



Semiannual Report

April 1, 1993 - September 30, 1993

Office of Inspector General

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

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

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

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 98-502	Single Audit Act of 1984
P.L. 99-499	Superfund Amendments and Reauthorization Act of 1986
P.L. 100-504	Inspector General Act Amendments of 1988
P.L. 101-121	Governmentwide Restrictions on Lobbying
P.L. 101-576	Chief Financial Officers Act of 1990
P.L. 102-486	Energy Policy Act of 1992
Office of Management and Budget Circulars:	
A- 21	Cost Principles for Educational Institutions
A- 25	User Charges
A- 50	Audit Follow-up
A- 70	Policies and Guidelines for Federal Credit Programs
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A- 76	Performance of Commercial Activities
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A- 88	Indirect Cost Rates, Audit, and Audit Follow-up at Educational Institutions
A-102	Uniform Administrative Requirements for Assistance to State and Local Governments
A-110	Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations
A-120	Advisory and Assistance Services
A-122	Cost Principles for Nonprofit Organizations
A-123	Internal Controls
A-127	Financial Management Systems
A-128	Audits of State and Local Governments
A-129	Managing Federal Credit Programs
A-133	Audits of Institutions of Higher Education and Other Nonprofit Institutions

General Accounting Office "Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

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

FOREWORD

This semiannual report summarizes the activities of the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) for the 6-month period ending September 30, 1993. It is submitted in accordance with the provisions of the Inspector General Act of 1978, as amended.

Among its accomplishments during this second half of the fiscal year, OIG conducted further reviews of Medicare and Medicaid accounts receivable with credit balances; investigated violations of the anti-kickback statute; examined the quality of service delivery under the Social Security and Medicare programs; and assessed the impact of expansion on Head Start grantees. The OIG also continued to play an integral part in the improvement of systems of accounting, financial management and internal controls within the Department. During this period, OIG reported on its audit of the Social Security Administration's financial statements for Fiscal Year 1992 and its audits of four Public Health Service funds.

Despite fiscal constraints, OIG is striving to carry out its fraud and abuse prevention activities and its major enforcement responsibilities. The OIG is committed to ensuring that HHS services are provided as intended, at the lowest reasonable cost, and will continue to target its resources to the most vulnerable areas within the Department's programs and operations.

Bryan B. Mitchell
Principal Deputy Inspector General

HIGHLIGHTS

In this second half of Fiscal Year 1993, the Office of Inspector General (OIG) has undertaken several major initiatives to protect the integrity of departmental operations and programs and the health and well-being of the beneficiaries served by those programs. Some of OIG's most significant accomplishments during this period are identified below.

Reducing Unnecessary Spending:

- A study of total parenteral nutrition (a very expensive form of nutrition for patients without a functioning intestinal tract) found that \$69 million, 43 percent of the total for this service, was overpaid on behalf of patients who did not meet guidelines for coverage. (See page 27)
- The OIG recommended that the Health Care Financing Administration (HCFA) take action to reduce excessive spending of Medicaid funds for intermediate care facilities for the mentally retarded (ICF/MRs). The OIG estimated that, if all States had capped their ICF/MR costs, at least \$683 million in Federal and State Medicaid funds could have been saved in 1991. (See page 33)
- The OIG determined that Medicare could substantially reduce costs by changing the reimbursement rate for hospital beds used in the home to reflect the useful life and rental cycle of these beds. (See page 28)
- The OIG reported that hundreds of millions of dollars in drug rebate funds are vulnerable to fraud, waste and abuse because States have not established adequate accountability and internal controls over their Medicaid drug rebate programs. (See page 31)

Preventing and Detecting Fraud:

- A Pennsylvania endocrinologist who was sentenced to serve 34 months in jail and fined \$20,000 for Medicare fraud and illegal drug distribution was also ordered in a civil judgment to pay \$2.3 million. (See page 17)
(3-90-00660-9 and 3-92-20473-9)
- The Florida Medicare carrier agreed to pay \$10 million for mishandling claims and submitting false claims. (See page 22) (4-93-20009-9)

- In Illinois, the owner of a durable medical equipment company was sentenced to 18 months in prison, and a Medicare carrier employee to 4 months home detention, for fraudulently processing Medicare claims. (See page 30) (5-87-01112-9)
- Seven persons were sentenced, for a total of 20 persons, in a kickback scheme involving x-ray materials in which several New York and New Jersey hospitals were defrauded of an estimated \$10 million. (See page 25) (2-90-00608-9)
- Two medical groups associated with a Washington State hospital agreed to pay \$850,000 to settle allegations they had "unbundled" and charged separately for physician services in order to receive higher Medicare reimbursement. (See page 23) (X-88-20128-9)
- After entering a plea in which he agreed to repay close to \$490,000 to Medicare and more than \$1 million to his employees' pension plans, the owner of two home health agencies in California was fined \$30,000 and sentenced to 22 months in Federal prison for Medicare fraud and pension plan embezzlement. (See page 17) (9-88-00981-9 and 9-93-24021-9)
- A nurse whose license was revoked in Oregon and California for psychiatric problems was excluded indefinitely from reimbursement by Medicare and State health care programs. (See page 21) (9-93-40012-9)

Identifying Systemic Management Problems:

- In a study that examined locating absent parents in the military to pay child support, OIG found that States did not collect child support payments in more than half of the sampled military cases because child support enforcement program staff have not been properly trained in handling military cases. The OIG recommended that the Office of Child Support Enforcement provide technical support to the States to improve coordination between Federal, State and military entities in these matters. (See page 66)
- Reviews by OIG of health and safety conditions at child care facilities identified violations of State codes ranging from discrepancies in employees' and children's records to fire code violations and unsanitary conditions. The reviews were conducted in North Carolina, Wisconsin and Nevada. The deficiencies parallel those previously reported in Delaware, Virginia, Pennsylvania and Native American Head Start facilities. (See page 65)

- The OIG's reviews found that a change in accounting standards for costs associated with retirees' health benefits has the potential for significant increases in costs charged to Federal programs. (See pages 12 and 81)
- Recent OIG reviews of general and administrative and fringe benefit costs charged by hospitals to Medicare found that the lack of clarity of HHS-established cost principles could result in hospitals charging unallowable, unreasonable, and unallocable general and administrative costs to federally sponsored research. (See page 79)

Promoting Improved Service Delivery:

- In two reports on Head Start expansion, OIG recommended that the Secretary convene a task force to conduct a formal and thorough review of the management of the program, and that the Administration for Children and Families develop strategic and long-range plans to handle future expansion. (See page 64)
- In an annual client satisfaction survey of Social Security beneficiaries, OIG found that satisfaction remains high, with 77 percent of clients rating Social Security Administration (SSA) services as good or very good. However, it has declined from 84 percent in 1990, and lower ratings from both disabled clients and retirement and survivors insurance clients have contributed to the overall decline. (See page 38)
- The OIG found that SSA has adequate safeguards to protect against unauthorized access to personal information by State and Federal agencies. (See page 45)

Developing and Assessing Performance Measures:

- The OIG concluded that SSA could further enhance its future reports on performance of the trust funds and problems encountered in meeting its mission and goals, and better inform its readers of changes in reporting performance indicators. (See page 39)

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High Risk Areas and Financial Management

Chapter I

HIGH RISK AREAS AND FINANCIAL MANAGEMENT

High Risk Areas

The Department's Fiscal Year (FY) 1992 Federal Managers' Financial Integrity Act (FMFIA) report identified four high risk areas. During this reporting period, Medicare program data was removed from the high risk list. Following is a description of the three remaining areas and a brief discussion of their present status:

A. Medicare Secondary Payer Program

The OIG has estimated that the Medicare program may be paying out as much as \$1 billion a year unnecessarily because Medicare fiscal intermediaries and carriers do not always identify the primary payers, and because insurers, underwriters and third party administrators often do not pay as primary payers when they are required to do so. This problem, which was first identified as a high risk area in 1989, has been addressed through several initiatives, including proposals for legislative remedies and legal actions against noncomplying insurers. Additionally, the Omnibus Budget Reconciliation Act (OBRA) of 1993 establishes a new health insurance reporting system for all employers who are required to file a Form W-2.

While the Health Care Financing Administration (HCFA) reported that it had completed most of the milestones in its 1992 corrective action plan, it recognizes that full achievement of additional possible savings under the Medicare secondary payer (MSP) program will require continued efforts over a number of years. The HCFA's strategy is to attack the problem in several ways: perform a data match between the Internal Revenue Service, the Social Security Administration (SSA) and Medicare files; obtain primary insurance information from beneficiaries on a prepayment basis and insert data gathered from these sources into the common working file to prevent future mistaken payments; and take actions to improve the MSP recovery activities of the Medicare contractors. One report was issued by OIG during the 6-month period ending September 30, 1993 that pertains to the high risk area of MSP:

- Oversight of MSP Backlog Claims (CIN: A-04-92-02057) (See page 14)

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

- Second Review of Monitoring of HCFA's Implementation of the MSP Provisions Contained in OBRA's 1989 and 1990
- Survey of MSP Part A Retroactive Recovery Backlog at Empire Blue Cross Blue Shield
- Review of Blue Cross Blue Shield of Michigan's Compliance with the MSP Legislation
- Review of Provident Insurance Company's and Its Third Party Administrator Customers' Compliance with the MSP Legislation
- Review of Blue Cross Blue Shield of Florida's Compliance with the MSP Legislation

B. Medicaid Program Data

The need for better Medicaid program data was reported as a high risk area in 1991. An Office of Management and Budget (OMB) and Department of Health and Human Services (HHS) review team identified a serious need for accurate and timely programmatic and financial data to aid in managing the national Medicaid budget. This requires the development and implementation of properly integrated financial and program data systems to record actual program costs on a timely basis.

The HCFA reported that most of the actions of its corrective strategy were completed during FY 1992. Cooperation between HCFA and the National Governors' Association led to legislation to resolve funding problems with voluntary contributions and provider-specific taxes. The HCFA also reported that it has completed a number of its other planned corrective actions, including the revision of State data collection instruments, the development of data systems and report tables for OMB, and the collection and processing of necessary baseline data for the profile system. The OIG plans to review HCFA's corrective actions during FY 1994.

The following review currently in progress pertains to this high risk area:

- Third Party Liability: National Review

C. Management of Indian Health Service

The management of the Indian Health Service (IHS) was designated as a high risk area in 1990. The IHS had not devoted sufficient resources and attention to management of its program and activities. A more responsive and efficient management had to be developed to assure quality health care in a time of growing demand and constrained resources. As a result, the development of effective management became a major priority.

In September 1992, IHS provided a status report to a joint meeting of the Department's Management Oversight Council and representatives of OMB, where it detailed its management improvement efforts and successfully petitioned OMB for a reduction to level one of the high risk category, "significant progress." However, the high risk designation remains in place.

The IHS previously reported that it continued to undertake key management improvement initiatives related to billing and managing third party collections, quarters construction and management, collection of rents and administration of travel. Corrected material weaknesses previously reported include improvements in the IHS scholarship and debt management program, and in the administration of equipment inventories. The IHS anticipates that its internalization of management control principles will have progressed to the point that it will petition OMB during Calendar Year 1993 for the complete removal from the high risk list. The OIG plans to review IHS's corrective actions in support of efforts to remove the high risk designation.

In addition, OIG continues to investigate cases involving potential fraud and corruption in IHS. (See page 55)

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

- Review of Use of IHS Youth Alcoholism Funds
- Survey of IHS Area Office Organization
- Survey of IHS Collections from Third-Party Payers
- Survey of IHS Procurement Practices Related to Small Purchases
- Community Health Representatives: Management Issues

Financial Management

Effective financial management is essential to assure that the Department uses its resources to achieve program goals. Financial management entails the organization, planning, policies

and procedures designed to achieve full and reliable accountability, including performance measurement for allocated resources. To promote accountability and measure performance, the Congress passed the FMFIA of 1982 and the Chief Financial Officers (CFO) Act of 1990. In response, OMB promulgated implementing guidelines in the form of Circulars A-123 and A-127, and Bulletins 93-02 and 93-06.

A. Federal Managers' Financial Integrity Act

Management control systems are a mechanism for preventing and detecting fraud, waste and abuse, and for ensuring the achievement of program goals. The OIG is actively involved in the Department's implementation efforts, providing technical assistance to management in its efforts to evaluate and improve management systems. In addition, OIG corroborates the effectiveness of the FMFIA process through audits, inspections and investigations that are designed to detect fraud, waste and abuse.

