurement functions, but who also, on a request or crisis basis, monitor purchase of service contracts.

4. Auditors

These are State auditors who may or may not be a part of the single State agency, but audit all State contracts on an annual basis. This is not very effective because the audit usually does not coincide with the contract renewal process.

5. Some combination of the above. Most effective when coordinated, but also most expensive.

In addition to the management problems enumerated in the first Annual Report, current audits have recommended financial adjustments of \$6.3 million in four areas:

1. Ineligible Clients (\$1,125,000);
2. Ineligible Services (\$278,191);
3. Ineligible Expenditures (\$4,515,775); and
4. Ineligible Matching Dollars (\$397,723).

A handbook, "Federal Financial Participation in the Title XX Program" to be published in May 1979, should assist the States in reducing the amounts erroneously claimed. Additionally our upcoming OIG

report on Title XX management will address many of the management inefficiencies together with recommendations for their solutions.

E. Proposed Regulations Permitting Debarment in Grant Programs

The Inspector General strongly supports the proposed regulations. They would affect all HEW discretionary grant and other financial assistance programs by permitting debarment of organizations and individuals whose past conduct evinces a lack of business integrity which directly affects their present responsibility to administer Federal funds. Debarment would be for a specific period of time, commensurate with the reason for debarment, except that debarment for discriminatory practices would be for an indefinite period until the cause is corrected. The regulations would be promulgated under 5 U.S.C. 301, the general authority of the Department to issue regulations.

The proposed regulations would further the overall HEW goal of assuring that funds awarded to carry out HEW assistance programs are expended solely for program purposes, by removing from eligibility fiscally irresponsible organizations and individuals. The key provisions would:

- Provide eight specific causes for debarment from financial assistance under HEW programs, including conviction of criminal offenses, showing lack of business integrity, and violation of the terms and conditions of previous awards.
- Provide all affected parties with an opportunity for a hearing, before debarment action is taken.
- Authorize suspension, pending debarment or other proceedings, for a limited period of time not to exceed 18 months, where there are compelling reasons to protect the interests of the Government. Hearings on suspension would also be provided upon request.

- Provide for publication of the names of debarred and suspended organizations and individuals in the Federal Register (comment is being specifically requested on alternative methods of informing affected members of the public such as grantees).

F. Assessment, Plans, and Recommendations

We believe that at this time the Department has identified the generic problems associated with contracts and grants management. At the direction of and with the strong support of the Secretary, the Assistant Secretary for Management and Budget and the Heads of Principal Operating Components, the Department is moving to correct the problems. A good start has been made in strengthening the Office of the Deputy Assistant Secretary for Grants and Procurement, instituting a program of review and oversight, and inclusion of a set of objectives in the Secretary's Management Initiatives Tracking System. Yet much remains to be done. We plan to maintain an overview of future progress and to conduct independent audits and reviews of these operations.

We believe the following matters warrant special attention in the coming year:

1. Contracting and grant practices throughout the Department should be examined by the Assistant Secretary, Management and Budget, to test the conclusions reached in OIG reviews, namely:
 - Special measures and controls are needed to separate contracting operations and peer reviews from program influence -- in order to assure that they are impeccably free from favoritism or cronyism, and that competition is obtained wherever feasible.
2. The General Counsel should assure that all new officials of the Department and others in very sensitive roles are given counsel and assistance to avoid their becoming involved in conflict-of-interest situations.

3. The proposed debarment regulation should be issued promptly to enable the Department to avoid, when appropriate, continued awards to programs or individuals who have demonstrated fiscal irresponsibility in administering discretionary grant or other financial assistance programs.
4. HEW should continue to work aggressively with the Office of Management and Budget and other appropriate organizations to improve the accountability of colleges and universities for Federal contract and grant funds. Prompt application of appropriate sanctions should be instituted against institutions who fail to correct systems deficiencies.
5. The "double payment issue" affecting Public Health Service grants should be addressed and resolved in the current year.
6. Special attention to improving the management of Title XX programs should be applied this year. An OIG report on the matter will be issued in the near future, and an OHSD technical assistance manual will become available in May.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

APPENDIX A
Page 1

May 18, 1978

MEMORANDUM

TO : The Secretary
Through: ES _____

FROM : The Inspector General

SUBJECT : Revision and Clarification of "Best Estimates" of Losses due to Fraud, Abuse, and Waste in HEW Programs

On March 31, 1978, we reported to you and to the Congress an inventory of "best estimates" collected from numerous sources, regarding the losses believed to be occurring in HEW programs. We stressed in the annual report:

- That the estimates range from well-established and scientific error measurement systems (such as those in AFDC and Medicaid) to simply the judgments of well-informed spokesmen in the Department, the Congress and outside organizations.
- That there might well be duplications or double counting (we have, in fact, found several).
- That the estimates were not complete.
- That the reader should recognize that the estimates do not represent monies that are fully recoverable.

We further stressed in the report that "fraud and abuse," as such, was the smallest part of the losses. In fact, only 15 percent of the estimates were attributed to unlawful, willful misrepresentation (fraud) or excessive services and program violations (abuse).

Despite these caveats, we have been distressed that the press and the public in many cases have construed the estimates to be totally attributable to fraud and abuse. Further, there has been an assumption that the entire amount of the estimates can be recovered simply by stopping wasteful practices. This, of course, is simply not true.

To put the matter into perspective, we have worked with Mr. Schaeffer and the Principal Operating Component Heads to obtain any additional information which they could furnish to help us refine the estimates, and to further analyze the extent to which reductions are possible under their current statutes and budgets.

As a result of these reviews, the estimates have been reduced by \$838 million (as explained below). The amounts on which significant action can be taken under present authorities and resources are less than half of the total. With respect to these amounts -- \$2.7 billion -- we are pleased to note that the cost reduction goals which have been developed by the POCs, working with Mr. Schaeffer, are designed to produce significant savings in 1979, 1980, and 1981.

REDUCTION IN LEVEL OF ESTIMATES
BY \$838 MILLION

	(Million)	
	<u>Original</u> <u>Estimates</u>	<u>Revised</u> <u>Estimates</u>
Low	\$ 6,333	\$ 5,521
High	7,370	6,532

Of the \$838 million in reductions, \$431 million result from errors made by the OIG in interpreting the data. The most important source -- over \$200 million -- is double counting of certain of the losses in the AFDC, SSI, and Guaranteed Student Loan programs. Quality Control measurement had already reflected losses which we separately reported as "fraud and abuse" in the AFDC program.

Also, we incorrectly reported "provider overpayments" under Medicare as a total loss of \$141 million. We later found that this amount is substantially all recovered in subsequent collections.

The remaining one-half of the reduction is attributable to new information furnished to us by the POCs in several areas.

In summary, the original and revised estimates are as follows:*

<u>Program</u>	<u>Original Estimates</u>	<u>Revised Estimates</u>
Health Cost	4,489-4,819	3,875-4,193
AFDC	635	468
SSI	333	292
SSA	159-866	173-866
Social Services	(88)	See "Unmet Audit Needs"
SFA Programs	345	321
ESEA Title I	97	97
Indirect Cost Negotiations	102	107
Unmet Audit Needs	<u>173</u>	<u>188</u>
TOTAL	6,333-7,370	5,521-6,532

*These are further discussed in my memorandum of April 30, 1978, a copy of which is attached.

LESS THAN 50 PERCENT OF ESTIMATES ARE AMOUNTS ON
WHICH SIGNIFICANT REDUCTION ACTIONS CAN BE TAKEN
UNDER PRESENT AUTHORITIES AND RESOURCES

We classified each of the estimates as to:

--Those on which savings can be realized now
under present authorities and approved budgets
(assuming FY 1979 budget requests are granted).

--Those where action can be taken if additional
resources are provided in the FY 1980 budget.

--Those where further action will require new
statutory authority.

--Those where further study and research is
needed to assess the extent of losses and
to develop new knowledge on how to cope with
the problems.

We are summarizing below our findings under these
four headings:

	<u>Extent To Which HEW Can Make Savings</u>	<u>Estimated Losses FY 1977</u>
A. Now, under present authority and re- sources		2,741
B. In 1980 and beyond, using existing au- thority, but re- quiring more re- sources		491
C. When Congress passes new legislation		1,217
D. Uncertain until fur- ther studies are com- pleted		<u>1,072-2,083</u>
TOTAL		5,521-6,532

A. LOSSES WHICH CAN BE SIGNIFICANTLY ATTACKED
UNDER EXISTING AUTHORITIES AND RESOURCES

	<u>Sources of Loss</u>	<u>Amount</u> (Million)	<u>Comment</u>
1.	Medicaid payments to ineligible; third-party liability; erroneous payments	\$ 1,100	
2.	Medicaid fraud and abuse, including unnecessary nursing home costs	668	Number is incomplete and probably low.
3.	Medicare cost report reviews	17	
4.	Unnecessary hospital stays	124	Based on PSRO review.
5.	SSI--erroneous payments	292	
6.	AFDC--erroneous payments	206	See further losses requiring additional resources to attack. (Section B below)
7.	SFA Programs	203	Same as above
8.	ESEA Title I	53	Same as above
9.	Indirect Cost Negotiations	23	Same as above
10.	Unmet Audit Needs	<u>55</u>	Same as above
	TOTAL	\$ 2,741	

B. ADDITIONAL LOSSES WHICH CAN BE ATTACKED IF
MORE RESOURCES ARE PROVIDED IN FY 1980

	<u>Sources of Loss</u>	<u>Amount</u> (Million)	<u>Comment</u>
1.	AFDC--erroneous payments	112	The additional resources are needed for technical assistance and management reviews of State systems.
2.	SFA Programs	118	Additional staffing is required to support expanded collection efforts.
3.	ESEA Title I	44	Provides for increased monitoring and auditing.
4.	Indirect cost negotiations	84	Provides for increased staff to support negotiations.
5.	Unmet Audit Needs	<u>133</u>	Provides increased audit effort. (Now only about 50% of desired level).
	TOTAL	491	

C. ADDITIONAL LOSSES WHICH CAN BE ATTACKED IF
NEW LEGISLATION IS ENACTED

<u>Sources of Loss</u>	<u>Amount (Million)</u>	<u>Comment</u>
1. Medicaid/Medicare Common Audit	*41	Provides for common audits of hospitals, nursing homes, and HMOs. Some States do not participate now..
2. Medicare--Renal Dialysis	**92	Pending legislation will permit increased home dialysis and improved cost data.
3. Excessive Hospital Beds	894	Legislation now pending provides closure and conversion. Further authority may be desired to restrict reimbursement when new construction is denied.

*NOTE: As of 6/5/78 the proposal was pending OMB clearance.

**NOTE: As of 6/5/78 this bill had passed the Congress and was pending Presidential action.

<u>Sources of Loss</u>	<u>Amount (Million)</u>	<u>Comment</u>
4. Excessive Physi- cian Costs	40	Legislation pend- ing deals with "ancillary hos- pital costs."
5. AFDC	150	Provides revisions in HR 7200 to strengthen State Administration.
TOTAL	\$ 1,217	

D. AREAS REQUIRING FURTHER STUDY BEFORE ESTABLISHMENT
OF LOSS ESTIMATE BY POCs AND POTENTIAL COST RE-
DUCTIONS

The remaining four items involve large areas of potential loss and savings, about which considerable uncertainty exists. Hence, further study or re-
search is needed.

<u>Sources of Loss</u>	<u>Amount (Million)</u>	<u>Comment</u>
1. Excessive Nurs- ing Differential	185	HCFA reports that a preliminary study is in process. Cur- rent Talmadge bill may eliminate the problem.
2. Unnecessary Surgery	282 to 600	Amount is under study. \$282 mil- lion is the first time HCFA has esti- mated a specific number. The second opinion program may help.

	<u>Sources of Loss</u>	<u>Amount</u> (Million)	<u>Comment</u>
3.	Unneeded and Repeat X-Rays	432	Opportunities for cost reduction depend upon long-range improvements through training of technicians, development of better criteria to guide X-Ray practices. Involves PSRO reviews. Will be difficult to track.
4.	SSA Title II Error Measurement	173-866	System will not begin operation until October. Range of error losses may exceed \$1 billion. In the meantime, any amount is speculative.
	TOTAL	1,072-2,083	

COMMENTS ON THE RECOVERABILITY OF ESTIMATED LOSSES

In my judgment, the complexity and difficulty of many of the losses cited in the inventory far exceed those of other Federal agencies. With many millions of recipients receiving monthly payments -- and with eligibility systems administered through hundreds of offices, many under State and local control -- and with eligibility dependent upon the willingness of individuals to report changes in their status -- errors and losses are inevitable.

I have made an initial review of the loss reduction goals thus far submitted by the Principal Operating

Components. I feel that their achievement over the next three fiscal years would be an outstanding accomplishment. I am particularly impressed with the fact that initiatives based on "present authorities and resources" are aimed at saving almost two-thirds of the losses which can now be attacked. It is the goal of this Office to contribute to this achievement through expanded audit, aggressive investigation of fraud, and practical ideas for improving systems of detecting errors and preventing abuses.

Thomas D. Morris

Attachments

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

April 30, 1978

TO : The Secretary
Through: ES _____

FROM : The Inspector General

SUBJECT : Revised Best Estimates of
Fraud, Abuse and Waste

During the week of April 24, 1978, we reviewed each of the estimates with the POCs and made a number of revisions as detailed in Attachments A, B, and C.

The resulting estimates are revised downward as follows:

	(Millions)	
	<u>Original Estimates</u>	<u>Revised Estimates</u>
Low	\$ 6,333	\$ 5,521
High	7,370	6,532

The details of the reduction (Attachment B) show that

--Half (\$431) are the result of OIG errors
due in part to unintended double counting.

--Half (\$407) are due to new data presented
by the POCs this week.

There are remaining differences with HCFA and are shown in Attachment C.

We are prepared to discuss these revisions at our hearing before Senator Nunn during the week of May 21.

Thomas D. Morris

Attachments

cc: Mr. Champion
Mr. Schaeffer

OFFICE OF INSPECTOR GENERAL

REVISION IN "BEST ESTIMATES" OF
FRAUD, ABUSE, AND WASTE
FY 1977 (MILLIONS)

PROGRAMS AND ITEMS	: ORIGINAL: : ESTIMATE:	: REVISED: : ESTIMATE:	: **REASON :	: COMMENT :
Medicaid				
1. Payments to Ineli- gibles, Third-Party Liability Losses, Erroneous Payments (Page 77; Items 1, 3, 4)	\$ 770- 1,100	\$1,100	No Change	POC and IG agree
2. Fraud and Abuse (Page 77; Item 2)	468	468	No Change	POC recommends \$100 million. All agree num- bers are "soft." IG considers low.
3. Common Audit (Page 77; Item 5)	50	35	2	
4. Quarterly Reviews and Audit Excep- tions	35	*	-	*See "Unmet Audit Needs"

**REASONS

- 1--OIG Error or Misunderstanding
- 2--New Data Presented by POC Week of 4/24/78

PROGRAMS AND ITEMS	: : ORIGINAL: : ESTIMATE:	: : REVIS : ESTIMATE:	: : ** REASON :	: : COMMENT :
<u>Medicare</u>				
1. Excess Nursing (Page 82; Item 1)	\$ 185	\$ 185	No	POC disagrees until prelimi- nary study (in process is completed
2. Renal Dialysis (Page 82; Item 2)	153	92	2	POC recommends \$55 million pending com- pletion of cost studies
3. Provider Overpay- ments Recovered (Page 82; Item 3)	141	0	1	All recoveries removed from "Best Estimates"
4. Cost Report Reviews (Page 82; Item 4)	16	17	2	
5. Common Audit (Page 82; Item 5)	8	6	2	POC and IG agree
6. Audit Exceptions (Page 82; Item 6)	3	*		*See "Unmet Audit Needs"

**REASONS

- 1--OIG Error or Misunderstanding
- 2--New Data Presented by POC Week of 4/24/78

PROGRAMS AND ITEMS	: : ORIGINAL: : ESTIMATE:	: : REVISD: : ESTIMATE:	: : **REASON: :	: : COMMENT: :
<u>Medicaid/Medicare</u>				
1. Excessive Hospital Beds (Page 87(a))	\$1,130	\$ 894	2	POC and IG agree
2. Unnecessary Surgery (Page 87(b))	655	282-600	2	POC now proposes \$282
3. Unnecessary Hospital Stays (Page 87(c))	124	124	No Change	POC agrees
4. Excessive Physician Cost (Page 88(d))	73	40	2	HCFA legislative proposal: "Ancil- lary Hospital Services"
5. Unneeded X-Rays (Page 89(a))	400	400	No Change	POC and IG agree
X-Rays - Genetic Effects (Page 89(b))	84	0	1	Savings very long-range
Repeat X-Rays (Page 89(c))	32	32	No Change	POC and IG agree
6. Nursing Home Costs (Page 90)	200	200	No Change	POC and IG agree
TOTAL HEALTH CARE	\$4,489 to 4,819	\$ 3,875 to 4,193		POC proposes 3,285

**REASONS

- 1--OIG Error or Misunderstanding
- 2--New Data Presented by POC Week of 4/24/78

PROGRAMS AND ITEMS	: ORIGINAL: : ESTIMATE:	: REVISED: : ESTIMATE:	: **REASON :	: COMMENT :
<u>AFDC</u>				
1. Erroneous Payments (Page 91; Item 1)	\$ 490	\$ 462	2	POC and IG agree
2. Fraud and Abuse (Page 91; Item 2)	145	6	1	Most fraud and abuse covered in Quality Control Measures. Agree on double dipper loss of \$6 mil- lion plus.
3. Quarterly Reviews and Audit Excep- tions (Page 91; Items 3, 4)	34	*	-	*See "Unmet Audit Needs"
<u>SSI</u>				
1. Erroneous Payments (Page 92; Item 1)	310	292 ***	2	POC and IG agree
2. Overpayments to Nursing Home Resi- dents (Page 92; Item 2)	23	0	1	Covered in SSI Quality Control
3. Audit Exceptions (Page 92; Item 3)	1	*	-	*See "Unmet Audit Needs"

**REASONS

1--OIG Error or Misunderstanding

2--New Data Presented by POC Week of 4/24/78

***In March 1979 this estimate was reexamined with SSA and restored to
\$310 million.

PROGRAMS AND ITEMS	: ORIGINAL: : ESTIMATE:	: REVISED: : ESTIMATE:	: **REASON :	: COMMENT
Income Security SSA				
1. Erroneous Payments (Page 98; Item 1)	\$159-866	\$173-866	2	\$173 is estimated non-recovery of "known" overpay- ments in 1977. \$866 is estimate of unidentified overpayments not recovered in 1977. (QC system in process)
2. Audit Exceptions	1	*	-	*See "Unmet Audit Needs"
TOTAL SSA	\$ 1,127 to 1,834	\$ 933 to 1,626		POC agrees with 933 and probabil- ity of higher number when QC system is opera- tional

**REASONS

- 1--OIG Error or Misunderstanding
- 2--New Data Presented by POC Week of 4/24/78

PROGRAMS AND ITEMS	:	ORIGINAL:	:	REVISED:	:	** REASON	:	COMMENT
	:	ESTIMATE:	:	ESTIMATE:	:		:	

Social Services

1. Quarterly Reviews and Audit Excep- tions (Page 93; Item 1, 2)	\$ 88	\$ *	-	*See "Unmet Audit Needs"
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Office/Education

1. BEOG (Page 94; Item 1)	109	109	-	POC and IG agree on 1977. Greater waste identified in 1978
2. Campus Based Program (Page 94; Item 2)	49	69	2	POC and IG agree
3. GSL (Page 94; Item 3)	187	143	1	Fraud and abuse double counted in defaulted loans.
4. Audit Exceptions (Page 94; Item 4)	11	*	-	*See "Unmet Audit Needs"
5. ESEA Title I (Page 100)	97	97	-	POC and IG agree
 TOTAL OE	 \$ 442	 \$ 418	 -	 POC and IG agree

**REASONS

- 1--OIG Error or Misunderstanding
- 2--New Data Presented by POC Week of 4/24/78

PROGRAMS AND ITEMS	: ORIGINAL: : ESTIMATE:	: REVISED: : ESTIMATE:	: ** REASON :	: COMMENT
Indirect Costs (Page 99)	\$ 102	\$ 107	-	Revised to reflect potential <u>new</u> recoveries
Unmet Audit Needs	173	188	-	All agreed upon recoveries deleted from estimates

RECAPITULATION

Health Care	4,489 to 4,819	3,875 to 4,193		
SSA	1,127 to 1,834	933 to 1,626		
HDS	(88)	*		Included in "Unmet Audit Needs"
OE	442	418		
Indirect Costs	102	107		
Unmet Audit Needs	173	188		
	\$ 6,333 to 7,370	\$ 5,521 to 6,532		

**REASONS

- 1--OIG Error or Misunderstanding
- 2--New Data Presented by POC Week of 4/24/78

EXPLANATION OF \$838 MILLION REDUCTION
IN HIGH "BEST ESTIMATES"

<u>ITEM</u>	<u>IG ERROR</u>	<u>NEW DATA SUBMITTED BY POC</u>	<u>TOTAL</u>
Medicaid Common Audit		- 15	- 15
Renal Dialysis		- 61	- 61
Provider Overpayment	-141		-141
Medicare Cost Reports Reviews		+ 1	+ 1
Medicare Common Audit		- 2	- 2
Excess Hospital Beds		-236	-236
Unnecessary Surgery		- 55	- 55
Excessive Physician Costs		- 33	- 33
X-Rays Genetic Defects	- 84		- 84
AFDC Erroneous Payments		- 28	- 28
AFDC Fraud and Abuse	-139 (Number is ok but double counted)		-139
SSI Erroneous Payments		- 18	- 18
SSI Overpayments to Nursing Home Residents	- 23 (Number is ok but double counted)		- 23

APPENDIX A
ATTACHMENT B
Page 2

APPENDIX A
ATTACHMENT B
Page 2

<u>ITEM</u>	<u>IG ERROR</u>	<u>NEW DATA SUBMITTED BY POC</u>	<u>TOTAL</u>
OE Campus Based Programs		+ 20	+ 20
OE-GSLP Fraud and Abuse	- 44 (Number is ok but double counted)		- 44
Indirect Costs		+ 5	+ 5
Unmet Audit Needs		+ 15	+ 15
	\$431	407	838

REMAINING DIFFERENCES BETWEEN
HIGH OIG AND POC ESTIMATES

<u>HEALTH CARE</u>	<u>OIG REVISED</u>	<u>POC REVISED</u>	<u>DIFFERENCES</u>	<u>COMMENT</u>
1. Fraud & Abuse	468	100	368	HCFA agrees problem exists but cannot price out
2. Excess Nursing Differential	185	-	185	HCFA would need comprehensive study to price out. Preliminary study in process.
3. Renal Dialysis	92	55	37	Questions are: percent of home dialysis in 1977; 10%, 14%, or 20%; cost base used.
4. Unnecessary Surgery	282 to 600	282	318	Problems are: (1) offset for medical care in lieu of surgery; (2) incidence of unnecessary surgery.
			\$908	

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I.G. ORIGINAL (1977) ESTIMATES OF LOSSES WHICH CAN BE ATTACKED
WITH PRESENT AUTHORITIES AND RESOURCES

APPENDIX B
PART 1
Page 1 of 4

Items	I.G.'s :		1979 Goals		FY 1980	
	Original :	Estimate :	Original	Revised :	Goals	Goals
<u>A. Health Care Financing</u>						
1. Medicaid payments to in-eligible; third party liability, erroneous payments	\$ 1,100		\$ 265	\$ 265	\$	524
2. Medicare/Medicaid fraud and abuse, including unnecessary nursing home costs	668		93	93		103
3. Medicare cost report review	17		16	16		16
4. Medicare-Renal Dialysis	b/		22	22		40
5. Medicare-reimbursement limitations (Section 223)						
a. Routine hospital costs	a/		36	35		50
b. Excessive home health provider and skilled nursing facilities costs	a/		--	3		105
c. Purchased inhalation therapy	c/		13	13		19
6. Unnecessary hospital stays	124		86	86		103

APPENDIX B
PART 1
Page 1 of 4

Items	I.G.'s :				FY 1980			
	Original :	Estimate :	1979 Goals	Revised :	Original	Revised :	Goals	
7. Brand name versus generic drugs	\$	c/	\$	--	\$	11	\$	11
8. Uneconomical purchases of hearing aids and eyeglasses		c/		--		--		3
9. Medicaid Quality Control Penalties		a/		--		--		14
10. Limitations on malpractice insurance premiums		a/		--		10		310
TOTAL HEALTH CARE FINANCING								
	\$ 1,909		\$ 531		\$ 554		\$ 1,298	
B. Student Financial Assistance								
1. Collection of defaulted Federally Insured Loans	\$ 72		\$ 71		\$ 68		\$ 70	
2. Validation of BEOG applications	109		165		300		200	
3. NDSL defaulted loans/excess cash	22		10		10		94	
4. FISL preclaims assistance to lenders	a/		11		11		--	

Items	: I.G.'s :				: FY 1980 :			
	: Original :		: 1979 Goals :		: Original :		: Revised :	
	: Estimate :		: Original :		: Original :		: Goals :	
5. Institutional program reviews	\$	a/	\$	27	\$	27	\$	30
TOTAL STUDENT FINANCIAL ASSISTANCE	\$	203	\$	284	\$	416	\$	394
C. Income Maintenance								
1. SSI--erroneous payments	\$	310	\$	100	\$	105	\$	135
2. AFDC--erroneous payments		206		89		25		50
a. Project Match	c/			12		12		12
3. RDSI--overpayment increased recovery	a/			--		34		--
4. AFDC--financial management reviews		25		--		10		20
5. SSA/RSI student benefit recontact	a/			--		100		25 (one-time recovery)
6. SSI/Disability Ineligibles	a/			--		1		2
TOTAL INCOME MAINTENANCE	\$	541	\$	201	\$	287	\$	244

Items	: I.G.'s :				
	: Original :		1979 Goals		: FY 1980
	: Estimate :	Original	Revised	: Goals	
D. <u>ESEA Title I</u>	\$	53	\$ 22	\$ 22	\$ 34
E. <u>Other</u>					
1. Indirect cost negotiations	\$	23	\$ 15	\$ 15	\$ 35
2. Unmet audit needs		30	15	15	30
3. OI investigations, fines, and recoveries		c/	10	10	15
TOTAL OTHER	\$	53	\$ 40	\$ 40	\$ 80
GRAND TOTAL	\$	2,759	\$ 1,078	\$ 1,319	\$ 2,050

a/ Not covered by IG.
b/ Legislation enacted.
c/ IG identified without an estimate.

REVISED (1978) ESTIMATE OF LOSSES WHICH CAN BE
ATTACKED UNDER PRESENT AUTHORITIES AND RESOURCES

APPENDIX B
PART 2
Page 1 of 6

Items	: I. G. Estimate of Losses :			Comment
	: (Millions) :			
	: Original	Revised :		
	: (1977)	(1978) :		

A. Health Care

1. Medicaid payments to ineligible; third party liability; erroneous payments	\$ 1,100	\$ 694	\$406 million allocated to "Requires Further Study" due to uncertainty of reducing errors nationwide below 4%.
2. Medicare/Medicaid fraud and abuse, including unnecessary nursing home costs	668	620	\$55 million allocated to "Additional Resources Required." 30 positions requested in 1980 Budget equals 8% growth for Office of Program Integrity. \$7 million added to Medicare goal.
3. Medicare-Renal Dialysis	--	40	\$52 million allocated to "Additional Resources Required" -- 11 positions. Total loss of \$92 was originally under "Legislation Required" -- enacted in 1978.
4. Unnecessary hospital stays	124	124	--

APPENDIX B
PART 2
Page 1 of 6

Items	: I. G. Estimate of Losses :			Comment
	: Original	: Revised	: :	
	: (1977)	: (1978)	: :	
5. Medicare cost re- port review	\$ 17	\$ 16	--	
6. Purchased inhala- tion therapy	--	19		Was discussed in first An- nual Report but no value was assigned.
7. Brand name versus generic drugs	--	11		Same as above.
8. Excessive home health provider and skilled nursing facilities costs	--	105		Same as above.
9. Uneconomical pur- chases of hearing aids and eyeglas- ses	--	3		Same as above. However, the clinical laboratories legis- lation would offer a greater range of opportunities of this type.
10. Reduce routine hos- pital costs (Sec- tion 223)	--	50		New POC initiative. Regula- tions being issued.

Items	: I. G. Estimate of Losses :		Comment
	: (Millions)	: Revised :	
	: Original	: (1978) :	
	: (1977)		
11. Medicaid quality control penalties	--	14	New POC initiative.
12. Limits on mal-practice insurance premiums	--	310	New POC initiative.
TOTAL HEALTH CARE FINANCING	\$ 1,909	\$ 2,006	
B. Income Maintenance			
1. AFDC erroneous payments	\$ 206	\$ 110	Allocates total loss of \$468 million as follows: . Attack now.....\$110 . Added resources needed..... 50 . New legislation... 92 . Further Study..... 216* (Based on uncertainty of reducing national error rate below 4%.)

*Represents the current best estimate based upon presently available information and knowledge. The tolerance levels reflected in this estimate will be modified as required to reflect the information developed in the study of the reasonableness of the proposed payment error rate goals.

Items	: I. G. Estimate of Losses :			Comment
	: (Millions)	: Original	: Revised :	
		: (1977)	: (1978) :	
2. Project Match	--	\$	12	New goal developed in 1978 based on national AFDC match versus Federal rolls and against all State rolls.
3. SSI erroneous payments	\$ 310		170	Allocates \$140 million to "Requires Further Study." Based on uncertainty of reducing national error rate below 3%.
4. AFDC administrative cost reviews	25		25	Positions have been furnished to permit increased cost recovery.
5. SSA/RSI student benefit recontact	--		50	Total estimated one-time loss is \$150 million. 1979 recovery target is \$100 million.
6. SSI/Disability ineligibles	--		3	Estimate based on SSA study in State of Washington.
TOTAL INCOME MAINTENANCE	\$ 541	\$	370	

Items	: I. G. Estimate of Losses :			Comment
	(Millions)	Original	Revised :	
		(1977)	(1978)	
C. <u>Student Financial Assistance Programs</u>	\$ 203	\$ 394		Potential found to be far greater than initially estimated.
D. <u>Elementary and Secondary Education Act, Title I</u>	\$ 53	\$ 97		Statutory authority recommended last year was granted. Increased State administration funds.
E. <u>Administrative</u>				
1. Indirect cost negotiations	\$ 23	\$ 43		\$64 million is allocated to "Additional Resources Required." An additional 15 positions are desired in FY 1980, and 50 in FY 1981.
2. Unmet audit needs	30	30		\$133 million allocated to "Additional Resources Required."
3. Interest on funds found by audits to be misspent by grantees.	--	17		New I.G. initiative. The amount misspent is estimated to be \$144 million. At a 6% interest rate, recovery would be \$17 million annually, based on two years of misspending per average case. At current Treasury borrowing rate recovery might reach \$25 million.

Items	: I. G. Estimate of Losses :			Comment
	(Millions)	Original	Revised	
		(1977)	(1978)	
4. I.G. fines, res- titutions, re- coveries, and savings from criminal investi- gations	\$ --	\$ 15		This estimate was made as a crude target in 1978. Includes possible civil litigation recoveries.
TOTAL ADMINIS- TRATIVE	\$ 53	\$ 105		
GRAND TOTAL	\$ 2,759	\$ 2,972		

REVISED 1978 ESTIMATES OF LOSSES WHICH CAN BE ATTACKED UNDER PRESENT
AUTHORITIES COMPARED WITH HEW SAVINGS GOALS FY 1980

APPENDIX B
PART 3
Page 1 of 3

Items	Inspector General's Revised (1978) Estimates (Appendix B-2)	FY 1980 Savings Goals (Appendix B-1)	Potential Savings Above FY 1980
A. Health Care Financing			
1. Medicaid payments to ineligibles; third party liability, erroneous payments	\$ 694	\$ 524	\$ 170
2. Medicare/Medicaid fraud and abuse, including unnecessary nursing home costs	620	103	517
3. Medicare cost report reviews	16	16	--
4. Medicare-Renal Dialysis	40	40	--
5. Medicare-reimbursement limitations (Section 223)			
a. Routine hospital costs	50	50	--
b. Excessive home health provider and skilled nursing facilities costs	105	105	--
c. Purchased inhalation therapy	19	19	--

APPENDIX B
PART 3
Page 1 of 3

Items	Inspector General's Revised (1978) Estimates : (Appendix B-2) :	FY 1980 Savings Goals : (Appendix B-1) :	Potential Savings Above FY 1980 :
6. Unnecessary hospital stays	\$ 124	\$ 103	\$ 21
7. Brand name versus generic drugs	11	11	--
8. Uneconomical purchase of hearing aids and eyeglasses	3	3	--
9. Medicaid Quality Control Penalties	14	14	--
10. Limitations on malpractice insurance premiums	310	310	--
TOTAL HEALTH CARE FINANCING	\$ 2,006	\$ 1,298	\$ 708
B. Student Financial Assistance	\$ 394	\$ 394	\$ --
C. Income Maintenance			
1. SSI--erroneous payments	\$ 170	\$ 135	\$ 35
2. AFDC--erroneous payments	110	50	60
a. Project Match	12	12	--

Items	Inspector General's Revised (1978) Estimates (Appendix B-2)	FY 1980 Savings Goals (Appendix B-1)	Potential Savings Above FY 1980
3. AFDC--financial management reviews	\$ 25	\$ 20	\$ 5
4. SSA/RSI student benefit recontact	50	25	25
5. SSI/Disability Ineligibles	3	2	1
TOTAL INCOME MAINTENANCE	\$ 370	\$ 244	\$ 126
ESEA Title I	\$ 97	\$ 34	\$ 63
E. Administrative			
1. Indirect cost negotiations	\$ 43	\$ 35	\$ 8
2 Unmet audit needs	30	30	--
3 Interest on misspent grant funds	17	--	17
4. OI investigations, fines, recoveries	15	15	--
TOTAL ADMINISTRATIVE	\$ 105	\$ 80	\$ 25
GRAND TOTAL	\$ 2,972	\$ 2,050	\$ 922

CONSOLIDATED SUMMARY OF FUTURE OPPORTUNITIES FOR SAVINGS
(Millions)

Items	:"A":	Steps Required Before Secretary Can Act			:"D":
		:"B":	:"C":	:"D":	
		Congress :	Congress :	Program Managers :	
		Provide :	Enact New :	Make Further :	
		More :	Program :	Studies :	
		Resources :	Legislation :		
		:(Appendix B-3):			
A. Health Care					
Financing					
1. Medicaid pay-ments to in-eligible; third party liability; erroneous pay-ments	\$ 170	\$ --	\$ --	\$ 406	Studies required to ascertain feasibility of error rate re- ductions nationwide below 4 percent
2. Medicare/Medi- caid fraud and abuse	517 (HCFA recom- mended \$300 million)	55 (30 new posi- tions)	--	--	
3. Medicare-Renal Dialysis	--	52 (11 positions)	--	--	
4. Mandatory common audit	--	--	**41 (\$34 Million can be saved in 1980)	--	

*Beyond goals set for FY 1980, See Appendix B, Part 3

**Items contained in FY 1980 budget plan and part of the \$2.9 billion legislative savings program.

Items	Steps Required Before Secretary Can Act			
	"A"	"B"	"C"	"D"
	Under Present Authorities* : (Appendix B-3) :	Congress Provide More Resources :	Congress Enact New Program Legislation :	Program Managers Make Further Studies :
5. Unnecessary hospital stays	\$ 21	\$ --	\$ --	\$ --
6. Excess hospital beds	--	--	**26	1,090
			Per year can be saved in a demonstra- tion project for which an appropriation of \$30 million is required.	Continuing study will be required over a long period. The realization of savings is uncertain.
7. Ancillary hospital services (excess physician costs)	--	--	**55	--
8. Excess nursing differential	--	--	--	185
				Validity of this item has been challenged and outlook for pay- off is poor, although further study is needed.