Management controls are reviewed as part of the FMFIA process and weaknesses are identified. Material weaknesses are identified by management as it carries out its FMFIA activities, and by OIG as it performs audits, inspections and investigations of Department programs. Material weaknesses are those problems of such magnitude that they may impede achievement of program mission and goals. Management control weaknesses that are reported as material are reviewed and approved or rejected by the Management Oversight Council, which oversees the Department's FMFIA program. Each year a summary of the Department's outstanding material weaknesses is reported in the Secretary's annual FMFIA report to the President and the Congress.

The Department uses a management oversight council (MOC) to provide high level attention to the reporting and resolution of important management control matters, especially serious deficiencies that can result in financial losses or the failure to accomplish program missions. The MOC, which was first proposed by OIG, is comprised of senior executives of the Office of the Assistant Secretary for Management and Budget and meets twice a year to review the status of the Department's FMFIA program, and progress on high risk areas and material management control weaknesses. The MOC relies on the Department managers to conduct the FMFIA reviews of management controls, surface significant weakness for high level discussion and monitor corrective actions. The OIG attends all MOC meetings and is given an opportunity to present the results of its work as it relates to the entities and issues being discussed, and to comment on the FMFIA progress of each departmental entity. The OIG is also a member of MOC's work group, which acts as the day-to-day intermediary between MOC and the respective departmental entities. The MOC has been an effective vehicle for instilling a departmentwide awareness of FMFIA and the need for managers to be attentive to important management control issues. It has also been effective in bringing serious management control issues to the attention of the Department's top managers and providing the guidance needed to formulate the Secretary's annual FMFIA report to the President and the Congress.

During the 6-month period ending September 30, 1993, OIG issued the following reports which reviewed management's implementation of FMFIA:

- SSA's Compliance with FMFIA for FY 1992 (CIN: A-13-92-00308) (See page 40)
- National Institutes of Health Risk Assessment Procedures (CIN: A-15-93-00039) (See page 52)
- Public Health Service's Identification of Program Management Control Areas for FMFIA Evaluation (CIN: A-15-93-00013) (See page 59)

The Secretary's 1992 FMFIA report identified 43 material weaknesses that were outstanding at the end of the fiscal year. During the last 6 months, OIG recommended that deficiencies noted in the following reviews be reported as material weaknesses or nonconformances in FY 1993:

- Oversight of MSP Backlog Claims (CIN: A-04-92-02057) (See page 14)
- Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991 (CIN: A-01-91-00525) (See page 10)

In addition, OIG followed up on this previously reported material internal control weakness:

- Food and Drug Administration's Headquarters Imprest Fund (CIN: A-15-92-00019) (See page 58)

B. Implementation of Chief Financial Officers Act

One of the most significant trends in the Federal Government today is the attention being given to accountability reporting. Examples are found in the recently enacted Government Performance and Results Act of 1993, the CFO Act of 1990, the proposed standards of the Federal Accounting Standards Advisory Board, the Government Accounting Standards Board (for State and local government), and the many "reinventing Government" efforts throughout the Federal establishment, including the Vice President's National Performance Review issue reports. While accountability reporting has been defined differently by each group, there is a common element to all these models — that the people entrusted with Federal resources are responsible for providing the public with an answer as to how well the resources were used to achieve their intended purposes.

An OIG objective is to attest to the reliability of management's accountability reporting, and thereby add valuable credibility to management's assertions. This is particularly true with regard to reporting on the performance measures and financial results of Department programs as required by the CFO Act.

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

- establish more effective general and financial management practices;
- improve each agency's systems of accounting, financial management and management controls to produce reliable financial information and reduce fraud, waste and abuse of Government resources;
- produce complete, reliable, timely and consistent financial information for use by program and financial managers and the Congress in financing, managing and evaluating Federal programs;
- monitor financial execution of the budget in relation to actual expenditures including timely performance reporting; and
- develop and maintain an integrated agency accounting and financial management system, including financial reporting and management controls which provide for the systematic measurement of performance.

During the 6-month period ending September 30, 1993, OIG issued the following reports as a result of financial management audits performed under the CFO Act:

- Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991 (CIN: A-01-91-00525) (See page 10)
- Financial Management Activities and Performance Indicators (CIN: A-13-93-00407) (See page 39)
- Internal Accounting Controls and Compliance with Laws and Regulations: FY 1992 (CIN: A-13-92-00222) (See page 39)
- Food and Drug Administration's Revolving Fund for Certification and Other Services (CIN: A-15-93-00007) (See page 59)

- National Institutes of Health Management and Service and Supply Funds (CIN: A-15-93-00008) (See page 52)
- Public Health Service's Service and Supply Fund: FY 1992 (CIN: A-15-93-00010) (See page 60)
- Working Capital Fund: FY 1992 (CIN: A-17-93-00007) (See page 79)

Also, HHS OIG was a major participant on the President's Council on Integrity and Efficiency (PCIE) Task Force on Improved Financial Management and Implementation of the CFO Act. This task force issued its final product on implementation of the CFO Act by the PCIE community. A PCIE audit policy manual for financial statement audits of Federal entities provides uniform guidance for adoption by the IGs responsible for conducting financial audits pursuant to the CFO Act. The manual is consistent with the audit methodology being taught at the IG Training Institute and that followed by the General Accounting Office.

C. Reporting Performance Measurement

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

The OIG has been very active in promoting the trend toward accountability reporting and performance measurement in the Federal Government. Members of OIG have delivered numerous departmental, governmental and professional seminars and training sessions on performance measurement reporting and auditing. The OIG participates in the Department's continuous improvement program (the HHS reinventing Government effort), as well as on the CFO Council Operations Group (COG) Burden Reduction Task Force, Government 2000, and other OMB and PCIE collaborative efforts to achieve a more responsive accountability.

The CFO Act requires agencies to develop and maintain financial management systems that include the systematic measurement of program performance. Under OMB guidance, accountability reporting includes a discussion and analysis of program performance as part of the CFO's annual report.

In order to identify OIG work in the area of performance measurement, we have tagged some items throughout the body of this semiannual report as "performance measures" with the symbol . Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program which is measured by the number of inoculations provided per dollar of cost. In OIG's opinion, the audits, inspections and investigations identified with the performance measure symbol offer information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals.

**Health Care
Financing
Administration**

Chapter II

HEALTH CARE FINANCING ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare and Medicaid programs. Medicare Part A provides hospital insurance for persons age 65 or older and for certain disabled persons. Financed by the Federal Hospital Insurance (HI) Trust Fund, Fiscal Year (FY) 1993 expenditures for Medicare Part A are expected to exceed \$82 billion. Medicare Part B (supplementary medical insurance or SMI) is an optional program which covers most of the costs of medically necessary physician and other services. Financed by participants and general revenues, FY 1993 expenditures for Medicare Part B are estimated at \$60 billion.

The Medicaid program provides grants to States for medical care for more than 30 million low-income people. Medicaid outlays have risen at a dramatic pace, causing Medicaid spending to become the fastest rising portion of both the Federal and State budgets. Federal Medicaid spending rose in FY 1992 to \$72.5 billion. Federal expenditures are expected to reach \$84 billion in 1993, a 600 percent increase since 1980. Eligibility for the Medicaid program is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children or Supplemental Security Income. The Federal grant is open-ended, paying from 50 to 83 percent of the State's Medicaid expenditures, based on a calculation of the State's relative wealth.

The Office of Inspector General (OIG) has devoted significant resources to monitoring and investigating the Medicare and Medicaid programs. These activities have helped ensure the cost-effective delivery of health care, improved the quality of health care and reduced the potential for fraud, waste and abuse.

Reform of the health care system has become a top policy concern of the Administration. Significant changes can be expected in the Nation's patchwork health care prevention and delivery systems in the coming years. The OIG is concerned that omissions, overlaps and other problems in the current systems which make them vulnerable to fraud, waste and abuse not be replicated. In this light, OIG will continue its oversight responsibility in the following significant areas: Medicare contractor reform, Medicare as secondary payer (MSP), Medicare fraud, Medicaid drug rebates, Medicaid fraud control, administrative burdens, electronic media claims, beneficiary participation in health care decisions, managed

care, sanctions and patient protection, kickbacks, reimbursement for durable medical equipment (DME), and implementation of the Clinical Laboratory Improvement Act Amendments of 1988.

Fraud and abuse of the Medicare and Medicaid programs or their beneficiaries may result in criminal, civil and/or administrative actions against the perpetrators. During the second half of the fiscal year, OIG was responsible for a total of 594 successful actions against wrongdoers in these programs.

Accounts Receivable Balances for the Hospital Insurance and Supplementary Medical Insurance Trust Funds at September 30, 1991

This report summarized the results of OIG's review of the systems that recorded the \$1.04 billion accounts receivable balance and supporting documentation reported by HCFA for the HI and SMI Trust Funds at September 30, 1991. The OIG also reviewed other systems and supporting documentation to identify unreported Medicare receivables. The OIG found that these systems, maintained by HCFA and Medicare contractors, were designed as overpayment and/or delinquent payment tracking systems and were not part of a fully integrated accounts receivable system containing attributes such as full accrual accounting, aging of accounts, proper cut-off procedures and adequate audit trails.

By not developing a full accounting and reporting system, HCFA's accounts receivable balances for the Medicare trust funds at September 30, 1991 were underreported. The HCFA estimated that there were about \$1.23 billion in MSP overpayments which were not reported as accounts receivable balances at FY 1991 year end.

The OIG recommended that HCFA develop and implement financial management systems and related accounting and administrative management controls, and report the lack of financial management systems as a material nonconformance under the Federal Managers' Financial Integrity Act (FMFIA). The OIG also recommended that HCFA perform FMFIA section 4 financial management system reviews on all systems used to track and record receivables. The HCFA agreed with OIG's assessments that improvements are needed in HCFA's accounting of Medicare receivables. The HCFA has also scheduled joint FMFIA section 2 and 4 reviews for its financial systems beginning with FY 1993. (CIN: A-01-91-00525)

Medicare Credit Balances at Hospitals

In a review of Medicare outpatient accounts receivable with credit balances (amounts due Medicare, usually as a result of overpayments) at 11 of the 40 hospitals serviced by Independence Blue Cross (IBC) of Pennsylvania, OIG determined that 8 hospitals received

and retained Medicare overpayments of more than \$230,000. The OIG estimated that the 40 hospitals received and retained Medicare overpayments of over \$1.2 million.

In a review of Medicare accounts receivable with credit balances at eight hospitals serviced by Blue Cross Blue Shield (BCBS) of Maryland, OIG found that the hospitals received and retained Medicare overpayments of more than \$1.3 million. Projecting the results to 39 of the 40 hospitals serviced by BCBS of Maryland, OIG estimates that the hospitals received and retained Medicare overpayments in excess of \$6.9 million. Moreover, OIG identified certain weaknesses in BCBS of Maryland's monitoring of hospitals' procedures for refunding Medicare overpayments included in credit balance accounts.