*Beyond goals set for FY 1980, See Appendix B, Part 3.

**Items contained in FY 1980 budget plan and part of the \$2.9 billion legislative savings program.

Items	Steps Required Before Secretary Can Act			
	"A"	"B"	"C"	"D"
	Under Present Authorities* (Appendix B-3)	Congress Provide More Resources	Congress Enact New Program Legislation	Program Managers Make Further Studies
9. Unnecessary surgery	\$ --	\$ --	\$ --	\$ 282-600 HCFA proposes lower estimate. Difficult to track savings. Second opinion program is proceeding well.
10. Unnecessary X-Rays	--	--	--	432 Problem is how to track. Near Term savings estimates \$1 to 6 million. Criteria being developed for skull, chest, pelvic X-rays.
11. Excessive payments for laboratory services	--	--	51 (New) See Appendix H. Chapter V.	--
12. Contracting with intermediaries and carriers	--	--	50+ (New) See Appendix H. Results from HCFA study. Productivity improvement study in process.	--

*beyond goals set for FY 1980, See Appendix B, Part 3.

Items	Steps Required Before Secretary Can Act			
	"A"	"B"	"C"	"D"
	Under Present Authorities* :(Appendix B-3):	Congress Provide More Resources :	Congress Enact New Program : Legislation :	Program Managers Make Further Studies :
13. Civil Money Penalty	\$ --	\$ --	\$ **24 Legislation has been in process for 2 years	\$ --
TOTAL HEALTH CARE FINANCING	\$ 708	\$ 107	\$ 247	\$ 2,395-2,713
B. Income Maintenance				
1. AFDC erroneous payments	\$ 60	\$ 50 40 new positions required to continue bolstering technical assistance programs to the States	\$ **92 To result from standardized work expense and income disregard, plus assistance to States on Management Information Systems and Fraud Control Units	\$ ***216 Need to determine feasibility of error rate reductions nationwide below 4 percent.

*Beyond goals set for FY 1980, See Appendix B, Part 3.
**Items contained in FY 1980 budget plan and part of the \$2.9 billion legislative savings program.
***Represents the current best estimate based upon presently available information and knowledge. The tolerance levels reflected in this estimate will be modified as required to reflect the information developed in the study of the reasonableness of the proposed payment error rate goals.

Items	Steps Required Before Secretary Can Act			
	"A"	"B"	"C"	"D"
	Under Present Authorities* :(Appendix B-3):	Congress : Provide : More : Resources	Congress : Enact New : Program : Legislation	Program Managers : Make Further : Studies
2. SSI erroneous payments	\$ 35	\$ --	\$ --	\$ 140 Need to determine feasibility of error rate reductions nationwide below 3 percent
3. SSA error rate	--	--	--	173-866 Quality Control System just becoming operational. First results may be known late this year.
4. Newly arrived aliens	--	--	***72 (New) Loss estimated by GAO requires statutory change	--
5. SSI/Disability duplicate payments	--	--	54 (New) Requires statutory change. Loss estimated by GAO. SSA estimate is \$33 million.	--

*Beyond goals set for FY 1980, See Appendix B, Part 3.

**SSA advised on 3-16-79 that OMB has approved. 1980 savings estimated at \$13 million.

Items	Steps Required Before Secretary Can Act			
	"A"	"B"	"C"	"D"
	Under Present Authorities* : (Appendix B-3) :	Congress Provide More Resources :	Congress Enact New Program Legislation :	Program Managers Make Further Studies
6. SSA/RSI student benefit recontact	\$ 25	\$ --	\$ --	\$ --
7. Child support enforcement	--	--	**35 Includes alimony collection and access to SSA wage data	--
8. AFDC--financial management review	5	--	--	--
9 SSI/Disability ineligibility	1 (Potential not known)	--	--	--
10. SSI/AFDC/match IRS dividends and interest	--	--	45 (New) Requires amendment to Tax Reform Act of 1976	--
	\$	\$	\$	\$
TOTAL INCOME MAINTENANCE	\$ 126	\$ 50	\$ 298	\$ 529-1,222

*Beyond goals set for FY 1980, See Appendix B, Part 3.
**Items contained in FY 1980 budget plan and part of the \$2.9 billion legislative savings program.

Items	Steps Required Before Secretary Can Act			
	"A"	"B"	"C"	"D"
	Under Present Authorities* :(Appendix B-3):	Congress Provide More Resources :	Congress Enact New Program Legislation :	Program Managers Make Further Studies :
C. <u>Student Financial Assistance Program</u>	\$ --	\$ --	\$ --	\$ --
D. <u>ESEA Title I</u>	\$ 63	\$ --	\$ --	\$ --
E. <u>Administrative</u>				
1. Indirect costs	\$ 8	\$ 64 Need about 65 additional staff members to achieve savings	\$ --	\$ --
2. Unmet audit needs	--	133 Requires up to 1,000 additional Audit staff paying back on ratio of 3-to-1	--	--
3. Checks--paid letter of credit	--	38 \$400 million one-time cash drawdown. \$38 million annual interest. 15 new positions needed.	--	--

*Beyond goals set for FY 1980, See Appendix B, Part 3.

Items	Steps Required Before Secretary Can Act			
	"A"	"B"	"C"	"D"
	Under Present Authorities* : (Appendix B-3):	Congress : Provide : More : Resources	Congress : Enact New : Program : Legislation	Program Managers : Make Further : Studies
4. Interest on misspent grant funds	\$ 17	\$ --	\$ --	\$ --
TOTAL ADMINISTRATIVE	\$ 25	\$ 235	\$ --	\$ --
GRAND TOTAL	\$ 922	\$ 392	\$ 273 New Items Total \$ 545	\$ 2,924-3,935

*Beyond goals set for FY 1980, See Appendix B, Part 3.
**Items contained in FY 1980 budget plan and part of the \$2.9 billion legislative savings program.

FY 1980 BUDGET
LEGISLATIVE PROPOSALS TO REDUCE COSTS

	<u>FY 1980</u>
1. Hospital cost containment	\$ 1,725
2. Restructure Medicare coverage for the working aged	
* 3. Limit Medicare reimbursements for hospital-based physicians	200
* 4. Require use of Medicare Audit findings in Medicaid and Maternal and Child Health Audits	55
5. Eliminate reimbursement for chiropractic services	34
* 6. Civil money penalty for Medicaid/Medicare fraud	35
7. Transfer of assets -- use of individuals' resources in lieu of Medicare funds	24
8. Medicaid eligibility -- use of Social Security information and stepparent income	5
9. Standardize AFDC work expense disregard (Medicaid)	29
10. Reimburse under Medicare based on reasonable costs	11
*11. Implement reforms in AFDC and Child Support Enforcement programs	3
	241

*Covered at least in part in the Inspector General's First Annual Report.

	<u>FY 1980</u>
12. Reform disability program by setting new limits on benefits and increasing work incentives to disabled (net savings)	\$ 35
13. Phase out out-moded lump sum death benefit under OASDI	221
14. Phase out high school OASDI student benefits	155
15. Eliminate minimum OASDI benefit	53
16. Phase out Social Security benefits after youngest child reaches age 16	23
17. Offset Social Security benefits for persons with high Federal Government pensions	18
18. Limit training to 3% of Title XX total	<u>26</u>
TOTAL	\$ 2,893

APPENDIX C

SYNOPSIS OF CONVICTIONS OBTAINED IN
CALENDAR YEAR 1978
AS A RESULT OF INVESTIGATIONS

By the OIG, Office of Investigations
By the HCFA, Office of Program Integrity

NOTE: Names are omitted so as to focus on the nature of the
problem

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*Excluding those done jointly with Office of
Investigations.

SYNOPSIS OF CONVICTIONS OBTAINED IN
CALENDAR YEAR 1978
AS A RESULT OF INVESTIGATIONS

A. Convictions Involving HEW Employees

- 1 - 2. An HEW Audit Agency review revealed fraudulent discrepancies in the travel voucher claims of a Regional Commissioner of Education. Prosecution was declined; however, the U. S. Attorney requested investigation based on additional information into common stock transfers involving the Commissioner. Investigation disclosed that the Commissioner had received \$10,000 in cash from a Consultant plus other favors from contractors and suppliers. Indictments were returned against the Commissioner and Consultant in April 1978. During trial in October 1978 both men entered changes of pleas and pleaded guilty to various counts of accepting and giving a gratuity. Both were sentenced to two years for each of the counts to run concurrently with three months to be served in custody, balance suspended, and placed on probation for three years.

3. The Bureau of Occupational and Adult Education, OE, advised that about \$1,700 in improper employee expense reimbursements had been made in late 1977 and March 1978.

Investigation disclosed that an employee had forged names of other employees for non-existent expenses and had been reimbursed.

The employee was charged in a Bill of Information with violations of Title 18 U.S.C. Section 1001. In September 1978 the employee was found guilty as charged, was sentenced to three years' probation, and ordered to retribute \$1,710.40.

4. IRS reviews of falsified income tax returns led to evidence of the issuance of SSI checks to a non-existent claimant. Subsequent OI investigation identified an SSA employee as to the false returns and issuance of the SSI funds. The employee was terminated from SSA in September 1977.

In February the ex-employee was indicted on 23 counts of violations of Title 18 U.S.C. Section 2071 (destruction), 475 (forging), and 287 (false claims to IRS). In April 1978 he pleaded guilty to three counts of the indictment and in May was placed on five years' concurrent probation on each count and ordered to reconstitute \$9,270.

5. An SSA Regional Office in attempting to resolve a deficiency in overpayment refunds, discovered that \$405 was misappropriated from two beneficiary refunds. An employee admitted converting the funds to her own use. A complaint was sworn out against the employee by OI, charging violation of Title 18 U.S.C. Section 641 (embezzlement) on March 13, 1978. She entered a guilty plea on August 3, 1978, to the complaint charge. She subsequently received a suspended sentence, was placed on probation for 18 months, fined \$300, and reconstituted the \$405.
6. SSA Regional Office advised that it suspected an employee had converted to her own use \$6,493.67 in SSI overpayment refunds. OI confirmed the activities of the employee.

An indictment of three counts was handed down against the employee in January 1978 charging with two violations of Title 18 Section 654 and one of Section 495. In April 1978 she entered a plea of guilty to count III (Section 495, forging and uttering a U. S. Treasury check). In July 1978 she was sentenced to two years, suspended; placed on probation for two years; and ordered to reconstitute \$6,493.67.

7. SSA advised that an audit procedure failed to verify that two SSA fund overpayment returns had been credited to the SSA system. Subsequent Investigation disclosed that the two overpayment refunds, in the form of checks, had been negotiated for personal use by an employee of SSA.

Two misdemeanor complaints were filed against the employee on March 6, 1978. She pleaded guilty to one count on March 14, 1978, and received a one year suspended sentence, five years' probation, and was fined \$250.

8. Investigation of this former employee was requested in 1975 to determine if she fraudulently received "Emergency Payment" check monies during periods she received her regular salary checks. Investigation disclosed that the employee illegally applied for and received three emergency payment checks in the total amount of \$1,074.60 through the forging of both her timekeeper's and supervisor's names.

In April 1978 subject pleaded nolo contendere to one count of an information charging violation of Title 18 U.S.C. Section 641 (theft of Government property.)

B. Convictions Involving Grantees and Contractors

1. HEW Audit Agency advised that a citizens' committee incurred a loss of \$5,541.31 in HEW funds and that an ex-employee was a suspect. Investigation confirmed the suspicion.

In April 1978 an indictment was returned charging the ex-employee with six counts of violation of Title 42 U.S.C. Section 2971f (embezzlement by program official or employee). She pleaded guilty to one count in August 1978, was sentenced to a three year suspended sentence, and ordered to make restitution of \$416.45.

2. The HEW Audit Agency advised that an audit of a Community Action Agency disclosed the misuse of \$710 in HEW grant funds by an employee of the agency. Investigation subsequently disclosed that the now ex-employee had converted the money to his own use.

On August 8, 1978, a True Bill of Indictment was returned against the ex-employee charging a violation of Title 42 U.S.C. Section 2971 (a misdemeanor) for converting \$59.83 to his own use.

On November 3, 1978, a six months' prison sentence was imposed upon the individual.

3. A private firm audit of a Public Health Service grantee disclosed that \$10,000 was missing.

Investigation disclosed that the business manager of the grantee had embezzled the funds by various means.

The business manager admitted his action and pled guilty to one count of 18 U.S.C. Section 641 (embezzlement) on December 14, 1978. Sentencing will be in early January 1979.

4. A Regional Office of Human Development advised that information had been received which indicated that a director of a grant funded program may have misappropriated Federal Head Start funds (HEW and USDA monies).

Investigation disclosed that the director had opened a bank account and had deposited to the account a \$3,000 Head Start program funding check which he subsequently converted to his own use.

On August 8, 1978, an indictment was returned against the subject charging a one count violation of Title 42 U.S.C. Section 2971. On October 8, 1978, subject pleaded guilty to the indictment charge and received a sentence of 18 months.

5. Officials of a medical peer review group alleged that a bookkeeper on four occasions embezzled Federal funds from various accounts by changing the dollar amounts on his paychecks. OI investigation led to the bookkeeper's admission to altering the check amounts.

In April 1978 an indictment was returned against the bookkeeper charging four counts of violation of Title 18 U.S.C. Section 641 (embezzlement). He entered a guilty plea to all counts on May 23, 1978, and was sentenced to one year's imprisonment to be followed by five years' probation on June 27, 1978.

6. - 7. HEW Audit Agency audit of a community action agency, as requested by a U. S. Senator, reflected that agency administrative officials mismanaged activities and converted funds, assets and resources to their personal use. Subsequent OI investigation led to

indictments and convictions of four officials in 1977. The agency is funded by Federal, State and local agencies.

Two officials were indicted for violations of Title 18 U.S.C. Sections 287 and two for submitting false work orders to DHEW for payments on repairs to MCAA vehicles which were not made. The indictment was returned October 11, 1977. On February 16, 1978, both entered guilty pleas as to count 2 of the 8 count indictments, the remaining counts being dismissed. Both were sentenced to five years suspended sentences and placed on five years' probation. One was further ordered to retribute \$6,000; the other \$4,000.

8. A Regional Office of Education advised that a former employee of a proprietary school alleged that the owner of the school misused BEOG, SEOG and NDSL funds.

Investigation disclosed that the owner had received funds from the NIH disbursement office for use as student loans and deposited them in corporate accounts for his personal use. Over \$53,000 had been misused.

In April 1978 a 12 count indictment was returned against the school's owner charging violations of 18 U.S.C. 2, 641, 1001, 1341 and 20 U.S.C. 1087-4(a) (mail fraud, embezzlement, false statements, false business records). On July 28, 1978, the owner was found guilty of nine counts of embezzlement. In September 1978 he received a five year suspended sentence, was placed on probation for five years and ordered to retribute \$17,000.

9. - 22. The Office of Investigations, OIG, HEW, conducted an investigation in concert with State agencies at the direction of the U. S. Attorney into the relationships between current and former OE officials with contractors and various State officials. This investigation was the most encompassing and possibly the most significant matter that OI has been involved in to date.

As of December 1978, 14 individuals had been convicted in State courts of charges which include conspiracy, conspiracy to bribe, conspiracy to defraud, conspiracy to commit larceny, conspiracy to accept a bribe and conspiracy to steal Federal/State funds.

These convictions were associated with the issuance of a \$500,000 contract by a State vocational agency for the production of training films.

C. Convictions Involving Student Financial Assistance Programs

1. A U. S. Attorney requested an investigation of a proprietary school's practices in the Federal Insured Student Loan Program.

Investigation disclosed that the school recruited students, certified them eligible for financial assistance, and obtained loans for them. Many of the students never attended the school, some withdrew before course completion, and still other students did not know they had received loans. The loans were sold by the school to four financial institutions and many were filed in default. OE was obliged to pay the institutions over \$800,000.

The school's owner and two other officials were indicted for conspiracy to defraud the Government and false statements. Two were convicted in 1977; one was convicted in February 1978. The U. S. Government recovered over \$500,000 in 1977.

2. - 23. A Department of Justice coordinated 18 month task force investigation, based on OI investigation, culminated an over three year effort to obtain evidence of misuse of student financial aid funds by corporately linked proprietary schools. In September 1978, 22 schools pleaded nolo contendere to all 55 counts of a July 1978 indictment charging violations of Title 18 U.S.C. Sections 287, 1001, and 1014. The controlling corporation was fined \$500,000 on charges contained in 49 of the 55 count indictment.

The indictment alleged that most students enrolling were encouraged to apply for FISL loans, and to sign promissory notes, oftentimes, months prior to the students' first day of attendance. The students' FISL loan applications, which were submitted to HEW for insurance commitments, were ineligible for the commitment because:

- a. the student was not eligible; or
- b. the course of study was not approved; or
- c. the school the student was attending was not an eligible institution; or
- d. the student was not in school.

It is further alleged in the indictment that:

- a. Refunds to students on the students' FISL loan accounts were not made in a timely manner, with the average delay being 4 months. Some refunds were delayed up to 2 years.
- b. Lenders were caused to submit false claims to HEW for interest benefits on FISL loans by the school's failure to advise of changes in the students' status and by not making refunds in a timely manner.
- c. False representations and claims were made in connection with default claims by misrepresenting students' status, loan disbursement dates and unpaid principal balances.

Of the \$40 million in FISL loans made to students, approximately \$15.4 million went into default. Civil action is continuing by the Justice Department.

24. OE reviews of student financial aid accounts at a proprietary school disclosed unaccountable withdrawals of funds.

Investigation disclosed that the former president of the school had used some of the financial aid

funds for personal reasons and deposited the rest in the school's corporate accounts.

An information was filed against the former school official on August 4, 1978, charging violations of Title 18 U.S.C. Section 1001 (false statements). He pleaded guilty the same date and agreed to retribute \$242,720. He was sentenced on October 16, 1978, to five years' imprisonment and a \$10,000 fine.

25. A college official advised that an apparent theft of the college's BEOG funds had occurred through the uttering of BEOG checks to fictitious non-students. The amount stolen was \$2,119.

Investigation and handwriting analyses disclosed that a secretary in the student financial aid office had uttered the checks.

In February 1978, the secretary was indicted on four counts of violation of Title 18 U.S.C. Section 641 (embezzlement). On March 10, 1978, she was found guilty on all counts and was subsequently sentenced in April 1978 to six months' imprisonment on counts 1 and 2 and to five years' probation on counts 3 and 4.

26. The HEW Audit Agency advised that a university indicated possible fraudulent misuses of their BEOG and CWS programs.

Investigation disclosed that the director of the student financial aid program at the university had conspired with others to issue checks to students, forge the endorsements and deposit them to his own or other personal accounts.

The U. S. Attorney declined prosecution in favor of local action. The student financial aid officer pled guilty in a local Superior Court to 14 counts of misappropriation of public funds. He was sentenced to four years' probation and ordered to retribute \$8,456.25.

27. A U. S. Attorney requested that OI conduct a joint investigation with the FBI into allegations that a city Board of Education official had converted Title I funds -- Elementary and Secondary Education Act -- to his personal use.

Investigation disclosed that the official had used Title I funds for entertainment and catering expenses and had submitted fictitious billings to the Board of Education to cover these expenses.

The official was indicted by a Federal Grand Jury on 22 charges of various misuses of Federal funds. In November 1978, he pleaded guilty to all counts and in December was sentenced to 18 months' imprisonment.

28. An internal audit disclosed that \$5,702.27 of financial aid was embezzled by a university disbursement official from 1974 to 1977. OI investigation disclosed that official retained student financial aid checks not claimed by students, forged their endorsements, and applied the proceeds to his own use.

On October 19, 1977, an indictment was handed down charging the official with 11 counts of violation of Title 18 Section 641 (embezzlement). On January 13, 1978, subject entered a guilty plea to four of the counts and was sentenced to three years' probation and ordered to restitute \$5,702.27.

29. Office of Education surveys, HEW audits, and student complaints led to investigations of the administration of the Federal Insured Student Loan programs fund by proprietary schools in Texas. During the course of the investigation it was ascertained that a school official had embezzled, stolen, and converted to his own use OE/HEW funds from the FISL, BEOG, and SEOG programs.

The official entered into a plea bargain agreement in September 1978 in which he pleaded guilty to various counts of violation of Title 18 U.S.C.

Sections 408(c) and 408(d). On March 24, 1978, she entered a guilty plea to one count 408(d) and was sentenced to six months and fined \$500, both suspended. SSA has recouped the \$2,000.

3. - 12. The HEW employee roll in Washington, D. C., was matched against the roll of the Department of Human Resources in Washington, D. C., to determine if any HEW employees were receiving public assistance. This was a pilot project; other public agencies have and will match their rolls against the rolls of various welfare agencies nationwide.

Of 142 matches 17 recipients were considered to be receiving public assistance illegally. In September 1978, 15 of the 17 were indicted on charges of False Pretenses, both felonies and misdemeanors.

From October through December 1978 eight of those indicted pled guilty to the charges. (A ninth and tenth subsequently pled guilty and a trial of one other is pending.) It appears that restitution and probation will be imposed.

E. Investigations Involving Medicare/Medicaid Investigations By the Office of Inspector General

1. A U. S. Attorney requested investigation of the Medicaid billing practices of a dentist based on complaints concerning the large number of patients the dentist treated.

Investigation by OI and State officials with the assistance of Blue Cross-Blue Shield found that the dentist had submitted claims to Medicaid for services not performed.

The dentist was indicted on 24 counts of mail fraud and Medicaid Fraud in June 1977. Subsequently he was convicted on all counts in May 1978 and sentenced to four five-year concurrent terms and fined \$10,000.

2. This investigation resulted from HEW Audit Agency surveys of pharmacy billings to the Medicaid program.

Investigation disclosed that this pharmacist owned a pharmacy which legally could bill Medicaid at higher rates than another of his pharmacies. The pharmacist billed Medicaid for prescriptions filled at the lower rate pharmacy at the rate of the higher rate pharmacy.

The pharmacist was indicted on January 24, 1978, on 15 counts of violations of Title 18 U.S.C. Section 1001, 1002, and 1341, 1342 (false statements and mail fraud). He was convicted on April 20, 1978, and fined \$15,000.

3. - 5. The Office of Program Integrity, Bureau of Health Insurance, Social Security Administration, advised that allegations had been made concerning the Medicare billing practices of a home health agency.

Investigation disclosed that Medicare was billed for home visits to beneficiaries which were not made and for services not rendered to beneficiaries when visits were made.

In June 1977 a three count indictment was returned against the home health agency, its executive director, and another official charging violations of Title 18 U.S.C. Sections 371 and 1001.

In March 1978 the three defendants were found guilty of 12 counts of the indictment; the executive director received a seven year prison term and five years' probation; the other official received a two year prison term and three years' probation; and the home health agency was fined \$20,000.

6. - 14. Investigation of a laboratory's practices in billing Medicare was requested by the U. S. Department of Justice.

Investigation disclosed that the laboratory had doubled its rates for services and procedures and had kicked back a portion of the money received to various practitioners as incentives to utilize the laboratory.

Sixteen convictions were obtained in this case, including laboratory personnel and practitioners.

Nine of the convictions were obtained in 1978. Over \$150,000 in fines and restitutions were imposed.

15. OPI/HCFE advised that preliminary inquiry reflected that a medical equipment supplier had billed Medicare for services not rendered. Investigation disclosed that the supplier charged Medicare for oxygen not received, padded Medicare bills to pay for equipment, and had paid a health care facility administrator consulting fees as kickbacks.

The supplier was indicted in April 1978 on charges of conspiracy and submission of false claims. In September 1978 he was convicted on 65 counts of the indictment and sentenced to a three year concurrent imprisonment on 45 counts and five years' suspended sentence on 21 counts.

16. This investigation resulted from HEW Audit Agency surveys of pharmacy billings to the Medicaid program.

A State indictment was handed down in September 1977 charging the pharmacist with 51 felony counts and 23 misdemeanor counts in the fraudulent reception of \$3,500 in Medicaid payments.

The pharmacist pleaded nolo contendere to all charges, including billing Medicaid for services not rendered, in State court in April 1978, was sentenced to five years' probation and fined \$5,000.

17. This investigation resulted from HEW Audit Agency surveys of pharmacy billings to the Medicaid program.

The pharmacist knowingly and willfully billed the Medicaid program for brand name drug prescriptions when less costly generic drugs were actually dispensed.

In September 1978 the pharmacist entered a guilty plea to a one-count Bill of Information charging a violation of Title 42 U.S.C. Section 1396(h). In October 1978 the pharmacist was sentenced to one year's imprisonment and fined \$15,000.

18. This investigation resulted from HEW Audit Agency surveys of medical doctor billings to Medicaid.

Investigation disclosed that the physician had submitted claims to Medicaid for services actually rendered by a nurse while he was hospitalized and incapacitated.

The provider reimbursed the U. S. Government \$2,372.22 in March 1978 for the Medicaid overpayments. He further pleaded guilty to a one count violation of Title 42 U.S.C. Section 1395nn (a misdemeanor - false representations), was placed on two years' probation, and fined \$5,000.

19. - 20. Investigation predicated on news media articles verified that from July 9, 1973 to May 8, 1975 a doctor and his office nurse submitted Medicaid claims totalling \$28,910 to South Carolina BC/BS for medical services rendered to obstetrical recipients by staff physicians at a university hospital.

In May 1978 both were found guilty of 26 counts of violation of U.S.C. Section 1001 and 1002 of a 33 count indictment.

On July 14, 1978, the physician was sentenced to three years' suspended as to count 2, fined \$10,000, and placed on probation for five years. As to counts 3, 4, 6-22, 24, 26 and 30, the physician was placed on probation five years and fined \$54,000 to be paid in six months.

On the same date the nurse was placed on five years' probation as to counts 2-4, 6-22, 24, 26, and 30, institutional sentence suspended.

Both were acquitted on counts 32, 33 and 34.

21. Investigation of a physician was requested by the U. S. Attorney through referral from the State Attorney General. Investigation determined that the physician had submitted Medicaid claims for obstetrical fees and had also billed the patients for the same services.

On June 22, 1978, the physician pleaded guilty to 42 counts of violations of Titles 18 and 42. He

was sentenced to one year's probation, fined \$10,000, and required to donate his services to public health clinics.

22. The U. S. Attorney requested that OI assist OPI, HCFA, in preparing testimony and additional evidence in the impending trial of a physician for Medicare fraud. (The physician had been found guilty in December 1977 of auto insurance fraud and conspiracy.) The physician was indicted in September 1977 on 74 counts of billing Medicare for services not rendered (Title 18 U.S.C. Section 1001).

On September 22, 1978, the physician was convicted on various counts of the Medicare fraud indictment and was sentenced to two and one-half years' imprisonment and fined \$7,400. In August 1978 the physician appealed the Medicare fraud conviction.

23. This investigation resulted from HEW Audit Agency surveys and State inquiries into a medical doctor's billings to Medicaid.

Investigation disclosed that the doctor had forged patients' names to billings for non-existent treatments and had received over \$6,500 illegally.

The doctor was indicted by a State court on one count of second degree theft in September 1978. He subsequently filed notice that he wished a trial in the matter for he stated the Government had no evidence. OI, upon State request, uncovered 165 false Medicare claims in two weeks. The doctor then pled guilty in December 1978. Sentencing imposed included a suspended sentence, five years' probation, suspension of medical license, court costs, over \$10,000 reimbursement, and donation of services to a health clinic.

24. State officials requested that OI conduct a joint investigation with them into allegations that a pharmacist had billed Medicaid for brand name drugs when lesser priced generic drugs had actually been dispensed.

Investigation verified the allegation; over \$52,000 had been illegally received by the pharmacist.

The pharmacist was indicted on charges of Theft by Deception by a County Grand Jury in June 1978. On December 28, 1978, he pleaded guilty to a one count indictment. Sentencing is scheduled for January 1979.

25. A State audit of a nursing home disclosed that a pharmacy had been paying kickbacks to the nursing home in return for receiving the nursing home's total prescription business. Investigation disclosed that the pharmacy had sent monthly payments to the home in the amounts of \$110 - \$125 during the period September 25, 1974 through November 6, 1975.

A criminal information was filed against a pharmacist in June 1978 charging violations of Title 42 U.S.C. Section 1396h (kickbacks). On June 23, 1978, the pharmacist pleaded guilty to one count of the information and was fined \$1,000.

26. OPI/HCFRA inquiry revealed that a chiropractor collected payments from patients in addition to billing Medicare for the same treatments. Additionally, he billed Medicare for services not performed, forged patients' signatures to Medicaid claims, and billed Medicaid for non-covered services.

On August 8, 1978, a 29 count indictment charging violation of Title 18 U.S.C. Section 1001 was returned. On October 12, 1978, the chiropractor was tried and convicted of 24 of the counts. On October 25, 1978, he received a five year sentence, four years suspended, and was placed on five years' probation commencing after service of one year's incarceration.

27. OPI/HCFRA reviews reflected that a physician had been billing both the Medicare and Medicaid programs for services not rendered.

A joint HCFRA-Office of Investigations effort verified the suspected fraudulent claims.

On November 16, 1978, a criminal information was filed against the physician charging violations of Title 18 U.S.C. Sections 1341 and 1001. On December 1, 1978, the physician pled guilty to five

counts of violation of Section 1341 mail fraud.
Sentencing is expected in January 1979.

28. The Office of Program Integrity, Bureau of Health Insurance, SSA, advised that a review of claims indicated a physician had received at least \$4,712 through submission of false Medicare claims.

Investigation by OI revealed that between 1973 and 1976 the subject filed false Medicare claims for drugs and injections that weren't rendered, and received over \$50,000 for the fraudulent claims.

The physician entered into a plea bargain agreement in June 1978 wherein he pleaded guilty to two counts of violation of Title 42 U.S.C. Section 1395. In July 1978 the physician received a two year suspended sentence and was fined \$5,000.

29. The U. S. Attorney requested investigation of a physician's Medicare billing practices based upon complaints by OPI/HCFR and the United Mine Workers (UMW). Investigation was conducted by OI and State officials and it was determined that the physician billed for services not rendered.

A criminal information was filed in December 1977 charging 40 counts of violation of Title 18 U.S.C. Sections 1001, 287 and 2.

On January 16, 1978, the physician pleaded guilty to one count (1001) and was sentenced to three years', suspended, fined \$10,000, and placed on three years' probation.

30. - 31. An investigation of a nursing home was initiated by BHI in 1975 relative to submissions of alleged false Medicare claims to SSA's fiscal intermediary, Blue Cross of New Hampshire, Vermont. In June 1976 two alleged subjects appeared before a Federal Grand Jury and both took the "5th." Prosecution was declined by the former U. S. Attorney.

Subsequently, the OI learned that the State had initiated an investigation of these subjects on similar allegations. The case was referred by the Division of Welfare and the new U. S. Attorney

requested an investigation by OI and Postal Inspectors with assistance of State investigators. The nursing home was alleged to have received \$49,497 for Medicaid patients assigned to noncertified nursing facility rooms. The claims in question were signed for the most part by the owner.

The results of the investigation were presented to an AUSA. In July 1978 a Federal Grand Jury returned a 41 count mail fraud (18 U.S.C. 1341) indictment against the nursing home and the owner.

On September 28, 1978, the nursing home was found guilty of 20 counts of mail fraud; the owner was found guilty of 24 counts of mail fraud, 6 counts for fraud on Medicaid bills, and 18 counts on Medicare bills. Recovery of funds is expected.

F. Convictions Involving Medicaid/Medicare Investigations
By OPI (HCFA)*

1. Ambulance Company Owner -- Medicare

Ambulance company billed for two oxygen services per beneficiary, one legitimate, the other fictitious.

On March 27, 1978, the owner pled guilty to one count criminal information and was sentenced to six months in prison, 18 months probation, and restitution of \$122,500.

2. Physician -- Medicare

Physician billed for laboratory tests not performed. Estimated overpayment over a 4 1/2 year period was \$200,000.

On April 12, 1978, pled guilty; sentenced to two years in prison which was suspended; ordered to provide free medical service at a designated health center for one year (every morning, five days a week, and two afternoons each week).

*Excluding those done jointly with Office of Investigations.

3. Nursing Home Chain Owner and Principal Officer -- Medicare/Medicaid

The subject established the corporation to transact business with each of its six nursing homes; the relationship was concealed in order to obtain profits on related party transactions; such profits are not allowable under Medicare regulations.

Pled nolo contendere on January 9, 1978; sentenced to one year in prison, nine months of which was suspended, two years' probation and a \$7,500 fine.

4. Nursing Home Chain -- Medicare/Medicaid

The subject established the corporation to transact business with each of its six nursing homes; the relationship was concealed in order to obtain profits on related party transactions; such profits are not allowable under Medicare regulations.

Fined \$2,500.

5. Doctor's Secretary -- Medicare

She altered bills of her employer and then sent them in with unassigned Medicare claims. She also deposited checks made out to the doctor into her own bank account.

On October 6, 1977, pled guilty; sentenced on February 2, 1978; pled guilty to one count mail fraud. Received a five year suspended sentence, five years' probation, fined \$1,000, and full restitution ordered.

6. Owner of Laboratory -- Medicare/Medicaid

The owner of a lab was billing the Medicare and Medicaid programs for manually performing certain laboratory tests. It was discovered, however, that he was contracting out his business to companies which used automated services. There was a considerable difference in reimbursement fees for manual as opposed to automated procedure.

7. Laboratory Itself (See No. 6 Above) -- Medicare/
Medicaid

Pled guilty August 2, 1978. No fine.

8. Hospital Administrator -- Medicare/Medicaid

Set up an inhalation therapy company which provided services to the hospital of which he was administrator. He hid the fact that he was the owner of the inhalation therapy company, and billed the hospital in excess of allowable costs.

On April 6, 1978, pled guilty; sentenced June 6, 1978; sentenced to one year in prison and three years' probation; fined \$10,000.

9. Independent Purchasing Agent "A" -- Medicare/Medicaid

Owned several corporations which would design and equip new hospital facilities. He had a contract with six hospitals to sell them the hospital equipment at manufacturer's cost, plus a five to eight percent mark-up and actual freight costs. Inflated costs 20 - 30 percent, causing an overbilling to these hospitals of \$470,000.

Guilty by jury November 30, 1978; sentence scheduled January 19, 1979.

10. Independent Purchasing Agent "B" -- Medicare/Medicaid

On May 1, 1978 pled guilty to same fraud as above. Sentence was postponed until completion of the trial of Purchasing Agent "A".