The OIG recommended that IBC and BCBS of Maryland: expand their audit coverage of Medicare credit balances to ensure that hospitals comply with HCFA's reporting requirements; identify and repay all Medicare overpayments; require that the hospitals reviewed refund the identified overpayments; and monitor the reporting of overpayments by the other hospitals that they serve. In response to the draft reports, IBC and BCBS of Maryland described actions taken in response to these recommendations. The OIG believes that, coupled with HCFA's revised credit balance reporting requirements, these actions will improve IBC's and BCBS of Maryland's controls over Medicare overpayments to hospitals. (CIN: A-03-92-00004; CIN: A-03-92-00007)

Incorrect Hospital Coding of Patient Discharge Status

In a prior audit (CIN: A-06-89-00021), OIG recommended that HCFA develop prepayment edits to detect incorrect use of patient status codes in the Medicare prospective payment system (PPS) when patients are transferred to another hospital or a distinct part of a hospital (e.g. a physical therapy wing) not participating in PPS. In a current review, OIG determined that while the edit detects most overpayment situations, it does not detect transfers that are improperly coded as transfers to nonPPS hospitals, which results in full diagnosis related group payments being made to both hospitals. Annual cost savings of \$8.1 million would be realized if HCFA revises the edit to also detect these incorrectly coded transfers. The OIG recommended that HCFA revise the transfer edit to detect incorrect use of the patient status code that identifies transfers to a nonPPS hospital. In response to the draft report, HCFA agreed with OIG's recommendation and plans to implement the new edit. (CIN: A-06-91-00061)

Reimbursement for Interpretations of Hospital Emergency Room X-Rays

This inspection evaluated the Medicare policy which allows payment to both the emergency room attending physician and a radiologist for their respective interpretations of the same x-ray. The OIG found that x-ray reinterpretations by radiologists, often performed after patients are discharged, did not result in the need to recall any of the patients in the sample

for further evaluation. A minimum of \$20.4 million was paid for reinterpretations in 1990 for the 38 codes sampled. The OIG recommended that Medicare pay for x-ray reinterpretations only when the attending physician requests a second physician's interpretation in order to render appropriate medical care before the patient is discharged. The HCFA indicated that it will present OIG's findings to an advisory committee for its evaluation and comment. (OEI-02-89-01490)

Employers' Accounting for Postretirement Benefits Other than Pensions

The OIG reviewed the implementation of Financial Accounting Standards Board Statement (FASB) Number 106 entitled "Employers' Accounting for Postretirement Benefits Other Than Pensions" to evaluate its potential impact on hospital costs claimed for reimbursement under Medicare. The FASB 106 requires an accounting change from the cash basis of accounting to the accrual basis for costs associated with retirees' health benefits. This change could materially increase hospital claims for Medicare reimbursement of retiree health care costs.

The HCFA issued a proposed rule in October 1991 which was intended to strengthen and clarify the Medicare policies for accrued costs. The OIG recommended that HCFA incorporate its proposed rule into Medicare regulations in a timely manner and alert fiscal intermediary provider audit staffs to give special attention to accrued retiree health costs on the Medicare cost reports. In response to the final report, HCFA concurred with both OIG recommendations. (CIN: A-01-92-00520)

Payments to Uniformed Services Treatment Facilities

Some military retirees are eligible to receive medical services under the Uniformed Services Treatment Facilities (USTF) program and the Medicare program. The Defense Authorization Act for FY 1993 mandated that the Department of Health and Human Services OIG conduct a joint review with the Department of Defense (DOD) OIG to determine the amount to be recovered by HCFA for incorrect Medicare payments made to USTFs.

The HCFA claimed that DOD owed \$36.9 million to the Medicare trust fund. However, based on the results of the joint review, OIG believes that DOD owes HCFA \$7.8 million for these services. The OIG recommended that HCFA and DOD negotiate an equitable settlement; clarify the eligibility rules of dually eligible beneficiaries; and, if necessary, propose legislation to clarify the law to prevent future duplicate payments. The OIG also recommended that HCFA work with DOD to establish periodic data exchanges of dually eligible beneficiary information to avoid future billing inaccuracies. (CIN: A-14-93-00377)

Medicare Administrative Costs

The HCFA contracts with private insurance companies (fiscal intermediaries and carriers) to process and pay Medicare claims. The OIG reviews the allowability of costs claimed for reimbursement by these contractors.

A. Blue Cross and Blue Shield of Florida

The OIG found that, during the period October 1, 1987 through September 30, 1990, Blue Cross and Blue Shield of Florida (the Plan) claimed costs of \$211.6 million for administering the Medicare Part B program, of which \$14.7 million were unallowable. This consisted of \$11.7 million in costs incurred and claimed in excess of budgeted amounts for which HCFA's approval was neither sought nor provided; questionable costs of \$2.7 million for legal and settlement expenses resulting from a lawsuit by an unsuccessful subcontract bidder, for which HCFA's approval was not sought; and additional unallowable costs totaling \$0.2 million. The Plan did not agree with the majority of monetary findings in the report, contending that their ongoing dialogue with HCFA and subsequent budget requests met the terms of the Medicare contract. However, since the Plan did not obtain the required approvals from HCFA, it was in violation of the Medicare contract which required prior approval to exceed budgeted amounts. (CIN: A-04-92-02056)

B. Independence Blue Cross

The OIG found that, during the period October 1, 1986 through September 30, 1989, IBC claimed over \$1 million more than its budget of \$34.4 million approved by HCFA. The overrun included two productivity investment projects totaling nearly \$60,000 mandated by HCFA for which OIG does not believe that IBC should be held accountable. The OIG also determined that IBC could not support its method for computing the complementary credits due Medicare. Complementary credits to Medicare result from Medicare sharing claimant data with a complementary insurance program. The OIG recommended that IBC make a financial adjustment of more than \$948,000 and that it provide HCFA with support for its complementary credits or coordinate with HCFA any recovery effort. Although IBC disagreed with the recommended adjustments, HCFA generally concurred. (CIN: A-03-91-02000)

C. Blue Cross and Blue Shield of Michigan

The OIG contracted for an audit of BCBS of Michigan covering administrative costs claimed on its final administrative cost proposals for FYs 1987 through 1989. Of the total claimed (approximately \$97.5 million), auditors questioned \$7.3 million. The BCBS of Michigan fully concurred with OIG findings and recommendations totaling \$6.7 million. It did not concur with the remaining \$.6 million regarding findings on understated credits, overallocated building occupancy costs and unallocable audit subcontract costs. (CIN: A-05-93-00013)

In a companion review of cost proposals for FYs 1980 through 1987 by BCBS of Michigan, OIG determined that \$1.4 million of the \$14.4 million subsidiary administrative costs claimed were unallowable. The OIG recommended a downward financial adjustment of \$1.4 million. The BCBS of Michigan fully concurred with the findings and recommendation. The HCFA also generally concurred with OIG's recommendation. (CIN: A-05-93-00057)

Oversight of Medicare Secondary Payer Backlog Claims

Contractor backlog reports disclose the status of MSP claims where the contractor is more than one quarter behind in sending a demand letter to the primary insurer. The OIG determined that these reports were not being filed timely and the information was not being adequately reviewed and verified by HCFA. The OIG noted that, because of the lack of management controls, contractors might not meet the regulatory deadline imposed on the collection of MSP overpayments once the primary payer has been identified. If contractors had not notified the liable primary insurers by December 31, 1992, the Medicare program could have lost approximately \$445 million.

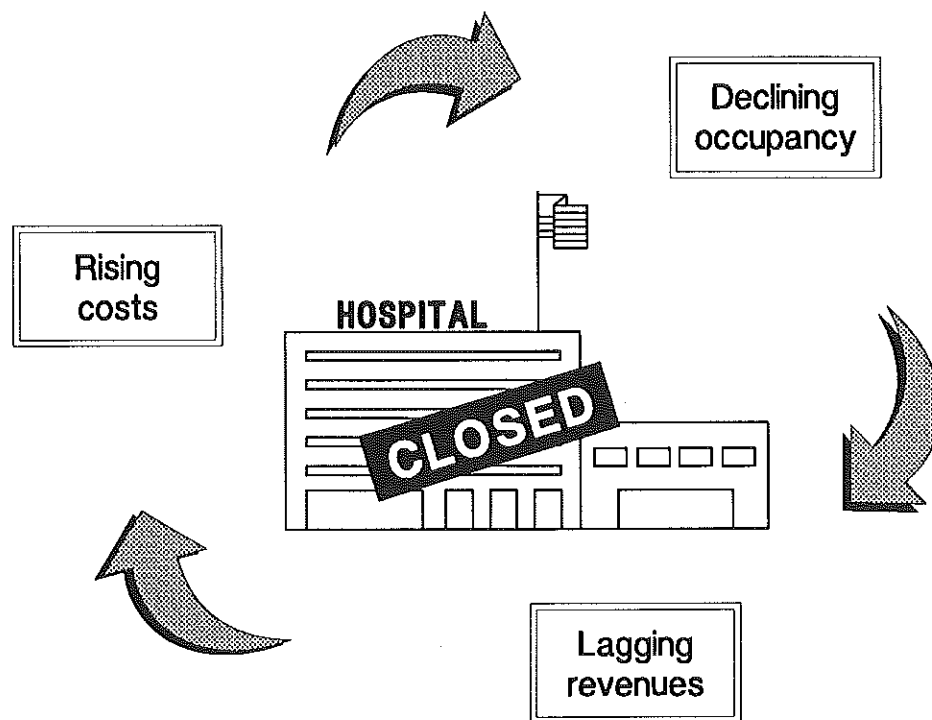
The OIG recommended that HCFA establish adequate internal control policies and procedures to correct deficiencies in the review and verification of the backlog reports and take the necessary actions to avoid losses before the regulatory deadline. The OIG also recommended that HCFA report this lack of adequate management controls as a material internal control weakness under FMFIA.

The HCFA took action to eliminate the at risk MSP backlog for Calendar Year 1992. It agreed that the MSP backlog activities be tracked as a material internal control weakness and that a corrective action plan be developed to address the specific deficiencies. (CIN: A-04-92-02057)

Rural Health Facilities

Performance Measure

The OIG issued three reports that describe rural hospital closures and initiatives that communities have taken to provide local access to health care in rural areas following hospital closure. During the 5-year period from 1987 through 1991, 193 general, acute care, rural hospitals closed. Most rural hospitals that closed were small and had low occupancy rates, and few patients were affected. The OIG found no single reason for rural hospital closure; rather a number of factors gradually weakened the financial condition of the hospitals.



Although most communities have another hospital available nearby, some rural communities have developed successful initiatives to maintain local access to health care services after a hospital closed. The OIG studies identify and describe six such successful initiatives. By tailoring services to meet community needs, the six initiatives improved the quality of rural health care delivery systems. The communities empowered themselves to meet their own health care needs. State governments helped them and they made use of existing Federal programs. One initiative, HCFA's Medical Assistance Facility demonstration program, appears to offer a viable option for providing access to basic inpatient, outpatient and emergency health care services in frontier areas. (OEI-04-92-00441; OEI-04-92-00730; OEI-04-92-00731)

Medicare Beneficiary Satisfaction: 1993

Performance Measure

This report is the result of a national survey of randomly selected beneficiaries. Overall, beneficiaries expressed satisfaction with the Medicare program. The number of beneficiaries who cited problems decreased significantly from surveys conducted in 1989 and 1991. Most beneficiaries said the program was understandable and they were able to get information when they needed it. Most were also satisfied with claims processing and said their claims were paid quickly enough. However, some beneficiaries did not understand exactly what Medicare had paid on their claims, and they did not understand Medicare's "Explanation of Benefits." Most beneficiaries who had called their carriers were satisfied with services they received, although some beneficiaries frequently found telephone lines busy when they called the carriers for information. (OEI-04-92-00480)

Medicare Beneficiary Satisfaction: Michigan

Performance Measure

Due to reports of problems with the Medicare Part B carrier in Michigan, OIG conducted a survey to compare the satisfaction of Michigan beneficiaries to those in the rest of the Nation. Overall, beneficiaries in Michigan and the Nation offer similar responses about the Medicare program. Both understand the Medicare program and are satisfied with Medicare claims processing. However, compared to the rest of the Nation, beneficiaries in Michigan are less satisfied with the telephone service they receive when they call their carrier. (OEI-05-92-00390)

Patient Advance Directives: Early Implementation Experience and Facility and Patient Responses

These related reports evaluate early implementation by hospitals, nursing homes and home health agencies of the advance directive provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1990. Patient understanding of advance directives, such as living wills and durable powers of attorney for health care, was also examined. The OIG found that most of the administrative requirements were being met, with the exception of documenting medical records as to whether or not a patient has an advance directive.

The OIG recommended that HCFA: develop and issue specific regulatory guidelines to assist providers in meeting documentation requirements; encourage the Joint Commission for Accreditation of Health Organizations to develop a specific review item about documentation; and collaborate with other departmental offices to provide leadership in the development of a coordinated plan for public education on advance directives. In its response to the draft, HCFA concurred with the second and third recommendations, but did not concur with the first. (OEI-06-91-01130; OEI-06-91-01131)

Nursing Home Survey Reforms

The OIG conducted an inspection to assess States' progress in carrying out their Medicare/Medicaid nursing home survey responsibilities under the 1987 nursing home reform of standards. These reforms marked a major shift in how States monitor nursing home quality, placing the emphasis on how well the staff meet individual resident needs and how well the home structure supports resident well-being.

Data were collected from 19 States containing 73 percent of the nursing home beds in the country. The OIG found that, although the 19 States are making progress in carrying out their new nursing home survey responsibilities, they are experiencing implementation problems which could jeopardize the intent of the reforms.

The OIG believes that HCFA has opportunities to foster continued progress in the implementation of these reforms by: invigorating its surveyor training program to enhance

surveyor skills; using its annual evaluation of each State agency's contract compliance to identify areas of weak performance and take action to prevent problems before they present any danger to users of State-surveyed health facilities; and improving its guidance to States by quickly issuing final regulations and ensuring the State Operations Manual reflects current HCFA policy. (OEI-01-91-01580)

Criminal Fraud

The most common fraud investigated by OIG against health care providers is the filing of false claims or statements in connection with the Medicare and Medicaid programs, as illustrated in the following cases:

- An Indiana man was sentenced to 6 years in prison after pleading guilty to mail fraud, illegal possession of a document-making implement and tampering with heart pacemakers he sold to hospitals. The man sold DME in at least 9 States under 34 aliases and 11 different corporate names. Seven of his employees were also sentenced on charges related to the unlawful sale of pacemakers, impeding the ability of the Food and Drug Administration to regulate the medical device industry, offering gratuities to physicians and committing mail fraud against hospitals. Because of the pacemaker tampering, during the investigation Federal authorities issued advisories to physicians receiving the devices warning of facts uncovered, including expiration dates lapsing before the devices were implanted, improper sterilization, recycling of pacemakers and mislabeling of pacemakers intended for animal use only. The owner also was given a 20-year exclusion from Medicare and Medicaid which cannot be appealed, and was ordered to never again operate a medical device company. A physician who did business with the man was also sentenced, and other sentencings are expected.
- A Pennsylvania endocrinologist was sentenced to 34 months imprisonment and 3 years probation, and fined \$20,000 for Medicare fraud and illegal drug distribution. The endocrinologist took blood and urine samples which he never sent to the lab, but he billed Medicare as if tests had been performed. He was also illegally prescribing and distributing Dexedrine. In a subsequent civil judgment, he and his organization were ordered to pay \$2.3 million. (3-90-00260-9 and 3-92-20473-9)
- The owner of two home health agencies was sentenced in California to 22 months in Federal prison and 300 hours of community service, and fined \$30,000 for making false statements on a Medicare report and embezzling funds from his employees' pension plans. Under an earlier plea agreement, he agreed to repay \$488,740 to Medicare and more than \$1 million into the

employees' pension plans. He lied to auditors and agents about owning one of the home health agencies, from which home visits were made to private insurance patients. The same employees worked at both agencies and made visits, but all employee wages were charged to the one reimbursed through Medicare cost reports. After investigation was initiated, the owner began stealing money from his employees' pension plans. When the money was almost depleted, he put the agency into bankruptcy and hid incoming funds from the bankruptcy court. (9-88-00981-9 and 9-93-24021-9)

- A man was sentenced in California to 51 months in prison, ordered to pay \$895,373 in restitution and fined \$450 for submitting false Medicare claims. He received almost \$1 million by using various physicians' provider numbers to bill for blood circulation tests he never performed. He diverted notices of payment to 38 mail drops he controlled by putting false beneficiary addresses on the claims. He attempted to avoid arrest by using stolen license plates on his car and an assumed identity, but was arrested when he purchased \$250,000 in gold bullion and coins. Another \$325,000 in California and Florida bank accounts was also seized. Asset forfeiture proceedings have been initiated to return funds to Medicare. (9-92-00111-9)
- In Connecticut, the husband and wife owners of an acupuncture center, the center itself and three physician employees were sentenced for filing false Medicare claims and evading income taxes. The owners performed acupuncture treatments but billed them as physical therapy performed by the doctors. They and two of the doctors also concealed considerable amounts of income in New York bank accounts to avoid paying taxes. The husband was sentenced to 10 months incarceration and 2 years probation, and fined \$30,000. His wife was sentenced to 3 years probation, fined \$21,000 and ordered to perform 250 hours of community service. Two of the doctors were given 12-month suspended prison sentences and 3 years probation, and fined \$10,000 each. The third physician was placed on probation for a year and ordered to pay a special assessment of \$25. The corporation, which made restitution of \$54,000 to Medicare before being sentenced, was sentenced to 3 years probation and fined \$50,000. (1-89-00026-9)
- In Illinois, a physician's wife was sentenced to 2 years probation and community service, and ordered to pay restitution of \$5,200 and a fine of \$3,000 for defrauding Medicare and Medicaid. The woman, who served as office manager and billing clerk for her husband, devised a scheme to file Medicare and Medicaid claims for services not rendered. She admitted submitting approximately 370 fraudulent claims over a 2 1/2-year period.

(5-89-00043-9)

- The final 5 of 11 defendants, the other 6 of whom were convicted and sentenced earlier, were sentenced in Ohio for diverting checks from the Medicare Part A intermediary. A former insurance company employee diverted checks totaling about \$200,000. She was responsible for locating and identifying unnegotiated checks issued by the company, determining why they had not been negotiated and, if indicated, altering computer records to generate replacement checks. She used her position to enter names and addresses of friends and acquaintances to generate checks payable to them, from which she got part. She was sentenced to 1 year in prison and 2 years supervised probation. Both she and another defendant were ordered to pay a special assessment of \$50. No fine or restitution was ordered because of their inability to pay. Two men were each sentenced to 2 years probation and ordered to pay \$100 in court charges and make restitution of the amount of the checks they had received (\$702 and \$539, respectively). One man also was fined \$500. Finally, a medical student who earlier made restitution of \$11,522, was sentenced to 1 year probation and an assessment of \$50. This case was investigated by a Southern Ohio Health Care Task Force comprised of several Federal agencies. (5-92-00177-9)
- A Florida man was sentenced to 13 months incarceration for impersonating a physician and submitting false claims to Medicare, the Civilian Health and Medical Program of the Uniformed Services and private insurance programs. After a pharmacist reported that a particular physician was prescribing large amounts of controlled substances, it was found that the physician had died in 1986. An attorney who had been a friend of the physician had intercepted a letter from Florida querying the physician's application to practice medicine. The attorney got the physician's renewed license, practiced medicine at various clinics in Florida, acted as medical director of one, then opened his own clinic with his wife as office manager. He was ordered to pay more than \$113,800 in restitution, \$45,800 of it to Medicare. (4-90-00453-9)

Fraud and Abuse Sanctions

During this reporting period, OIG imposed 576 sanctions, in the form of exclusions or monetary penalties, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries. The majority of the exclusions were based on conviction of program-related crimes, conviction of controlled substance manufacture or distribution, conviction related to patient abuse or loss of license to practice health care.

A. Patient and Program Protection Exclusions

The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health Block Grant, and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation and controlled substance abuse, as well as for revocation or surrender of a health care license while a disciplinary proceeding is pending before a State licensure board. Exclusion is mandatory for those convicted of program-related crimes or crimes relating to patient abuse. A significant number of OIG exclusions involve failure to repay health education assistance loans (HEALs), as discussed in more detail in the chapter on the Public Health Service. During this reporting period, OIG imposed exclusions on over 500 individuals and entities in all.

The OIG reviews all factors involved in a case to determine whether an exclusion is appropriate and, if so, the proper length of the exclusion. Factors reviewed include information solicited directly from the provider and information obtained from outside sources such as courts, licensing agencies or other Federal or State programs. During FY 1993, OIG began limiting its attention primarily to mandatory exclusions because of resource constraints. The types of exclusions imposed for the present reporting period therefore do not represent as wide a range as those reported during prior periods, as indicated by the following examples for this period:

- The former chief financial officer of a New Jersey medical center was excluded for 25 years for conviction of mail fraud and conspiracy that included Medicare and Medicaid fraud. The officer was part of a network of conspirators who diverted checks made out to the hospital, overbilled for collection notices sent on overdue accounts, processed invoices for goods never delivered, and paid and accepted kickbacks. The officer filed false tax returns, failing to list fraudulent funds received. Total financial damages from the conspiracy amounted to an estimated \$2.5 million. (2-90-40608-9)
- An Indiana physician was excluded for 20 years after a patient-rape conviction. The physician had injected the patient with a drug to subdue her. Evidence was presented that in 1984 he had raped a 12-year-old during her first pelvic exam, in the mid-1980s he had raped a teenage patient in the same way as that for which he was convicted, and in 1988 he had raped a pregnant adult patient. In 1989, the physician's license had been put on a 1-year probation because of unprofessional and immoral conduct with a female patient. (5-93-40008-9)

- The owner and operator of several Tennessee home health agencies was excluded for 15 years after conviction and imprisonment for 57 months for conspiracy, Medicare theft, kickbacks and obstruction. (4-93-40014-9)
- A New York physician was excluded from the Medicare and State health programs for 15 years after being convicted of distributing a controlled substance. The physician had accepted thousands of dollars in payoffs from drug dealers in exchange for writing thousands of illegal prescriptions. The drug dealers used the prescriptions to obtain controlled substances from pharmacies. The physician had been sentenced to 12 years and 7 months in prison. (2-93-40131-9)
- A Florida osteopath and his wife were excluded from the Medicare and State health care programs for 10 years because of conviction for obstruction of justice and filing more than \$800,000 in fraudulent Medicare and private insurance claims. The pair filed claims for medically unnecessary or nonperformed tests, much of them for services supposedly performed for the wife's parents. The osteopath used an independent laboratory for the tests but filed claims indicating the services were rendered in his office, in order to obtain higher reimbursement. He tried to conceal the fraud by presenting falsified documents to a grand jury. The osteopath's clinic was also excluded for 10 years. Both the osteopath and his wife received prison sentences and were ordered to make restitution of \$584,500. (4-92-40323-9)
- An Iowa nurse's aide was excluded for 10 years as a result of his conviction for an offense related to patient abuse. He engaged in sexual intercourse with a nonverbal, nonambulatory, profoundly retarded resident of a health care facility. As a result of the assault, the victim became pregnant with twins and had to undergo an abortion because it was felt she could not withstand childbirth. (5-82-40564-9)
- A Colorado pharmacist who owned two drugstores was excluded for 5 years for conviction of Medicaid fraud. He submitted claims for prescription drugs when he really dispensed over-the-counter medication. (8-93-40098-9)
- The OIG excluded indefinitely from Medicare and State health care programs a nurse whose license was revoked in Oregon and California because of his long-standing and untreated psychiatric disorder and his preoccupation with dead bodies and anesthetized patients. Since the nurse is or has been licensed in 17 States and works throughout the United States on temporary contracts, OIG took its exclusion action to assure that he cannot move from State to State, creating a threat to the patient population. (9-93-40012-9)

- In New Jersey, a doctor was excluded indefinitely after his license was revoked because he did not meet minimal standards of acceptable medical practice. (2-93-40014-9)

Once a decision has been made to impose an exclusion, the provider is given notice and advised of the right to request a hearing before an administrative law judge (ALJ). If the provider is dissatisfied with the ALJ's decision, he may request a review by the Departmental Appeals Board (DAB). If he is still dissatisfied after this review, he may take his case to District Court. An appeal generally involves disagreement on whether the exclusion should be imposed at all and related issues, and the length of time of the exclusion. The OIG decision to exclude is upheld in almost all cases, although occasionally the time period is reduced.

B. Civil Penalties for False Claims

Under the civil monetary penalty (CMP) authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law, therefore, allows recoupment of some of the monies lost through illegitimate claims, but it also protects health care providers by affording them due process rights similar to those available in the program exclusion process. Many providers, however, elect to settle their cases prior to litigation. The Government, with the assistance of OIG, recouped approximately \$122.7 million through both CMP and False Claims Act civil settlements and hearing decisions related to health care during this period.