11. Independent Purchasing Agent "C" -- Medicare/Medicaid

On May 1, 1978 pled guilty to same fraud as above. Sentence was postponed until completion of the trial of Purchasing Agent "A".

12. Owner of Skilled Nursing Facility -- Medicare/Medicaid

Pled guilty to filing a false 1974 Medicare cost study and a false 1974 Medicaid cost study. He

promised to make restitution to both the Medicare and Medicaid programs.

On November 17, 1978, pled guilty; sentence has been scheduled for a future date.

13. Physician -- Medicare

Billed for services not rendered.

On November 3, 1978, convicted; fined \$1,000.

14. Laboratory -- Medicare

Billed Medicare for laboratory tests and services that were not ordered or performed.

On June 9, 1978, pled guilty to one felony count; 60 days confinement, \$12,000 fine.

15. - 17. Durable Medical Equipment Supplier (DME) -- Medicare

A company billed Medicare for the rental of equipment which beneficiaries thought they had purchased. The firm was convicted and fined \$2,000 on June 29, 1978, while two of the firm's officers pled nolo contendere to 24 misdemeanor counts. The individuals received a sentence of 12 months confinement (suspended) with two years probation and fines of \$2,000 each.

18. Physician -- Medicare

Billed Medicare for far greater number of office visits than had actually been made.

Convicted October 19, 1978; one year confinement on each of five counts to run concurrently; four years' suspended sentence on 19 counts; five years' on probation; \$5,000 fine.

19. Podiatrist -- Medicare

Made false statements and misrepresented facts in order to receive payment under Medicare.

Convicted February 11, 1978, of seven counts; sentenced to three years' probation on condition that first 60 days in a work release program; fined \$10,000.

20. Home Health Agency -- Medicare

No fine.

Convicted February 6, 1978, of four counts, two conspiracy, two false statements.

21. Durable Medical Equipment Supplier -- Medicare

Submitting false claims in three categories:

- a. Equipment that was never actually provided.
- b. Billing for an upgraded quality of equipment which was not provided.
- c. Billing for equipment for people in skilled nursing facilities.

Convicted August 28, 1978; three years' imprisonment, five years' on probation.

22. Podiatrist -- Medicare

Billing for services not rendered in order to obtain money for surgery that was not performed.

Convicted November 18, 1978; pending sentence.

23. Physician -- Medicare

Billing Medicare for services not rendered and charged with 29 counts of filing false statements. As part of plea bargaining, U. S. Attorney agreed to three counts of mail fraud.

Convicted February 8, 1978; pled guilty to three counts of mail fraud. Concurrent jail sentence on two counts; two and one-half years; five years' on probation following jail sentence. Doctor fled country, fugitive for ten months. When Doctor finally was arrested,

added three years to sentence. Currently serving a five and one-half year sentence.

24. Optician -- Medicare

Billed for prosthetic devices which were not provided.

On August 17, 1978, pled guilty of one count misdemeanor and one count felony.

--Misdemeanor -- One year in prison, to be released after six months on parole.

--Felony -- Three years imprisonment (suspended), to be placed on probation for two years with the condition that he seek psychological treatment and keep his bookkeeper in business

25. Physical Therapist -- Medicare

Billed for services not rendered.

On March 28, 1978, pled guilty; sentenced to eleven months on each of four counts; sentences to run concurrently (suspended); placed on five years' probation.

26. Podiatrist -- Medicare

Billed for services not rendered.

On December 29, 1978, pled guilty to one count misdemeanor; sentence pending.

OFFICE OF INVESTIGATIONS (OIG)
CASES REFERRED TO THE U. S. ATTORNEYS
CALENDAR YEAR 1978

Case #	Judicial District	Class	Nature of Offense	U.S. Attorney	Date Referred to	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
1	E - Pennsylvania	MD	Billing for services not rendered	1-78				1-78	Closed
2	Colorado	CL	Misuse of funds	1-78				1-78	Closed
3	E - Oklahoma	MD	Billing for services not rendered	1-78	3-78	4-78			Closed
4	Minnesota	PHAR	Kickbacks; rebates	4-78	6-78	6-78			Closed
5	W - Michigan	CL	Billing for services not rendered	3-78					Pending Investigation
6	Minnesota	SNF	Billing for services not rendered	8-78			8-78		Closed
7	E - Wisconsin	PHAR	Billing for drugs not used	5-78			5-78		Closed
8	M - Louisiana	PHAR	Billing for brand name drugs when generics dispensed	5-78	9-78	10-78			Closed
9	S - Texas	MD	Billing for services not rendered	6-78			6-78		Closed

Class: HOSP: Hospital PHAR: Pharmacy Judicial District: N: Northern E: Eastern
 MD: Medical Doctor SNF: Skilled Nursing M: Middle S: Southern
 CL: Clinic Facility W: Western
 DC: Doctor of
 Chiropractic

Case #	Judicial District	Class	Nature of Offense	Date Referred : to : U.S. Attorney	Date of : Indictment : Conviction	Date of : Declination : Investigation	Status Pending Further
10	W - Louisiana	MD	Billing for services not rendered	6-78	6-78	6-78	Closed
11	S - Mississippi	MD	Billing for services not rendered	4-78		4-78	Closed
12	New Jersey	DC	Billing for services not rendered	6-78			Pending Investigation
13	N - Mississippi	PHAR	Billing for services rendered by another person	3-78		3-78	Closed
14	New Mexico	PHAR	Billing for brand name drugs when generics dispensed	8-78			Pending Investigation
15	W - Pennsylvania	DC	Improper billing	8-78		8-78	Closed
16	Maryland	MD	Billing for services not rendered	11-78		11-78	Closed
17	S - Florida	MD	Billing for services not rendered	10-78		10-78	Closed
18	N - Alabama	DC	Submission of false claims	5-78	8-78	10-78	Closed
19	South Carolina	PHAR	Billing for drugs not prescribed	8-78	10-78		Pending Decision
20	S - New York	MD	Billing for services not rendered	4-78	4-78		Pending Decision

Case #	Judicial District	Class	Nature of Offense	U.S. Attorney	Date Referred to	Date of Indictment	Date of Conviction	Date of Declination	Status Pending
21	S - West Virginia	MD	Billing for services not rendered	4-78	4-78	5-78			Closed
22	W - Louisiana	PHAR	Billing for drugs not prescribed	4-78	9-78				Pending Decision
23	New Jersey	SNF	Billing Medicaid for personal expenses	1-78	5-78				Pending Decision
24	E - Washington	MD	Billing for services not rendered	10-78	11-78	12-78			Closed
25	W - Tennessee	MD	Billing for services not rendered	11-78	11-78				Pending Decision
26	W - Pennsylvania	MD	Billing for services not rendered	10-78	11-78				Pending Decision
27	E - Pennsylvania	MD	Billing for services not rendered	9-78	11-78				Pending Decision
28	W - Pennsylvania	MD	Billing for services not rendered	2-78	11-78				Pending Decision
29	N - California	PSRO Book-keeper	Embezzlement	4-78	4-78	6-78			Closed

OFFICE OF PROGRAM INTEGRITY (HCFA)
CASES REFERRED TO THE U. S. ATTORNEYS
CALENDAR YEAR 1978

Case #	Judicial District	Class	Nature of Offense	U.S. Attorney	Date Referred to	Date of Conviction	Date of Declination	Status Pending
1	Connecticut	DPM	Misrepresenting services	3-78				USA Action
2	Massachusetts	MD	Misrepresenting services	5-78				USA accepted case on an informal basis
3	Massachusetts	LAB	Billing for services not rendered	5-78				Pending Decision
4	New Hampshire	SNF	Misrepresenting services	1-78	7-78	11-78		Civil aspects also closed
5	New Hampshire	CL	Billing for services not rendered	8-78				USA Action
6	New Hampshire	DME	Chicanery (Misrepresenting services)	3-78				USA Action
7	New Hampshire	MD	Billing for services not rendered	3-78				USA Action
8	Rhode Island	DO	Billing for services not rendered	2-78			10-78	Pending Civil Action
Class:								
OP: Other Practitioners								
DO: Doctor of Osteopathy								
MD: Medical Doctor								
CL: Clinic								
HHA: Home Health Agency								
LAB: Laboratory								
DPM: Doctor of Podiatric Medicine								
DME: Durable Medical Equipment								
BEN: Beneficiary								

Case #	Judicial District	Class	Nature of Offense	U.S. Attorney	Indictment	Conviction	Date of Declination	Date of Further Investigation	Status Pending
9	Rhode Island	LAB	Falsifying recorded documents	8-78			12-78	Civil aspects also closed	
10	S - New York	HOSP	Kickbacks; rebates	4-78				Active Investigation	
11	S - New York	HOSP	Payroll padding	4-78				Active Investigation	
12	S - New York	LAB	Misrepresenting services	4-78				Pending Decision	
13	S - New York	MD	Billing for services not rendered	4-78				Pending Decision	
14	S - New York	MD	Billing for services not rendered	4-78				Pending Decision	
15	S - New York	LAB	Kickbacks; rebates	1-78				Pending Decision	
16	S - New York	LAB	Billing for services not rendered	2-78	5-78	8-78		Pending Civilly	
17	S - New York	MD	Impersonating a physician	6-78				Arrested	
18	S - New York	MD	Billing for services not rendered	5-78				Active Investigation	
19	Puerto Rico	HOSP	Falsifying records/documents	4-78				Active Investigation	

Case #	Judicial District	Class	Nature of Offense	U.S. Attorney	Date Referred to	Date of Indictment	Date of Conviction	Date of Declination	Status
20	E - Virginia	BEN	Altering of bill/ receipt	3-78	3-78			3-78	Civil aspects also closed
21	Delaware	MD	Misrepresenting services	9-78					Active Investigation
22	E - Virginia	MD	Misrepresenting services	2-78				4-78	Civil aspects also closed
23	W - Pennsylvania	MD	Billing for services not rendered	9-78		11-78			Pending
24	W - Pennsylvania	MD	Falsifying records	2-78		11-78			Pending
25	N - Illinois	HHA	Fraudulent cost reporting	2-78					USA Action
26	N - Illinois	HHA	Undisclosed related organization	9-78					USA Action
27	N - Illinois	HHA	Fraudulent cost reporting	2-78					USA Action
28	N - Illinois	HHA	Undisclosed related organization	9-78					USA Action
29	N - Illinois	SNF	Undisclosed related organization	3-78					USA Action
30	N - Illinois	HOSP	Fraudulent cost reporting	1-78					USA Action

Case #	Judicial District	Class	Nature of Offense	U.S. Attorney	Indictment	Conviction	Date of Declination	Date of Further Investigation	Status Pending
					Referred to				
31	N - Illinois	HHA	Undisclosed related organization		9-78				USA Action
32	N - Illinois	HHA	Undisclosed related organization		2-78				USA Action
33	N - Illinois	HHA	Undisclosed related organization		9-78				USA Action
34	W - Michigan	POD	Billing for services not rendered		2-78				USA Action
35	N - Ohio	DME	Billing for services not rendered		3-78				Pending Decision
36	N - Ohio	DPM	Billing for services not rendered		9-78				Active Investigation
37	N - Ohio	SNF	False cost reporting		12-78				Pending Decision
38	S - Ohio	SNF	False cost reporting		7-78				Pending Decision
39	S - Ohio	SNF	False cost reporting		7-78				Pending Decision
40	S - Ohio	SNF	False cost reporting		7-78				Pending Decision
41	S - Ohio	SNF	False cost reporting		11-78				Pending Decision

Case #	Judicial District	Class	Nature of Offense	U.S. Attorney	Date Referred to	Date of Conviction	Date of Declination	Status
42	W - Wisconsin	MD	Billing for services not rendered	11-78				Pending Decision
43	W - Wisconsin	SNF	False cost reporting	7-78				Active Investigation
44	S - Texas	LAB	Kickbacks	7-78			11-78	Pending Civilly
45	S - Texas	DPM	Billing for services not rendered	2-78		11-78		Pending Civilly
46	W - Missouri	DO	Misrepresentation/false claims	4-78				Active Investigation
47	W - Missouri	DO	Billing for services not rendered	1-78			1-78	Closed Civilly
48	W - Missouri	DO	Billing for services not rendered	3-78			6-78	Closed Civilly
49	Kansas	MD	Billing for services not rendered	8-78	1-79			Pending
50	Colorado	HOSP	Kickbacks--1877B	2-78	12-78			Active Investigation
51	Montana	SNF	False cost reporting	6-78				Active Investigation
52	Utah	OP	Billing for services not rendered	4-78	6-78	8-78		Closed Civilly

Case #	Judicial District	Class	Nature of Offense	U.S. Attorney	Date Referred : to	Date of : Indictment	Date of : Conviction	Date of : Declination	Status Pending Further : Investigation
53	Utah	DPM	Billing for services not rendered		6-78	12-78	12-78		Closed Civilly
54	Oregon	DO	Billing for services not rendered		3-78				Pending Decision

SUMMARY OF ESTIMATED ANNUAL SAVINGS FROM SYSTEMS CHANGES
RESULTING FROM PROJECT INTEGRITY I AS OF JANUARY 26, 1979

Following are projected annual savings brought about by procedural and systems changes made or planned by the State Medicaid Agency. These savings are the result of Project Integrity initiatives and have been referred to in some of the Lessons Learned Reports to the States.

Region I -- New Hampshire-Massachusetts-Connecticut --
\$415,800

In New Hampshire, based on the finding of Project Integrity that excessive prescriptions were being filled for recipients in nursing homes (i.e., multiple fillings made primarily to obtain dispensing fees), the State agency implemented a policy which now allows a minimum of a 30-day supply for such prescriptions. Dollar savings of \$151,200 will be realized and is based on only 18 pharmacists selected under Project Integrity. Actual savings resulting from this policy are undoubtedly greater but cannot be accurately estimated.

This is a typical problem area which will be examined in other States to identify further opportunities for this type of systems/policy revision.

Our review of payments to physicians for nursing home visits in Massachusetts disclosed that physicians were billing at an erroneous procedure code when more than one recipient was seen in a nursing home on a given date. At the request of the State we expanded the scope of our review to cover a 3-1/2 year period and identified potential recoveries of about \$151,000. Recommendations to require physicians to identify the nursing home's Medicaid identification number on the billing form and then keying it into the paid claims file, will permit monitoring through a pre or post payment edit. Annual savings of \$43,100 is projected.

A research project in Connecticut disclosed physicians using procedure codes which provided them a greater reimbursement than they would have received using a more appropriate code. Over a two year payment period we identified over \$443,000 excessive payments. The State agency

has taken action to strengthen its procedure code system and monitoring process to insure proper payments. We estimate annual savings to be \$221,500.

Region III -- Maryland and Virginia -- \$1,502,400

In this region a pervasive practice was found among physicians and pharmacists of failing to properly support their claims. As a consequence claims were being paid which were in fact excessive in relation to the actual services rendered. Project Integrity identified these problems. In Maryland it was found that 15 percent of the physician services reimbursed were not supported by patients' medical records, and that "underdocumented" claims included office visits and laboratory services. The annual loss is estimated, conservatively, at \$471,400. This will be avoided in the future.

In Virginia a similar loss was attributable to unsupported physician claims and billing error amounting to \$781,000 annually. Unsupported drug claims in Virginia were conservatively estimated at \$250,000 annually.

Region III -- District of Columbia -- \$500,000

During the review of the District of Columbia (DC) Dental Project we noted a duplicate payment control problem in the overall claims processing system. Although DC had an edit program to cover duplicate payments, we identified over \$1 million in overpayments during a two year period. New recommended pre-edit procedures have been implemented to help eliminate this problem. We are currently projecting annual savings of \$500,000 although this estimate will probably be much larger.

Region IV -- Alabama -- \$2,256,300

The State Commissioner from Medicaid Services has acknowledged that improved computer edits as a result of Project Integrity "Lessons Learned" are being applied to all Medicaid programs -- even though the primary revelations occurred in relation to Project Integrity Drug and Physician reviews. As a result of the improved prepayment edits and post-payment utilization reviews, the drug claims rejected have reached 5.3 percent with an annual

savings of \$100,000 per year. The physician claim rejection rate has reached 15.3 percent with an annualized savings based on \$23.66 per claim of \$2,156,300.

Region IV -- South Carolina -- \$67,585

Project Integrity drug cases revealed a high incidence of duplicate payments which are now being detected by prepayment edits. The annual savings estimated from these edits (based on \$7.18 average value per duplicate prescription) equals \$67,585.

Region VI -- Louisiana -- \$2 Million

A detailed HEW audit report has been submitted to the State, in respect to improved management of the Medicaid Drug Program. The report noted that Louisiana Medicaid recipients were receiving an unusually large number of prescriptions compared to recipients in other States. This is a direct result of Louisiana's "unlimited" Medicaid Drug Plan, and inadequate controls of administering the plan. We recommended tightening of these procedures and limiting the number of prescriptions to one refill per month per drug.

In addition, the State regulation on pricing of drugs to Medicaid provides that the total price of a prescription cannot exceed the prevailing wholesale price plus a dispensing fee of \$2.35. Our Project Integrity findings showed that the State was allowing pharmacists to bill amounts above the prevailing wholesale price.

The savings from these two recommendations, if fully implemented, will be about \$2 million annually. These and other recommendations were still under study at the time of this report.

Region IX -- Hawaii -- \$100,000

The Project Integrity cases for pharmacies revealed a widespread practice of "discriminatory billing" -- meaning that the Medicaid program was being billed charges far in excess of those made to private patients, contrary to Medicaid regulations. Based on the actual

billings of 8 pharmacies analyzed under Project Integrity, the annual Medicaid overpayments of 1976 were about \$100,000. It is possible that the total overpayments to all pharmacists would approximate \$187,000. However, for conservatism, we are claiming only \$100,000 as the savings resulting from the State's issuance of a new instruction to pharmacists participating in the program.

Summary

Region I	\$ 415,800
Region III	1,502,400
	500,000
Region IV	2,256,300
	67,585
Region VI	2,000,000
Region IX	100,000
	<u>\$6,842,085</u>

PROJECT INTEGRITY II
RESEARCH AND DEVELOPMENT PROJECTS

The HEW Audit Agency is doing research and development work -- Project Integrity II -- which has resulted to date in 30 computer applications, field tested in 17 States, designed to help search out fraud, abuse and error in the health care field. Each project includes research in a specific program area and development of computer detection screens in cooperation with States having a high degree of interest or expertise.

The development process begins with a systematic inquiry into a program area to discover its make-up, objectives, and operations. The research is first conducted at the Federal level. Then, an affiliation with a State is established and a pilot project is initiated. Research is completed at the State level. With the cooperation of the State we develop criteria for computer screens or matches, test them against the State's payment records, and validate computer output. Once our validation has been completed, a summary of results is prepared and further testing, if needed, may be extended to other States. The resulting product is a tested package of computer detection programs and methodology for probing segments of a State's health care program.

The research and development packages can be used in various ways. Operational initiatives can be launched as joint State-Federal projects involving the cooperative efforts of the State Medicaid agency, the Office of Inspector General, and the Health Care Financing Administration, as well as related State Medical Associations. Also, the test programs and results of operations can be made available to States for use in their regular monitoring activities, either to supplement a State's existing checking system or as a new detection tool.

The program areas covered to date under Project Integrity II are dental services, laboratories, physicians' billings for hospital inpatient services, physicians' procedures codes, outpatient hospital services, medical supplies and equipment, transportation, and services of medical practitioners such as optometrists, podiatrists, and chiropractors.

Thirty different computer applications have been designed. Projects are being conducted in 17 different States. Two

of the test packages -- dental and laboratory services -- are now in operation in several States.

Dental Services

Similar to Project Integrity I, our review of dental services uses special computer applications to identify dentists whose utilization patterns warrant further analysis and evaluation. The applications are designed to compare individual dentists' practices for selected services against what should normally be expected. The applications identified dentists and recipients who exceed parameters established for selected procedures. Full advantage is taken of the in-mouth review system already in use in some States. An in-mouth review on selected recipients will determine if the services were rendered as billed. More States are participating in this project. (See Page 12)

Laboratories

This project centers on the identification of laboratories that exceeded parameters established for 26 selected procedures or groups of tests or were reimbursed more than \$75,000 during a one year period. Our computer applications are designed to identify laboratories which:

- . Bill for services not performed.
- . Bill for individual tests when actually tests done as part of a panel.
- . Bill for tests not ordered by a physician.

Another application was designed to detect instances where both the laboratory and the ordering physician submitted claims for the same laboratory test.

The State of California cooperated with us in exemplary fashion on this project, and six others are participants. Further detail is presented at the end of this Appendix. (See Page 10)

Hospital Inpatient -- Physician Billing Match

The primary objective of this project is to identify physicians' inpatient hospital services paid but not provided

under the Medicaid program. The computer application matches the dates of service of physicians' billings with dates of service shown on hospital inpatient billings. A mismatch of dates indicates a discrepancy requiring further review.

Testing in Connecticut, the pilot State, is completed. Discrepancies were found for 32 of 50 physicians reviewed. However, the dollar value of the identified questionable services were not significant in terms of the dollar value of total services reviewed. Also, validation work showed many erroneous dates of service on the records.

Further State involvement in this project has included an expansion of the period of review and sending letters requesting refunds from a large number of providers. Many responses have been received and refunds made. The State has also notified all physicians participating in the Medicaid program of the seriousness in billing for services not rendered and reemphasizing the administrative sanctions that would be applied.

Physician Procedure Code

This study attempts to identify the extent to which physicians are using correct medical procedure codes on billings submitted to a State agency. Under the Medicaid reimbursement system, each medical service provided by a physician is described, coded, and through a relative value scale, it is priced. During Project Integrity I, we identified numerous examples of physicians using procedure codes which provided them a greater reimbursement than they would have received using a more appropriate code.

In pursuing this project in the test State of Connecticut, computer applications included the establishment of parameters which placed a limit on the number of times the physician services could be billed on behalf of an individual before potential excessive payments would be calculated. These parameters were established on the basis of input provided by State agency personnel.

We identified 1,365 physicians who had exceeded established parameters for a 2-year payment period. The potential excessive payments is estimated to be about \$443,000. The State used the computer printouts as one of the bases for writing letters requesting refunds from physicians. The

State expects to recoup thousands of dollars through this campaign. The Federal Government will participate in these refunds. The State has also taken action on its own to strengthen its procedure code system and its billing, payment, and monitoring process to insure that payments made to physicians are proper.

The project has been extended to Colorado for further testing.

Outpatient Hospital Services

The overall goal of this project has been to develop audit approaches leading to the detection of fraud and abuse in the area of outpatient hospital services. Computer applications are used as a tool for identifying those providers whose billing patterns indicate a high or abnormal utilization of services. The research and development effort has focused on the States of New York and New Jersey.

Three major categories of computer detection programs were developed and tested -- primary, auxiliary, and match.

Our preliminary work included developing and applying three primary computer programs. The major objective of the first program is to array or summarize the utilization patterns of the various outpatient/clinic facilities that exceed established parameters. This program also identifies all recipients exceeding the limits, as well as the number of visits, within each group exceeded. Those facilities that exhibit an abnormal or high utilization of services, or exceed other criteria in comparison to others, are singled out for a further detailed review. A second program identifies and summarizes utilization patterns of recipients exceeding established parameters. In this application the clinic utilization activities of the recipient are summarized and used to support the output from the first application or as an aid in determining which recipients of selected facilities merit further review. A third program, which generates recipient profiles on these individuals or those selected for further review, presents in detail the outpatient/clinic utilization of recipients and their families during a specific time period.

Preliminary results show potential abusive practices. Initially 136 providers and 13,585 recipients exceeded parameters. Work continues on the computer applications.

Three auxiliary computer programs were also developed and tested. These programs can identify facilities providing several possible unnecessary services to a recipient in the same day (ping-ponging of services) and possible unnecessary referral practices among two or more facilities on the same day, or one day apart. Although some examples of potential abuse were noted, they did not appear to be indicative of a trend.

Finally, four computer match detection programs were developed which included the following applications.

Outpatient services billed for periods of recipient's inpatient stay: A two tier program was used. The first tier matched inpatient outpatient billings at the same hospital while the second tier matched outpatient billings at one hospital against inpatient billings for all hospitals. This application disclosed that hospitals were billing for both inpatient and outpatient services for a recipient in the same day in violation of both Federal and State regulations. For example, a recipient was an inpatient at one hospital for a period June 29 through July 28 while he was billed as an outpatient at another hospital for 13 days within this period.

Two or more outpatient billings for the same recipient in the same day: Under an all inclusive rate established for hospital clinics in the test locations, a hospital is not permitted to get reimbursed for more than one visit per recipient per day regardless of the number of clinics attended by the recipient in the day. The application at two test sites disclosed duplicate billing amounting to about 15 percent of total billings reviewed.

Other match computer applications were (1) drugs dispensed and billed for separately on the same day as an outpatient visit and (2) outpatient services against the entire physician payment file to determine services billed on same day for same recipient by both physician and outpatient clinics.

The pilot States of New York and New Jersey are enthusiastically following-up on the results of all computer applications.

Medical Supplies and Equipment

Providers of medical supplies and equipment under Medicare and Medicaid programs fall into two basic groups. The first group is providers of durable medical equipment such as oxygen, beds, wheelchairs, and canes. The second group includes providers of prosthetic appliances (replacement limbs and parts), orthotic devices (braces, splints and supports), replacement eyeglasses and hearing aids.

Field work in the research and development project was conducted largely in South Carolina in cooperation with the State Medicaid agency and the Medicare intermediary. Input was also obtained from Georgia, and further testing is underway in Indiana.

We developed and tested several computer programs to analyze the paid claims for providers of medical supplies and equipment. One approach was to analyze paid claims by comparing billing practices of each provider with others in a similar group to identify providers whose billing practices vary substantially from norms and parameters. A wide range of norms or group of norms can be used to identify deviant billing practices. For specific items of medical supplies and equipment, the norms include total services per recipient, total cost per item, and average cost per item. These norms can be considered as parameters, or established limits of reasonableness, against which the billing practices of each provider is compared.

Another approach was to analyze paid claims by keying on specific types of transactions which more readily lend themselves to fraud and abuse. In this approach we asserted that certain types of transactions were "higher risk" than others and computer programs were developed to analyze these types of transactions in considerable depth. Some of the transactions which our research showed has a high potential for fraud and abuse were:

- . Routine delivery of items on a route basis but Medicare or Medicaid was billed for individual deliveries.
- . Billing for services after death.
- . Billing for individual components rather than fully assembled items when the assembled item

is less costly than the sum of the individual components.

Using the norm approach we identified 2,334 providers from a one year payment period who received reimbursement from Medicare and Medicaid. Of these providers, our printouts identified 259 who exceeded Statewide average costs for the selected medical supplies and equipment items. Profiles were obtained from Medicare and Medicaid for some of the providers. The profiles contained many and various types of questionable transactions. This approach required extensive purging of the payment transactions and extensive manual analysis to identify specific transactions for in-depth review.

Under the specific type of transaction approach, we isolated several cost items which lend themselves to fraud and abuse. One item under both Medicare and Medicaid programs is payment to providers for delivery of medical supplies and equipment, especially routine deliveries to replenish oxygen. A computer program was developed to identify providers who charged the same amount in the same day for deliveries. This program was effective in identifying providers who were making route deliveries but charging for individual deliveries.

Another situation when providers who are supplying rented items or items purchased under an installment plan inadvertently submit claims during the month, or after, the patient dies. Other providers may be intentionally submitting claims after death.

Computer programs were developed to explore this problem. The approach required use of a tape containing all deaths in the State for the period of review, and matching them to recipients who were receiving services. One program identifies those providers who billed for rental services or installment purchase services during the month of death. Another program identifies providers who billed for all types of medical supplies and equipment services after death. Using these approaches we identified 89 providers for review. The number of recipients for which these providers billed for service ranged from 1 to 37.

Transportation

Transportation includes travel expenses necessary for securing medical examinations and/or treatment by ambulance, taxicab, common carrier or other appropriate means.

Our objective was to develop and test special computer applications to aid in identifying vendors and recipients who display the greatest potential for fraud and abusive practices. In Illinois, computer applications have been designed to:

- . Assist in identifying transportation vendors who may have billed for excessive or unnecessary trips, and the same service more than once.
- . Identify transportation vendors who may have billed for services not provided.
- . Identify basic information concerning the transportation services received by each recipient for the purpose of identifying potential over-utilization of services.
- . Identify recipients who were provided with transportation services but for who there were no corresponding Title XIX medical service.

Two computer applications have been developed for the purpose of identifying those transportation vendors with total billings in excess of \$1,000. The first vendor application identified the number and amount of potential duplicate payments and the percentage of potential duplicates to total payments. Potential duplicates were payments made for services to the same recipient on the same date and for the same amount. The second vendor application matched dates of service for recipients on the transportation payment record to the payment records of the medical providers, such as physician, hospital, clinics, and dentists.

Initially, vendor computer applications identified, 121 transportation vendors showed the greatest potential for fraud and abuse. As a result of validation effort -- a review of bills and recipient profiles in an effort to confirm the information upon which we based our selection -- 55 vendor cases were selected for further review and analysis.

One such case involved the payment of transportation services on the date when no medical service was rendered. The computer application had identified a no match rate of 31 percent for this vendor. Three recipients had a total of 13

transportation dates for which there was no corresponding medical services. The medical providers were able to support the recipients receiving medical services on only 2 of the 13 transportation dates.

Several other cases involving potential fraud and/or abuse of over \$10,000 were uncovered and investigations are being performed.

Two other computer applications were developed. From these applications, we can identify the recipients who; (1) received the most transportation services, (2) received the greatest dollar amount of transportation services, (3) utilized the most transportation vendors and (4) received transportation services for which there was no corresponding medical services. These applications will be useful in identifying potentially fraudulent recipients and evaluating a State's procedures for controlling fraud and abuse in transportation services.

Work has been extended to Minnesota for further developing computer applications in this area.

Other Medical Practitioners

This project has involved the development of screening parameters and prototype computer programs that will identify potential abusive and/or fraudulent practices of other medical practitioners under the Medicaid program -- podiatrists, optometrists, and chiropractors. The computer programs were employed in Texas and Illinois.

The program to screen these provider services summarizes the value and quantities of services that the practitioners give to their patients. A limit for the total amount paid for all services to all patients, and a limit for the number of services given to one patient in each service category, was established. The computer program also keyed on provider claims by specialty code or doctor type and established parameters based on State program limitations. This produces peer average data on the various screening parameters, for example, nursing home visits and eye examinations. The use of peer average deviations in patterns of practice is an important element in the process of identifying and/or isolating providers with attributes known to be significant in past provider investigations, prosecutions, or believed to be indicative of potential abusive or fraudulent practices.

A total of 617 podiatrists whose claims were paid under the Medicaid program were screened, and 242 exceeded one or more of the computer screens. Seventy of these providers were subjected to a further examination. In one instance, over 50 percent of the claims of one of these providers (a podiatrist's) was for noncovered services (i.e., routine foot care). An investigation is underway and a large dollar recovery is contemplated.

Our computer applications were also applied against Medicaid paid claims for 1,962 optometrists. One or more computer screens were exceeded for 554 of these providers, of which 70 were selected for further review. An example of potential abuse was disclosed when profile data was analyzed for one of the optometrists. The data showed instances where a recipient received three eye examinations and four pairs of glasses during the year, and three members of the recipient's family received a total of seven eye examinations -- from one to four each -- and eight pairs of glasses -- from two to four each, within a 3-month period.

Based on the project's results, further scrutiny was warranted for practitioners who appear to have the most aberrant practices. Reviews and investigation continue.

PROJECT INTEGRITY II LABORATORIES

The review of laboratory services will be patterned after a pilot research project that was made in California. It will be tailored, to the extent possible, to fit the particular needs and preferences of each of the participating States. The pilot review was a joint HEW Audit Agency and California State Department of Health Services effort and included audits of independent laboratories and physicians.

The Laboratory Project is presently operational in seven States, California, Georgia, Massachusetts, Michigan, New York, Texas, and Washington.

Reviews at the participating States will include; (1) the development and testing of computer programs to identify aberrant providers, (2) the conduct of audits to determine

if there are, in fact, problems with the providers identified by the computer programs, and (3) the initiation of criminal investigations and prosecutive and administrative actions where appropriate.

The joint Federal/State audit in California, which is still in process, has uncovered discriminatory billings by laboratories charge Medicare and Medicaid considerably more than they do physicians for the same lab tests. For example, a laboratory charged physicians \$5.00 for a SMA 12 panel. However, the laboratory billed Medicaid \$42.00 for this test and was paid \$12.30, or 146 percent more than what a physician would pay. For Medicare, the laboratory charged \$42.00 and was paid \$20.00, or 300 percent more than what a physician would have had to pay. We reviewed price lists at several different laboratories, and for ten frequently ordered tests, we have determined that the maximum amounts allowed by the State were 20 to 254 percent greater than the prices quoted to physicians. The practice of laboratories charging Medicaid more than physicians for the same service is the rule, rather than the exception.

State regulations prohibit laboratories from employing discriminatory billing practices as described above. Also, the review team noted that the State's maximum allowances for laboratory tests appeared to be too high based on prevailing rates that were available to physicians.

This matter was brought to the attention of the Department of Health Services, California, who promptly agreed to study the feasibility of establishing computer edits to detect and reject claims where laboratories bill Medi-Cal more than physicians for the same service. They also agreed to study and revise the Medi-Cal maximum allowances to reflect the rates at which tests are made available to physicians. This should result in millions of dollars in savings per year in California. We plan to cover discriminatory billing in all the States participating in this project, and then expand the review, depending on our findings, to all States.

Other improper billing practices at independent laboratories include:

- Billings for lab tests that were not done. One lab, for example, billed for urinalysis tests even though the ordering physician failed to provide the required urine specimens. In another

case, a lab claimed to have performed sensitivities although the initial culture tests on the specimens were negative and sensitivities could not have been made.

--Duplicate claims. One lab, for example, submitted claims for complete blood counts and also billed separately for one of the individual blood tests comprising the complete blood counts.

--Billings for more expensive tests than those ordered by the physicians. At one lab, physicians ordered a test costing \$4 but the lab conducted a different test for which it received about \$21. In another situation, a lab performed additional tests which had not been ordered by the physicians and were not apparently needed by the patients.

--Improper profiteering on lab work performed by subcontractors. A lab had its biopsy tests done by another lab at a cost of \$10 and billed the Medicaid program \$15 for the tests.

In addition to the problems noted at independent laboratories, the Federal/State teams have disclosed physicians who claimed to have performed lab tests in their offices when, in fact, the work was done in outside independent labs. In these cases the physicians billed the Medicaid program more than their costs and thereby received payments to which they were not entitled under State regulations. As an example, one physician had a panel of six tests performed in an outside lab at a cost of \$7 but billed Medicaid for six individual tests for a total of \$42.

The individual examples which we have cited are minor in amounts. However, with the use of special computer techniques and statistical sampling methods, we are quantifying the overall extent of improper payments, some of which are expected to be substantial.

PROJECT INTEGRITY II DENTAL

The review of dental services is based on information developed by research projects performed in Virginia and

the District of Columbia. It will be tailored, to the extent possible, to fit the particular needs and preferences of each of the participating States. The project will be handled as a joint Federal/State effort utilizing staff from HEW offices of Program Integrity, Investigations, and the Audit Agency, and appropriate State officials.