- The Florida Medicare carrier agreed to pay the Government \$10 million to settle allegations that the company mishandled and caused massive backlogs in Medicare claims, submitted false claims and increased costs to Medicare. In December 1988, the company, the second largest Medicare processor in the Nation, switched to a new computer system to process Medicare Part B claims. Beginning in early 1989, computer deficiencies created a backlog of payments for these claims. In an effort to reduce the backlog, the company bypassed computer audits and edits, created false prescriptions and paid duplicate claims to providers, thereby increasing administrative costs for the program. 4-93-20009-9)
- An ambulance company signed a civil settlement with the United States and the State of Minnesota agreeing to pay \$3 million for filing false Medicare and Medicaid claims. The company also agreed to provide \$97,542 in free ambulance services to financially eligible consumers in Minnesota. The company was overpaid more than \$1.17 million by Medicare and Medicaid as a result of the false billings. (5-93-20005-9)

- An Oregon pharmacy agreed to pay the United States Government a \$1 million settlement for false Medicaid claims filed between 1989 and 1993 for prescription drugs. Investigation showed that the pharmacy falsely certified that physicians had mandated brand name drugs rather than generic drugs as medically necessary. (9-93-27270-9)
- Two medical groups associated with a Washington State hospital agreed to pay the Government \$850,000 in settlement of allegations that they submitted inflated Medicare claims for laboratory services. Investigation showed that thousands of profile tests ordered by physicians were split, or "unbundled," into components which were then billed individually to Medicare. In this way they received a higher reimbursement. (X-88-20128-9)
- The Florida peer review organization (PRO) signed a court-ordered civil settlement for \$1 million for approving and backdating hospital payments, without required reviews, on claims previously denied. More than a year ago, the PRO pled guilty to related criminal charges, its contract with HCFA was prematurely terminated and almost \$2 million of the approved overpayments was withheld. The civil case was initiated by former PRO employees. Of the \$1 million settlement, \$680,000 will be used to pay amounts owed to the Internal Revenue Service, the employees pension fund, and unpaid benefits due employees and former employees. Another \$320,000 is to be applied toward directly related false claims. (4-90-30031-9)
- In Ohio, an accountant, an audiologist and their corporation, along with an osteopath, signed an agreement to pay a total of \$130,000 in settlement of civil liabilities. Through their corporation the accountant and the audiologist hired another audiologist to perform routine hearing tests on nursing home patients, which are required by Medicaid regulations. They then obtained a Medicare provider number in the osteopath's name, without his knowledge, and paid him to perform quality reviews of the audiologist's work. They never told the osteopath that they were filing Medicare claims as if he had performed the tests. At one point the accountant had someone impersonate the osteopath in a meeting with a carrier representative. Later, the audiologist forged patient charts which were forwarded to the osteopath for signing. Toward the end, the osteopath realized what the two were doing, but he did not advise the proper authorities and even assisted in hiding what had happened. He agreed to pay \$30,000, while the other two and the corporation will pay \$100,000. (5-96-20002-9)
- A Florida ophthalmology group agreed to pay \$2.5 million to resolve civil claims arising from two fraudulent Medicare billing schemes. The first

scheme involved billing for services under an erroneous code to obtain maximum reimbursement for laser surgeries. The second scheme involved a contract with a billing service which resubmitted to Medicare fraudulent claims for individual procedures already reimbursed under global payments. The billing service, which is now defunct, solicited medical groups throughout the country and contracted to review their billing records to ensure full reimbursement. The billing service kept 50 percent of any additional reimbursement it identified and received for a group.

(4-91-30008-9)

- A major laboratory agreed to pay \$830,000 in settlement of false Medicaid claims that it submitted. Under a promotion called the Patient Profile Program, the laboratory gave physicians a pharmaceutical product it manufactured along with preprinted prescription pads and questionnaires. The company awarded physicians points towards free airline tickets or other honoraria each time they completed a questionnaire for a new patient placed on the product. Claims for the product were then submitted to the Medicaid program of various States. (3-93-20230-9)

Sanction Referral Authority

The PRO sanction referral authority, which requires PROs to recommend that OIG sanction physicians and hospitals for violating Medicare obligations, has become moribund. Referrals have dwindled from a high of 72 in FY 1987 to a low of 12 in FY 1991 and 14 in FY 1992. This study found three factors that explain this drop: the statutory requirement to demonstrate unwillingness or lack of ability to comply with requirements; the PROs' cumulative experience with the complex, costly and contentious referral process; and the PROs' emphasis on educational approaches to quality-of-care problems. Despite dwindling referrals, PROs still consider the authority important to achieving their mission because it gives them leverage with the medical community.

The OIG offered three policy options regarding the sanction referral process: repeal or modify the unwilling or unable requirement; increase the monetary penalty; and maintain the PRO sanction referral authority as it exists now, but mandate referrals to State medical boards when PROs confirm serious quality-of-care problems. The HCFA disagreed with OIG that additional legislation is needed to achieve the goal of increasing the PROs' sanction referral authority. (OEI-01-92-00250)

Kickbacks

Many businesses engage in referrals to meet the needs of customers or clients for expertise, services or items which are not part of their own regular operations or products. The medical profession relies heavily upon referrals because of the myriad specialties and technologies associated with health care. If referrals of Medicare or Medicaid patients are

made in exchange for anything of value, however, both the giver and receiver may violate the Federal anti-kickback statute. They also may directly or indirectly increase Medicare/Medicaid costs.

Over the years, some 500 convictions, judgments and settlements have been obtained as a result of OIG investigations of violations of the anti-kickback statute. The following cases are examples of some of the achievements in this area during this period:

- Seven persons were sentenced during this period, for a total of twenty who were involved in a series of conspiracies that defrauded ten hospitals in New Jersey and New York of millions of dollars through phony billing schemes and theft of x-ray film. Included were hospital officials and employees, x-ray manufacturers' sales and technical representatives, and x-ray film distributor company owners and employees. The schemes involved diversion of shipments, kickbacks, sale of stolen film, phony invoices, money laundering, bribery and no-show jobs. An estimated \$10 million was defrauded from hospital funds comprised of Medicare and private insurance monies. (2-89-00719-9)
- The last 3 of 22 persons were sentenced in a New York kickback case this period. The owner of a DME company was sentenced to 2 years probation and ordered to repay \$3.8 million in Medicaid funds. Two physicians were each fined \$2,000, and one was sentenced to 2 months incarceration. Altogether a total of 16 physicians, 2 physician assistants, 3 office managers and the DME company owner were convicted for paying or receiving kickbacks of \$50 to \$300 each in exchange for prescriptions for oxygen concentrators and nebulizers. They paid more than \$60,000 in fines to the Government. (2-89-00039-9)
- The owner and operator of a Florida clinic was sentenced to 18 months in prison for paying illegal kickbacks for patient referrals and filing false Medicare and Medicaid claims. The owner routinely paid "recruiters" \$5 to \$10 for each Medicare/Medicaid-eligible adult they referred to his clinic. He also paid patients directly for coming and bringing their children to the clinic. He was ordered to make restitution of \$129,000 he received by submitting false claims for these individuals. (4-92-00098-9)

Intraocular Lenses

This management advisory report provided preliminary information on the costs of intraocular lens (IOL) implants used in cataract surgery. Based on results of this study, OIG believes that it is reasonable to reduce the \$200 flat fee currently paid for IOLs in ambulatory surgical centers by Medicare. Also, it is important to reexamine Medicare's

method for reimbursing hospital outpatient departments for the IOLs they obtain, since it allows them to pass on inflated IOL costs to Medicare. The recently enacted OBRA 1993 lowers the flat fee to \$150, and projects a savings of \$84 million. (OEI-05-92-01031)

Physician Office Surgery

Performance Measure

The OIG conducted a review to evaluate the appropriateness of the surgical setting, the medical necessity of the surgery, and quality of care for selected surgical procedures performed in physicians' offices. In its sample, OIG found that 20 percent of the physician office medical records did not document reasonable quality of care; 13 percent did not document an indication for surgery; and the physician's office was not an appropriate setting for a small number of surgeries. The OIG recommended that PROs extend their reviews to surgery performed in physicians' offices. Such reviews should ensure that medical records document reasonable quality of care; physicians perform only those procedures appropriate for an office setting; physicians perform only medically necessary procedures; and accurate procedure codes are used to submit claims for physician services. The OIG agreed with HCFA to defer implementation of this recommendation pending completion of the pilot projects testing the feasibility of physician office review and related protocols. (OEI-07-91-00680)

Peer Review Organizations and State Medical Boards

In a review of the status of PRO efforts to provide State medical boards with information about physicians responsible for substandard medical care, OIG found that legislation enacted in 1990 to mandate such information-sharing has had little, if any, effect. Because of uncertainty about the meaning of the "notice and hearing" provision included in the legislation, PROs still share little information with the boards.

The OIG recommended that HCFA propose legislation mandating that PROs provide case information to State medical boards when they have confirmed, after medical review, that a physician is responsible for medical mismanagement resulting in significant adverse effects on the patient. This would provide increased protection to Medicare beneficiaries; limit referrals to serious quality-of-care cases; be clear-cut, workable and fair to physicians; and provide valuable information to boards. (OEI-01-92-00530)

Limits on Beneficiary Financial Liability

This final report addresses the adequacy of Medicare's implementation of the "limiting charge" provision of the OBRA 1989. The report describes Medicare carriers' related activities and experiences in 1991. Excessive charges by physicians appear to be limited, and some carriers have helped beneficiaries obtain refunds from physicians who charged more than the amount allowed by Medicare. The OIG recommended that HCFA advise those carriers who had never requested physicians to make refunds to beneficiaries, based on

1991 violations, to do so. The HCFA disagreed with the recommendation. (OEI-02-92-00130)

Medicare Tests of Lower Extremity Arteries

Diagnostic arterial tests of the lower limbs have increased dramatically in recent years. In 1991, total allowed dollars exceeded \$71 million. The HCFA has identified limb arterial studies as an area in which abuses occur and for which medical review is appropriate. In a review of carriers' utilization review practices for lower extremity tests, OIG found that over half the carriers have special utilization policies. The OIG determined that Medicare could realize savings nationally by adopting policies such as the setting of prepayment thresholds to identify claims which merit additional review prior to payment.

The HCFA has convened a work group to review coverage policies for these tests and plans to issue new medical review guidelines. The OIG recommended that HCFA continue to work with the carriers to ensure that there are sufficient safeguards to prevent the unnecessary utilization of lower extremity tests. The HCFA and the Assistant Secretary for Planning and Evaluation concurred with the recommendation. (OEI-03-91-00950)

Inappropriate Payments for Total Parenteral Nutrition

In an examination of Medicare coverage of total parenteral nutrition (TPN), a "high tech" means of feeding patients who do not have a functioning intestinal tract, OIG determined that Medicare overpaid \$69 million for TPN in 1991 (43 percent of the total of \$162 million paid for this service). More than half the patients in the sample had end stage renal disease (ESRD) and received parenteral nutrition as a supplement three times a week. The OIG concluded that the benefit of supplemental parenteral nutrition for these patients is unproven and the charges were disproportionately high for the nutrients supplied. A review of TPN use in the nonESRD population revealed inappropriate patient selection, and both overfeeding and underfeeding.