The Dental Project has, at present, nine States confirmed to participate in the project. They are Arkansas, Connecticut, District of Columbia, Georgia, Illinois, Iowa, Massachusetts, Michigan and Minnesota.

Computer programs have been designed to compare individual dentist's practice patterns for selected service against what should normally be expected for the particular service selected. The program will enable a comparison of an individual dentist's practice to that of all participating dentists within the State. Dentists whose patterns significantly deviate from the norm will be selected for further review. If the dentist's patterns appear fraudulent or abusive, an in-mouth review on selected recipients will be made, by an independent dentist, to determine if the services were rendered as billed. States may also consider using in-mouth reviews to determine the quality of services rendered by participating dentists.

Advantages to using the in-mouth reviews technique are:

- . immediate classification as to potential fraud or abuse with no costly expenditure of time and resources in visiting dentists' offices.
- . work of investigators will be reduced during the investigative phase as it will be supplemented by professional medical assistance.
- . verification of dental services performed by a medical professional whose opinion should stand up in court.
- . review phase will not have to be duplicated since results can be used for prosecution.
- . results of investigation will be clear cut. The dentists either rendered service as billed or did not. There is little need for depending on recipients who may or may not be reliable.

Fraudulent and abusive practices of dentists have been detected and reported by several States throughout the country. Many of these dentists have been indicted and convicted. Some examples are:

- . dentist claimed a large number of surgical extractions on deciduous (baby) teeth. Investigation of the dentist revealed that he was fraudulently claiming for services, such as, surgical extraction and periodontal scaling on deciduous teeth which were never performed.
- . dentist claimed 2 1/2 times the average number of services for his Medicaid recipients than his peers. Investigation revealed that many of the services were not rendered.
- . dentists claimed twice the average number of patient education services than his peers. Investigation revealed that many of these services were not rendered.
- . dentist claimed to have extracted 38 teeth from one patient, even though the average adult has 32 teeth.

Working with State Medical Officials computer applications and parameters have been developed and tested by HEW that will help screen and identify dentists whose practices reflect these aberrant patterns.

PROJECT CRACKDOWN

Background

Project Crackdown had as its roots a series of newspaper articles written by an enterprising investigative Philadelphia reporter. The reporter went undercover and submerged himself in the Philadelphia drug culture which, in part, fed off of the Medicaid program. According to the reporter, there was a widespread, systematic rip-off of the Medicaid program caused by unscrupulous physicians, pharmacies and recipients. The rip-off begins when a recipient, either a drug pusher or user, visits a physician who has the street reputation of prescribing drugs on demand. The physician or "croaker", as he is known on the street, requires the recipient to sign one or more blank Medicaid claim forms in return for the drug prescriptions filled. All three parties to this rip-off profit: the physician charges Medicaid for at least an office visit, and oftentimes for ancillary services; the pharmacy charges Medicaid a dispensing fee; and the recipient has the drugs to abuse or to sell on the street.

Project Crackdown Objectives and Approach

As a result of this deplorable situation in Philadelphia, the Secretary ordered a nationwide crackdown on Medicaid drug abuse. The project was assigned to the Health Care and Financing Administration and is under the direct management of their Office of Program Integrity. The Office of the Inspector General is working very closely with the Office of Program Integrity, the Medicaid State Agencies and, where applicable, the newly established Medicaid Fraud Control Units. The project is making maximum use of the information generated by the States' computer systems now in place but the Inspector General's Office stands ready to provide States additional computer expertise wherever necessary.

The objectives of Project Crackdown, as this effort has been titled, are twofold. First, we intend to identify and to take action against Medicaid drug pushers at all levels, including those who operate under the guise of medical practitioners as well as those who do their dealing on the streets of our cities. The actions will

range from a jail term to licensure revocation to termination from the Medicaid program for those practitioners guilty of drug abuse. The most flagrant recipient pushers will be prosecuted and the others will have their Medicaid utilization practice restricted to a single physician and/or pharmacy in accordance with established State policy. Secondly, working with the States involved in the project, we will develop for immediate implementation regulatory and administrative improvements which will prevent the Federal and State Governments from ever again subsidizing drug abuse on such a wide scale.

Project Crackdown is taking place in ten cities listed below.

Boston, Massachusetts	San Francisco, California
Dallas, Texas	Los Angeles, California
New York, New York	Atlanta, Georgia
Detroit, Michigan	Minneapolis/St. Paul, Minnesota
Kansas City, Kansas	Philadelphia, Pennsylvania
and Missouri	

In all of the cities actions are underway to identify physicians and pharmacies for review.

The results in Philadelphia, although preliminary, are nevertheless encouraging.

As previously reported, court action had already been taken against four identified "croakers". Three were convicted and the fourth committed suicide prior to trial. The State Agency has taken administrative action against an additional four "croakers". One has been given a life time suspension from Medicaid (this automatically applies to Medicare also) and two have been suspended for ten years.

To date, the Philadelphia District Attorney's Office in conjunction with the Medicaid Fraud Control Unit is taking the lead role in Project Crackdown. Its investigations of two "croakers" under the Operation Weak Link concept has led them into concurrent investigations of three additional "croakers", four pharmacies, two Medicaid mills and one laboratory. There are strong indications of common ownership of the two mills and

the laboratory; and, the investigation continues. One investigator extremely familiar with the case suspects that Project Crackdown will eventually show a mass conspiracy to defraud the Medicaid program by a small group of businessmen who control a large number of medical providers including mills, ambulance services, and laboratories.

The FBI has limited its primary investigations to one "croaker" and one pharmacy.

We also agreed to provide the Assistant U. S. Attorney data packages on ten additional investigative targets. Five targets will consist of a "croaker", a pharmacy, a radiology laboratory, an independent laboratory and an ambulance service, if appropriate.

OTHER LEGISLATIVE IDEAS TO ENHANCE MEDICAID
FRAUD, ABUSE AND ERROR CONTROL

It should be stressed that none of these ideas have been put through a formal review and drafting process. However, they are matters worthy of discussion and further development where agreement can be reached as to their value.

1. Legislation Needed to Permit Competitive Selection Of Fiscal Agents

- As proposed in an excellent task force report HCFA should seek new legislation to permit a combined and fully integrated Part A and Part B structure for administration of the Medicare program. In combining the administration of Part A and Part B, the number of contractors should be reduced, the contractor areas should be defined on a geographic basis using States as the building block, the nomination process should be eliminated, the prime contract with the Blue Cross Association should be terminated, and the role of the Division of Direct Reimbursement should be limited to dealing only with Federal providers and special cases where the Government believes it is advantageous to efficient program administration. In addition, all contractors should be selected on a competitive basis and should not be limited to insuring organizations currently serving as contractors. Contractors should be reimbursed on a fixed price or fixed rate basis rather than on a cost basis. Implementation of these recommendations would be phased in over a period of time to ensure a very effective transition to the new contracting mode and to assure no disruption to Medicare operations. Furthermore, HCFA should experiment with separating the provider reimbursement and audit function from other contractor functions under a combined Part A and Part B arrangement.
- If a decision is made not to combine the administration of Medicare Part A and Part B under a single contractor, legislation should be sought to eliminate the nomination process under Part A and to select and reimburse intermediaries on a competitive fixed price or fixed rate basis. In addition, the number of

intermediaries should be reduced by redefining intermediary jurisdictions based on geography with State boundaries as the building block, but not to exceed an HEW region. Furthermore, the Blue Cross Association prime contract should be terminated and the role of the Division of Direct Reimbursement should be limited to dealing only with Federal providers and special cases where the Government believes it is advantageous to efficient program administration. HCFA should also experiment with separating the provider reimbursement and audit function from other functions performed by intermediaries. For Part B, carrier jurisdictions should be redefined based on geographic and workload characteristics using State boundaries as a building block to allow for multistate or substate areas and the number of areas should be reduced. In addition, legislation should be sought to select and reimburse carriers on a competitive fixed price or fixed rate basis and should not be limited to insuring organizations.

--HCFA should conduct experiments with respect to integrating the administration of the Medicare and Medicaid programs under a single contractor. These experiments can be conducted under existing statutory authorities.

--HCFA should impose substantive requirements and mechanisms to improve, monitor and evaluate State procurement practices to ensure effective competition for contracts in the Medicaid program. Additionally, policies should be standardized, wherever possible, to institute uniformity between Medicare and Medicaid contracts and contracting procedures. These actions can be implemented on an administrative basis and do not require enabling legislation.

--In order to promote fair and open competition for Medicaid procurements as well as assure the proper and efficient administration of State contracts, it is recommended that the following be developed:

--a mechanism to generate, evaluate and monitor a coherent national picture and understanding of State procurement practices

--an overall program strategy for contract administration under Medicaid

--comprehensive policies and regulations to guide State procurement processes

--detailed procedures to provide effective oversight and monitoring of procurements.

2. Statute to establish Federal criminal jurisdiction for theft or embezzlement of Federal grant and contract funds. Once the proceeds of an HEW grant are in the possession of the grantee, it is not a Federal offense to steal them. Yet substantial sums are at risk, and it is the Federal Government that has the primary interest in their protection. We should not have to rely on the vagaries of local law enforcement and State statutes when the basis for Federal jurisdiction seems clearly to be present. We would suggest that the Congress give consideration, therefore, to enacting legislation which would make it a Federal crime to embezzle or otherwise criminally convert Federal grant, contract, or other assistance funds. In this regard it is noteworthy that similar provisions already cover certain Federal grants and are continued or expanded in proposed Section 1731 of the Criminal Code Reform Act.
3. Amend 42 U.S.C. 1396h to upgrade from misdemeanor to a felony, penalties against persons who knowingly use their Medicaid cards to aid in the procurement of controlled substances under certain conditions. When a Medicaid card is used to procure drugs in violation of a Federal or State controlled substances or narcotics law, make it a felony for a Medicaid recipient whose card has been used for that purpose to have loaned or sold his card knowing that it was to be used for that purpose. In a sense, the recipient will have been shown to have engaged in a conspiracy to violate the narcotics law.
4. Amend 42 U.S.C. 1396h to make it unlawful for a practitioner to pay a druggist to fill his prescriptions for controlled substances. This type of "reverse kickback" has been found in use by Operation Crackdown.

5. Amend 42 U.S.C. 1395 cc to require termination from participation (or a very long suspension) from the State's Health Care programs after being convicted of violating any provision of the Controlled Substances Act or any provision of a similar State law. The same statute might likewise provide HCFA authority to suspend from Medicare and Medicaid (following due process procedures) any practitioner who excessively prescribed the controlled substance in violation of standards HCFA would set by regulation.
6. Propose model legislation to States providing for lifting a doctor's license to practice medicine if he knowingly supplies prescriptions for controlled substances, or controlled substances themselves, where a doctor-patient relationship has not been established, where the drugs are not medically necessary, or where the drugs are to be sold on the streets in violation of narcotics laws. Also provide for a quick "temporary restraining order" upon indictment for a violation of 21 U.S.C. 841. This is an action that would help bolster our ability to act adequately in the types of problems being investigated in Operation Crackdown.
7. Support legislation such as the Church Amendment to extend the period for funding of State Fraud Control Units (Section 17) for a full three year period from date of certification. We believe this is only fair and proper and in accordance with the original intent of Section 17 of P.L. 95-142. Since many of the Units have only been recently certified and there are a number of other applications yet to be submitted, the available period of funding has already been reduced to two years or less. This is inadequate in many cases for a unit to establish itself and demonstrate its cost effectiveness.
8. Statute to establish Federal criminal jurisdiction for bribing certain non-Federal administrators who control the expenditure of Medicare or Medicaid funds. This problem is analagous to that in Item 2 above. It was also discussed in our Senate testimony last summer as a further problem of enforcement due to lack of adequate statutory authority. Under present law one who gives

to a State Medicaid official -- neither of whom is a Federal public official -- has not violated the Federal Bribery Statute. It would seem proper for Congress to enact legislation making it a Federal offense to give something of value to a carrier, intermediary, State or Fiscal Agent employee with the intent to influence his action in connection with either Medicare or Medicaid programs.

9. We reaffirm our support for modifying the "Free Choice of Providers" provisions in the selection of laboratories and suppliers of medical supplies and equipment. This would permit awards based on competitive bid prices and effect savings estimated conservatively at \$5 million annually for eyeglasses and hearing aids alone. Last year the Senate passed a Bill (S.705) known as the Clinical Laboratories Bill, and the House held hearings on but did not pass a companion Bill -- H-10909.

EXAMPLES OF INTERJURISDICTIONAL MATCH CASES

1. Illinois/Michigan

The recipient apparently maintained residences in both Chicago, Illinois; and Detroit, Michigan. From June 1971 through March 1978, the recipient received AFDC benefit payments of \$38,171 from Illinois. The amount does not include Medicaid or food stamps. The recipient also received approximately \$40,000 from the State of Michigan in AFDC benefits during that same period.

The case is still under review by the Illinois Department of Public Aid, preparatory to referral to authorities for investigation and prosecution. Actions to be taken by the State of Michigan, so far as we can determine at this time, will depend on the results of the Illinois investigation.

2. New York/California

This case has been active in New York State continuously since 12/1/69 and in California since 1/75. The client was visited in New York City and admitted to receiving four (4) duplicate grants. She has apparently defrauded California for \$15,000. The FBI is pursuing the case.

3. Kentucky/Illinois

The HEW Interjurisdictional Match identified one individual receiving AFDC benefits from Kentucky and Illinois. Preliminary review had shown that for the 14-month period of June of 1977 - July of 1978 this individual received AFDC payments of about \$2,000 from Kentucky and about \$2,800 from Illinois.

The recipient was determined to be living in Louisville, Kentucky, and was removed from Kentucky AFDC program in July of 1978. He was also

removed from Illinois AFDC program in August of 1978.

This case is still being reviewed by Kentucky and Illinois AFDC officials.

4. Arkansas/Illinois

During Phase I of the Interjurisdictional Match, this client was identified as a possible recipient of AFDC assistance in both Illinois and Arkansas. As a result, a more detailed review of case records was conducted and it appears that duplication of payment was made for the period August 1976 through October 1977 and February 1978 through November 1978. The total amount of AFDC funds paid by Arkansas during this time was \$3,964. In addition, this recipient was a participant in the Food Stamp Program continuously during this period resulting in an overpayment of indeterminate amount. The case has been referred to the Fraud Investigation Unit for investigation and referral for prosecution if warranted.

5. Virginia/District of Columbia

This individual applied for and received ADC assistance from the Arlington County Department of Social Services during the following periods: May 1974 - March 1975; September 1975 - November 1975; and November 1976 - September 1977.

After detection by Project Match in July 1977, the case was investigated by the Office of Inspection, District of Columbia, Department of Human Resources. Their investigation revealed that during the above periods this recipient had resided in the District of Columbia and had continuously received assistance from the District since May 1974, under another name.

According to information received from the District's Department of Human Resources, the case was referred to the District of Columbia's Corporation Council for possible prosecution.

The Department of Human Resources has classified this case as an overpayment rather than ineligible since the recipient was a resident of the District and therefore was entitled to assistance. As of March 1978, this recipient was drawing assistance from the District.

As a result of this individual's failure to report to the Arlington County Department of Social Services her receipt of assistance from the District of Columbia and of her failure to report her residence in the District, she was totally ineligible for assistance and received a total of \$5,000.00 in AFDC funds and \$2,844.58 in Medicaid funds to which she was not entitled.

6. California

During the course of the Interjurisdictional Match when the State attempted to review the case file of a recipient, the eligibility worker stated that he could not locate the file. State investigators later searched his desk and located the file as well as the files for three other cases which should have been discontinued because the individuals had moved to other States. The eligibility worker had apparently continued the cases as active and was preparing monthly authorizations for payments. The payments section of the Welfare Department then sent the checks to an apartment rented by the eligibility worker who received the checks and apparently forged the signatures of the welfare clients and deposited the money in his own bank account. The amount involved was in excess of \$70,000. The eligibility worker was arrested and charged with embezzlement.

7. Delaware/Pennsylvania

This overpayment resulted from verifying HEW's Interjurisdictional printout received on May 3, 1978. Verification received from Pennsylvania indicates that this individual is currently receiving assistance and has been since December 1974.

This recipient has been receiving assistance in Delaware since August 8, 1974. Applications filled out by the client on August 8, 1974; September 19, 1975; March 18, 1977; and May 17, 1978, make no mention of receiving assistance in Pennsylvania. An entry of February 18, 1975, indicates the case was closed effective March 1, 1975, because the client was moving to Philadelphia, Pennsylvania. However, there wasn't a PA-1 in the record that indicated the case was ever closed.

It appears the client has fraudulently received assistance in Delaware for nearly four (4) years in the amount of \$8,075. Prosecution is recommended per APM sections 7101, 7102, and 7200.

8. Maryland/Delaware/New Jersey

This is the case of one of a number of "triple dippers".

From January 1976 through November 1978 the client and her husband, while claiming three dependent children, applied for and received AFDC payments totaling \$9,235 from Maryland. The initial and four subsequent applications for assistance did not show the receipt of any income and did not list receiving any other financial assistance. A review by HEW investigators showed that the husband held a full time job from late 1977 through most of 1978. Also, the husband received \$444.00 a month in educational assistance from the Veterans Administration from January 24, 1977 to July 21, 1977.

From March 1976 through October 1978 the client received AFDC payments totaling \$7,640 from Delaware. On the application for assistance the client stated that her husband had left her and that she had two dependent children.

From July 1976 through October 1977 the client received AFDC payments totaling \$4,683 from New Jersey. On her assistance application the client stated that she was separated from her husband and had two dependent children. In a related case, New Jersey

investigators discovered that the client's brother-in-law received AFDC payments totaling \$3,947 from the two New Jersey counties at the same time while claiming two of the client's children as dependents.

The Department of HEW's Office of Investigations is making a special review of this case. The results will be presented to the United States Attorney for the District of Maryland for appropriate legal action.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

APPENDIX J
Page 1

August 10, 1978

PROJECT MATCH II
OPERATING PLAN

A Nationwide Program to Adjust Benefits For or Remove From
the Supplemental Security Income Program Those Federal
Employees Who Are Illegally Receiving Benefits

This paper describes the goals and procedures to be used in the computer comparison of the Supplemental Security Income (SSI) files maintained by the Social Security Administration (SSA) with the Federal civilian employee roll maintained by the Civil Service Commission (CSC). The operating plan establishes the controls and discretion to be maintained over the CSC Federal employee data during the entire matching program to prevent premature or unwarranted disclosure of names of individuals and to ensure complete compliance with the Federal Privacy Act of 1974 and the confidentiality provisions of the Social Security Act.

A. Supplemental Security Income Program

Supplemental Security Income (SSI) is a Federal income maintenance program for the aged (65 or older), blind and disabled in the 50 States and the District of Columbia. Through monthly payments, the program provides a floor of income for aged, blind and disabled people who have little or no income and resources.

The basic SSI payment level is \$189.40 a month for an individual and \$284.10 for a couple. The amount of SSI which an individual obtains may vary depending on his other available income and whether the State in which he resides provides its own supplement to the basic benefit.

During FY 1977, the SSI program provided an estimated \$6 billion in Federal benefit payments to 4.2 million recipients.

B. Need for Matching Program

- . Estimates of overpayments and payments to ineligible recipients under the SSI program reported in the Inspector General's Annual Report were \$310 million (later revised to \$292 million).
- . One major cause of overpayment and payment to ineligibles is unreported income -- whether unreported by the SSI recipient or not included in the determination of benefits because of agency error.
- . A pilot project matching HEW employees with the SSI file resulted in 638 "raw" matches. Of these matches, 158 cases are undergoing investigation to determine whether overpayment or payment to ineligibles exists.
- . Based on the information gained as a result of this pilot project, it is estimated that approximately 12,000 cases may exist where employees from Federal agencies are also listed on the SSI file. Although it is not known what percentage of these cases will result in determinations of overpayment or payment to ineligibles, it is felt that the matching program will serve as an effective deterrent and reduce inappropriate SSI payments.

C. Goal and Objectives of Matching Program

The overall goal of this matching program is to eliminate from the SSI rolls any Federal employee who is illegally receiving SSI payments.

The specific objectives of the matching program are:

1. To reduce the amount of SSI overpayments and payments to ineligible recipients by eliminating those Federal employees whose Federal salary makes them ineligible for the program.
2. To refer cases to the United States Attorneys for criminal prosecution where appropriate.

3. To refer cases where fraud has been determined to the Federal employer agencies so that they may take appropriate administrative action.

D. Privacy Safeguards and Security Procedures

On August 18, 1977, the Office of the Inspector General consummated a Memorandum of Understanding with the Civil Service Commission which set forth the conditions under which the CSC would release their extract of the Central Personnel Data File to HEW for use in Project Match (the match with AFDC files). This agreement has been amended to include the match with the SSI file. The agreement sets forth the safeguards to be applied in the use of the CSC information.

In accordance with the OMB Supplemental Guidance for Matching Programs, the Civil Service Commission published a new routine use for the disclosure of their file to HEW. HEW has published a Report on New Systems under which the matching program for CSC/SSI is run. All disclosures made during the matching program are in accordance with the provisions of the Privacy Act and the OMB guidelines.

The CSC tapes are under the control of and personally handled by the Division of Social Security Audits, HEW Audit Agency, OIG. The tapes are returned to the CSC by the HEW Audit Agency. SSA takes custody of the match tapes from the HEW Audit Agency and processes them in a secure area. All the match tapes and work tapes are held in a locked tape library and are degaussed at the completion of the matching program.

No further use of the CSC records, not matching SSI records, is made. Where payment under both SSI and RSDI, (Retirement, Survivors, and Disability Insurance) is disclosed under the matching program, both SSI and RSDI records and case folders are used in determining eligibility.

The Central Office Integrity Staff retains the combined CSC and SSI data under lock and key once it is received from the HEW Audit Agency. The data is available only to those senior personnel who are actually assigned to the project.

The Central Office Integrity Staff maintains an automated records control system for the purpose of tracking the cases through the various processing steps. The system is computer-based, complete with back-up data base. This system is accessed only by a single analyst.

Data is disseminated to the various Regional Integrity Staffs by registered mail through the SSA Regional Commissioners. The transmitting memoranda are stamped "FOR OFFICIAL USE ONLY" to designate them as confidential material. Embodied in the envelope address is the phrase "TO BE OPENED BY ADDRESSEE ONLY." The envelope is also annotated "DO NOT OPEN IN MAILROOM" across the bottom to prevent opening by anyone other than the designated SSA Regional Commissioner.

In the Regional Integrity Staff Offices, a limited number of staff members have access to the data on a "need-to-know" basis. The material is maintained under lock and key. Similar handling takes place in the SSA District Offices. The District or Branch Manager is responsible for safeguarding the data. The same safeguards used by the Central Office Integrity Staff in transmitting the data are followed at all levels.

E. The STEP-BY-STEP Plan for Operation of the CSC/SSI Matching Program

- . At Attachment A is a flow chart showing the principal action steps involved in the CSC/SSI matching program.
- . At the national level, the Inspector General and the Commissioner, Social Security Administration, personally approve each key action required.
- . Once the matching program, including the publication of notices in the Federal Register, the acquisition of data files from CSC and SSA, and the computer comparison of files is accomplished, the resultant cases are handled in accordance with the routine procedures of the Social Security Administration. These procedures, for investigation and referral of cases to the U. S. Attorneys, are

published in the SSA Claims Manual, Part VII,
Bureau of Retirement and Survivors Insurance,
Office of Program Operations.

- . The STEP-BY-STEP procedure is as follows (See Attachment A):

Step 1 - Acquisition of Data Files from CSC and SSA.

Computer tapes are obtained from the Civil Service Commission and the Social Security Administration. (See Section D for the details of the agreement with CSC)

Senior members of the Division of Social Security Audits, HEW Audit Agency, are personally responsible for acquiring and controlling the CSC tape and SSI tape. They are also responsible for returning the tapes once the matching program has been completed.

Step 1a - Return of Data Tapes to CSC and SSA.

The computer tapes from the CSC and SSA are returned to them within 60 days from the beginning of the matching program by the Division of Social Security Audits, HEW Audit Agency.

Step 2 - Computer Processing of Files

The computer processing of the CSC and SSI files is conducted under the direction of the Division of Social Security Audits, HEW Audit Agency, on HEW computer equipment. (See Section D for details on privacy safeguards and computer security)

The basic matching criterion is Social Security number. Gross counts of total matched records by Federal agency and total records by agency are produced for control purposes.

The SSI file contains active and inactive records. An inactive record is one for which no cash payments are being made currently.

Step 3 - Request to Federal Agency for Pay Data

Once the cases have been matched, those cases where the SSN and date of birth or first 6 letters of surname match are sorted by Federal agency and forwarded by the HEW Audit Agency to the Federal agencies for validation of employment status and submission of quarterly wage data for the past 8 quarters -- October 1, 1976 - September 30, 1978. The wage data must be provided on a quarterly basis so that the SSA may make an accurate re-determination of eligibility for the cases in question.

Data sent to the Federal agencies includes SSN, name, and date of birth. Federal employer agency is also indicated.

Where possible, the exchange of requests and pay data is conducted via computer tape (or cards). In cases where this is not possible, a listing of cases is forwarded to be completed with pay data by the Federal agency. Attachment B shows the format for tape, card and listings used in the Federal agency exchange.

Step 4 - Further Computer Processing

Once the matched cases are produced and the pay data has been received from the Federal agencies and entered into the computer, the computer sorts these matched cases by region and identifies those cases for priority handling based on the following criteria:

1. Matching factors -- those cases where SSN and date of birth and/or first 6 letters of surname match;
2. SSI payment status -- those cases in current receipt of SSI payments;
3. Title II involvement -- those cases where there is indication of receipt of both SSI and RSDI benefits;

4. Payment amount -- those cases with highest SSI payment amounts.

Inactive SSI cases which do not involve actual receipt of SSI payments are separated from the main processing. These cases are checked to see whether Federal employment was indicated on the application and, if not, appropriate action is taken by the District Offices. The SSI records are updated to include the fact of Federal employment. This eliminates any possibility of subsequently putting cases into payment status improperly.

Those cases involving HEW employees who were already investigated as part of the pilot project are sorted out from the main processing so that no duplicate investigation takes place.

Step 5 - SSA Central Integrity Staff Review of Prioritized Cases and Referral of Cases to the Regional Commissioner for Further Processing

Further development of cases is accomplished by Central Office Integrity Staff including: preparation of detailed instructions for Regional Integrity Staff; entry of data into the automated control system; and requesting research of the SSN or related information. Cases are then referred to the Regional Integrity Staff through the SSA Regional Commissioner for further processing.

Step 6 - Regional Office Review of Cases and Initial Indication of Improper Payment

Based on the Regional Integrity Staff review of cases, the cases are separated into those in which improper payment is indicated and those cases are forwarded to the SSA District Office for further processing.

Those cases in which there is no indication of improper payment and which contain Federal employment data are closed as far as the matching

program is concerned. The Central Office Integrity Staff is informed and they update the control system to reflect this situation.

Step 7 - Cases of Improper Payment Forwarded to District Offices

Those cases in which there has been an initial indication of improper payment are referred to the SSA District offices for further processing.

Step 8 - District Office Processing

District office personnel conduct personal interviews of recipients and review appropriate files and based on all information received (1) redetermine eligibility, (2) take any post adjudicative action (including suspension of benefits), and (3) initiate any overpayment recoupment procedures.

Step 9 - Regional Office Review of District Office Redeterminations

The Regional Office Integrity Staff makes a complete review of the data gathered by the District Offices in all cases.

Step 10 - Further Action Required on Potential Fraud Cases

In some cases there may be a need for further information to be gathered in order to make a determination of fraud. The District Office or Regional Office is involved in collecting and reviewing the additional data.

Step 11 - Cases Referred for Routine Processing

Once the additional information has been obtained, the cases are channeled back into the routine process at the appropriate level - either District or Regional.

Step 12 - Cases With No Fraud Indicated

Once there has been a determination that no fraud exists in a case and the necessary adjustments

have been made by the District Office (e.g., payments reduced due to income previously reported but not acted on because of agency error), the cases are closed and the control system is updated.

Step 13 - Referral of Cases to U. S. Attorneys for Investigation and Prosecution

In accordance with established operating procedures, all cases where there is sufficient evidence of fraud are referred to the appropriate U. S. Attorneys.

Some of the cases are recommended for prosecution by the U. S. Attorneys, others are referred with recommendation that, because of extenuating circumstances, no prosecution be pursued. Data is reported on the number of cases referred to the U. S. Attorneys, number investigated for prosecution, and number of cases where prosecution was declined. The results of all prosecutions are reported also as a part of the bi-weekly reporting system.

Step 14 - Referral of Cases to Federal Agencies for Administrative Sanctions

All cases where fraud has been determined, whether prosecuted or declined by the U. S. Attorneys, are referred to the Office of the Inspector General (Division of Social Security Audits, HEW Audit Agency) for referral to the appropriate Federal agencies employing the individuals involved in the fraudulent activity.

It is expected that the Federal agencies will pursue the application of administrative sanctions in accordance with their established procedures.

Step 15 - Reporting Procedures

Status reports on the matching program will be provided to the Inspector General through the Division of Social Security Audits, HEW Audit Agency. These reports are produced from data entered into the automated control system as well

as from any supplementary source as required.

Reports should include the following data:

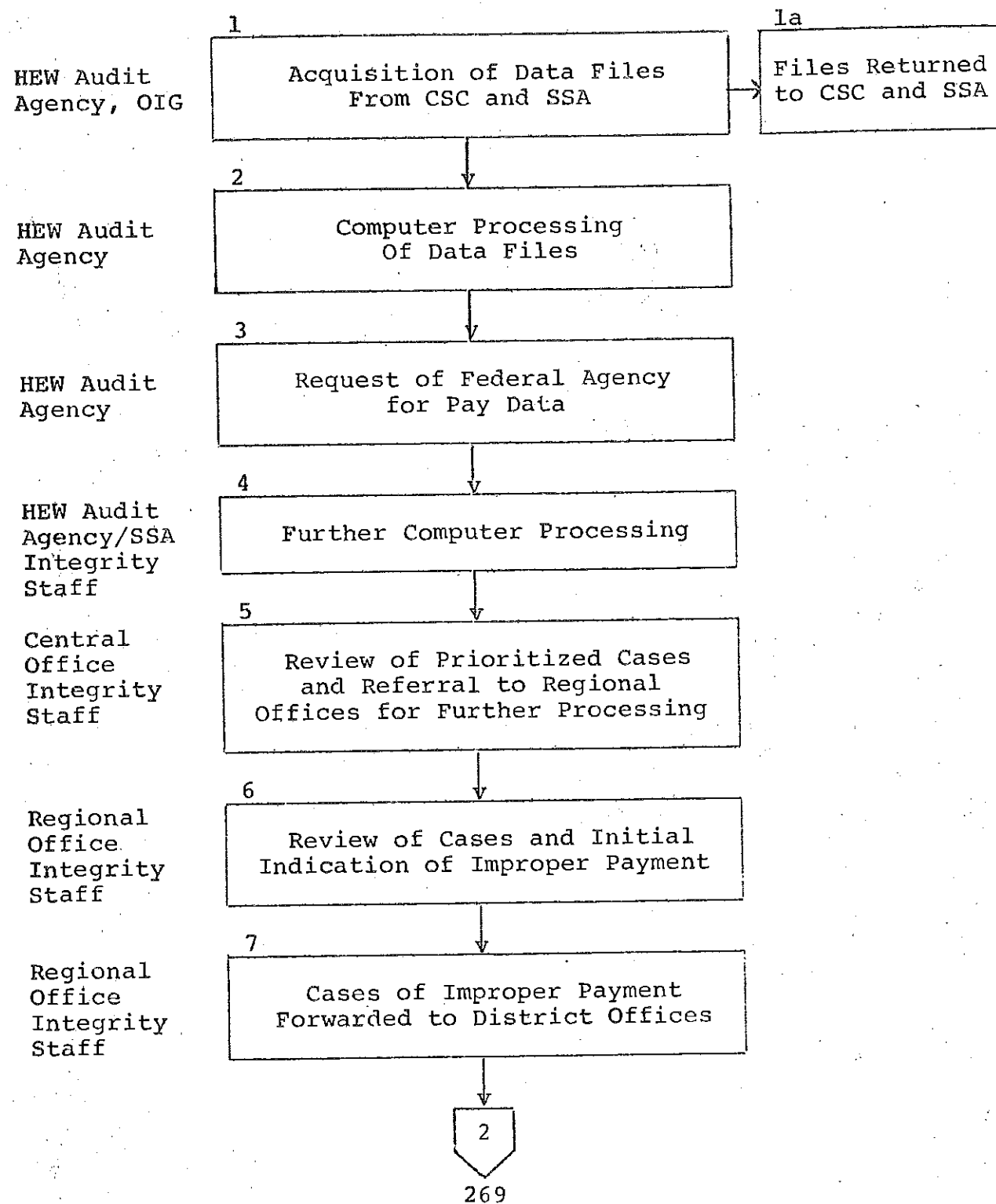
1. Number of matches on SSN only;
2. Number of matches on SSN and date of birth or first 6 characters of surname;
3. Number of cases referred to Federal agencies for employment validation;
4. Number returned from Federal agencies;
5. Number referred to Regional Integrity Staff through SSA Regional Commissioners;
6. Number found eligible in Regional Office review;
7. Number referred to District Offices;
8. Number of cases where no fraud has been involved;
9. Number of fraud cases referred to U. S. Attorneys;
10. Number of cases undergoing investigation for prosecution by U. S. Attorneys;
11. Number of cases declined by U. S. Attorneys;
12. Disposition of cases prosecuted by U. S. Attorneys.