The OIG recommended that HCFA: instruct carriers to adhere to a strict interpretation of the coverage guidelines for estimated annual savings of \$69 million; require carriers to intensify review of certificates of medical necessity, discuss therapeutic options with physicians and monitor the use of nutrients over time; and review research into the clinical appropriateness of and payment methodologies for intradialytic parenteral nutrition. The HCFA concurred and has taken steps to implement the first two recommendations. The HCFA also concurred with the recommendation to review research, though it is deferring action on this recommendation until a coverage decision has been made. (OEI-12-92-00460)

Payments for Referral of Parenteral Nutrition Patients

This management advisory report alerts HCFA to payments for referrals by suppliers of intradialytic parenteral nutrition made to ESRD facilities. The HCFA may wish to issue clarifying instructions to dialysis facilities regarding these payments, which OIG believes may violate the Medicare and Medicaid anti-kickback statute. The statute prohibits the offer or receipt of remuneration to induce the referral of Medicare-reimbursed items or services. The OIG intends to alert the provider and supplier communities to the prohibition on payments for referrals through this report and other communication. (OEI-12-92-00461)

Coverage Policies for Transcranial Dopplers

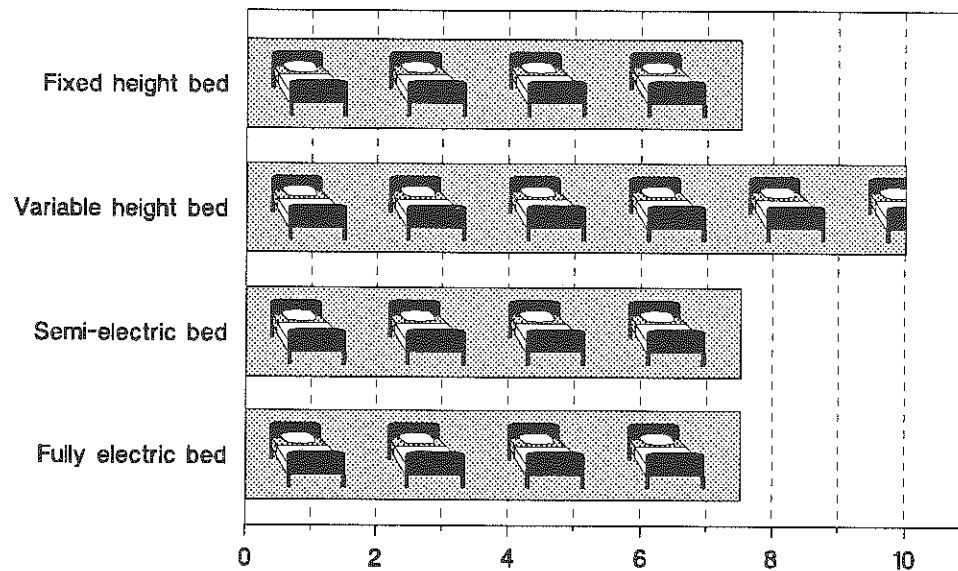
The OIG reviewed Medicare carriers' coverage policies for use of transcranial dopplers (TCDs), a noninvasive ultrasound technique that measures blood flow velocities in the major arteries in the skull which was introduced in 1982. When HCFA issues policy guidance on a new technology, carriers are required to follow it. When no guidance is provided, each carrier establishes its own coverage policies. Carriers use the HCFA Common Procedure Coding System to reimburse Medicare Part B services. This system is based on the current procedural terminology (CPT) coding system developed in 1966 and updated annually. Effective January 1, 1992, two new CPT codes were established for TCD services.

In late 1991, OIG reviewed carriers' coverage policies and guidelines for TCDs. In early 1992, OIG recontacted those carriers that did not cover TCDs in 1991 to determine if they had changed their policies, and, if so, what had influenced their decisions. The OIG found that: carriers' coverage policies for TCDs are inconsistent; some carriers pay for TCDs despite noncoverage policies; new CPT codes influenced carriers' coverage decisions for TCDs; and HCFA's efforts to update the coverage process and improve communications with carriers do not appear to have resolved problems with carriers' coverage of this technology. The OIG recommended that HCFA continue its efforts to review, coordinate and guide carrier coverage policies of TCDs as well as other new technologies. The HCFA concurred with the recommendation. (OEI-03-91-00951)

Medicare Reimbursement for Hospital Beds

The OIG determined that HCFA's current methodology for Medicare reimbursement to suppliers of hospital beds used in the home does not adequately reflect the useful life of these beds and the many times that they can be rented, resulting in substantial profits for DME suppliers. The OIG found that a hospital bed typically can be rented 7.5 to 10 times over its 5-year useful life, as illustrated below.

NUMBER OF TIMES A HOSPITAL BED COULD BE RENTED DURING ITS USEFUL LIFE



From an analysis of Medicare beneficiaries in Texas, OIG concluded that changing the reimbursement methodology to reflect the life and rental cycle of these beds would result in annual Medicare savings of \$6.2 million to \$7.8 million and beneficiary savings of \$1.6 million to \$2 million in Texas alone.

In developing a new methodology, OIG believes that HCFA should consider the following options: lower the monthly rental payments, but extend the rental reimbursement period and eliminate the purchase option; separate the equipment costs from other costs and profit in determining the monthly Medicare rental payment; and use a competitive bidding process in paying suppliers for hospital bed use. In response to the draft report, HCFA did not concur with the recommendations and stated that a more comprehensive study of hospital beds should be conducted after the DME provisions of the OBRA 1990 have been fully implemented. (CIN: A-06-91-00080)

Fraud Involving Durable Medical Equipment Suppliers

The successful actions against fraud in the DME industry during this 6-month period were the result of investigations begun before HCFA published new regulations last year. These regulations addressed reimbursement problems that recurred over the years, especially carrier shopping and telemarketing. The consolidation of claims processing into four

regional jurisdictions should resolve many of these problems. The following successful actions were accomplished during this reporting period:

- The president and owner of an Arkansas DME company was sentenced to 12 months home detention for billing Medicare for equipment not requested or supplied. He had also billed for hospital beds he claimed to have put in the homes of Medicare recipients, when he really delivered seatlift chairs. The owner pled guilty, agreeing to pay the Government \$1.5 million to settle all claims against him and his company. (6-88-00318-9)
- The largest DME marketer in the Pennsylvania area and owner of two DME companies was sentenced to a year in prison, barred from participating in Government programs for 3 years and ordered to make restitution of \$9,160 for Medicare fraud. His confederate, a former Medicare carrier employee who served as president of one of his two companies and assisted with the other, was sentenced to 9 months incarceration, ordered to make restitution of \$6,500 and fined \$6,000. The owner had hidden funds from one company to avoid a Federal court freeze, tried to hide proceeds of the other and directed destruction of records to prevent a grand jury from getting them. Nonetheless, he was given a downward departure from sentencing guidelines because a psychiatrist said he was manic-depressive and suicidal, and because he submitted documents showing that he was destitute. It is estimated that the Government lost more than \$1 million. A civil case is underway. (3-88-00837-9)
- The owner of an Illinois DME company was sentenced to 18 months in prison and 3 years probation, and ordered to repay Medicare \$11,560 he had received fraudulently. His confederate, a former supervisor of DME claims processing for the Illinois Medicare carrier, was sentenced to 4 months home detention and 5 years probation for her part in the scheme. The DME owner hand-carried claims to the supervisor who processed them without a control number or microfilming. The claims involved payment for new oxygen concentrators which were really used, and the resale of at least two machines for a total of three times each. (5-87-01112-9)
- In Washington State, the owner of a DME company was charged in a negotiated information with filing false claims with Medicaid, Medicare and Group Health Cooperative. He agreed to make restitution of \$123,400, of which \$21,750 goes to Medicare, and not to bill any of the affected programs again. He had billed for items not provided or more expensive items than those provided. (9-91-07601-9)

Medicaid Credit Balances at Hospitals

An OIG review at 64 hospitals in 8 States disclosed that, while many hospitals reviewed their Medicaid credit balances (amounts due Medicaid, usually as a result of overpayments) to identify Medicaid overpayments and assured that overpayments were returned to the State, some of the credit balances were not reviewed in a timely manner. Accordingly, OIG estimates that the 64 hospitals received Medicaid overpayments totaling \$1.79 million (\$1.01 million Federal share) which should have been refunded prior to the review. Projecting the results of the review nationwide, OIG estimates that hospitals received and retained \$73.3 million (\$41.9 million Federal share) in Medicaid overpayments.

The OIG recommended that HCFA perform a formal evaluation of the States' oversight of hospital procedures in the area of Medicaid credit balances and the timely refunding of overpayments, and increase its monitoring of State activities to reduce overpayments in the areas of third party liability and duplicate payments. The OIG estimates future annual savings of approximately \$43.7 million (about \$25 million Federal share) if these strengthened controls are properly implemented. The HCFA agreed with the first recommendation, but disagreed with the second. (CIN: A-04-92-01023)

Medicaid Cost Sharing

This inspection surveyed Medicaid programs in all 50 States and the District of Columbia to review their cost sharing policies and determine their impact on the programs. Cost sharing — in which patients pay a portion of the cost of their health care — reduces Medicaid expenditures without significantly impacting on utilization of services or access to care. States without cost sharing could save between \$67 million and \$355 million annually (of which the Federal share would be \$99 to \$198 million) by applying cost sharing to just four services: inpatient hospital, outpatient hospital, physician visits and prescription drugs. States with cost sharing have not experienced excessive administrative, recipient and provider burdens. However, Federal requirements may hinder States from designing even more effective cost sharing programs.

The OIG recommended that HCFA promote the development of effective cost sharing programs by allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts, and/or recommending changes to Federal requirements allowing for greater State flexibility in implementing cost sharing. The OIG also recommended that HCFA promote the use of cost sharing in States that do not currently have such programs. (OEI-03-91-01800)

Management Controls over the Medicaid Prescription Drug Program

Based on a review conducted in eight randomly selected States, OIG determined that States have not established adequate accountability and internal controls over their Medicaid drug

rebate programs. Moreover, OIG concluded that HCFA has not established a reporting mechanism to capture consistent and reliable information from the States which would provide it with the means to effectively monitor and manage the drug rebate program. As a result, hundreds of millions of dollars in drug rebate funds are vulnerable to fraud, waste and abuse.

The OIG recommended that HCFA ensure that States implement accounting and internal control systems in accordance with Federal regulations for the Medicaid drug rebate program; include a State reporting mechanism that will capture consistent and reliable data from the States on rebate transactions; and establish a limit on the dollar amount of rebates which can be written off without HCFA's approval. The HCFA agreed with the OIG recommendations. (CIN: A-06-92-00029)

Disputed Medicaid Drug Rebates

The OBRA 1990 enables State Medicaid agencies to receive rebates from drug manufacturers for drug purchases made under the Medicaid program. An OIG review disclosed that 72 drug manufacturers had disputed nearly \$769,000 of rebate billings for drug purchases by the Arkansas State agency for the quarter ended March 31, 1992. The value of this disputed amount and OIG work at various States indicate that disputed rebates are a significant issue nationwide.

The OIG recommended that Arkansas aggressively seek collection of disputed amounts by: identifying the amount of and reasons for disputes; prioritizing its efforts on the resolution of disputes by developing profiles of manufacturers to identify those with the greatest potential for resolution; investigating and analyzing the specific manufacturer disputes; revising and expanding the onsite pharmacy reviews; and considering either legal action or restricted participation of manufacturers that do not attempt to resolve disputes. The State agency fully agreed with four of the six recommendations and partially agreed with the other two. (CIN: A-06-93-00003)

Ulcer Treatment Drugs Reimbursed under Medicaid

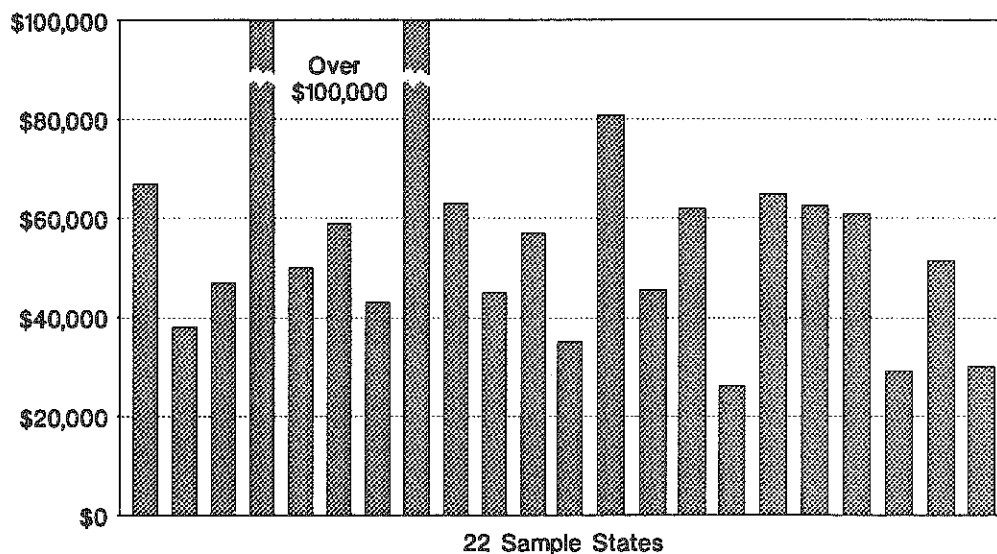
Based on an audit conducted in eight randomly selected States, OIG determined that the States did not have restrictions to limit reimbursement for ulcer treatment drugs to the dosages recommended by manufacturers. A survey of all States, conducted prior to this audit, showed that only nine States had limitation programs for ulcer treatment drugs. The OIG believes that the remaining 41 States (and the District of Columbia) should establish prospective limitation programs that not only improve the quality of care but also limit reimbursement for six ulcer treatment drugs to the manufacturers' recommended dosages. This would reduce Medicaid prescription drug expenditures by about \$112 million annually.