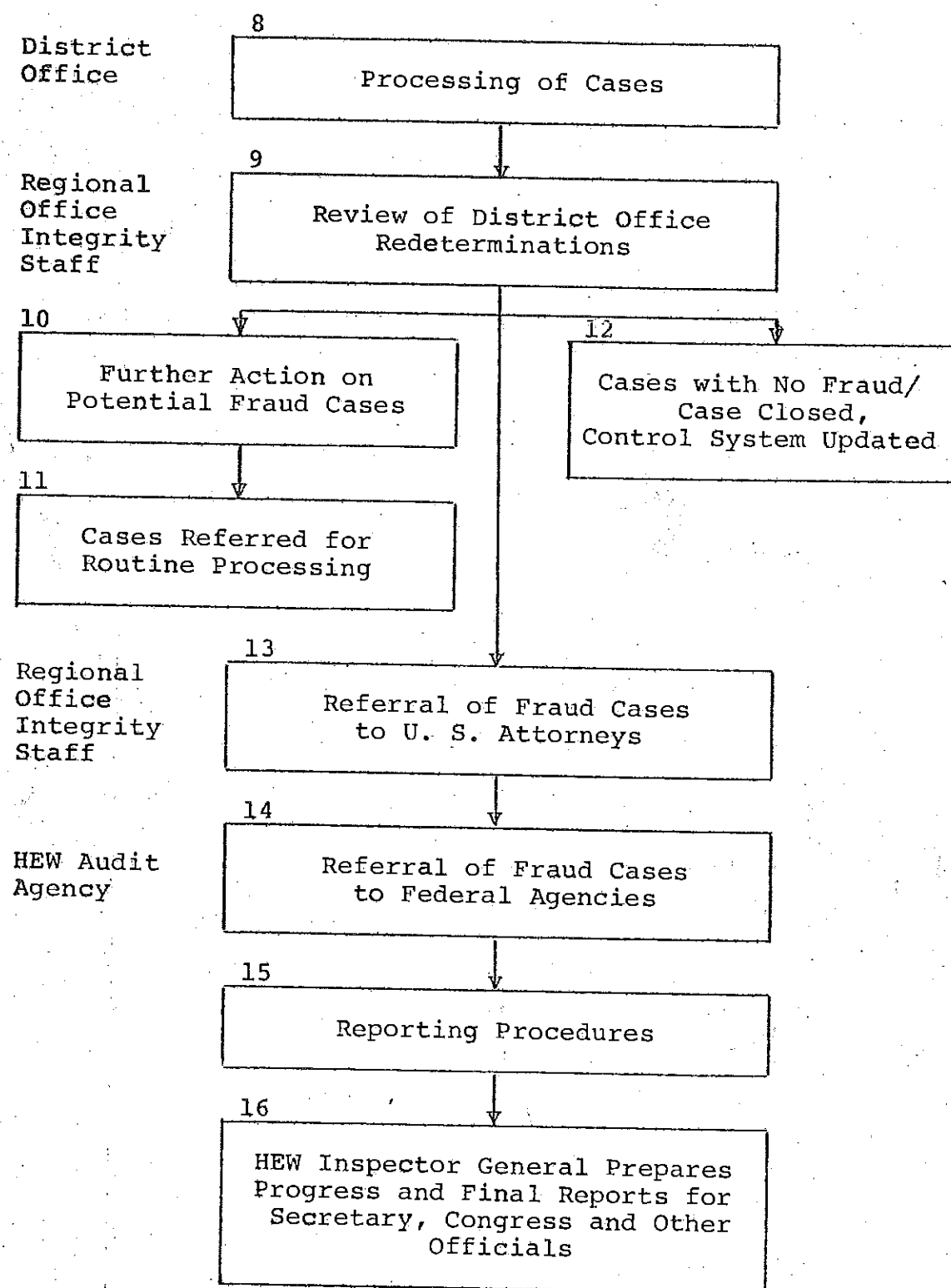
In addition, reports should be made of the savings and recoupments made as a direct result of the matching program.

Step 16 - HEW Inspector General Prepares Progress and Final Reports for Secretary, Congress and Other Officials

The Inspector General will report results of this matching program to the Secretary, Congress and other interested officials as required.

CSC/SSI
MATCHING PROGRAM
FLOW CHART





Information Request Record

Source: DHEW, Office of Inspector General, HEW Audit Agency

Media Available: Tape (IBM Standard label, 9 Trk, 1600 BPI)
Cards (80 Column)
Listing

Description: A record with the following employee information will be provided to the participating Federal agency for each SSI/CSC match case. The agency can specify the desired media.

Format:

<u>Location</u>	<u>Contents</u>
1- 9	Social Security Number
11-14	Agency ID
16-35	Name
37-44	Value 'DHEW/OIG'

If a printed record is requested by the Federal agency, the format of the record will be as shown on the attachment. The original printed record should be completed and forwarded back to HEW.

Payroll Information Record

Source: Participating Federal Agencies

Recipient: DHEW, Office of Inspector General,
HEW Audit Agency

Media Requested: Magnetic Tape (IBM Standard Label,
9 Track, 1600 BPI)
Punch Card
Listing

A record for each SSI/CSC match case should be returned to DHEW with the requested employee information in the format provided for below. If the requested information is not available for a particular case, a record with the DHEW supplied information should be returned and the other data fields left blank.

Format:

<u>Location</u>	<u>Contents</u>
1- 9	Social Security Number
10-15	Date of Birth
16-23	First 8 digits of surname
24-24	First initial of given name
25-28	Separation Date, month and year (MMYY)
29-32	Entry on Duty Date, month and year (MMYY)
33-36	Gross Wages 10-76 thru 12-76
37-40	Gross Wages 1-77 thru 3-77
41-44	Gross Wages 4-77 thru 6-77
45-48	Gross Wages 7-77 thru 9-77
49-52	Gross Wages 10-77 thru 12-77
53-56	Gross Wages 1-78 thru 3-78
57-60	Gross Wages 4-78 thru 6-78
61-64	Gross Wages 7-78 thru 9-78

SSA PROGRAM INTEGRITY HIGHLIGHTS

PREPARED BY THE ASSOCIATE COMMISSIONER FOR
MANAGEMENT AND ADMINISTRATION

- I. Administrative Matters Affecting SSA Program Integrity
 - A. Reorganization of Program Integrity Components
 - B. Study of Fraud Case Methods, Policies, and Procedures
 - C. Problem in Getting Fraud Cases Prosecuted
 - D. Study of Fraud Case Processing Time and Accuracy
 - E. Analysis of Fraud Cases for Corrective Management Action
 - F. Improving Fraud Case Reporting Methods
 - G. Revised Agreement Between SSA and the Office of the Inspector General (OIG)
 - H. Social Security Number (SSN) Matters
 - 1. Tightening of SSN Issuance Process
 - 2. Study of Validity of SSN Issuances
 - 3. Penalties for Illegal SSN Activity
 - I. Program Integrity Workshops and Training
 - 1. Identification of False Immigration and Naturalization Service (INS) Documents
 - 2. Investigative Training
 - 3. Workshop on AFDC Fraud

- 4. Other Fraud Training Courses and Conferences
- J. SSA Future Process Project
- II. Retirement, Survivors, and Disability Insurance (RSDI) Programs -- Program Integrity Developments
 - A. RSDI Quality Review System
 - B. Systems Control of RSDI Overpayments
 - C. Inclusion of Non-Disability Aspects in End-of-Line Review of DI Cases
 - D. Student Benefit Initiatives
 - 1. Recontact Operation
 - 2. School Certification of Student Attendance
 - 3. Study of Erroneous Payments to Student Beneficiaries
 - 4. Interface of SSA Student Records with Basic Education Opportunity Grant (BEOG) Program Records
 - E. Redesign of RSDI System
 - F. Match of HEW Payroll Against RSDI Payment Records
 - G. Master File Duplicate Record Detection (MAFDUP) Program
 - H. Project PROBE (Periodic Random Operational Benchsite Evaluation)
- III. Supplemental Security Income (SSI) Program -- Program Integrity Developments
 - A. Reduction in SSI Payment Error Rate
 - B. Study of SSI Disability Conversion Cases

- C. Concentration of Resources on High-Risk Cases
- D. SSI Job Specialization
- E. Coordination of SSI/DI Disability Payment Process
- F. Records-System Interfaces to Prevent or Detect Erroneous SSI Payments
- G. Legislation Sought for Match Against IRS Records
- H. Match of HEW Payroll Against SSI Payment Records
- I. Match of Federal Civilian Payroll Against SSI Records
- J. Supplemental Security Record (SSR) Internal Match to Detect Duplicate Payments
- IV. Aid to Families with Dependent Children (AFDC) Program -- Program Integrity Developments
 - A. Slight Change in AFDC Payment Error Rates
 - B. Welfare Management Institute
 - C. Six-State Plan
 - D. Data-Exchange Initiatives
 - 1. National Recipient System
 - 2. Data-Exchange Survey
 - 3. Data-Exchange -- Laws and Regulations
 - 4. Data-Exchange Conferences and Meetings
 - 5. Beneficiary Data Exchange (BENDEX) Improvements
 - E. New Quality Control Regulations

- F. Expanded Financial Management and Audit Activity
- G. Expanded Technical Assistance and Management Audit Activity
- H. Expanded Program Integrity and Corrective Action Planning Staff
- I. Administrative Cost Study
- V. Child Support Enforcement Activity -- Program Integrity Developments
- VI. Legislative Proposals Affecting Program Integrity
 - A. Assume for AFDC Purposes That a Stepparent's Income is Available to Stepchildren Unless the Stepparent Signs An Affidavit that the Income is Not Available
 - B. Restrict SSI Eligibility of Persons Who Dispose of Property in Order to Qualify for Benefits
 - C. Recover SSI Overpayments From RSDI Benefits
 - D. Define Aliens as Public Charges

I. Administrative Matters Affecting SSA Program Integrity

A. Reorganization of Program Integrity Components

SSA consolidated RSDI and SSI program integrity responsibilities, which had been scattered among various components, and also moved to establish an AFDC program integrity unit.

Under this consolidation, all cases in which SSA recommends prosecution now flow to United States Attorneys through the Offices of the Regional Commissioners, thus assuring uniformity of case presentation regardless of the program the offense involves. Regional staffs also now have an investigative capability across program lines.

SSA also established a headquarters component independent of program operations, with responsibility for developing agency-wide integrity policies and standards, and for reviewing and reporting on agency performance in this area.

B. Study of Fraud Case Methods, Policies, and Procedures

SSA began planning an intensive study of its methods for identifying suspected fraud cases for investigation, and of its policies and procedures for handling such cases once identified.

The latest available data shows that over 90 percent of all reported cases wash-out from a prosecutive standpoint. While investigation of such cases does yield data useful for the evaluation of claims systems and processes, and sometimes spurs refund of overpayments, the high rate of case closure short of recommending prosecution raises a question about the overall efficiency of SSA operations in this area.

2. Study of Validity of SSN Issuance

SSA completed the redevelopment of 550 San Francisco Region cases in which SSNs had been issued, and began analysis of the results. The objective is to test the efficiency of SSN issuance procedures. Although the test cases involved SSNs issued prior to the May 1978 tightening of issuance requirements, the findings will be useful in designing the planned 1979 national study of SSN issuances, and an SSN quality assurance system.

3. Penalties for Illegal SSN Activity

SSA recommended that the FY 1980 legislative program include increasing the maximum monetary penalty for SSN fraud from \$1,000 to \$5,000, and putting a specific provision in the Social Security Act that would make it illegal to counterfeit, alter, buy, or sell social security numbers and cards. This underscores SSA's view that SSN fraud is a serious matter and that more severe penalties ought to be applied where convictions result.

I. Program Integrity Workshops and Training

A number of program integrity workshops and training courses were planned and/or conducted for SSA and State personnel.

1. Identification of False Immigration and Naturalization Service (INS) Documents

Working with INS, in December 1978, SSA scheduled a series of pilot training sessions designed to help SSA field personnel identify fraudulent INS documents presented with SSN or benefit applications. Initial efforts are to be concentrated in the San Francisco and

Chicago Regions, where a large number of false documents have been encountered, and in the New York, Atlanta, and Dallas Regions, where the same problem is suspected.

2. Investigative Training

SSA developed and presented three times in the course of the year a 9-day comprehensive training course on how to investigate violations of the Social Security Act. Instructors included representatives from a U. S. Attorney's office; the FBI; the Secret Service; the Postal Inspection Service; State and local police agencies; and the HEW Office of the Inspector General (OIG). About 120 individuals from central and regional office program integrity components took the training.

3. Workshops on AFDC Fraud

SSA sponsored a Fraud Prevention Workshop in Seattle in January 1978, to facilitate the exchange of ideas and methods for preventing fraud in the AFDC program. The Workshop was attended by SSA central and regional office staff, and by representatives of OIG and all the States in the Seattle Region. A document entitled "A Blueprint for Fraud Prevention" was developed as a result of this Workshop, and will be distributed to all States for use in their AFDC fraud control efforts. SSA also began planning a series of similar workshops or conferences, to be held in the remaining nine regions.

4. Other Fraud Training Courses and Conferences

In December 1978, SSA helped arrange and participated in the Secretary's National Conference on Fraud, Abuse,

and Error. SSA representatives also participated in the Fourth Regional Conference on Welfare Fraud presented in June 1978 by the Eastern Regional Council on Welfare Fraud, and in the Sixth Annual Conference of the National Welfare Fraud Association held in October 1978.

J. SSA Future Process Project

The Future Process Project will result in a new systems design under which SSA will do business in the 1980's and beyond. While the primary emphasis is on more efficient use of computer technology to reduce costs, SSA also contracted for concept studies and the development of performance requirements in the areas of privacy, systems security, and freedom of information. This effort will culminate in the integration of privacy protections, freedom of information mechanisms, and security and audit safeguards in the basic fabric of the Future Process.

As part of this effort, the contractor will also identify current and projected trends in fraud and abuse and provide performance requirements for their prevention and detection in the SSA Future Process.

II. Retirement, Survivors, and Disability Insurance (RSDI) Programs -- Program Integrity Developments

A. RSDI Quality Review System

SSA completed preliminary work on the RSDI Quality Review System to go into effect in 1979. This system will measure payment accuracy in the RSDI program, and provide information showing where corrective management action is needed.

B. Systems Control of RSDI Overpayments

Prior to 1978, only about 10 percent of all RSDI overpayments were under systems control. In January 1978, the Recovery of Overpayments Accounting and Reporting (ROAR) system began to control about 80 percent of all newly-detected overpayments. ROAR has facilitated overpayment recovery and the identification of error-prone areas for corrective management action.

C. Inclusion of Non-Disability Aspects in End-of-Line Review of DI Cases

SSA began a pilot of a system for identifying the cause of SSA error in processing the non-disability aspects of disability claims. Previously, only the medical aspects of these claims were reviewed for accuracy. This system will enable SSA to better isolate problem areas for corrective management action.

D. Student Benefit Initiatives

1. Recontact Operation

Late in 1977, SSA had instituted a student recontact operation, to attack the problem of overpayments caused by failure to report cessation of school attendance. During the October 1977 - March 1978 period, about 25,000 more students were terminated than had been terminated in the same period in the previous year. It is estimated that this resulted in cost-savings of about \$14 million in the last two quarters of FY 1978.

2. School Certification of Student Attendance

Late in 1978, SSA finalized plans to require students to provide certification

of attendance from the schools beginning in February 1979. Previously, there were no standard requirements to furnish corroborating evidence of school attendance.

3. Study of Erroneous Payments to Student Beneficiaries

SSA began analysis of data from a study to determine the amount of money paid in error to student beneficiaries. The data will be used to develop error-prone profiles, for corrective management action.

4. Interface of SSA Student Records with Basic Education Opportunity Grant (BEOG) Program Records

SSA finalized plans to interface its student records in April 1979 with records from the BEOG program run by the Office of Education. The BEOG records may show that a student's status is such (married or not attending school full time) that he or she is ineligible for RSDI student benefits.

E. Redesign of RSDI System

SSA continued work on this major redesign effort. The objective is to automate processing of several types of extremely complex cases which are now worked clerically, and thus to improve accuracy and efficiency. Systems modifications are scheduled for implementation in March 1979.

F. Match of HEW Payroll Against RSDI Payment Records

SSA began investigation of 549 cases identified by OIG as involving possible improper receipt of RSDI benefits by HEW employees. As of the end of the year, the fraud aspects of 212 cases had been closed for a variety of reasons. One case had been referred to the U. S. Attorney

for prosecution. The remaining 336 cases were still under investigation.

G. Master File Duplicate Record Detection (MAFDUP) Program

The MAFDUP program identifies individuals with the same name, date of birth, and zip code who appear on SSA's RSDI benefit payment record under more than one SSN and thus may be receiving some benefits improperly. In 1978, SSA completed development of cases identified in the 1977 MAFDUP operation. A total of \$2.3 million in RSDI overpayments was disclosed. The MAFDUP program will be run again in 1979.

H. Project PROBE (Periodic Random Operational Benchsite Evaluation)

Late in 1978, SSA began a pilot program of unannounced auditor visits to work areas in which there is potential for employee fraud. Under this program, the auditor selects from the worksite, at random, computer input forms or other claims payment authorization materials for review and checking back against documentation in claims folders. The objective is, of course, to deter employee fraud.

III. Supplemental Security Income (SSI) Program -- Integrity Developments

A. Reduction in SSI Payment Error Rate

SSA reduced the SSI payment error rate from 5.2 percent to 4.6 percent for the 6-month period ending with March 1978. Total erroneous payments in FY 1978 were \$297 million, a reduction of \$53 million from the previous 6-month period, when the payment error rate was 5.2 percent. SSA also targeted further reductions in SSI erroneous payments, through various corrective management actions as described below.

B. Study of SSI Disability Conversion Cases

SSA conducted a pilot study of SSI disability conversion cases (individuals getting benefits under State plans prior to 1974, when the SSI program was implemented) which never had and were not scheduled for a continuing disability investigation. The objective of the study was to detect and correct conversion cases where continuation of payment was incorrect because the individual was not disabled.

The original study included a 5-percent sample of the converted cases in the State of Washington. Results were such that SSA extended the review to all disability conversion cases in that State. Corrective action could result in cost-savings of as much as \$3 million per year.

SSA also began efforts to determine whether extension of this review process to other States would produce similar results.

C. Concentration of Resources on High-Risk Cases

SSA implemented a short form questionnaire for redetermining SSI eligibility in cases with characteristics indicating a low probability of incorrect payment. This action freed-up resources for concentration on cases more likely to contain errors. It is estimated that administrative cost-savings may be as high as \$3 million per year under this new procedure.

D. SSI Job Specialization

SSA sought increased accuracy in SSI workload processing by having certain claims-taking personnel specialized in SSI cases. By the end of 1978, the specialization concept had been implemented in 1,000 of SSA's 1,300 district and branch offices. Evaluation of the results was also begun in 1978.

E. Coordination of SSI/DI Disability Payment Process

SSA developed and scheduled for March 1979 piloting a plan for improving coordination of the DI/SSI disability payment process, to reduce erroneous payments caused by certain systems and procedural problems. National implementation was scheduled for July 1979, pending results of the pilot test.

F. Records-System Interfaces to Prevent or Detect Erroneous SSI Payments

SSA planned, operated, and/or developed cases stemming from a number of records-system interfaces to prevent or detect erroneous SSI payments. These actions involved the interface of SSI payment records with:

1. Veterans Administration Records
2. (The then) Civil Service Commission Retirement Records
3. Railroad Retirement Board Records
4. Military Retirement Records
5. State of Florida Records of Wages, and Unemployment and Workmen's Compensation Payments

G. Legislation Sought for Match Against IRS

SSA is developing legislation that would make IRS interest and dividend income records available for matching with SSI (and AFDC) payment records, in search of unreported resources. Preliminary studies indicated that such an interface could result in SSI cost-savings of up to \$45 million in the first year. IRS's view is that the Tax Reform Act of 1976 prohibits such use of taxpayer information, hence the need for legislation to pursue this initiative.

H. Match of HEW Payroll Against SSI Payment Records

SSA began investigation of 158 cases identified by OIG as involving possible improper receipt of SSI benefits by HEW employees. As of the end of the year, the fraud aspects of 103 cases had been closed for a variety of reasons. Two cases had been referred to the U. S. Attorney for prosecution. The remaining 53 cases were still under investigation.

I. Match of Federal Civilian Payroll Against SSI Records

SSA assisted in developing this OIG-managed match of the entire Federal civilian payroll against all SSI benefit payment records. The objective is to detect incorrect payments to Federal employees. Based on preliminary data, SSA began making plans to process as suspected SSI program fraud matters about 10,000 cases stemming from this matching operation.

J. Supplemental Security Record (SSR) Internal Match to Detect Duplicate Payments

The SSR contains SSI benefit payment records, with the SSN as the key identifier. In 1978, SSA developed for 1979 implementation a system for detecting cases in which the same individual is on the SSR under different SSNs and thus possibly receiving some SSI payments illegally. A similar internal-checking operation is in use in the RSDI program.

IV. Aid to Families with Dependent Children (AFDC) Program -- Program Integrity Developments

A. AFDC Payment Error Rates

The AFDC payment error rate declined from 8.7 percent for July-December 1977 to 8.1 percent for January-June 1978, exclusive of errors in the IV-D program which were counted for the first time in this period. Total erroneous

payments for the 12-month period ending with June 1978 were \$853 million, a \$9 million reduction from the erroneous payment level for the previous 12-month period.

B. Welfare Management Institute

SSA has established a Welfare Management Institute (WMI) which will:

1. Identify innovative State practices which result in improvement of program management; and
2. Disseminate information about those and other improvements to the States.

The Director of the WMI entered on duty at the end of December 1978, and activities identified above have begun.

C. Six State Plan

SSA developed and began operations under a plan calling for intensive work with the six States that account for over 61 percent of total erroneous AFDC payments. The objective of the plan is to make a rapid and significant reduction in erroneous payments. By the end of the year, corrective action plans had been developed by all six States, and certain elements of the plans were being implemented; it was anticipated that most of the remainder would be implemented by FY 1980. It was further estimated that, when all corrective action plans are implemented (the last few in FY 1981), payment errors would decline by \$145 million per year, corresponding to a 1.2 - 1.4 percent reduction in the AFDC payment error rate.

D. Data-Exchange Initiatives

SSA promoted and developed several data-exchange initiatives designed to reduce erroneous AFDC payments, working closely with

OIG in some projects of this type. These initiatives included:

1. National Recipient System

SSA obtained approval of a pilot program to test the feasibility of a National Recipient System (NRS). The NRS, if approved, would allow inter-State matching of welfare records and verification of SSNs and would provide States with information on the receipt of various Federal benefits by AFDC recipients. The NRS, which should lead to reductions in erroneous AFDC payments, is scheduled for pilot implementation in two States by September 1979. If approved for national use, States could implement the NRS at the rate of two per month, with full implementation by the close of 1981.

2. Data-Exchange Survey

SSA, in cooperation with OIG, conducted an extensive survey of the States in order to obtain a profile of State data-exchange use and capability. A work-plan for implementing recommendations flowing from this survey has been developed.

3. Data-Exchange -- Laws and Regulations

HEW approved a new regulation requiring the 40 States which maintain quarterly wage data for employment security purposes to use such data on a quarterly basis to help determine eligibility for AFDC payments.

SSA also began planning methods for implementing a new provision of the Social Security Act which, effective October 1, 1979, requires States that

do not maintain quarterly wage data to request and use income data from SSA's earnings records in determining AFDC eligibility. (States that do maintain quarterly wage data are required to use it to help determine AFDC eligibility.) In this connection, SSA experience in providing such data to the first few States which requested it in 1978 was valuable in developing procedures for handling this workload.

4. Data-Exchange Conferences and Meetings

SSA held meetings in all regions with State AFDC personnel, to encourage more effective use of all forms of data exchanges. SSA also provided technical assistance and information concerning (a) the Beneficiary Data Exchange (BENDEX) system, which is used by SSA to provide States with RSDI benefit information; and (b) the Inter-jurisdictional Data Exchange (IDEX) system, which facilitates intra-State checking of AFDC eligibility and also allows States to check with neighboring States for similar information. Use of income information from SSA's earnings records has been particularly emphasized.

5. Beneficiary Data Exchange (BENDEX)

In 1978, SSA upgraded the BENDEX system noted in (4), above. It was expanded to provide additional data useful in determining AFDC eligibility, and modified to permit State requests for data twice a month rather than just once a month.

E. New Quality Control Regulations

SSA developed and HEW published for comment new regulations which affect Federal financial participation in State AFDC costs by

providing sanctions for performance below defined levels and incentives to encourage improved performance by States in reducing the AFDC payment error rate.

F. Expanded Financial Management and Audit Activity

SSA developed plans for intensifying the monitoring of State claims for Federal reimbursement of AFDC costs. It was estimated that implementation of the plans early in 1979 could result in cost-savings of \$10 million in FY 1979, and \$20 million per year in FY's 1980 and 1981.

G. Expanded Technical Assistance and Management Audit Activity

As a supplement to Welfare Management Institute initiatives (see B., above), SSA -- working with contractors -- developed several other initiatives for improving technical assistance to States, to achieve better AFDC administration. These included development of:

1. Work measurement models, and an agenda for a March 1979 work measurement conference.
2. Plans for an April 1979 national workshop concerning the use of error-prone profiles as a tool in workload planning.
3. An agency self-evaluation guide.

SSA also took steps to intensify monitoring of State performance in AFDC program management: SSA staffing in this area was increased, and drafting of a management guide for reviewing State operations and work plans for developing State performance standards were begun.

H. Expanded Program Integrity and Corrective
Action Planning Staff

SSA moved to establish several new positions in the AFDC program integrity and corrective action planning areas. Also, working with a contractor, SSA began developing plans to hold AFDC fraud deterrence conferences for the States in several regions in 1979. One such conference was held in Seattle during 1978.

SSA also worked with a contractor to develop and report on an extensive study of AFDC fraud, and used the contractor's report in formulating plans for future efforts to control AFDC fraud.

I. Administrative Cost Study

SSA initiated an extensive study of AFDC administrative costs. The study involves more specific identification of items presently represented as costs, as well as a review of costing practices and cost-allocation methods. The objective is to determine the reasons for increased AFDC administrative costs.

V. Child Support Enforcement Activity -- Program
Integrity Developments

Child Support Enforcement is inherently a cost-saving, or waste prevention, program. It does this by locating, or securing support from, parents absent from the home. One of the basic goals of the program is to reduce public assistance expenditures by securing support from legally liable parents. During FY 1978, AFDC expenditures were reduced by \$410 million as a result of child support collections. In addition, the provision of service to non-AFDC applicants permits individuals who would otherwise have to apply for AFDC to maintain financial independence through child support payments. Non-AFDC collections amounted to \$578 million in FY 1978.

A secondary effect of the program is to detect fraud or abuse in the AFDC program by identifying:

--Cases in which eligibility is based on the absence of a parent from the home, but where the parent is found to be still residing in the home.

--Cases in which there are fewer children in the home than reported by the AFDC recipient.

--Cases where the recipient is receiving, directly from the absent parent, child support that has not been reported to the welfare agency.

To prevent the waste or misuse of Child Support Enforcement program expenditures or collections, the Office of Child Support Enforcement conducts an annual audit of each State's program. One of the important products of these audits is the assurance that States and Counties are properly claiming expenditures, handling collections, and making reimbursements to the Federal Government.

VI. Legislative Proposals Affecting Program Integrity

In addition to legislation concerning (a) penalties for improper activity in connection with SSNs and (b) record system interfaces with IRS (both described above), SSA has made a number of legislative proposals which, if enacted, would also improve the integrity of its programs. SSA has recommended the following for inclusion in the FY 1980 legislative program.

A. Assume for AFDC Purposes That a Stepparent's Income is Available to Stepchildren Unless the Stepparent Signs an Affidavit That the Income is Not Available

In many States, at present, families which include a stepparent may receive AFDC, regardless of the amount of a stepparent's income. The proposal would reduce the number

of high-income stepparent families receiving assistance by counting income to the stepparent as income available for the support of stepchildren. Affidavits claiming non-availability would be subject to verification.

B. Restrict SSI Eligibility of Persons Who Dispose of Property in Order to Qualify for Benefits

This proposal would curtail abuse of SSI and Medicaid (because of automatic Medicaid eligibility for SSI recipients) by people who transfer substantial assets to relatives or others immediately prior to filing for SSI, in order to meet eligibility requirements.

C. Recover SSI Overpayments from RSDI Benefits

This proposal would permit recovery of SSI overpayments from RSDI benefits without the consent of the recipient. Under present procedures, the consent of the recipient is required. This proposal, if enacted, should increase the amount of recovery of improperly paid SSI benefits.

D. Define Aliens as Public Charges

An alien who receives cash assistance that is based on need and provided by any Federal or State public assistance program would be considered a "public charge" and thus would be subject to the Immigration and Nationality Act provision concerning deportation of "public charge" aliens in certain circumstances. If the aliens were deported under these circumstances, cash assistance would no longer be provided.

OVERVIEW OF THE WORK OF THE DIVISION OF COMPLIANCE
BUREAU OF STUDENT FINANCIAL ASSISTANCE
CALENDAR YEAR 1978

As part of the reorganization in late 1977 of the Bureau of Student Financial Assistance, the Division of Compliance was created to detect and investigate instances of potential fraud and abuse by institutions and students participating in the seven aid programs administered by the Bureau.

Starting with a legacy of approximately 35 Washington based staff members from the Compliance Branch of the Office of Guaranteed Student Loans, the Division of Compliance has built a permanent staff of 71 across the country. There are 51 investigators with 20 support staff in the 10 regional offices and there are 25 headquarters staff members. Temporary technicians, varying in numbers, have added significant support to the field offices.

The Division is comprised of 1810 series investigators who chiefly develop facts to support civil and administrative sanctions against institutions and students who abuse student financial aid programs. However, the investigators also regularly work with the Office of Investigations (Office of the Inspector General) and/or the Department of Justice in developing criminal fraud cases. The Division's accomplishments in each of these areas are detailed in the case highlights section (page 11).

Major achievements in organization include the naming of the first permanent Director of the Division in late May and the placing of investigators in each Office of Education regional office in order to make Compliance a nationwide effort. The increase in the scope of the Division is another significant achievement. As of late 1977, the entire Compliance staff only had a history of compliance activities in the Guaranteed Student Loan Program. By the end of 1978, investigators were developing cases in each of the five major programs--Guaranteed Student Loans (GSL), Basic Educational Opportunity Grants (BEOG), Supplemental Educational Opportunity Grants (SEOG), College Work Study (CWS), and National Direct Student Loans (NDSL). 1/

1/ The Health Professions Loans were first made in late 1978. No investigations have been initiated involving the State Student Incentive Grants.

In addition, in the fall of 1978, the Division was delegated the responsibility for instituting limitation, suspension, or termination actions for its own cases. This is an effective administrative tool to reduce or cut off funds to an institution and/or terminate their eligibility to participate if Federal funds are not being managed properly.

The Division continues to collect information for its National Early Warning Tracking System (NEWTS). The NEWTS is a filing system which is constantly fed by numerous sources of information across the country and is intended to detect abuse problems and prevent them from progressing to more serious fraudulent activity. While most work with the NEWTS had been in developing sources for leads and amassing information, we are now using the information for the development of cases. It is our goal to have the information more organized and accessible by computerization during the next year or two.

A principal function performed by the Division is acting as the Bureau's link to the law enforcement community and other agencies engaged in combating fraud and abuse. We have established good working relationships with the Inspector General and his Office of Investigations and Audit regional offices; numerous FBI field offices, U.S. Attorneys' offices, Veterans Administration offices, State Approving Agencies, Federal Trade Commission, State Attorneys General, the Postal Inspection Service, etc.

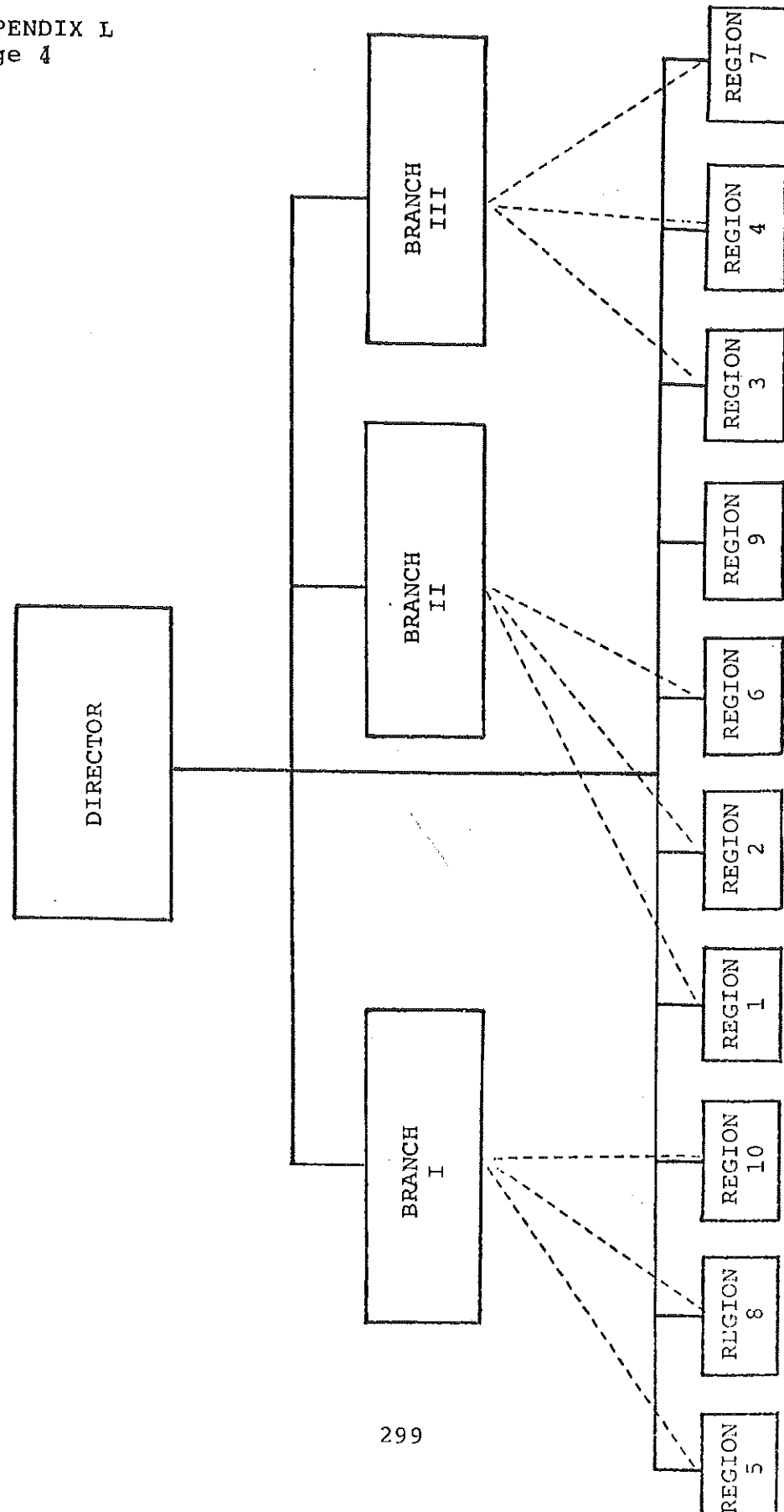
The Compliance Division has worked with the Division of Program Operations and the Regional Collections Units in establishing a specific code in the Guaranteed Student Loan collections computer system to stop collection efforts on accounts of students who attended an educational institution which is being investigated by the Division of Compliance, the Inspector General, or the Department of Justice. This "Code 81" prevents the Office of Education from dunning a student who may have a legitimate defense for not repaying the defaulted loan. "Code 81" is merely a suspense code which allows time for the facts to be determined by the investigation or court action before taking future action.

The Compliance case load has increased significantly this year. In January 1978, there were 20 cases being actively

pursued. In December 1978, there were 67 active cases, resulting from the evaluation of more than 200 "leads" or allegations from a multitude of sources. Of the 67, 54 were institutional cases, of which 17 were being worked jointly with the Office of Investigations, the FBI, or the U.S. Attorney's Office. Thirteen were individual student cases, of which 2 were being worked jointly with the Office of Investigations or the FBI. Examples of the wide variety of cases handled are in the case highlights section.

BUREAU OF STUDENT FINANCIAL ASSISTANCE
DIVISION OF COMPLIANCE

APPENDIX L
Page 4



COMPLIANCE CASE INITIATION

This chart shows the functional relationship between the Headquarters and Regional Compliance Staffs in (1) receiving allegations of fraud and abuse in BSFA programs from a wide variety of sources (2) initiating and conducting investigations (3) negotiating administrative actions and (4) assisting in Court proceedings.