Accordingly, OIG recommended that HCFA establish procedures that prospectively limit payment to the dosages recommended by the manufacturers for ulcer treatment drugs, while allowing for physician override for special patient treatment. The HCFA does not believe that it should mandate a limit. Rather, it believes that each State should implement a limit. To assist the States, HCFA agreed to send OIG's report to them. (CIN: A-06-92-00003)

Medicaid Payments to Institutions for People with Mental Retardation

The OIG conducted a study to determine the extent and causes of variation among States in per resident Medicaid reimbursement to intermediate care facilities for the mentally retarded (ICF/MRs). The OIG found that Medicaid reimbursement rates for large ICF/MRs are more than five times greater in some States than in others, as illustrated below.

**ANNUAL PER RESIDENT REIMBURSEMENT RATE
BY STATE, 1991**



Further, OIG determined that State policies, rather than quality of service, facility characteristics or resident demographics account for the variation in ICF/MR Medicaid reimbursement rates among States, and the lack of effective controls results in excessive spending.

The OIG recommended options for HCFA to consider, including: encouraging States to adopt cost controls, strengthening Federal rate setting guidelines and providing technical

assistance to States to help them adopt effective controls; seeking legislation such as mandatory cost controls, a Federal per capita limit, a flat per capita payment, a case-mix reimbursement and a national ceiling for ICF/MR reimbursements; and seeking comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community based waiver services for developmentally disabled people. The HCFA agreed with the findings, but considered that the Medicaid statute and regulations allowed it little discretion in imposing additional controls to curb ICF/MR payments. Further, HCFA stated that any legislative changes should be considered within the framework of national health care reform. The OIG believes that controls over unnecessary Medicaid spending should not be delayed. (OEI-04-91-01010)

Recovery of Denied Medicaid Claims

The OIG reviewed denials for admissions for two PROs in New York, Island PRO and Network Design Group, to determine if New York State had recovered the denied amounts and refunded the proper share to the Federal Government. The OIG found that the State did not recoup more than \$17.5 million in overpayments and did not credit the Federal Government with its share of the overpayments (approximately \$7 million) within 60 days of recovery as required by the Social Security Act.

The OIG recommended that the State immediately return the \$7 million to the Federal Government, and ensure that all denial determinations identified by PROs are recovered timely with the proper amount refunded to the Federal Government. The HCFA generally concurred with the findings and recommendations. (CIN: A-02-92-01009; CIN: A-02-93-01007)

Short/Doyle Payments: California

Short/Doyle is a special program serving the mentally ill and is operated by the various counties in California which arrange for hospital and clinic services. By 1988, the State had negotiated Short/Doyle contracts with 14 counties. According to the State's Medicaid plan, payments to contract counties were limited to the lower of negotiated rates, customary charges or statewide maximum allowances. The OIG determined that California did not apply the customary charge limits or maximum allowances to the counties and that excessive Medicaid payments of approximately \$15 million (\$7.5 million Federal share) were made over 5 years. California argued that it had properly applied the provisions of the State Medicaid plan.

Based on advice from the Office of General Counsel, OIG believes that California's position is inconsistent with the language of the State's Medicaid plan and that the Federal Government should not share in the costs which were paid in violation of the limits imposed by the plan. The OIG recommended that the State refund \$7.5 million in excess Federal Medicaid funds paid to the counties and establish procedures to ensure that payments are

properly limited in the future. While the State did not agree, HCFA did agree. (CIN: A-09-92-00094)

State Medicaid Fraud Control Units

Medicaid health care provider payments currently exceed \$91 billion annually, representing an almost 500 percent increase over the \$18 billion expended in 1978. Medicaid fraud control units (MFCUs) are currently responsible for investigating fraud in more than 92 percent of all Medicaid health care provider payments.

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

During the second half of FY 1993, OIG administered \$65.8 million in appropriated grants to the MFCUs. The MFCUs reported 242 convictions and \$12.8 million in fines, restitutions and overpayments collected for the period January 1, 1993 through June 30, 1993.

**Social Security
Administration**

Chapter III

SOCIAL SECURITY ADMINISTRATION

Overview of Program Area and Office of Inspector General Activities

Nearly 60 years ago, the Social Security Act established a national insurance system that would be financed through payroll taxes collected from workers and employers and would pay benefits to workers in their old age. The Old Age and Survivors Insurance (OASI) program, and the Disability Insurance program, added in 1956, are popularly called Social Security. In Fiscal Year (FY) 1993, the Social Security Administration (SSA) expects to pay over \$295 billion in cash benefits to more than 41 million beneficiaries. The program is financed almost entirely through payroll taxes paid by employees, their employers and the self-employed. Benefits are distributed to retirees and disabled persons, their spouses and dependent children, and certain surviving family members of deceased insured workers.

The Supplemental Security Income (SSI) program is a federally administered, means-tested assistance program that provides a nationally uniform, federally funded floor of income for the aged, blind and disabled. Beginning January 1974, SSI replaced State and county run assistance programs for the aged, blind and disabled that were funded by a mix of Federal and State money. Federalization of assistance for these categories permitted the establishment of uniform eligibility criteria. In FY 1993, SSA expects to pay SSI benefits in excess of \$23 billion to over 5 million recipients. This amount includes more than \$3 billion reimbursed by the States.

The Office of Inspector General (OIG) reviews all aspects of SSA's programs and operations, including: disability insurance benefits, information resource management, program integrity and efficiency, quality of service, representative payees and SSI benefits. The OIG is also providing oversight to SSA's financial management by auditing SSA's financial statements, examining internal controls and reporting on the status of debt management activities.

Fraud and abuse in Social Security programs have historically been based on two types of deception: concealment of a recipient's status and/or the use of false Social Security numbers (SSNs) to obtain benefits. Over the past few years, the misuse of SSNs has grown far beyond mere benefits fraud to include a wide range of "con" games and violent crime. Moreover, during this reporting period successful prosecutive actions were taken against several persons involved in the sale of confidential information available by using SSNs to

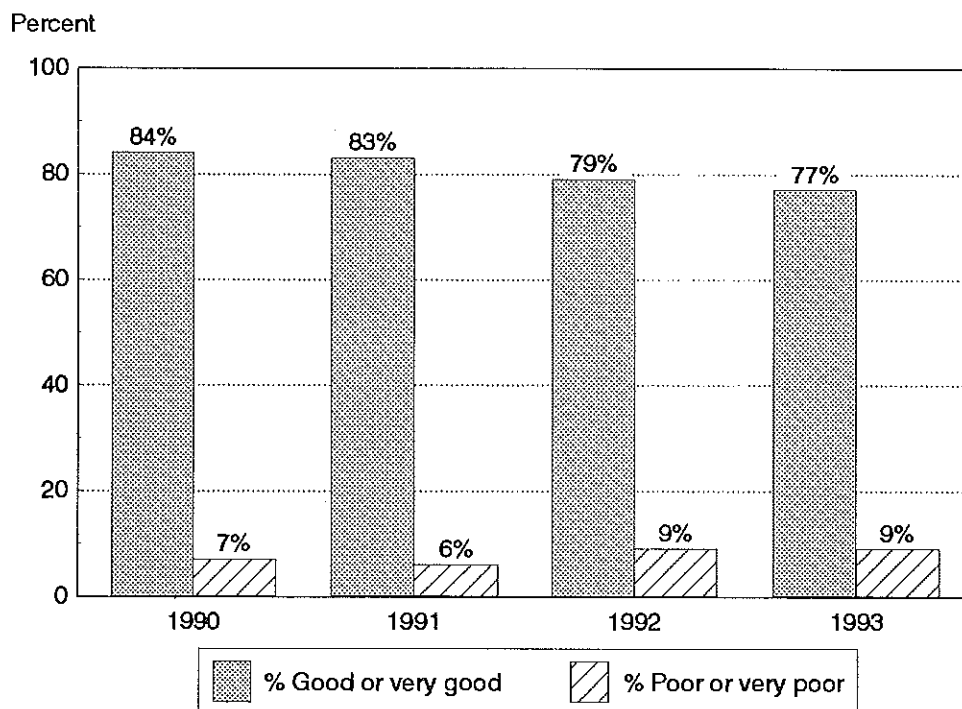
gain access to employment earnings records. The extraordinary increase in Social Security fraud, particularly SSN fraud, comes at a difficult time for OIG because of diminishing investigative resources.

Client Satisfaction: Fiscal Year 1993

Performance Measure

Annual reviews are conducted to determine the level of client satisfaction with Social Security services and to monitor SSA's progress toward selected service-delivery objectives, both with regard to the general client population and selected client subgroups. While a large majority of respondents continue to rate SSA service as good or very good, this year's satisfaction rating represents a third year of decline.

SATISFACTION AND DISSATISFACTION RATINGS BY YEAR



The surveys also found a decline in performance on the service-delivery objectives for office waiting times and mail response time. The surveys found no progress on five other objectives: referrals to related social services programs; access to the national 800 number; courteous service; understandable mail; and informing the public about SSA programs. Further, disabled, urban and non-English speaking clients consistently rated service somewhat lower than others. (OEI-02-92-00760; OEI-02-92-00761)

Financial Management Activities and Performance Indicators

Performance Measure

This report summarizes OIG's audit activities under the Chief Financial Officers (CFO) Act of 1990. Included in its appendices are the FY 1992 report on internal controls and compliance with laws and regulations, opinion on SSA's financial statements and summary of work performed under the Federal Managers' Financial Integrity Act (FMFIA). The report also contains OIG's assessment of SSA's presentation of program and financial performance indicators in the overview of the reporting entity section of its annual financial statement for FY 1992.

The OIG found that: SSA's FY 1992 overview is in compliance with the Office of Management and Budget's form and content requirement; the financial data presented in SSA's overview is not inconsistent with the corresponding data presented in the principal statements; and the internal control structure within the cost analysis system supports the preparation of the workload and unit cost data contained in the overview.

The OIG believes that SSA could further enhance future overview reports by providing more discussion on the status of the trust funds and problems encountered in meeting its mission and goals, and informing readers of changes in reporting performance indicators. The discussion of the status of the SSA trust funds could be enhanced considerably by including an analysis of possible steps to be taken by the Federal Government to meet its future obligations to SSA beneficiaries. Also, a more complete presentation of the dramatic shift in the estimated depletion date of the Disability Insurance Trust Fund along with a discussion of possible solutions to the pending funding shortfall would improve the overview considerably. The portion of the overview related to the problems encountered in meeting its mission and goals does not fully examine the problems encountered by SSA in alleviating the backlog of disability claims, overcoming the high busy signal rate encountered by callers to its field offices (FOs), and the inadequate staffing of its FOs. In reporting its initial payment accuracy rates, SSA modified the definition of payment accuracy to include only the initial claim time period, thereby reducing its accuracy rate from 99.8 percent to 94.8 percent. No explanation for the changed methodology was provided in the overview, thus leaving its readers to question why its performance declined so significantly. The SSA is in the process of reviewing and commenting on the final report. (CIN: A-13-93-00407)

Internal Accounting Controls and Compliance with Laws and Regulations: Fiscal Year 1992

This review was performed in conjunction with OIG's audit of the financial statements for the fiscal year ended September 30, 1992. The OIG continued to qualify its opinion regarding the uncertainty of SSA's reported trust fund balances of \$2.97 billion as a result of its failure to certify its wages based on the records established and maintained by the

Secretary of Health and Human Services, as required by the Social Security Act. The OIG also qualified its opinion based on the uncertainty of the valuation of accounts receivable. As a result of improvements by SSA, OIG did not qualify its opinion regarding the current year's valuation of equipment, as it had done in prior years. The OIG also found that, although SSA has made considerable progress over the years in improving its benefit payment systems, there is a need for similar improvements in its accounting systems.

The SSA stated that it is important to expeditiously determine the most appropriate method for crediting revenues to the trust funds, but believed that it was premature to decide which method to use and did not plan to report the wage certification issue as a material weakness as recommended by OIG. In its comments to the draft report, SSA generally agreed with OIG's recommendations and stated that it has already begun to implement those concerning property management, debt management and accounts payable. (CIN: A-13-92-00222)

Compliance with The Federal Managers' Financial Integrity Act: Fiscal Year 1992

This report presents the results of OIG's review of SSA's compliance with the requirements of FMFIA for FY 1992. The review included evaluations of: the effectiveness of internal controls for administrative and program areas at various field sites; the adequacy of personal property inventories; procedures for identifying critical control areas; the adequacy of management control reviews (MCRs) performed by regional review teams; the adequacy of accounting system reviews; and the reporting of the status of material findings.