I. Source of Leads	II. Headquarters Functions	III. Regional Functions
- Bureau of Student Financial Assistance, e.g. DCPR - Collegions - Claims - Department of Justice - Veterans Administration - Office of Inspector General (OI and HEWAA) - Federal Trade Commission - Students - Employees of Institutions - Consumer Protection Agencies - State and Local Law Enforcement Agencies - State Guarantee Agencies - Accrediting Agencies - Regional Investigators*	- Contacts Regional Investigator-in-Charge - Contacts Regional Administrator - Collects additional data - Analyzes data - Sets up preliminary case file - Obtains Director's concurrence - Sends case file to Regional Investigator - Sends Advice of Scheduled Investigation to Regional Administrator and appropriate OE officials - Retrieves documents as needed - Sets case priorities - Participates in case related meetings - Reviews interim and closed case reports - If necessary, recommends further investigative activity - Sends Advice of Closed Investigation to appropriate OE officials - Monitors cases we have referred to other investigative agencies	- Reviews preliminary investigative file - Plans investigation - Requests additional documents as needed - Conducts investigation - Participates in case related meetings - Submits Weekly Activity Reports - Submits interim and final case reports - Recommends when case should be closed and/or referred - Negotiates IS and T Actions - Negotiates repayment of Federal funds - Technical assistance to criminal or civil court proceedings

*Frequently leads from the sources listed above are sent in by Regional Investigators.

Sources of Allegations for
Compliance Cases Opened in 1978

- 20% Program Review by Division of Certification and
Program Review (six Taxonomy VI program reviews)
- 13% BEOG Validation, Division of Certification and
Program Review
- 11% Students
- 9% School Officials
- 9% GSL Collection Activity
- 7% FBI Reports
- 4% State Attorney General
- 4% HEWAA
 - 4% Informtion found during a separate Compliance
investigation
 - 4% GSL Claims Examination
 - 2% Each (Assistant U.S. Attorney, Office of
Investigations, Division of Policy and Program
Development, Veterans Administration Compliance,
State Audit, State Guarantee Agency, and one
unknown)

About one-half of the opened cases were a result of allegations discovered from within the Bureau of Student Financial Assistance with the other half coming from outside OE or DHEW.

COMPLIANCE CASE HIGHLIGHTS

Calendar Year 1978

1. The Compliance investigation of this beauty school was prompted by a Program Review conducted by the Regional Division of Certification and Program Review (DCPR) which revealed possible misuse of BEOG funds.

The Compliance investigation has established that ineligible students (non-high school graduates, students not in attendance, and non-matriculated students) have received Federal Student Financial Aid (SFA) funds. A civil liability to the Office of Education of approximately \$95,000 has been established thus far. Additionally, Compliance's analysis of the institution's books and records reveals inappropriate transfer and use of SFA funds.

During the course of Compliance's civil investigation, preliminary evidence indicating possible criminal violations has been discovered and referred to the Regional Office of Investigations. The Division of Compliance and Regional Office of Investigations are now jointly pursuing evidence of criminal violations.

The Division of Compliance has also initiated contact with the State Cosmetology Board in an attempt to develop evidence of the institution's violations of State regulations which could result in the institution's loss of license and ultimate withdrawal of the institution's eligibility to participate in BSFA programs by the Division of Eligibility and Agency Evaluation.

The Division of Compliance has also initiated contact with the Regional Veterans Administration office since Compliance determined that some BEOG recipients were also receiving Veterans benefits. By separate action, the Veterans Administration withdrew VA approval of the institution in November 1978.

2. As a result of preparation to file a class action suit on behalf of students of this closed business college, the State Attorney's office requested that the Division of Compliance investigate the possible misuse of Federal SFA funds. The institution closed several days into a new semester leaving large refunds due to the students. Regional DCPR conducted a Close-Out Review (i.e., collection of Federal SFA funds) of this institution. The subsequent Compliance investigation uncovered other previously unidentified Federal SFA monies which had become subject to creditor liens. Additionally, Compliance investigators determined that funds contained in a corporate account (\$23,000) were directly traceable to misappropriated NDSL funds. Based upon the evidence supplied by the Division of Compliance to the U.S. Attorney, a preferred claim to recover these monies has been filed with the bankruptcy court. The U.S. Attorney has requested that the Division of Compliance work with OI in developing evidence of criminal violations.

3. In response to a request by the Program Operations Branch, Compliance conducted a review of a school which had applied for a Federal contract of insurance as a Federal Insured Student Loan Program non-regulated lender. During this review, documents were found that indicated a questionable relationship between the school and a lending institution.

Further investigation by the Division of Compliance revealed (1) that the lending institution submitted false information on \$300,000 of FISL applications which had obtained the Federal insurance commitment and (2) an attempt to circumvent the regulations on lender participation.

The evidence developed by the Division of Compliance allowed OE to cancel the insurance commitment, thus averting the potential liabilities on default claims generated by the loans, plus saving interest and special allowance charges and maintaining the integrity of the FISL program.

4. Two individuals were deported this year for defrauding the Federal Insured Student Loan (FISL) program. These individuals were illegal aliens who obtained FISLs from Florida and New York lenders. Compliance

assisted in obtaining documentation of the fraud, and the case was turned over to HEW's Office of the Inspector General, Office of Investigations. Criminal prosecution of the pair was declined in favor of their immediate deportation.

Compliance received initial information concerning this fraud from the Program Review Staff of the Atlanta Regional Office. Both Atlanta and New York Compliance Field Teams worked to document the case.

5. As a result of a request from DCPR for an audit survey of 1976-77 at this business school's three campuses, shortages in the Federal student financial accounts were discovered. School faculty were also complaining of missed paydays and concerns about the financial situation at the institution. Compliance began its investigation in October 1978. Within one month, enough evidence had been gathered regarding large deficits in the Federal accounts to initiate a freeze on further draws from DFAFS and an emergency suspension for the three campuses. Further losses in BEOG, SEOG, NDSL, and GSL were therefore prevented. In December, termination proceedings began and the investigation traced Federal monies to a fourth school against which OE has also begun termination proceedings. In January 1979, two of the schools closed. The Civil Division of the Department of Justice will be consulted regarding civil recoveries of approximately \$550,000. The FBI has already been contacted and is following up on the criminal aspects of the case.
6. As a result of problems found in a program review by DCPR, this university was offered extensive assistance and direction in the proper administration of the programs. A followup review revealed, however, that the school had not followed the directions given, and there were serious discrepancies in the BEOG, SEOG, CWS, and NDSL programs including: the use (and loss) of Federal monies as collateral for personal loans, and the fraudulent submission of claims. Compliance investigators have established liabilities of approximately \$400,000 and worked with DCPR in initiating proceedings against the school to terminate participation in BSFA programs. The termination hearings are currently in progress.

Compliance has also been sought out by the FBI for assistance in a related criminal investigation of the school owners.

7. An Illinois State investigator, who was prosecuting a family for welfare fraud, notified Compliance of possible fraud by the three children in receiving BEOG's to which they were not entitled. An investigation by Compliance revealed that BEOG applications for a four-year period had false income information. A referral is now being made for further criminal or civil action.
8. The opening of a Compliance investigation was prompted by a program review done by the Regional DCPR. The review highlighted improper transfers of Federal SFA funds into the institution's operating accounts.

As a result of the program review, a limitation agreement was prepared by a Washington DCPR. The agreement required that the institution correct past violations, institute procedures to insure that current operations were in accordance with prescribed regulations, and submit a non-Federal audit for two award periods. The institution was to repay, or make provisions to repay, the liabilities identified by the non-Federal audit. The agreement also provided for partial funding of several BSFA programs while the institution made a good faith effort to correct the identified problem areas.

The subsequent Compliance investigation uncovered several violations of the limitation agreement as well as liabilities not fully identified by the non-Federal audit which had been submitted to and accepted by HEW-AA.

The information developed during the Compliance investigation also raised serious questions about the institution's financial condition and ability to preserve the integrity of BSFA programs.

Based upon the evidence developed by the Compliance investigation, HEW-AA retracted its acceptance of the non-Federal audit and has requested a meeting with the CPA firm which conducted the audit.

The findings of the Compliance investigation have been given to OI for review and determination if criminal violations may have occurred in this case.

9. A Compliance investigation of this proprietary school resulted from a number of student complaints, allegations of false information being submitted on applications for Federal SFA funds, and evidence that a significant number of SFA documents normally sent directly to the students were being sent directly to the institution's address.

The Compliance investigation developed that the institution was not properly licensed by the appropriate State body. After obtaining the appropriate documentation, the Division of Eligibility and Agency Evaluation (DEAE) was notified and the institution's eligibility to participate in BSFA programs was withdrawn. This precluded the institution from drawing additional Federal SFA funds.

The Compliance investigation also developed evidence of potentially large liabilities based upon SFA funds being disbursed to students attending ineligible branches of the institution, as well as other program violations which raise concerns about the institution's handling of all Federal SFA funds.

At the request of Compliance, an audit by HEW-AA is being conducted to establish the magnitude of the institution's liabilities for Federal SFA funds. Additionally, Compliance is working with the Civil Division of the Department of Justice to recover Federal SFA funds still in the possession of the institution.

The Division of Compliance is assisting the FBI in developing evidence of criminal violations in the institution's administration of BSFA programs.

10. The Compliance investigation of this correspondence school was initiated in conjunction with a criminal investigation by the FBI due to allegations of criminal violations involving the Guaranteed Student Loan Program.

As a result of the Compliance activity, "hold" actions were placed on all associated lenders involved with this school. The school has terminated operations, and the school's eligibility to participate in the GSLP has been withdrawn by DEAE.

The Division of Compliance has provided assistance to the Assistant U.S. Attorney in the criminal case and has now been given the responsibility of reviewing the school's and lender's records in order to develop civil liabilities.

The Division of Compliance is continuing to supply technical assistance to the Assistant U.S. Attorney in the criminal action as well as developing the evidence necessary to effect civil recoveries.

11. A Compliance investigation has documented over \$30,000 in misused Federal student financial aid money on the part of this beauty school. The school owner funneled monies through its eligible campus to students attending its ineligible campus. The investigation disclosed that the school owner was not only aware that that campus was ineligible, but attempted to conceal the misuse of funds.

The case was referred to the Office of Investigations who presented it to the U.S. Attorney's office for a prosecutive decision. Prosecution was declined due to the questionable character of the witnesses. Compliance has initiated informal compliance action to recover the misused funds.

12. Forty-three (43) schools owned by a large U.S. corporation have been under investigation by a special HEW/Department of Justice task force for conspiring to defraud the government of Federal student loan money. The corporation submitted billings to OE for interest on ineligible loans.

Criminal investigations on all 43 schools resulted in a 55-count criminal indictment, plea of nolo contendere, and a \$500,000 fine paid to the Federal Government. The criminal case was closed during the summer of 1978. Compliance is now providing technical assistance to the Civil Division, Department of Justice, for civil investigation.

13. A review of student financial assistance programs conducted at this four-year college by BSFA's Division of Certification and Program Review revealed several deficiencies in the school's administration of the College Work-Study program. A subsequent Compliance investigation disclosed that students, upon advice of coaches and teachers, claimed college work-study monies for time they spent practicing sports, choir, or attending classes. School officials signed documents certifying work that was not performed, and in some cases even filled out the students' time sheets for them. The investigation revealed the misuse of over \$190,000 in Federal funds resulting from ineligible College Work-Study payments.

Compliance's final investigative report was referred to the Office of Investigations which is currently conducting a criminal investigation. At the conclusion of the criminal investigation, Compliance will take action to recover the misused funds.

14. This investigation, by OI, New York State Higher Education Assistance Commission (NY SHEAC) and the Department of Justice, was predicated upon allegations made by a Chief of Security at a New York City Community College. The Chief of Security alleged that the subject was using various aliases to obtain Federal funds. Subsequent investigation with extensive technical assistance from Compliance disclosed that the subject used as many as 16 aliases to fraudulently obtain both Federal loan and grant funds.

The subject was indicted and arrested in November 1978, and is currently awaiting trial.

15. OE was notified by the major lender of a nationwide chain of schools of certain irregularities regarding loans made to students attending this computer school. Compliance conducted a preliminary review which disclosed false certifications to OE, refunds due to students, the lender and OE, loans disbursed to students not in attendance, and excessive interest billings to OE.

An agreement was negotiated with the bank and a "hold" action was placed on loan processing to prevent Federal payments of interests or defaults attributable to any violations by the school. The school owner was forced to immediately repay certain interest and tuition refunds exceeding \$1 million. The eligibility of the primary institution and its subsidiaries was terminated, thus preventing future damages.

OI was provided documentation supporting certain alleged criminal activities at the institution. This continues to be an open case under investigation by OI and the FBI.

16. Student complaints, as well as information provided by a lender in the FISLP, led Program Officers of the FISLP to look into the difficulties at this correspondence school. Based on OE Compliance's initial findings, OI was able to build a case which has resulted in the school's owner pleading guilty to conspiracy and mail fraud. The school owner was later sentenced to 4 years in Federal prison for his activities as president of the now defunct vocational school.
17. A program review by DCPR in May 1978 disclosed many program violations by this proprietary school. Among the most serious allegations were that the school had not been depositing refunds due on National Direct Student Loans (NDSL) into their NDSL account and had avoided the restrictions placed on proprietary schools by obtaining "non-profit institution" status even though they appear to be in violation of course eligibility requirements for institutions of higher education.

The school closed its doors in June 1978. The Division of Compliance initiated an investigation and recovered \$17,000 by closing the school's financial aid accounts. As this investigation continues, Compliance anticipates additional recoveries.

AUDITS OF STUDENT FINANCIAL AID PROGRAMS

Our audits of the Office of Education student financial aid programs continue to show the same types of findings that were reported last year. These broad categories are:

- Improper recipient eligibility determination and award procedures.
- Late, incorrectly calculated, and no refunds.
- Poor financial condition of schools.
- Improper use of, or accounting for, Federal funds.
- Maintenance of excessive cash balances.
- Internal controls, accounting systems, and record maintenance deficiencies.

A continuing problem that we believe may need legislative remedy is the practice of institutions maintaining excessive Federal cash and improperly using the funds without being assessed an imputed interest cost. Our audits have shown that the excess funds are being used in a variety of ways--payment of general operating expenses; used to obtain short-term financing or other institutional functions; diverted to the owner(s) of the school. The use of the funds when disclosed by audits or program reviews amounts to an interest-free loan to the institution for which the Federal Government was incurring interest costs. The cost principles contained in 45 CFR 100, Section 100a 232(c) "Interest Income" requires that the "recipients shall remit to the Federal Government any interest earned on advances of Federal funds." Since the usage of the excess Federal funds does not earn any interest, the institution is required to repay to the Federal Government only the funds improperly used.

We have not normally computed the interest lost on about \$10 million which was identified in the reports as being improperly used or drawn in excess of cash needs. However, we estimate that hundreds of thousands of dollars have been lost to the Federal Government. During the next year, we plan to develop a consolidated multi-institutional approach

to fully develop this area of concern and attempt to project the significance of the problem.

The Education Amendments of 1976 placed two additional requirements for eligibility which are applicable to all Title IV programs. Institutions must now determine that students are maintaining satisfactory academic progress in their course of study at that institution. Schools must also determine that students do not owe a refund on a Basic or Supplemental or State Student Grant or are in default on a National Direct Student Loan received from the institution at which the student is enrolled before making a payment under the OE student aid programs. During the past year, our audits disclosed that some schools were making awards to individuals who were not meeting the institution's standards of satisfactory academic progress. This area and that of the determination of student-owed refunds are essential to the eligibility process and will receive increasing audit attention in the future.

The Bureau of Student Financial Assistance, through its Division of Compliance and program review staffs, has established a means of identifying "problem schools" and has also established priorities for conducting compliance and program reviews. Program review reports are sent to the Audit Agency for informational purposes and use in audits. The improved communications flow should do much to improve management of the OE student aid programs.

The Office of Education, over the last 12 months, has also taken positive action on several recommendations we made in our report on Student Financial Aid Programs at Proprietary Vocational Schools. This report, a consolidation of the results of 25 individual audits, disclosed serious weaknesses in these areas of administration of the student aid programs:

- refunds
- advertising
- recipient eligibility determinations
- awarding procedures
- financial condition

The following is a brief synopsis of the actions that BSFA has taken on our recommendations.

OE has published, in draft or final, regulations covering areas we noted as deficient.

OE is enforcing these regulations through its authority to limit, suspend, or terminate the continued participation of eligible institutions in all Federal Student Assistance programs.

OE is taking a more active role in assessing the capability of schools to manage these programs and will require biennial audits of all schools which, in many cases, will include additional financial information and assurances.

During Calendar Year 1978, we issued 983 audit reports on institutions administering the financial aid programs; 1,028 of these reports were done by certified public accountants or State or local audit groups. About \$800 million in financial aid awards was audited and about \$13.4 million of these expenditures were questioned or recommended to be refunded to OE. In analyzing these reports, we found ranging from minor internal control weaknesses to the problems of poor financial condition and major areas of non-compliance with Federal regulations.

The newly instituted biennial audit requirement for the student aid programs will significantly increase the number of audit reports issued each year. In an effort to both increase the awareness of the accounting profession to these new requirements and to improve the quality of the audits performed by public accountants, we developed a training program. The program was developed in cooperation with the American Institute of Certified Public Accountants, Division of Continuing Professional Education. Three seminars were conducted during October and November 1978 with attendance averaging about 80 participants at each of the sessions. The AICPA has scheduled seven seminars on audits of student financial aid programs for 1979.

We have issued audit guides for the Basic Educational Opportunity Grant Program and the National Direct Student Loan, College Work Study, and Supplemental Educational Opportunity Grant Programs. In addition, we are developing an audit guide for the Guaranteed Student Loan Program. We believe that this major initiative of the development

and publication of audit guides for all Title IV student aid programs, and the training course for public accountants will greatly aid OE in managing the student aid programs.

Illustrations of Major Deficiencies in Audit Reports
Issued Fiscal Year 1978

Touro College, New York, NY
Issued October 21, 1977

Our evaluation of the audit report prepared by a CPA firm showed that the school had used Federal funds for general operating purposes (about \$51,000) and had made over-awards of financial aid to students totaling about \$76,000.

Washington Business Institute, New York, NY
Issued July 6, 1978

The audit disclosed that WBI had not adequately administered the BEOG program. We found that the school inappropriately applied about \$245,000 in BEOG funds toward tuition, had not made refunds totaling approximately \$116,000 for student dropouts, and paid awards of about \$299,000 to ineligible students.

McCarrie Schools, Inc., Philadelphia, PA
Issued July 20, 1978

The audit disclosed that the school did not maintain adequate control over the grants and loans made from the NDSL and BEOG programs. The lack of control resulted in: grants and loans totaling \$111,731 were made to students enrolled in ineligible programs; a shortage of \$4,706 in the cash balance of the BEOG account; and that \$3,200 in BEOG funds could not be accounted for.

Florida Memorial College, Miami, FL
Issued June 28, 1978

Our audit showed that the college was in deep financial trouble--current assets were about \$474,000 while current liabilities totaled over \$2.3 million--and that FMC improperly spent or did not properly account for or safeguard Federal funds of about \$2.4 million. We found that financial aid awards had been made to academically

ineligible students and that FMC had not exercised due diligence in the NDSL program and had not made refunds for student dropouts.

Wayne State University, Detroit, MI
Issued March 8, 1978

The audit disclosed that \$80,000 in student financial aid awards as reported to OE could not be supported by university accounting records. We also noted that WSU did not have procedures for monitoring all payments to students and had made overpayments of about \$12,000 to students.

Kennedy - King College, Chicago, IL
Issued September 19, 1978

Our examination disclosed severe weaknesses on CWS payment procedures. We found that hours reported by students as working time conflicted with class schedules; CWS awards were made to ineligible students; and students were permitted to earn amounts in excess of their computed need. We also noted that the college had entered into off-campus job agreements with ineligible institutions.

Vogue Academy of Beauty Culture, Inc., Chicago, IL
Issued October 15, 1977

Our limited review showed that at least 58.8 percent of the students enrolled at the school did not have the required high school diploma or HS equivalent. We found that non-high school graduates were admitted as regular students contrary to the school's published admissions policy. It is our contention that the school misrepresented its admissions policy and was, thus, never an eligible school. Vogue Academy was accountable for about \$387,000 in financial aid funds.

Penn Valley Community College, Kansas City, MO
Issued January 9, 1978

The audit showed a general lack of administration over the student financial aid programs. We found that about \$717,000 of the \$1.5 million in student aid funds which had been awarded was improperly spent. The overpayments resulted from the college awarding Federal financial aid to students who did not meet the standards of academic progress, did not attend any classes for which they had enrolled; and

who were ineligible for BEOG awards because of prior post-secondary education.

Nebraska Academy of Hair Design, Omaha, NE
Issued June 14, 1978

The review showed that many of the school's administration practices and operating procedures were not in compliance with program regulations. We found that documentation to support awards of about \$70,000 was inadequate and often contradicted other eligibility information; overawards of about \$10,000 had been made because of improper calculations and that approximately \$11,000 had been awarded to ineligible students.

Federico's College of Hairstyling, Sacramento, CA
Issued September 28, 1978

The College did not meet the Federal standards for a proprietary school of higher education and was thus not eligible to participate in the student financial aid programs. Our audit disclosed that about 39 percent of the students who had enrolled at the college and received financial aid did not have a high school diploma or the recognized equivalent. We have recommended that the College revise its admission policy to comply with Federal regulations and refund to the Federal Government \$582,955 of program funds.

Oregon College of Business, Medford, OR
Issued April 12, 1978

Our audit disclosed that the school had maintained excessive cash balances and had used about \$250,000 of Federal funds improperly for operating costs and personal expenses of school officials. We also found that students were overawarded about \$30,000 and that students working under the CWS program received funds in excess of need of about \$10,000.

OVERVIEW OF WORK OF OFFICE OF INVESTIGATIONS
STUDENT FINANCIAL ASSISTANCE CASES

Education cases represent 25.9 per cent of the Office of Investigations workload. As of October 1978, OI had 103 education cases under investigation as follows:

<u>Type of Investigation</u>	<u>Number</u>
Students	32
Proprietary Schools	29
Colleges & Universities	25
Employees	9
Lending Institutions & Collectors	4
Grants and Contracts	2
Public Schools	2
TOTAL	<u>103</u>

These investigations involve a conservative estimate of \$30,000,000 worth of grants and contracts in the following areas:

<u>Type of Loan or Grant</u>	<u>Number</u>
Guaranteed Student Loan Program	51
Basic Economic Opportunities Grants	7
National Direct Student Loans	3
College Work Study	2
Multiple Loans	27
Miscellaneous & Other	13
TOTAL	<u>103</u>

A variety of frauds have been uncovered from simple misrepresentation of facts, forgery and fictitious applicants to sophisticated schemes involving double sets of books, kickbacks and collusion with lending institutions. The following is a brief analysis of the current education-related caseload of OI, including a summary description of illustrative cases.

Proprietary Schools

Suspected misappropriation and misuse of Student Financial Aid funds account for 34 per cent of the proprietary school cases. Most of these involve false statements and forgeries on disbursement vouchers, paying employees out of grant funds, and transferring Student Financial Aid funds to personal and corporate accounts.

OE reviews of Student Financial Aid accounts at a proprietary school disclosed unaccountable withdrawals of funds.

Investigation disclosed that the former president of the school had used some of the financial aid funds for personal reasons and deposited the rest in the school's corporate accounts.

An information was filed against the former school official on August 4, 1978, charging violations of Title 18 U.S.C. Section 1001 (false statements). He pleaded guilty the same date and agreed to retribute \$242,720. He was sentenced on October 16, 1978, to five years' imprisonment and a \$10,000 fine.

A Department of Justice coordinated 18 month task force investigation, based on OI investigation, culminated an over three year effort to obtain evidence of misuse of Student Financial Aid funds by corporately linked proprietary schools. In September 1978, 22 schools pleaded nolo contendere to all 55 counts of a July 1978, indictment charging violations of Title 18 U.S.C. Sections 287, 1001, and 1014. The controlling corporation was fined \$500,000 on charges contained in 49 of the 55 count indictment.

Embezzlement accounts for 32 per cent of the proprietary school investigations. One case in particular involves over one hundred proprietary schools where evidence of

bribery and kickbacks to Government personnel, school officials and collection agencies are involved. Much of the suspected embezzlement is on behalf of proprietary school owners, but many enterprising employees find imaginative ways of exploiting the program, such as failing to make refunds to students who withdraw from school early in the semester.

Office of Education reviews of BEOG applications submitted by a computer school reflected that many of the applications contained pre-printed answers.

Subsequent investigation and audit disclosed that the school did not maintain student financial assistance records as required, and that the owner of the school had converted assistance monies to his own use and to the school's corporate accounts.

OE deobligated \$409,000 that was due the school in FY 1976. In 1977, the owner was tried on civil fraud counts resulting in a verdict in favor of the U. S. Government which was then awarded \$778,206 plus an \$8,000 forfeiture.

In 1978, both the owner and the school were criminally indicted on charges of violation 18 U.S.C. Section 1001 - false statements. Trial commenced in May 1978, with both subjects being found guilty in June 1978.

Office of Education surveys, HEW audits, and student complaints led to investigations of the administration of the Federal Insured Student Loan programs fund by proprietary schools in Texas. During the course of the investigation it was ascertained that a school official had embezzled, stolen, and converted to his own use OE/HEW funds from the FISL, BEOG, and SEOG programs.

The official entered into a plea bargain agreement in September 1978, in which he pleaded guilty to various counts of violation of Title 18 U.S.C.

A variety of miscellaneous schemes to defraud and misrepresent compose about 34 per cent of the proprietary school cases. A home study school and a variety of

holding companies and subsidiaries under investigation by an HEW/FBI task force has manipulated millions of dollars worth of education loans.

One school made several hundred thousand dollars worth of loans prior to receiving HEW approval. Another appears to have forged student names on contracts for tuition and sold the contracts to a finance company. Two others allegedly forged student names on Student Financial Aid checks and deposited them to personal accounts. In one school a large quantity of Guaranteed Student Loan applications are thought to have been executed and processed fraudulently. In another, students are said to have been induced to file fraudulent applications. Documents in other cases which were thought to be filed with false statements are being investigated.

A U. S. Attorney requested an investigation of a proprietary school's practices in the Federal Insured Student Loan Program.

Investigation disclosed that the school recruited students, certified them eligible for financial assistance and obtained loans for them. Many of the students never attended the school, some withdrew before course completion, and still other students did not know they had received loans. The loans were sold by the school to four financial institutions and many were filed in default. OE was obliged to pay the institutions over \$800,000.

The school's owner and two other officials were indicted for conspiracy to defraud the Government and false statements. Two were convicted in 1977; one was convicted in February 1978. The U. S. Government recovered over \$500,000 in 1977.

Universities and Colleges

Twenty-five universities and colleges, including two seminaries, are under investigation. In many cases it is difficult to determine in the initial phases of

the investigation who the culpable subjects are -- university officials, students, or individuals posing as students. Most of these cases (44 per cent) involve possible forgery of applications for loans and grants or the loans and grants are made out to non-student applicants. In many instances, either the bank or subsequent investigation could not verify the applicants as students yet checks made out to the students are uttered. In one case, grant funds were obtained by certifying ineligible students to participate in student financial aid programs. The students claimed that they did not receive the grant funds. The funds appear to have gone directly into the working capital of the school.

Twenty-eight per cent of the university and college cases involve misapplication of funds. This includes allegations from using Title III (developmental funds) for lobbying, travel, recruiting and other operating activities to altering school records to obtain accreditation for courses so that students taking these courses can be eligible for Federal funds. One case involves allegations that students and a financial aid officer of the school have submitted false student-work time sheets. Other cases involve converting student grant and loan funds to operating accounts. One individual admitted using Basic Educational Opportunity Grant funds for purchasing real estate.

The remaining 28 per cent of the university and college cases involve various falsification of documents, including embezzlement and other manipulations of the program. In one school students have alleged that they are forced to turn over their financial assistance checks to the school without seeing the checks. In another school a financial aid officer is suspected of falsifying students' financial status to gain larger grants which were then given to ineligible students. In other cases it appears that schools have submitted large numbers of grant and loan requests for nonexistent students.

A college official advised that an apparent theft of the college's BEOG funds had occurred through the uttering of BEOG checks to fictitious non-students. The amount stolen was \$2,119.

Investigation and handwriting analyses disclosed that a secretary in the student financial aid office had uttered the checks.

In February 1978, the secretary was indicted on four counts of violation of Title 18 U.S.C. Section 641 (embezzlement). On March 10, 1978, she was found guilty on all counts and was subsequently sentenced in April 1978 to six months' imprisonment on counts 1 and 2 and to five years' probation on counts 3 and 4.

The HEW Audit Agency advised that a university indicated possible fraudulent misuses of their BEOG and CWS programs.

Investigation disclosed that the director of the student financial aid program at the university had conspired with others to issue checks to students, forge the endorsements and deposit them to his own or other personal accounts.

The U. S. Attorney declined prosecution in favor of local action. The student financial aid officer pled guilty in a local Superior Court to 14 counts of misappropriation of public funds. He was sentenced to four years' probation and ordered to retribute \$8,456.25.

An internal audit disclosed that \$5,702.27 of financial aid was embezzled by a university disbursement official from 1974 to 1977. OI investigation disclosed that official retained student financial aid checks not claimed by students, forged their endorsements, and applied the proceeds to his own use.

On October 19, 1977, an indictment was handed down charging the official with 11 counts of violation of Title 18 Section 641 (embezzlement). On January 13, 1978, subject entered a guilty plea to four of the counts and was sentenced to three years' probation and ordered to retribute \$5,702.27.

A banking institution notified a junior college that the college's BEOG, SEOG, and Law Enforcement Educational program grants were overdrawn or showed unaccounted cash disbursements. A former secretary of the

college admitted after investigation that she had withdrawn the funds and converted them to her own use. It was shown that the ex-employee had withdrawn at least \$64,477.95.

In March 1978 the former employee pleaded guilty to an information charging violation of Title 18 U.S.C. Section 641 (embezzlement). Also in March she was given a suspended sentence and ordered to reconstitute \$64,477.95.

Students

Similar to investigations of universities and colleges and some proprietary schools, when investigating students it is frequently impossible to determine the culpable party at the outset of the investigation. Therefore, some of the investigations discussed in this section may result in schools or school officials being the violators.

Forty per cent of the student cases involve forgeries. Two cases involve individuals who received loans and grants at several different institutions. Others involve multiple forged applications at one institution. In five cases it was determined that the applications for loans and grants were clearly forgeries by unknown suspects. In several cases loans and grants are also received by forging parents' signatures and student aid officers' signatures. In one case it was determined that an enterprising individual not only obtained a loan for himself by forging his application but also obtained loans for eight other individuals.

OE advised that between September 1975 and March 1978 a student using aliases had made applications and received student financial aid from ten Colorado schools in the amount of about \$23,689.

The student pleaded guilty to one count U.S.C. 1341 and was sentenced to five years' imprisonment.

The U. S. District Judge ordered a stay in execution of sentence while the individual underwent psychiatric treatment; the sentence may be modified.

In 22 per cent of the student cases suspected falsification of application and alteration of loans are the reason for investigation. Information that is falsified includes family income, length of residency, and eligibility certification.

Nineteen per cent of the student cases involve individuals who are not students or are dropouts who default. Most of these are unknown subjects that apply for and receive Guaranteed Student Loans.

A Community College advised that an internal review of its BEOG student financial aid program disclosed that ten BEOGs had been received through the same Post Office Box and that none of the ten individuals to whom the grants were awarded attended the college.

Investigation disclosed that BEOG applications which had initiated the BEOG grants were for fictitious persons; six of the grant checks had been deposited in the personal account of one individual.

The subject was indicted by a county grand jury in August 1978, and pled guilty to charges of Fraudulent Scheme or Artifice in December 1978. In January 1979 a sentence of one year imprisonment with five years' probation was imposed, along with the requirement of restituting \$3,600.40.

Another 19 per cent of the student investigations are illegal aliens who received student loans under false pretenses.

Employees

Six of the employee cases involve Office of Education employees allegedly influencing contract awards to their own firms or receiving kickbacks and other favors from contractors. Two cases involve suspected travel voucher fraud and one case involves falsification of a Basic Education Opportunities Grant by an Office of Education employee.

The Office of Investigations, OIG, HEW, conducted an investigation in concert with State agencies at

the direction of the U. S. Attorney into the relationships between current and former OE officials with contractors and various State officials. This investigation was the most encompassing and possibly one of the most significant matters that OI has been involved in to date.

As of December 1978, 14 individuals had been convicted in State courts of charges which include conspiracy, conspiracy to bribe, conspiracy to defraud, conspiracy to commit larceny, conspiracy to accept a bribe and conspiracy to steal Federal/State funds.

These convictions were associated with the issuance of a \$500,000 contract by a State vocational agency for the production of training films.

Lending Institutions and Collection Agencies

Three investigations involve lending institutions. They are under investigation for discounting Student Financial Aid loans, filing fraudulent Federal Insured Student Loan Claims and extorting proprietary schools by forcing them to pay management fees or buy stock of a company before they could purchase school loans. One investigation of a collection company is based on the allegation that collected defaulted loans were not being returned to the schools.

Grants and Contracts

One case is based upon the allegation that grant funds are being misused and that false information was filed with the initial grant proposal. Another case involves allegations that a firm had received duplicate payments for their services and had converted \$48,000 of these payments to their personal use.

Public Schools

In one case Title VII (bilingual education) funds are alleged to have been misused in an independent school district. In another case Title I (underprivileged education) funds allegedly were used for personal and business purchases.

A U. S. Attorney requested that OI conduct a joint investigation with the FBI into allegations that a City Board of Education official had converted Title I funds -- Elementary and Secondary Education Act -- to his personal use.

Investigation disclosed that the official had used Title I funds for entertainment and catering expenses and had submitted fictitious billings to the Board of Education to cover these expenses.

The official was indicted by a Federal Grand Jury on 22 charges of various misuses of Federal funds. In November 1978, he pleaded guilty to all counts and in December was sentenced to 18 months' imprisonment.

INDUSTRY STUDY: EARLY INDICATORS

The OIG Audit Agency is conducting an industry study of a select group of high risk institutions participating in the Basic Educational Opportunity Grant (BEOG) program in order that OIG can develop indicators to systematically and routinely detect institutional fraud and abuse in the student financial assistance programs. The study is directed at the proprietary school population with a focus on the cosmetology industry.

The study has three major components which are detailed below with an update provided to reflect what appear to be early indicators of possible fraud and abuse of the BEOG program.

1. Overview of Industry:

Background information is being gathered and analyzed about the cosmetology industry through data bases available within HEW, other Federal agencies, State agencies, and other sources as available. Information is being sought about the size of the schools, tuition charges, level of participation in student financial aid programs, chain school operations, accreditation and licensing requirements, default levels in student loan programs, etc. Findings uncovered through program reviews, HEW audit reports, and Office of Investigations case files are being reviewed to reflect trends.

Because the various computer based data files in HEW do not contain one common identifier for each institution maintained, a special effort is now underway to merge the files under one common identifier -- the IRS Employer Identity Number. If this proves successful, a crosswalk will be available to pick up information on some 900 beauty schools eligible to participate in the HEW student financial aid programs.

2. Analysis of the BEOG Application and Payment Information Systems:

Systematic indicators are being developed to point to fraudulent or abusive behavior by institutions

against the BEOG program. These indicators are being sought through computer analysis and scans of the BEOG applicant and payment information systems, as well as through the use of a questionnaire to a random sample of BEOG recipients.

● Computer Analysis:

The OIG Audit Agency has been conducting a series of computer scans of the application records of BEOG proprietary school applicants for the school years 1976-77, and 1977-78, as well as the BEOG recipient file for 1977-78. Preliminary findings (February 1979) are as follows:

- Some 65 proprietary schools have surfaced reflecting unusual trends in the data elements of applications filed for students who indicated their intention to attend that particular school. Many of these schools show a large number of students eligible for a BEOG award. Of the schools identified so far, more than one third are beauty schools.
- An additional computer scan of the applicant file has identified to date about 100 other instances of aberrant behavior on the part of either schools or individual recipients. A number of these cases have been referred to the Office of Investigations (OI) for follow-up.
- A computer scan, named "Finder," is being developed and refined now to identify schools or individuals that are applying for and receiving BEOG funds under the accounts of fictitious students. The results thus far are promising. We are continuing to develop and refine this computerized method to detect the use of aliases or fictitious accounts in order to receive HEW funds, and we hope to be able to apply it to other HEW programs such as Aid to Families with Dependent Children and Medicare.

● Questionnaire

The OIG Audit Agency selected from the BEOG 1977-78 recipient file a random sample of 2,500 students from 50 beauty schools who, according to Office of Education (OE) records, had received a BEOG award for 1977-78. A questionnaire was mailed to these individuals requesting that they verify whether or not they received the award and under what conditions. The responses to the questionnaires will be compared to the information provided to OE by the schools. Certain problems have arisen due to the mobility of the population in that approximately 20% of the questionnaires were returned by the Post Office marked "Address Unknown." Additional file searches are underway to attempt to obtain a more recent address. Findings from the questionnaire are not conclusive to date.

3. Selected Audits

Once the statistical indicators have been refined, they will be validated through a select number of audits to be conducted at the proprietary schools by the OIG Audit Agency. It is anticipated that the schools will be selected for audit at the close of March 1979. An Interim Report may be available by Fall 1979.

4. Early Indicators Confirmed

Of the initial findings which have been referred to OI for follow-up, the cases described below immediately surfaced:

- Open OI case on a recent conviction of a student who had devised what he thought was a sound plan to defraud student assistance programs without detection. Investigation established that this individual had obtained over \$50,000 from Campus Based and the Guaranteed Student Loan programs. The student's method of operation was simple: He attended a school with a large student population. He

would appear in the school's security office to obtain a new I.D. card claiming to have lost his old one. Through this simple device, he established multiple identities which he used to apply for and receive student assistance in the form of grants and loans, including College Work Study aid. This individual used his previously obtained identity cards to cash the proceeds. This individual was caught due to the sharp observation of the school's security officer who remembered seeing the student before--but under another name. Follow-up investigation then ensued, leading to a successful conviction.

A number of factors incidental to this scheme triggered the identification of this student as being of investigative interest in the Beauty School Study. Even if this individual had not already been picked up due to the diligence of the school, we believe that the present Beauty School indicators would have initiated an investigation of this individual and detected the scheme used to defraud the student assistance programs.

- Identification of another individual who has been receiving a number of student assistance grants. Preliminary results have established that this person has since abandoned the rented post office box he used as a mailing address. Further, he is currently being sought by another Federal investigation agency as a fugitive. Although this is still an ongoing investigation, we cite this as an example indicating that the program will bear fruit.

The remaining cases are still being researched by OI, and we believe will lead to instances of institutional fraud and abuse.

STATUS REPORT ON INSPECTOR GENERAL SUBPOENAS

Section 205(a)(3) of the HEW Inspector General statute gives the Inspector General authority to issue a subpoena for records and other documents which the Inspector General determines are necessary to carry out his functions under the Act.

During the first year of our operation (which commenced in March 1977), we used the subpoena power sparingly and issued our first subpoena on March 23, 1978. During the past eleven months since that time, we have found it necessary to issue eleven subpoenas. Each has proven invaluable to us for obtaining access to records we needed to carry out our audit and investigative functions. Several have required us to depend upon the courts for an enforcement order requiring compliance. In such instances, we have depended upon the Department of Justice to represent us in court. As a general matter, we have been pleased with the representation they have provided. We have won every enforcement case in which a final order has been issued. One case is currently in litigation. We have every reason to believe, based upon a case in another jurisdiction, that the judge will rule in our favor.

Following is a brief summary of the subpoenas we have issued to date:

1. "A" Nursing Home

Background

"A" Nursing Home was one of the nursing homes selected last winter for a full-scale audit to test the theory that high overhead costs for nursing homes may signal the presence of fraudulent or abusive practices. An audit was begun in February 1978. However, after ten days of auditing, OIG staff were denied further access to the nursing home.

Service of Subpoena

A subpoena for the nursing home's records was issued on March 23, 1978, returnable April 6, 1978.

Outcome

The Nursing Home complied with the subpoena. The audit was completed and the information was referred to the United States Attorney for possible prosecution. Prosecution was declined.

2. "B" and "C" Companies

Background

These companies are owned and operated by the same individual. They served as collection agents of defaulted student loans for several colleges. The loans included loans that were federally insured. The Office of Investigations was informed that the companies may have been collecting on the overdue student loan accounts, but were not reporting the payments to the schools. The Office of Investigations opened an investigation of the companies.

Service of Subpoenas

Six subpoenas were served in the course of this investigation: one on each of the two companies under investigation, and one on each of four banks where one or both companies were known to have held accounts.

Outcome

Following is a history of each of the subpoenas:

a. "B" Company

A subpoena for the company's records was issued on June 14, 1978, returnable on June 26, 1978. The company refused to comply with the subpoena. On July 12, 1978, we formally requested the Department of Justice to seek judicial enforcement of the subpoena. On August 16, 1978, a United States District Judge ordered the company to comply with the subpoena. The company has complied.

b. "C" Company

The enforcement of this subpoena was handled concurrently with the one served on "B" Company. The company has, likewise, complied with the court order.

c. "D" Bank

A subpoena for the companies' bank records was issued on June 12, 1978, returnable on June 28, 1978. The bank refused to comply with the subpoena unless the Department first agreed to cover the costs in complying. We refused to do so. After some further communication, we formally requested the Department of Justice to seek judicial enforcement of the subpoena. On September 21, 1978, a United States District Judge ordered the bank to comply with the subpoena on the condition that the Department cover their costs. The Department did so, and the bank provided the records.

d. "E" Bank

A subpoena for the companies' bank records was issued on June 12, 1978, returnable on June 27, 1978. The bank refused to comply with the subpoena unless we substantially narrowed its scope or agreed to pay the costs incurred by the bank as a result of complying with the subpoena. We requested the Department of Justice to seek judicial enforcement of the subpoena. On September 26, 1978, a U.S. Magistrate ordered the bank to comply with the subpoena. The Magistrate postponed consideration of the cost issue until the bank complied. The bank appealed the order, but the Judge dismissed the appeal. The bank has now fully complied with the subpoena, and has incurred costs of \$1,000. They have returned to court with a motion to require us to reimburse them. We have answered their claim, but the Judge has not yet set a date for the hearing.

e. "F" Bank

A subpoena for the companies' bank records was issued on June 12, 1978, returnable on June 28, 1978. The bank did not have the staff to respond quickly to our subpoena. We considered having the Justice Department seek a court order. However, before we pursued this matter, the bank complied with the subpoena.

f. "G" Bank

A subpoena for the companies' bank records was issued on June 12, 1978. The bank moved slowly to comply with the subpoena, but eventually did so.

3. "H" Day Care Center

Background

The HEW Audit Agency referred an audit of the day care center to the Office of Investigations on account of a number of questionable expenses. The Office of Investigations requested a subpoena for the bank records of the Center and of its Executive Director.

Service of Subpoena

We issued a subpoena addressed to the bank on October 19, 1978, returnable on November 14, 1978.

Outcome

The bank has complied with the subpoena.

4. "J" PSRO

Background

The PSRO had been conditionally certified as a professional standards review organization. A partial audit of the PSRO raised a number of questions regarding the finances of the PSRO.

As a result of the audit findings, the Department did not renew the PSRO contract when it expired, and the information obtained was referred to a U.S. Attorney. A Grand Jury convened and subpoenaed additional records of the PSRO.

Service of Subpoena

Subpoena for the records of the PSRO was issued on November 15, 1978 returnable on December 7, 1978.

Outcome

The PSRO refused to comply with the subpoena. We referred the matter formally to the Justice Department for enforcement proceedings on December 11, 1978. This matter involves a number of complex issues resulting from the parallel grand jury investigation. The matter is currently in litigation. Meanwhile, we have issued a second subpoena for more recent records of the PSRO.

5. "K" Accounting Firm

Background

This firm is the accountant for a college which is the subject of a current criminal investigation and a review by the HEW Audit Agency. The Audit Agency believes that access to the firm's records is necessary to verify the financial accounts of the college, and also to monitor the college's compliance with its agreement with HEW. With respect to the criminal investigation, a Grand Jury was convened and has also issued a subpoena.

Service of Subpoena

The subpoena was served on December 27, 1978, returnable on January 10, 1979.

Outcome

On January 17, 1979, we obtained written authorization from the accounting firm for Audit Agency access to the records before the Grand Jury. On January 22, 1979, the Judge permitted access to the Audit Agency based upon a Rule 6e motion.

OVERVIEW

OFFICE OF PROGRAM INTEGRITY
HEALTH CARE FINANCING ADMINISTRATION

MISSION STATEMENT

Minimize the opportunity for fraud and abuse in Medicare/Medicaid by conducting reviews and investigations on individual cases and providing oversight and support to Medicaid State agencies, Medicare contractors, and Medicaid fraud units.

Program Authority and Background

The Office of Program Integrity (OPI) was established in 1977 by merging the Office of Program Review in the Social Security Administration with the Division of Fraud and Abuse Control in the Social and Rehabilitation Service. Program Integrity staffs are now in each of the ten HEW regional offices, in addition to OPI's central office in Baltimore. The office has 274 people in the regions and 77 in the central office. Funding for OPI activities comes through annual appropriations from Congress and from the Medicare Trust Fund.

Program Description

OPI plans, administers, and oversees programs designed to prevent improper expenditure of Medicare/Medicaid funds based on health provider fraudulent or abusive actions. In meeting this responsibility, we relate to the Medicare/Medicaid claims-paying process primarily in two areas:

1. postpayment review systems--the process of identifying health providers whose billing practices are questionable, and
2. the cost report audit activity--the process by which the Medicare/Medicaid paying entity determines the allowable level of reimbursement for providers reimbursed on a cost or cost-related basis.

It is principally through these processes along with individual complaints flowing into the system that individual providers are identified where fraud or abuse may be a problem.

OPI's central office develops national policy for fraud and abuse control, provides administrative and management support and oversight to regional office operations, and prepares manuals and other instructional materials required by the regions.

Regional staff work in two areas, case development and management review.

Case Development--Conducting reviews and developing facts on individual cases of suspected fraud and abuse.

Management Review--Providing oversight training and technical assistance to Medicare contractors, Medicaid State agencies, and Medicaid fraud control units.

Major Activities

Case Development: Cases of potential fraud or abuse are worked by OPI regional staff, Medicare contractors, and Medicaid State agencies. If, in the course of developing the facts related to an individual health provider, it appears fraud is involved, the case is at that point referred to an investigative agency. Staff in OPI regional offices are heavily involved in conducting what we refer to as "preliminary investigations." These cases involve an allegation or other indication of fraud. Through the course of conducting preliminary investigations, we determine if a pattern exists which would support referral to the Office of Investigations (OI) who in turn would initiate a full-scale fraud investigation.

If no fraud is found, the OPI RO determines whether the potential for abuse exists and, if so, refers the matter to the Medicare contractor to establish and collect an overpayment or take other administrative action as appropriate.

Based on reporting from OPI regional offices, Medicaid State agencies, Medicaid fraud control units, and Medicare contractors, there were a total of 16,850 providers identified during 1978 where a potential of fraud or abuse

existed. We do not have a specific breakout of how many of these cases would be considered significant cases requiring a substantive amount of review or investigation, but that number would approximate some 10 to 15 percent of the total or around 2,000. The adjudicative effort related to these cases, some of which were ultimately prosecuted*, identified overpayments of approximately \$29 million.

Management Review: During the course of 1978, OPI staff participated along with other HCFA staff in performing assessments of State Medicaid agency and Medicare contractor performance. Our role in relation to these assessment reviews is specific to measuring the capacity of Medicare/Medicaid claims payors to control fraud and abuse. Systems and processes for identification, investigation, and adjudication are examined and recommendations for improvement made where deficiencies are noted. During 1978, OPI participated in a total of 165 such reviews.

Our activities so far and our plans for the future have been geared, in large measure, to make compatible Medicare and Medicaid systems for fraud and abuse control. The same Program Integrity staff reviewing Medicare claims paying operations are reviewing Medicaid. Approaches for detecting and reviewing aberrant providers by a Medicare claims payor are compared and evaluated along with the Medicaid claims payor's operation. Common reporting systems for cases (potential fraud or abuse) have been developed, and information on such providers will be routinely exchanged through reporting by the Medicaid or Medicare appropriate agency to the OPI regional office. Profiles, State-by-State, relating to both Medicare and Medicaid capabilities in fraud and abuse control are being established. All of the regional PI offices have held meetings with the Medicare and Medicaid contractor and State officials jointly participating to establish lines of communication at the operations level State-by-State. We are working to establish a national advisory committee representative of Medicare and Medicaid third-party payors, PSROs, and State Medicaid fraud control units.

*See the body of the Inspector General's Annual Report for data on numbers of prosecutions.

Also in support of our management review responsibility, the Office of Program Integrity has been instrumental in developing a series of review guides which State and Federal personnel can use in performing reviews of specific provider types to determine whether there is program abuse. The series includes, in various stages of development, guides pertaining to hospitals, nursing homes, laboratories, physicians, and pharmacies.

Program Validation: In late 1978, OPI developed a systematic approach to identifying potential fraud and abuse situations and determining the degree to which program provisions are being properly applied. We call this effort program validation. The three major elements of this process are:

- Aberrant Cost Studies--To identify providers reimbursed on a cost or cost-related basis, to determine if aberrant cost or billing practices indicate fraud or abuse, and to evaluate the appropriateness of the Medicare contractor or Medicaid agency reimbursement and audit process.
- Systematic Fraud and Abuse Studies--To identify providers reimbursed on a fee or reasonable charge basis, to determine aberrant utilization or billing practices of fraud or abuse, to evaluate Medicare/Medicaid reimbursement and postpayment systems, and to improve the capacity of Medicaid State agencies and Medicare contractors to utilize postpayment review systems.
- Program Implementation Reviews--To determine if specific policies or manner of implementation contribute to unreasonable or inappropriate levels of reimbursement.

Several reviews have already been undertaken. While it is premature to comment on results because of the newness of the validation effort, we have high hopes. We believe we will be able to demonstrate several million dollars in savings to HCFA programs based either on problems noted

with individual providers or weaknesses in policy or procedures demonstrated through individual provider review.

Other Significant Activities:

PARE (PAmement REview)

Under the PARE (PAmement REview) system, Medicare Part B carriers review and report to OPI on physicians with high incidences of utilization in the program. This year, OPI focused on evaluating the carriers' prepayment and post-payment controls, to determine their adequacy for identifying physicians with questionable patterns of practice.

A total of 3,012 Part B PARE reports were processed during calendar year 1978, resulting in 102 fraud investigations and in the identification of \$2.2 million in overpayments.

OPI began to develop and test screening techniques for use in a planned PARE system for reviewing institutions participating in Part A of Medicare. The system would make possible the identification of high-cost departments within the institutions in terms of per-diem or per-bed costs. Once data are processed, they are used as screens to select and review hospitals with aberrant costs in certain departments for the possibility of Medicare fraud and abuse.

Fraud Control Units

OPI is responsible for helping the States to establish fraud control units in accordance with Section 17 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142), which furnished a special incentive for States to do so. Any State establishing such a unit receives 90 percent Federal funding for its costs.

Once a State unit is certified, OPI monitors it to ensure timely and accurate reporting of the necessary payment and workload data and responds to questions raised. At least once each year, regional staff must perform onsite reviews of all State units for which they are responsible. They must report their findings to the central office for recertification purposes.

During 1978, 20 Medicaid fraud control units were certified. Through this procedure, some 800 professional investigators,

auditors, and lawyers have been added to the effort to deal with fraud against the Medicaid program.

Suspensions and Terminations

Based on Section 7 of Public Law 95-142, HCFA now has greater authority to suspend and terminate health providers found guilty of fraud from Medicare/Medicaid participation. Based on this section and other sections of the Social Security Act providing secretarial sanction authority against providers found guilty of fraud or gross abuse, we have suspended or terminated a total of 53 health providers. Thirteen of these providers have been completely terminated, one has been reinstated, and the remainder are suspended for periods ranging from 1 to 10 years.

Summary

We believe we made significant progress in 1978. We anticipate that 1979 will be even a better year as we gain more experience working within the HCFA organizational structure. We can do better, and we see several areas for needed improvement. Among those are:

- greater capacity to take administrative sanction;
- improving techniques in abuse control by assuring medical review and peer review in the process of addressing overutilization problems;
- forging stronger relationships between State Medicaid agencies and fraud control units to assure proper and timely referral of apparent fraud cases;
- greater capacity to judge State Medicaid agency, Medicare contractor, and our own regional office performance based on results, as opposed to process;
- improving our own ability and that of the States and Medicare contractors to recognize and deal with instances of institutional provider fraud and abuse;

- systematically assessing Medicare/Medicaid reimbursement policies which may be contributing to fraud, abuse, or waste;

- greater recognition through the budgeting process of those elements of State Medicaid agency and Medicare contractor activities dealing specifically with fraud and abuse.

We are in the process of developing strategies to effectuate improvements in each of these areas. Success will give us a greater ability to play our respective role in the total process of controlling fraud and abuse in Medicare and Medicaid.

M E M O R A N D U M

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
Office of the Administrator

TO: Inspector General February 28, 1979

FROM: Administrator

SUBJECT: Inspector General's Annual Report -- Report
of the Administrator, Health Care Financing
Administration

Introduction

In response to the attached Secretarial memorandum, I am enclosing material summarizing the Health Care Financing Administration's (HCFA's) activities to detect and prevent fraud, abuse, and waste. To provide maximum detail on these activities, most of the material describing these efforts is appended to this memorandum.

As you know, I am personally committed to ensuring that HCFA designs and implements a credible fraud, abuse, and waste program, reflecting real accomplishments in improved program management and productivity.

Toward this end, I have reviewed HCFA's FAW activities to date and am currently revising organizational relationships, reporting systems, targets, and the general scope of the FAW agenda to ensure that this effort receives the full attention it requires in this agency. I intend to make FAW the focal point for an integrated Efficiency/Productivity Improvement plan now being formulated. I will keep you informed of any significant actions taken in the near future in this regard.

Many of HCFA's FAW activities were generated by the 1978 Inspector General's report. These activities are described in some detail at Tab I*. Of the projects initiated in response to the sources of fraud, abuse, or waste identified in that report, most of them were developed as FAW initiatives monitored by the Assistant Secretary for Management and Budget. Copies of quarterly status reports on these initiatives are contained in Tab III, as you had requested.

Further, HCFA has undertaken additional projects to reduce fraud, abuse, or waste and to improve program efficiency in areas not directly related to the specific issues cited in last year's report. These activities include:

*Omitted due to detail.

- . Improved management efforts within HCFA;
- . Improved coordination with the Public Health Service, other components of HEW, and other Federal agencies;
- . Proposed changes in Legislation; and
- . Changes in Regulation.

The following is a short description of both the overall HCFA effort to date and relevant Tabs:

At Tab I* we have summarized actions, either taken or proposed, which address the concerns raised in last year's report. I believe HCFA has moved aggressively to respond to those areas identified.

These initiatives are being accomplished through a variety of means: We are expanding our capacity to collect better data; we are using the experience gained in the Medicare program in the area of contractor relations to improve the Medicaid State/Federal efforts; we are increasing our staff in the financial management area in Medicaid to assist the States in improving the management of their programs; and we are improving our data processing systems and extending our audit and cost review activity under Medicare.

In response to the Secretary's anti-inflation announcement last April, HCFA has now completed many of those activities. These are described in Tab II-A and are intended to:

- . Develop post-payment provider files and pre-payment screens;
- . Expand the number of HMOs in which Medicare participates;
- . Publish a regulation to establish lowest charge levels for reimbursement for certain laboratory tests and durable Medical equipment;
- . Fully implement the Maximum Allowable Cost program which already saves \$5.5 million annually;

*Omitted due to detail.

- . Publish inhalation therapy guidelines to control the cost of contracted respiratory therapy services;
- . Improve our public relations effort for the Second Opinion Program;
- . Develop specific objectives for each PSRO as a means of assessing its effectiveness in reducing unnecessary stays and the resulting costs;
- . Monitor the President's Wage and Price Guidelines and investigate the feasibility of imposing selected cost-constraints on HCFA fiscal contracts.

In addition to the program management changes mentioned above, we have initiated a series of Medicare-Medicaid integration projects detailed at Tab II-B. The purpose of these 20 projects is to explore opportunities for functional consolidation of various administrative aspects of the Medicare and Medicaid programs, including development of common Medicare and Medicaid billing forms, integrated coding systems, and improved over-payment recovery systems. We are also looking into the possibility of combined fiscal agent contracts for both Medicare intermediaries and carriers, as well as between Medicare and Medicaid. We expect implementation of some of these projects to begin this spring and to result in administrative savings.

You have explicitly requested information on improvements made and planned in management systems, eligibility determination procedures, claims payment procedures, productivity, contract and grant practices, and personnel management. Major activities in this area are summarized at Tab II-C.

Central to our ability to identify fraud and abuse in our programs has been the creation of Section 17 Fraud Control Units. To date we have certified 21 State Fraud Control Units, adding 794 professional investigators, lawyers, and auditors to the effort to counteract Medicaid fraud. More savings can also be realized as these units develop more effective and defined relationships with Medicaid State agencies. In this regard, we have taken steps to clarify the respective rolls and responsibilities of the Section 17 units and State Medicaid agencies and to ensure that identified overpayments are ultimately collected by the Medicaid State

agency. One means of achieving this coordination is through expanded use of the Medicaid Management Information System. See Tab II-D for a more detailed explanation of this effort.

An important component of efforts to reduce waste, fraud, and abuse involves joint PHS-HCFA activity in evaluating or redefining the capacity of the health care delivery system, and in better targeting our programmatic resources. We have taken the following steps to minimize duplication of services, and to improve the Department's integrated approach to controlling costs in the health care field:

- . HCFA's Health Standards and Quality Bureau (HSQB) has been working with the Food and Drug Administration to develop written criteria for assessing the appropriateness of x-rays, including skull and chest x-rays and pelvimetry. A pilot project in the State of Washington has already led to the establishment of standards in that State for the use of skull x-rays in emergency rooms. Criteria developed for x-rays will be distributed to PSROs, the Veterans' Administration, and the Department of Defense for their use in curtailing unnecessary utilization of x-rays.
- . We are also working with the PHS to foster close working relationships with the Health System Agencies to assist in defining the extent to which services are being inappropriately utilized and to reduce unnecessary hospital beds. As part of that effort, last year we distributed data describing the hospital utilization experience of the area's Medicare population to every Health Systems Agency. Similar data will again be distributed within the month to these same agencies. The data is of particular importance to health planners, since Medicare beneficiaries, which represent one-tenth of the population, account for one-fifth of the discharges, and one-third of all important visits in short-stay hospitals. This information should be extremely useful in the analyses of hospital admissions and review procedures as well as health delivery practices.

- . HCFA is also working closely with the Public Health Service to implement the uniform cost reporting and discharge data requirements of P.L. 95-142. Coordination of data collection activities, and the resultant elimination of duplicative projects between PHS and HCFA will occur as we jointly determine the type of fiscal agent more suited to implement the data requirements of this law. An NPRM was recently published dealing with a System for Hospital Uniform Reporting (SHUR). HCFA is working closely with the hospital industry and public accountants to assure that the burden of these reporting requirements is minimized, while the necessary reporting information is gathered.

- . HCFA, in conjunction with the Food and Drug Administration, has also taken an aggressive role in expanding the Maximum Allowable Cost (MAC) Program. In 1978 we expanded the number of MACs realizing savings at an annual rate of \$10.5 million. In addition, we have worked closely with the FDA to develop a Model Generic Drug substitution law for distribution to States. This law would enable pharmacists to substitute less expensive drugs, unless such substitution was indicated by the prescribing physician. Those States which have implemented laws of this type have effected significant savings in the cost of drugs.

Additional activities are being carried out by HCFA in conjunction with both your Office, other HEW agencies, and the GAO.

- . OPI has worked closely with the Inspector General's Office of Investigations in reporting Medicare cases for investigation and in providing both technical and professional assistance as needed.
- . OPI participated with the Inspector General's Office in Project Integrity I, designed to detect aberrant patterns of practice among physicians and pharmacists (see Tab II-E).
- . OPI is also participating in a joint HCFA-OIG effort to implement Section 3 of P.L. 95-142, requiring disclosure of ownership for providers, carriers and intermediaries. The plan calls for collection of ownership data for all Medicare and Medicaid

providers and fiscal agents through the programs' certification process, and the utilization of a pilot project in two States. Further, a proposed rule has been issued recently dealing with costs to related organizations. HCFA is now reviewing public comments on that regulation.

- . We worked closely with the HEW Audit Agency to develop procedures and guidelines for abortion and sterilization monitoring to ensure that payments for these services are in compliance with both the statute and the regulations. OPI and Audit Agency staffs are now reviewing State Medicaid agencies to assure accurate reporting of abortion claims.
- . We are working closely with SSA to improve both our information on determining other third-party coverage for SSI recipients and the assistance of the Office of Child Support Enforcement in identifying third-party coverage of absent fathers. Both of these cooperative efforts will assist us in improving our ability to capture third-party payments for Medicaid. Further, SSA is helping HCFA to collect sample data for AFDC and SSI programs to determine desirability error rates in the MQC program.
- . We are intensifying our cooperative activities with the GAO and to ensure that HCFA responds more aggressively to any allegations of fraud, abuse, or waste in our programs. I have asked for a complete report by mid-March on how our relationship with GAO may be strengthened in this regard.

Legislative Changes

HCFA has proposed major legislative proposals which, if enacted, will save approximately \$2.14 billion during FY 80. Of special note among these are Civil Money Penalties, Common Audit, and Hospital Cost Containment proposals described in more detail at Tab II-F. These proposals supplement other legislative amendments we have supported over the last year which would streamline the administration of some aspects of our program. These are also described in the referenced attachments.

Still under active consideration is a proposal to extend the 90% Federal matching rate for a full three years for

every certified Section 17 unit. Under statute, the Federal Financial Participation (FFP) rate for State Medicaid Control Units is 90% until September 30, 1980, after which date the units are to become fully self-supporting. Under current law, those units which have not yet been certified, or others which only recently have been certified, would not have three years of operating experience before the 1980 funding expiration date. We believe some of those units may terminate activity altogether or significantly reduce workloads when this Federal funding ceases and, in so doing, jeopardize the potential effectiveness of these units. Others might not feel it worth applying at this time given the short period of higher funding which remains.

Regulation Changes

Our coordinated approach to FAW is particularly manifest in our approach to reviewing and developing regulations. In conjunction with the Public Health Service, we have initiated a two-year project to review significant health care regulations from a cost-benefit perspective. Last month, we established an Office of Health Policy Regulation, with staff furnished jointly by HCFA and PHS. This project is aimed at eliminating costly duplication in existing Federal regulations, reducing reporting requirements, and ensuring that health care delivery system incentives created by these regulations have intended results.

This project will have important consequences from a cost savings standpoint and will supplement current efforts to produce cost-effective, sensible regulations. As a related matter, HCFA has recently promulgated a number of regulations which are intended to control waste and fraud in many of our programs. These regulations, summarized at Tab II-G, define the framework in which our programs will be administered. Many of them have been developed in recognition of the fact that some programmatic areas are susceptible to fraudulent or abusive activities.

Leonard Schaeffer
Administrator

Anti-Inflation Initiative

In April 1978, HCFA agreed to promulgate regulations which would:

- . limit Medicare payments for laboratory tests and medical experiments;
- . encourage non-profit hospitals or providers to share services;
- . require 60 day public notice of any proposed fee increase under Medicaid.

HCFA has promulgated proposed regulations in each of these areas and plans the following follow-up activity:

- . In August 1978, HCFA published final regulations which limited Medicare payments for laboratory tests and medical equipment to the lowest price that is widely available for the same quality in a particular community. These regulations apply to the twelve most utilized tests and the two most commonly purchased pieces of medical equipment--hospital beds and wheelchairs. Currently, HCFA is in the process of expanding the coverage of this authority to other tests and equipment.
- . In August 1978, HCFA published proposed regulations which encouraged the sharing of services between non-profit health care providers. Final regulations are due to the Office of the Secretary in January 1979.
- . In May 1978, HCFA published proposed regulations requiring 60 days' public notice of any proposed increase in fees paid under the Medicaid program. Final regulations are currently under development.

Phase I of the Anti-Inflation Program also called for HCFA to:

- . Introduce Medicare computer screening techniques to flag services for which special auditing is required;

- Strengthen the PSRO program's efforts to reduce excessive and unnecessary hospitalization;
- Accelerate and expand implementation of the second surgical opinion program;
- Accelerate the number of contracts put up for competitive bidding under Parts A & B;
- Promote substitution of generic prescription drugs;
- Stimulate development of HMO's and coverage of Medicaid and Medicare enrollment;

HCFA has initiated action on these items and will continue to build on those projects in the following ways:

- Pre- and Post-Payment Services: A HCFA-wide task force was established to develop post-payment provider profiles and pre-payment screens.

While staff-level discussions have apparently progressed, little concrete progress has been demonstrated. The Medicare Bureau has completed revising instructions to Part B carriers to strengthen their review of claims. These instructions will be issued within several weeks. While this activity will serve as foundation for future efforts, in my judgment, progress has been too slow to date on this initiative.

I have asked to see a revised project work plan by February 20, with clear delineation of Bureau responsibility for explicit deliverables. At that time, I should have a better sense of how to move this project more aggressively. It should be an important cost-saving activity within HCFA.

- PSROs: As the recent PSRO evaluation study documented, PSROs are becoming more effective in reducing unnecessary hospital care and, in doing so, realizing cost savings. As part of our ongoing efforts to improve PSRO program efficiency, we have set a target rate of \$8.70 for unit cost per discharge review for FY 1979. This figure

represents a \$4.97 reduction from the unit costs for the four quarters preceding your April anti-inflation announcement.

We project saving \$4.7 million this year through closer monitoring of individual PSRO operations, and through greater PSRO effectiveness in reducing hospital utilization.

In addition, we will begin to apply more aggressively PSRO legislatively based sanction authority for providers who provide consistently poor quality care. The implementing regulations to enable PSROs to apply these sanctions will be issued this year.

We will also build more effective relationships between PSROs and carriers so that PSROs can appropriately follow-up on specific cases flagged by carriers' more restrictive pre- and post-payment screens.

- Second Opinions: As described more fully at Tab I-B, we have implemented a Second Opinion program.

To generate increased program usage this year, additional publicity efforts are required. I have asked the Office of Public Affairs to submit a public relations strategy by January 15. I am inclined to believe more can and should be done to sell the program.

- Generic Drugs: HCFA will continue to implement the Maximum Allowable Cost Program (MACP). This cost-containment plan limits the amount the Federal Government will pay for prescribed drugs under Medicare, Medicaid, and other HEW health programs. This program saves \$37.2 million annually in Federal, State, and local funds.

By December 1979, we expect to increase the number of MAC drugs to 70 from a current level of 34.

- HMOs: HCFA is intensifying efforts to increase the number of HMOs in which Medicare participates. With the cooperation of the Public Health Service

we anticipate increasing the number of HMOs participating in Medicare from 21 to 31 by June 1979 and to 38 by September 1979.

Fraud Abuse and Waste Cost-Savings

In addition to completing initiatives started under Phase I of the Anti-Inflation program, HCFA is implementing the following fraud, abuse, and waste projects in addition to those which we have outlined in Tab A. These efforts are the heart of HCFA's cost-containment program.

- Identification of Medicare and Medicaid Overpayments: Approximately \$62.1 million in overpayments can be identified and corrected this year. Through efforts of the Medicaid Fraud Control Units, State Medicaid agencies and Regional Office Medicare Integrity programs.
- Medicaid Management Improvement: An estimated \$265 million can be eliminated from expenditures associated with the Medicaid program by identifying and eliminating erroneous payment of funds due to ineligibility, third-party liability, and claims processing errors.
- Medicare Contractor Productivity Improvement: Current Medicare claims processing costs can be reduced by \$48.7 million by maintaining error rates and claims processing times at or below current levels.
- Audit and Cost Review: An estimated \$16 million will be identified through increased efforts to identify Medicare overpayments resulting from intermediaries' failure to detect allowable cost overstatements submitted by providers. A good portion of these funds will be recovered.
- Lower Limits on Routine Hospital Costs: \$32.5 million can be saved by reducing the costs of hospital inpatient general routine services. This will occur by lowering the inflation factor used to calculate limits on hospital routine costs from 14 percent to 11.5 percent.

- . Reduce Medicare Reimbursement for Inhalation Therapy: \$13 million will be saved under Medicare by revising the way in which HCFA reimburses providers for respiratory (inhalation) therapy services furnished under arrangements with outside suppliers. HCFA will begin limiting the amount Medicare will recognize as reasonable costs for these services.
- . Medicaid Financial Management: HCFA will reduce expenditures in the Medicaid program by \$25 million by improving the review of States' financial management systems and by closely scrutinizing the quarterly expenditures claims for Federal financial participation.

Administrative Cost Savings

- . HCFA is currently evaluating the legality and feasibility of applying the following constraints on all Medicare and intermediaries/carrier contracts, all PSRO contracts and grants, and all research, demonstration, and evaluation contracts and grants:
 - . For contracts/grants continuing from year to year, salary increases of employees paid from Federal funds would be limited to the President's voluntary guideline (7 percent). Another option is to restrict salary increases to the level approved for Federal General Schedule employees (5.5 percent).
 - . For all contracts/grants, we would require a certification that the recipient organization is in full compliance with all aspects of the President's anti-inflation guidelines. This would include cost and revenue increase guidelines. We would also apply the provision, where appropriate, to subcontractors/grantees.
- . HCFA has completed an evaluation of HCFA policies on contracting with fiscal intermediaries/agents which includes recommendations for improvements with respect to efficiency, effectiveness, and cost containment. These recommendations are currently under review in HCFA.

- . HCFA currently is evaluating the feasibility of the use of competitive fixed price contracting for the services provided by Medicare carriers. If practical, such a system has the potential for reducing the administrative costs associated with the processing of claims.
- . HCFA is currently developing uniform operating systems for both Medicare and Medicaid. Various activities associated with this effort are in progress and when completed will result in substantial savings to the Federal Government and providers through reductions in administrative burden.
- . HCFA through demonstration grants is sponsoring the development of various alternative reimbursement systems. The objective of these demonstrations is the establishment of a more cost-effective method of reimbursement for services without impairing quality of care.

MEDICAID/MEDICARE INTEGRATION

Problem

One of the most immediate areas of administrative improvement which presented itself when the Health Care Financing Administration (HCFA) was established, and which was a major consideration in the decision to create a single agency focused to encompass both the Medicare and Medicaid programs, was to assure that the common elements of both programs were administered with uniform procedures, that all unnecessary duplications in policies and procedures were eliminated, and that instructions, reporting obligations, and data publication were as comparable and inclusive of both programs as possible. Considerable progress has been made in the last 18 months.

Prior to the creation of HCFA, both programs generally operated independently of the other. The majority of cooperative actions were direct outcomes of legislation mandates. This absence of ongoing coordination has resulted in beneficiary confusion, administrative inefficiency, and the inability to develop uniform policies at the national level.

Actions Taken to Address Problem

This consolidation of the Medicare and Medicaid programs under HCFA was based on the realization that although basic differences did exist between the two programs, there were many opportunities for uniformity present. HCFA has directed specific components to identify common areas between the programs and develop coordination plans. As a result, 20 individual task forces were established, each with discreet responsibilities for implementing specific directives. The final result of these efforts will be a significant simplification of the two programs and a reduction of the burden on beneficiaries and providers. For example, at present a physician or a hospital dealing with Medicare and Medicaid must use different billing forms, although the data required is essentially identical (with some variations State by State). HCFA is currently designing common forms for physicians and hospitals which when implemented will allow a physician or hospital in one

State to use one billing form for both programs. In addition, the form will be similar throughout the country. While Medicare has always had national forms, this will be the first time that Medicaid had utilized such a form.

Concurrently, HCFA is developing common Medicare and Medicaid coding systems and provider identification numbers. This will allow various Federal and State agencies to more accurately prepare profiles of providers' patterns of treatment; better assess patterns of care in specific areas; and more easily identify aberrances. As these recoding systems are implemented, HCFA will have the capability to make cross program checks thus comparing services provided in each program.

Other activities in progress include establishment of common reporting systems, preparing common contracting and financial management language, design of uniform standards for processors, and joint reviews of common contractors.

The task force efforts were initiated late in the third quarter of FY 1978. By early February, HCFA expects that the decisionmaking phase of eight of these groups will be complete, and implementation should begin shortly thereafter.

In addition to the 20 task force projects, we are examining contracting issues within and between the two programs. A report has recently been released for comments with a number of significant recommendations (see Section IX). One of those relates to an experiment providing for a single claims processor for both programs in a State. This will allow HCFA to determine whether they can enjoy certain economies by combining the separate processes into one. This project is scheduled to begin in the second quarter of FY 1979 with actual implementation probably no earlier than the first quarter of Fiscal Year 1980.

Improvements Made and Planned in Management Systems,
Eligibility Determination Procedures, Claims Payment
Procedures Productivity, and Contract and Grant
Practices, and Personnel Management

HCFA has initiated several improvements in these areas.
A synopsis of each follows.

Contract Experimentation

- . HCFA has launched an active contract experimentation program to determine what benefits would accrue to the Medicare Program by using fixed-price competitive contracts for carrier functions. Three such contracts have been awarded to date in Maine, Illinois, and upstate New York. A fourth noncompetitive fixed-rate contract has been awarded for Maryland. Another Part A experiment is currently being planned for the State of Missouri.

Administrative cost savings in excess of \$35 million are projected for the three fixed-price experiments. More importantly, the experiments place a premium on the quality of carrier performance. Monetary liquidated damages are assessed against the contractor if it fails to meet specified performance standards. These standards are set at, or above, the national average for designated areas.

- . The Medicaid Bureau has also initiated closer monitoring of proposed State claims processing contracts with fiscal agents. Over the last year, we have worked with States such as New York, California, Alabama, and Tennessee among others to ensure that they pursue a course of action which will result in the most competitive, and cost effective, award.

Last year the Medicaid Bureau was successfully able to convince one State, for example, to move from a sole source contract award to a process culminating in the receipt of two proposals, of which the two lowest bidders were a mere \$.02 apart. The Medicaid Bureau believes their early intervention in this process resulted in a substantial savings to the Federal Government.

HCFA did petition OMB for authority to approve or reject any State's procurement proposal. While this request was denied, we were authorized to develop a regulation, currently being drafted, which would require States to submit to HCFA for review any major and critical step in the procurement process for these contracts. This proposal should provide a basis for which to target limit Medicaid technical assistance responses.

Improved Management Systems

HCFA's Office of Program Integrity has combined the fraud and abuse activities of the Medicare and Medicaid programs under the direction of one office. In so doing, it has been possible to draw upon expertise of employees from each program. In this way, duplication is avoided, savings result, and an increase in the workload is effected. OPI has also developed a uniform reporting system for Medicare and Medicaid fraud and abuse activity. When fully operational, this system will provide much needed comparative information on fraud and abuse activity in both programs.

Your office and our Office of Program Integrity have reached an understanding to allow for review of contracts prior to either organization's awarding a contract. Because of this coordinated effort, duplication of contract effort will be eliminated and an increase in coverage will evolve. Finally, by combining administrative tasks within the Office of Program Integrity, we have been able to more easily shift work priorities to accomplish special assignments dealing with fraud, abuse, and waste on a timely basis.

Finally, I have taken steps in recent weeks to strengthen the Medicaid Management Information System's certification process. In the near future, we will begin certifying, and recertifying, these systems based on specific and promulgated performance standards. I believe this move away from process review to performance evaluation will result in the development of data systems more capable of generating information of use for program management purposes.

We will continue and expand current efforts to:

- . Streamline review, approval, and certification procedures;
- . Develop certification standards, information systems management guides, update general systems design and performance standards;
- . Design and test new systems modules to meet States' changing needs;
- . Transfer technology through the identification and documentation of exemplary or innovative systems practices for distribution to States to aid in the implementation of their systems initiatives.

Quality Assurance

Beginning in July 1978, the Medicare Bureau implemented the Cost Report Evaluation Program, a national program designed and developed to aid in assessing and improving Part A intermediary performance in the review and settlement of cost reports submitted by hospitals participating in the Medicare program. This program measures the quality of intermediary actions in reviewing, adjusting, and settling cost reports and the accuracy of the intermediaries' reimbursement and audit capabilities, as well as their adherence to Medicare program policy.

The program involves a review of a statistically representative sample of hospital cost reports settled by intermediaries during the year. The review is carried out by regional office personnel. Reports are submitted to Central Office for analysis and publication of results. HCFA expects to recover \$16 million which is overpaid annually because provider cost reports were not being properly reviewed.

The Medicare Bureau presently maintains a formal ongoing carrier quality assurance program. The primary purpose of the program is to provide a statistically valid and objective procedure for evaluating Part B contractors' performance in the area of the quality of claims processing. Each carrier's claims processing operation is evaluated to determine the number and type of processing errors associated with its adjudicated claims and the dollar amounts related to those errors. This evaluation

program provides definitive insight into the quality of each carrier's claims adjudication operation and how a contractor's operation compares to that of other program carriers. A correlative objective of this program is to provide each carrier with management information which can be used to improve the quality of its claims processing operation. The identification of processing errors by number, category of occurrence, subcategory of occurrence, and resulting monetary impact equips each carrier with management tools for identifying and monitoring actions needed to derive further improvement in its claims processing operation.

Personnel Management Improvements

The following are the most significant improvements:

- HCFA developed and is implementing the first Performance Rating Program which complies with the Civil Service Reform Act of 1978.
- HCFA developed and implemented an internal evaluation effort which concentrates on legal and regulatory compliance.
- HCFA has completed the majority of our classification audits and this has resulted in the determination of proper titles, codes, and grades.
- HCFA has prepared a new Merit Promotion Program which complies with the Civil Service Reform Act.
- Streamlining of the recruitment process enables HCFA to substantially reduce vacancies despite the move to the Baltimore area.
- A dynamic outplacement effort including a highly successful Job Fair has resulted in over 100 outplacements.
- HCFA has established a Supervisor's Institute to assure that all new supervisors receive good supervisory training.
- An Executive Manpower Management Council has been named to coordinate executive development, executive search, SES related matters, and feeder group development.
- HCFA prepared a Commissioned Corps manual for our Commissioned Corps employees which provides procedural and policy guidance.
- A new approach for assisting Regional Administrators and employees has been formulated.
- A tracking system for key personnel actions was developed to identify delays and eliminate them where feasible.

- The first HCFA Honor Awards Ceremony was conducted.
- The ceiling for the staff of the Office of Personnel Administration has been cut from 92 to 52 and 21 recent losses have not been replaced. This will save over a million dollars by the beginning of FY 80.

Medicaid Management Information Systems (MMIS)

MMIS offers an important mechanism to control fraud, abuse, and waste. In addition to providing a more timely means to process and pay claims, MMIS can help to identify overpayments, payments for non-covered services, and duplicate payments. This system also represents a valuable link in capturing other third party reimbursement. Further, MMIS can serve as an important source of data for other activities such as the State Fraud Units and PSROs. Lastly, MMIS can assist in the collection of necessary data to help determine who is getting served and where gaps exist, thus improving our ability to modify and expand the Medicaid program on a more rational and cost effective basis.

Currently 23 States have implemented certified MMIS programs which are matched at a 75% Federal rate. In addition, 10 States are in the process of developing such systems and anticipate certifications during FY 1979. Our ability to fully utilize this program has, nevertheless, not been realized. In order to improve upon our current efforts, the following steps are planned:

- a. A task force involving Medicaid central and regional office staff, as well as State representatives, has been established to examine the current system, develop performance standards, and identify areas where technical assistance is needed.
- b. Performance standards will be established by regulation that will go beyond current requirements which only stipulate what the systems must include, but do not deal with the actual implementation of those systems. States that cannot meet those standards will be subject to decertification of their systems and, thus, not be eligible for the higher matching rate.
- c. States will be required to meet certain uniform requirements to have their existing certification. Recently certified States have, for example, been required to include ICD-9-CM procedure codes in their system and, in the future, States will have the capacity to be able to gather and report data required under the Medicaid Minimum Data Set.

- d. Medicaid will test State systems to assure that required edit checks are operational in those systems. These edit checks are very helpful in detecting instances of fraud, abuse, and waste.
- e. Future changes in MMIS required by the Medicaid program will be announced on a regular, periodic basis (e.g., once a year), and States will be given a 90% match to upgrade their systems to meet those requirements. However, if such requirements are not met by a State, they would lose their 75% match.

Additional Areas Ripe for FAW Actions

Home Health Abuses

The GAO identified substantial variation in home health care administrative costs in a draft report issued on November 30, 1978. We share the GAO's concern that the sixfold increase in home health care Medicare expenditures from 1968 to 1977 demanded close scrutiny to determine the degree to which inappropriate use of service or unallowable costs may be inflating this expenditure.

In response to the GAO report, and as the basis of their working papers for that report, we have implemented the following changes in clarification of Medicare policy, also described in the attached workplan:

- . We revised regulations governing allowable costs for expenses of related organizations;
- . We published an additional instruction to intermediaries advising them of how to deal with long term contracts between Medicare providers and organizations providing management and related services. This instruction also addressed the issue of controlling any inappropriate practices by home health agencies in potential solicitations;

We distributed national accumulated data on costs per visit for intermediaries to establish guidelines similar to those used by the Medicare Bureau's Division of Direct Reimbursement in identifying costs which are "substantially out-of-line" with other home health agencies;

- . We are planning to publish Section 223 limits on overall home health costs;
- . We increased Medicare budget allocations in FY 1979 for intermediary audits of home health in areas of the country where the high concentration of elderly residents makes the establishment of Medicare-only agencies attractive to investors. We are also considering ways to

preclude an agency from limiting its service solely to Medicare beneficiaries.

- We issued an NPRM providing for the use of areawide Medicare intermediaries in the handling of home health agency claims. In effect, this proposed regulation would result in more uniform administration of the home health benefit by having fewer intermediaries involved in the claims process.
- We are exploring the desirability of tailoring the utilization review committee concept to the special needs of home health agencies. We now have regulations that require an annual evaluation of home health agencies by a group of professionals, but this evaluation process is not as definitive as the utilization review requirements for hospitals and skilled nursing facilities. We want to sharpen the professional review of the adequacy of home health agency treatment plans and the appropriateness of care.
- We are considering proposals to prohibit physicians from certifying home health plans of treatment for patients of home health agencies in which the physician has a significant interest.

Drug Reimbursement as a Function of Eligible Medicaid Determinations

A situation was uncovered in the Philadelphia area involving narcotic drugs obtained through the use of improper Medicaid eligibility on prescriptions from physicians known in the vernacular as "croakers." An illegal Medicaid eligibility card was published from the State. The card was then utilized to obtain narcotic drugs on prescriptions from "croakers" who either did not examine the recipient to determine whether he had any condition requiring the narcotic drug prescribed or who prescribed the drugs without even having seen the recipient.

HEW has undertaken joint projects with State Medicaid agencies and State fraud units (including involvement

of other Federal investigative activities such as FBI, DEA, etc.) in 10 selected high drug volume cities to identify and root out similar situations involving Medicaid recipients, physician "croakers," and pharmacies for sanction activities including prosecution, where possible. OPI will also be working with State Medicaid agencies to establish screens which would provide greater assurance that these situations are detected in the future. These screens will be used to locate spurious prescriptions. Those that involve large amounts of narcotics, i.e., prescriptions which represent more drugs than could possibly be used by the individual, are investigated for fraud.

. Improper or Excessive Intercompany Charges

Validation efforts have uncovered significant potential problems in large chain organizations which may be causing the Government to be reimbursing the private sector for intercompany costs which may not be the result of arms-length transactions. OPI is currently looking into hospital construction costs charged by a wholly owned subsidiary of a major conglomerate and used as a basis by hospitals also owned by the conglomerate to determine whether they were consistent with normal construction costs for similar facilities. Of particular concern is the potential for kickbacks from subcontracts.

OPI is also reviewing interest charges in refinancing arrangements in situations where the major purpose of the refinancing appears to be to pass along higher interest costs to the Medicare and Medicaid programs.

Recently, significant problems have surfaced with regard to the high costs claimed by Medicare/Medicaid providers for certain lease arrangements and management contracts. It appears that lease agreements and management contracts are being negotiated on a percentage of revenue basis. We intend to initiate projects to assess:

- . how prohibitive these costs are;
- . whether intermediaries are evaluating these contractual arrangements;

- . whether the contractual arrangements are competitive with the market price; and
- . whether the contractual arrangements are at arms length.

The current inflation impact is also placing pressure on providers to artificially create a sale and lease-back transaction as a means of getting away from program reimbursement based on historical costs (depreciation vs. rental costs). In all these reviews, the integrity of the transaction that it is at arms length is to be evaluated.

- . Improper Dental/Laboratory Charges

Project Integrity II represents two major initiatives commencing in early 1978 in which HCFA is participating. The initiatives are (1) review of dental services and (2) review of independent laboratory services. In the dental project, a qualified dentist is used to do in-mouth reviews on selected recipients to determine if the services were rendered as billed. The laboratory project requires onsite audits in its verification process. A medical person also works with this team. This project is a joint Federal/State effort utilizing staff from FAW Office of Program Integrity, HEW's Office of Investigations, and the Audit Agency and appropriate State personnel. State participation is voluntary and to the extent possible the project is tailored to fit the management and resource needs and preferences of each participating State.

The overall objective of Project Integrity II is to identify fraud and abuse on dental and laboratory claims, initiate appropriate prosecutive and administrative action and evaluate the effectiveness of current procedures for controlling fraud and abuse in Medicaid payments. An additional objective is to institute strong controls for ineffective ones and put in place ongoing review systems where none exist to assure efficient, economical, and prudent program operations.

Each of these items provide for significant savings in the long run. However, because they are relatively

new initiatives and sketchy, we are unable at this time to place a finite dollar figure on them.

• Sterilization and Abortion Monitoring

I informed all Medicaid State Agencies of the Inspector General's preliminary findings of abortion misreporting in Illinois. I directed each State to review their procedures to ensure that they are not certifying, for Federal matching funds, abortion claims which are ineligible for payment under the law.

I have been especially concerned over apparent discrepancies between abortion data reported quarterly by the States (on Form HCFA-58) and States' actual requests for Federal matching submitted in quarterly expenditure reports (Form HCFA-64). To correct this problem, we have incorporated the Form HCFA-58 as part of the quarterly expenditure report.

This combined reporting form was approved on December 18 by the Office of Management and Budget and was implemented for the January quarter. HCFA will begin receiving this data in April 1979.

By requiring the States to submit these forms as a single package, State Medicaid financial management staffs will have to correlate their findings with data collected by the statistical units of Medicaid State agencies. To ensure that this coordination occurs, we have convened several training sessions for those State representatives who exercise responsibility for the abortion report. We are also requiring that the combined forms be signed by a senior official within the State agency who will be held accountable for the accuracy of the data submitted.

In addition, to assure that only those abortions which meet the requirements of P.L. 95-205 received Federal reimbursement, HCFA has planned an intensive State monitoring campaign in conjunction with the Inspector General. The Office of Program Integrity (OPI) will monitor States' compliance with abortion regulations through annual State assessment reviews in addition to special validation studies.

Between now and January 30, 1979, OPI will conduct field validation reviews in 41 jurisdictions to supplement the 12 State reviews conducted by the Inspector General's office. OPI will review State systems now in place for processing abortion claims, while also reviewing documentation submissions for those claims which do qualify for Federal financial participation.

In addition, as part of the ongoing Medicaid State assessment reviews, OPI will review annually every State's abortion processing activity. Guidelines have already been submitted to HCFA regional offices to ensure that uniform and adequate reviews are achieved.

During these State assessments, OPI auditors will also pay particular attention to the records of those individual providers who, prior to enactment of P.L. 95-205, performed great numbers of abortions for which they claimed Federal reimbursement. We plan to determine whether such providers are now disguising abortions under other gynecological procedures in order to qualify for payment under service categories not actually coded as abortions.

Sterilization Monitoring Activities

- . Under the new regulations, States are required to maintain sufficient records and documentation to assure compliance with the regulations and to protect Medicaid recipients from any abuse.
- . In conjunction with OGC, OHDS, and PHS, HCFA developed a departmental reporting form which has been approved by OMB.
- . The Office of Program Integrity informed States at Medicaid Training Sessions held in Atlanta and San Francisco in December that States will be monitored in one or more of the following ways:
 - . DHEW Audit (HCFA will not duplicate monitoring in those States);
 - . OPI special validation survey;

- . As part of State assessment normally done by the Medicaid Bureau, OPI will monitor State sterilization procedures and records.

OPI will conduct a review in all States and territories within a year of the date the sterilization regulations are implemented.

OPI is presently preparing internal guidelines for conducting a statistically valid review.

State agencies administering approved Title XIX programs and Title XX programs will be required to report on a quarterly basis. Data from the report will be tabulated and summary data will be published as part of the statistical publications effort of both HCFA and OHDS.

. Allocation of Costs Between Federal and State Governments for Surveys of Facilities under Medicare and Medicaid

Public Law 92-603 passed by Congress in 1965 authorized the Secretary of Health, Education, and Welfare to enter into agreement with State governments to implement the provisions of the Act which embody the conditions for the participation of Medicare and Medicaid providers and suppliers of health care services. Under these agreements, appropriate State agencies, usually to State health departments, (1) employ Federal standards to survey facilities which apply to participate in the Medicare and/or Medicaid programs; (2) certify to the Secretary whether a potential provider or supplier is in compliance with Federal requirements; and (3) resurvey and recertify providers and suppliers which are already participating in the program.

The statute also authorizes the Secretary of HEW to reimburse the States for the reasonable costs of performing these functions. In most States, the surveys of Medicare and Medicaid are conducted by the same State employees who are engaged in inspections of health care facilities under State licensure programs. From the onset of the Medicare and Medicaid survey and certification programs, State agencies and Federal program managers have experienced considerable difficulty in allocating the

costs of surveys between licensure and Federal survey and certification activities. This is due in part to the substantial variations in the scope of licensure programs among the States, and in part to the absence of Federal guidelines for cost allocation among the variety of multi-program activities within the framework of Federal-State partnership.

In recent years, the allocation of survey costs between the Federal programs and State licensure programs has been subjected to considerable scrutiny by HEW auditors. As a result of that attention, the bulk of the major audit exceptions related to survey and certification expenditures have involved the inappropriate allocation of costs between Federal and State standards enforcement programs.

HCFA plans to contract a study to assist this agency in developing an effective methodology for allocating the costs related to the survey of facilities for Medicare and Medicaid between the Federal programs and State licensure programs. Such methodology must be effective with the substantial variations in the scope of licensure programs among the States and in the recordkeeping capabilities of State health departments. The results of this study will: (1) provide an improved basis for supportive accounting affecting Federal survey and certification costs; (2) facilitate negotiations between State health departments and HSQ Regional Offices affecting survey and certification budgets; (3) provide an improved basis for the resolution of current audit exceptions identified by the HEW Audit Agency and reduce the likelihood that audit exceptions related to the allocation of costs will reoccur.

In the performance of this contract, the contractor shall conduct a study of the issues and problems related to the allocation of costs of surveying facilities for the Medicare and Medicaid programs. This will include but is not limited to:

- . Identification of significant differences and similarities in the scope of licensure requirements among the States;

- . Identification of the mechanisms now used by State health departments to allocate staff time and costs between licensure activities and Medicare and Medicaid survey and certification;
- . Identification of alternative methodologies for cost allocations with particular attention to:
(a) potential uniform approaches to employee time and effort reports; (b) an approach that attempts to identify the relative benefits that accrue to State licensure and to the Federal Government from the federally mandated survey and certification programs;
- . Identification of additional factors and/or approaches that need to be considered in developing an effective methodology for cost allocation.

In accordance with Procurement Manual Circular HEW 78.2, we will be submitting this procurement package to your office for review. Ultimately, we will develop Federal guidelines/regulations for allocation of the costs related to the survey of facilities for Medicare and Medicaid between the Federal programs and the State licensure programs. No such guidelines/regulations have ever existed and none exist at the present time.

HOME HEALTH AGENCY WORK PLAN

Commitments Made in Administrator's Testimony in August 1978

Item	Status
1. Use papers on 11 home health agencies turned over to us by GAO for follow-up on GAO findings LEAD - OPI	OPI performed reviews at three of the home health agencies in South Florida as a continuation to the reviews performed by GAO. OPI plans to review the other eight home health agencies included in the GAO report as part of their fraud and abuse control effort this year (1979).
2. Publish Related Organization Regulation September 30, 1978 LEAD - MAB	NPRM issued on January 29, 1979, and published in <u>Federal Register</u> . Comment period ends March 27, 1979.
3. Issue intermediary letter (I.L.) on term contracts and patient soliciting by end of August 1978 LEAD - MAB	I.L. 78-39 issued September 1978.
4. Provide intermediaries with national accumulated data on cost per visit LEAD - MAB	I.L. 78-37 issued August 1978.
5. Publish 223 limits on cost per visit by end of 1978 LEAD - MAB	Notice of Proposed Schedule of Limits in final stage of Department review. Publication expected before March 1, 1979.

Item	Status
6. If practical, publish limits on administrative compensation in September 1978 LEAD - MAB	First priority in Medicare reimbursement limits on home health costs is to issue limits by type of home health visit. After these limits have been published in final, data collection for establishing limits on elements of cost can begin.
7. Consider ways to preclude participation in Medicare program by home health agencies which limit services solely to Medicare beneficiaries LEAD - OGC	Options paper submitted to Galen Powers who decided it should be rewritten as a non-options paper, simply setting forth legal authorities which could be used to prohibit 100 percent Medicare home health agencies. Revision not yet begun.
8. Issue NPRM on areawide intermediaries by mid-October 1978 LEAD - MAB	NPRM published November 9, 1978, in Federal Register. Comment period closed January 9, 1979. Last comments received about February 1, 1979. Proposal being redrafted. Will be sent forward shortly.
9. Publish draft revised cost report by end of 1978 LEAD - MAB	Draft has been prepared and printed. Will be distributed for comment in February 1979.
10. Increase home health agency audits of selected home health agencies LEAD - MAB	20 percent increase in home health agency audit funds included in FY 79 Medicare contractors' budgets for audits of problem home health agencies. Medicare contractors' budget guidelines for FY 80 mandate that 100 percent of Medicare and Medicaid home health agencies be audited.

Item	Status
11. Compile existing policies affecting home health agencies and consider ways of tightening up; analyze other Federal rules to determine applicability to home health agencies LEAD - MAB	Two I.L.s have been prepared--one on fringe benefits and one on advertising costs. These are in final Bureau review, expected to be issued shortly.
12. Issue more definitive guides following up on I.M. 78-50 which requires changes in intermediary to be in program's best interest LEAD - MAB	Instructions to regional offices supplementing I.M. 78-50 have been prepared and are in the Bureau's final stages of review.
13. Revised Claims Processing Procedures LEAD - MAB	Procedures redrafted to incorporate regional comments of instructions related to tightening utilization patterns. Draft rejected and now being rewritten.
14. Develop Part A Quality Assurance Program for home health agencies LEAD - MAB	Further action on home health agency Quality Assurance Program deferred until FY 80 because of problems, both centrally and regionally, in implementing Hospital Part A Quality Assurance Program.

Legislative Proposals

HCFA has several major legislative proposals that, if enacted, will save approximately \$2,141,000,000 during 1980. They are:

<u>Proposals</u>	<u>Savings</u>
Common Audits	\$ 34.0
Civil Money Penalties	23.6
Hospital Cost Containment	1,725.0
Hospital-Based Physicians	55.0
Elimination of Chiropractic Benefits	35.0
Medicare Coverage of Working Aged	200.0
All Other	68.0
Total	\$2,140.6

There are several other proposals for FY 1980 that, if enacted, will lead to savings. However, we are unable to estimate specific savings at this time. Included in this listing are the following proposals designed to promote operational efficiency and reduce costs of HCFA programs:

- . A proposal to amend Title XVIII of the Social Security Act to apply to deductible and coinsurance requirements under Part A of Medicare on the basis of the calendar year in which services are furnished. Amendment of the law, which now requires patient cost sharing on the basis of the deductible and coinsurance amounts in effect in the calendar year in which the beneficiary's benefit period begins, would ease the record-keeping responsibilities of hospitals which must apply, bill, and collect patient cost-sharing amounts.
- . A proposal to provide authority for the Secretary to designate, and incentives for the States to use, common contractors for carrying out

administrative functions under Medicare and Medicaid. Use of common contractors would eliminate multiple confusing dealings which providers and beneficiaries may now experience as a consequence of fragmentation of fiscal intermediary functions among Medicaid and the two parts of the Medicare program.

- . As a part of the Department's Child Health Assessment Program (CHAP) initiative, HCFA has recommended inclusion of provision under which physicians would use a uniform form on a statewide basis for reporting to the States the services they provide to eligible children. Use of a single uniform report would significantly simplify and reduce the reporting burden currently imposed on physicians who render services covered under the early and periodic screening, diagnosis, and treatment (EPSDT) provisions of Title XIX programs.

Additional information regarding each of these proposals is contained in the attached HCFA legislative proposal package.

Fraud, Abuse, and Waste Related Regulations

The following is a list, by Bureau, of regulations to implement HCFA's Fraud, Abuse, or Waste agenda, including implementation of P.L. 95-142. We have also enclosed copies of press releases for those regulations particularly noteworthy in this regard:

- 1/23/78 State Medicaid Fraud Control Units; 42 CFR 450.80, 450.310; sets forth conditions under which State Medicaid Fraud Control Units can receive 90 percent matching.
- 3/3/78 Prohibition Against Reassignment of Claims; 42 CFR 449.31; technical changes including extension of the prohibition to all Medicaid providers.
- 3/10/78 Medicaid Claims Processing Systems: Explanation of Benefits Notices; 42 CFR 450.80(a)(6) and 450.90(b)(2); permits States with mechanized claims processing systems to send explanation of benefit notices to a sample of beneficiaries, rather than all beneficiaries.
- 3/31/78 Medicaid Quality Control Systems; 42 CFR 450.25; adds to existing quality control system a review for available medical insurance and a determination of the completeness and accuracy of claims.
- 7/24/78 State Medicaid Fraud Control Units; 42 CFR 450.80 and 450.310; clarify policies in January 23 regulations as a result of public comments and experience in working with States.

The following list contains regulations currently under development:

- 6/8/78 NPRM; Suspension of Physicians and other Individual Practitioners Convicted of Crimes Related to Medicare or Medicaid; would establish policies for suspending convicted practitioners from participation in Medicare and Medicaid.

- 8/4/78 NPRM; Disclosure of Information and Access to Provider Records; Requirements and Conditions for Participation; would require Medicaid and Medicare providers and fiscal agents to disclose certain information on owners, employees, subcontractors, and suppliers; would authorize the Secretary to refuse to enter into agreements with providers who do not disclose the information.
- 8/18/78 NPRM; Timely Payment of Medicaid Claims; intended to improve State program management, increase provider participation, and aid in preventing and detecting fraud.
- 8/29/78 NPRM; Assignment of Rights to Benefits; Collection of Medical Support and other Third Party Liability Payments; would require applicants, as a condition of eligibility, to assign to the State their rights to third party payments for medical care.
- 9/1/78 NPRM; Protection of Patients' Funds; would require accounting for private funds of patients in long term care facilities and the use of a separate account for each patient's funds.
- 10/13/78 NPRM; Imposition of Sanctions on Health Care Practitioners and Providers of Health Care Services; would allow HEW to sanction providers who furnish services which are not medically necessary, do not meet professional standards, or are not properly documented.
- 11/1/78 NPRM; Medicaid Utilization Control; would reduce the Federal share of Medicaid payments to States that do not have effective programs of control over utilization of inpatient institutional services; would lessen the severity of the existing penalty and encourage more effective program management procedures.

Statistical Data on Fraud and Abuse Cases
Detected, Referred to Prosecution, Resultant
Indictments and Convictions, Value of Fines, Recoveries

Time frame reported on: January 1, 1978, to September 30,
1978

Total number of cases of fraud and abuse identified:	21,103
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Cases referred to State or Federal prosecutors:	635
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Value of overpayments identified:	17,879,612
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Funds recovered from January 1, 1978, to June 30, 1978:	2,824,173
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(Period of July 1, 1978,
to December 31, 1978, not
available)

A summary of the convictions obtained by OPI in Calendar
Year 1978 is attached.

In addition, we have attached another quantitative des-
cription of OPI's impact in case development and manage-
ment review, among other areas.

FRAUD AND ABUSE

Nature of Problem

Inappropriate utilization by providers of Medicare and Medicaid funds resulting in excessive Federal expenditures.

Actions Taken to Address Problem

In 1977, the Office of Program Integrity (OPI) was established within the Health Care Financing Administration (HCFA). A primary responsibility of OPI is the development and application of systems designed to measure and analyze the level and nature of improper expenditures attributable to fraud and abuse involving the Medicare and Medicaid programs. This responsibility is implemented through a network of OPI Regional Offices and State Medicaid fraud control units. These limits were established under the authority of the 1977 Medicare and Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act.

Impact to Date

- 1) Case Development - Between June 1977 and June 1978, OPI identified 10,575 instances of fraud and abuse in the Medicare program (7,595 fraud and 2,980 abuse). Of these, 9,751 were investigated and closed (6,851 fraud and 2,900 abuse).

Investigations of alleged irregularities in the Medicare program resulted in 148 subjects referred to the Department of Justice for criminal prosecution; 104 of these are still pending, while 12 subjects were convicted of criminal fraud. This activity resulted in identification of \$11.8 million in overpayments. Of this amount, \$4.6 million has been collected, and the balance is being actively pursued.

In the Medicaid program, OPI identified 7,324 instances of fraud and abuse from March 1977 through June 1978; of these, 4,611 were investigated and closed. Cases referred to law enforcement organizations totaled 460, with 74 convictions.

- 2) Management Review - OPI performed State abuse reviews of providers in Massachusetts, Idaho, Ohio, Texas, Louisiana, and Oregon. In addition, OPI assisted in the assessment of 14 State Medicaid agencies.
- 3) Implementation of Medicare/Medicaid Anti-Fraud and Abuse Amendments - Section 17 of these amendments provided HCFA with the authority to provide grants to establish State Medicaid Fraud and Abuse Control Units. At the conclusion of FY 1978, 16 such units were certified. Approximately 30 additional units are expected to be certified by the close of calendar year 1978.
- 4) Project Integrity - In a nationwide, cooperative venture between OPI and the Office of the Inspector General, Project Integrity No. I was initiated in 1977 to examine Medicaid fraud and abuse by physicians and pharmacists.

The HEW Audit Agency developed computer screens that identified some 47,000 physicians and pharmacists for review. Under that agency's direction, OPI undertook a further screening and verification, through which 2,464 cases (1,340 physicians and 1,124 pharmacists) were identified as candidates for indepth investigation and given a preliminary administrative review.

Of the 2,464 cases, 830 were closed, 768 were identified for possible administrative action by the States, 590 were referred for fraud investigation, and 277 are still in the preliminary stage at this fiscal year's end. Of the 768 cases marked for administrative action, 659 were actually referred to the States, which found 86 cases that represented \$591,908 in overpayments. Twenty-one other cases involved miscellaneous actions, 80 were closed with no action taken, and 439 are still pending. In 33 cases, Medicaid staff visited the physician or pharmacist to provide advice and assistance on proper methods for submitting Medicaid claims.

At the end of the fiscal year, Project Integrity No. II was launched. It focuses on possible fraud

and abuse by dentists and laboratories under Medicaid. More limited in scope than Project Integrity No. I, it will be applied in 18 States where the potential for improvement seems greatest.

- 5) Utilization Reviews - During FY 1978, OPI expanded its techniques for reviewing overutilization by physicians under Medicare and Medicaid. Under the Payment Review system (PARE), Medicare Part B carriers review and report to OPI on physicians with high incidence of utilization in the program. This year, OPI focused on evaluating the carriers' prepayment and postpayment controls, to determine their adequacy for identifying physicians with questionable patterns of practice.

A total of 3,329 Part B PARE reports were processed between April 1977 and June 1978, resulting in 75 fraud investigations and in the investigation of \$1,594,323 in overpayments.

6. Administrative Sanctions - Improved administrative sanctions against fraud and abuse are needed in both Medicare and Medicaid programs. The New Medicare/Medicaid Anti-Fraud and Abuse Amendments provide for some needed administrative sanctions. Under Section 7, physicians and other individual practitioners convicted of a criminal offense related to their involvement under either of the two programs can be suspended from participation. OPI issued a notice of proposed rulemaking to implement this provision and has received comments preparatory to developing final regulations. To date, 27 physicians have been suspended from program participation for from one to ten years (suspension periods are determined by the HEW Secretary). Also, seven persons were excluded from participation for an indefinite period of time because of gross abuse or inferior services, under another section of the Social Security Act.