The OIG believes that, overall, SSA is in compliance with the requirements of FMFIA. However, the review showed there are opportunities for improvements both at the field and central office levels of management. To the managers of those field sites reviewed, OIG recommended reconciliation of property listings with results of the OIG reviews and the installation of bar code stickers on all personal property. At the central office level, OIG recommended periodic reviews of MCRs performed by regional reviewers; dissemination of the personal property inventory results to all locations for corrective actions; and assurance that all subsystems of critical accounting systems are reviewed within the 3-year period. In addition, OIG believes that SSA should include physical and protective security as a management control area for tracking under FMFIA. In its comments to the final report, SSA generally agreed with the recommendations. (CIN: A-13-92-00308)

Financial Accounting System

The OIG contracted with a management consultant/certified public accountant firm to evaluate selected aspects of SSA's general and application controls as they relate to its financial accounting system (FAS), to determine conformance with accounting standards and to assess FAS' internal control risks. The objectives of FAS are to disclose the financial results of SSA activities; provide financial information for internal and external management

in the formulation and execution of the administrative budget; and provide information to control SSA's assets.

The review identified a number of opportunities to improve internal controls in FAS. The report highlights the findings relative to the major strengths and weaknesses of the internal control structure and the risks inherent in SSA's accounting system which could result in material misstatement of its financial statements. In its comments to the draft report, SSA generally agreed with the recommendations and agreed that it is important to have mechanisms in place to ensure the reliability of account balances. The SSA, however, does not believe that all recommendations are necessarily cost-effective. (CIN: A-13-92-00217)

Debt Management System

This report is the fifth in a series of reports to be issued periodically through completion of the debt management system (DMS) implementation. It presents the results of OIG's review of the objectives scheduled for completion between October 1, 1992 and March 31, 1993.

The objectives scheduled for completion during the period of the review, contained in Releases 9 and 10 of the DMS project plan, were to: enhance previously implemented data entry screens; revise software to enable same day processing cycle update of all overpayment records necessary to record a transaction; and complete steps necessary to prepare data for the Internal Revenue Service to use in recovering SSA overpayments from 1992 tax refunds. The objectives scheduled for DMS Releases 9 and 10 appear to have been successfully implemented. (CIN: A-13-93-00402)

Duplicate Postings of Self-Employment Income

The OIG determined that SSA controls are inadequate to provide reasonable assurance that self-employment income (SEI) data are properly posted to the master earnings file (MEF). Not all SEI transactions are checked for duplication when updating the MEF. Because of duplicates on the MEF, SSA has overpaid an estimated \$10.5 million to Social Security beneficiaries on 31,700 master beneficiary records for Calendar Years 1978-1992. However, SSA can recover only \$1.3 million in overpayments on 11,300 benefit records because Social Security regulations generally prevent SSA from recovering overpayments after 4 years from the date of the initial notice of benefits. The OIG recommended that SSA implement controls to prevent duplicates and negative balances, and correct the earnings records, benefit payments and trust funds. At the time of OIG's review, SSA had implemented or scheduled implementation of controls to prevent duplicate postings and negative balances of SEI to MEF. The SSA agreed with OIG's recommendations and, in most cases, is already taking corrective actions. The SSA is in the process of reviewing and commenting on the final report. (CIN: A-13-92-00228)

Modernized Enumeration System

The modernized enumeration system (MES) is the combination of manual and automated methods that SSA uses to take, input and process SSN applications. In a review of MES internal controls, OIG found that automated controls provide reasonable assurance that after application information is input, it is processed accurately and in a timely manner. However, FO controls for taking and entering SSN application information are not sufficient to prevent or detect errors or fraud. Also, FO controls for processing system-generated error messages need to be improved.

Recent investigations of SSN-related fraud demonstrated that SSN enumeration control weaknesses are being exploited. The OIG's analysis of the investigation reports on SSN-related fraud and its review of the internal controls indicated a high degree of risk in FOs for fraudulent enumeration of aliens and United States citizens age 18 and over. The OIG attributes this vulnerability to fraud, errors and abuse to a lack of separation of duties in FOs, ineffective detection controls and FO noncompliance with procedures. Although SSA has taken steps to reduce the risk of fraud and SSN misuse, OIG recommended additional changes. The SSA generally agreed with the recommendations. (CIN: A-13-90-00045)

Social Security Number Records Correction Process

The OIG found that internal controls were not adequate and weaknesses existed throughout the correction process. Specifically, instances were found where: SSN cards without the legend "NOT VALID FOR EMPLOYMENT" were issued to aliens not allowed to work; alien citizenship codes were established on the SSN data base for United States citizens; sensitive documents containing personal information were not sufficiently safeguarded; computer controls were not adequate to prevent unauthorized access; SSN records corrections were not processed timely; and processing controls for emergency SSNs were inadequate.

To ensure that fraud and errors are prevented or detected, OIG recommended that SSA correct automated system deficiencies; improve management oversight of the SSN records correction process; establish procedures that ensure that data is safeguarded and correction cases are processed timely; and ensure separation of duties in the emergency SSN card process. In its comments to the draft report, SSA generally agreed with the recommendations. In most cases, corrective action is either underway or has been completed. (CIN: A-13-92-00237)

Fraudulent Social Security Numbers

One of OIG's most important responsibilities is protection of the SSN enumeration system. In addition to misuse of SSNs to obtain undeserved program benefits, attempts to compromise the application process are relatively common, as shown in the following examples:

- The leader of an interstate forgery and stolen check ring was sentenced in Ohio, along with one of his ring members. Key to the ring's activities were false identification documents obtained through the use of false SSNs. The ringleader was sentenced to serve 41 months in a Federal penitentiary and to pay more than \$33,000 in restitution. His associate was sentenced to 10 months in prison and 3 years supervised release, and faces warrants for other activities committed under the ringleader's direction. Thus far, four individuals have been sentenced in this scheme and more arrests are expected. The case is part of Project Umbrage, a joint OIG/State/local effort. (5-92-00897-6)
- An Ohio man was sentenced to 15 months in prison for using the identity of a deceased individual to obtain an SSN under which he staged false accidents in order to defraud insurance companies, obtained drugs and purchased firearms. The case was a spin-off of a project to identify individuals in the Cincinnati area who pose as acquired immunodeficiency syndrome patients in order to obtain controlled narcotic pain killers as well as azidothymidine and other antibiotic drugs. (5-91-00086-9 and 5-92-00451-6)
- A Catholic priest complained that his brother had secretly obtained numerous credit cards by using the priest's name, date of birth and SSN. Investigation showed an outstanding balance of more than \$10,000 on three credit cards and smaller balances on others. The brother was sentenced to 6 months in jail and a year of probation, and fined \$50. (2-92-00145-6)
- A woman was sentenced to 15 months in prison for using a false SSN to conceal her employment while receiving more than \$24,100 in welfare. The SSN under which she was employed was one of four she obtained for one of her daughters; among them, her four children had eleven SSNs. She would not concede using a false SSN to get Aid to Families with Dependent Children benefits because she had used so many she did not know her true one. (5-91-00434-6)
- The owners of a now-defunct Michigan paraprofessional training institute were sentenced for defrauding various student loan programs of more than \$1 million between November 1989 and March 1990 by making loan applications under the names and SSNs of former students or by using SSNs not belonging to the supposed applicants. The two were sentenced to serve 18 months imprisonment and ordered to pay restitution totalling \$1,174,136. (5-91-00352-6)

- An accountant at an Air Force base in Texas used false SSNs to divert more than \$2 million to a fictitious supply company. He was sentenced to 5 months in Federal prison and ordered to make restitution. (6-92-00504-6)

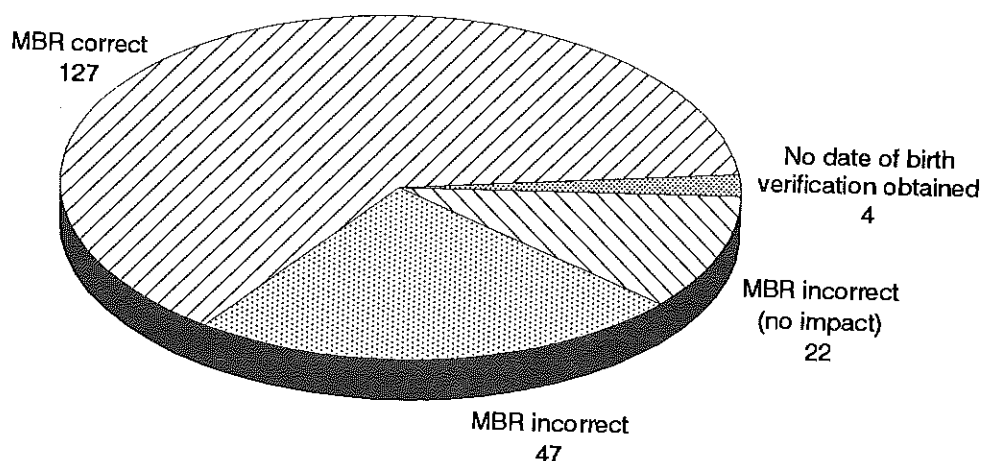
Although SSN fraud presents a major problem to true number holders and the general public, the decline in OIG investigative resources has necessitated that fewer SSN cases be investigated. The OIG has developed criteria for limiting SSN fraud investigations to situations that adversely affect issuance of SSNs or maintenance of wage records, and to those affecting departmental programs or trust funds.

Child Dependents' Dates of Birth on the Master Beneficiary Record

When an SSN is assigned, SSA FO personnel establish a Numident record. The FOs also establish a child dependent claim for benefits on the master beneficiary record (MBR) at the time of application, at which time they are responsible for reviewing proof of the child's birth. For child dependent and child-in-care benefits, the child dependent's date of birth contained on the MBR is the key on which such benefits continue.

In a review of 200 sample cases of child dependents whose MBR dates of birth showed them to be younger than their Numident record dates of birth, OIG found 69 instances in which the MBR dates of birth were incorrect.

RESULTS OF 200 CASE SAMPLE



The OIG estimates that, based on incorrect dates of birth on the MBR, SSA could overpay child dependent or child-in-care benefits of about \$26.4 million to more than 3,000

beneficiaries. The OIG recommended that SSA: review the universe of child dependents with a different date of birth on the MBR than that shown on the Numident file and correct the erroneous dates of birth; identify and collect overpayments that have been made as a result of incorrect dates of birth on the MBR; modify its claims system software to create a mandatory edit whenever the claim application date of birth differs from the Numident date of birth; and redefine the Beneficiary's Own Social Security Number Alert Verification process. In response to the draft report, SSA agreed with the first two recommendations, disagreed with the third believing that it would create a significant workload, and indicated that more time was required to evaluate the fourth. The SSA is now in the process of reviewing and commenting on the final report. (CIN: A-01-92-02001)

Safeguards to Protect Personal Information from Unauthorized Access by Third Parties

The OIG reviewed the safeguards used by SSA to prevent unauthorized accessing of personal information contained in SSA data bases by users who are not SSA employees (third party users). There are three major types of third party users of SSA data bases: other Federal agencies, State agencies and private contractors having agreements with SSA to obtain certain wage and employment information.

The SSA is required by Federal law to protect the privacy, confidentiality and integrity of all personal data. The OIG found that the necessary safeguards are in place with respect to access by State and Federal agencies. Further, action is in progress to correct those weaknesses previously identified by OIG with respect to private contractors. Consequently, OIG made no recommendations at this time. (CIN: A-03-93-02601)

Concealment of Changes in Entitlement Factors

The SSA has several lines of defense against individuals' continuing to receive benefits after they are no longer eligible. Recipients of OASI benefits and SSI benefits, as well as representative payees for these beneficiaries, are required to periodically confirm beneficiary status. Moreover, to some extent as a result of OIG projects, SSA has instituted computer program matches to spot those no longer eligible, such as matches of beneficiary rolls against State death and Federal incarceration records as well as earnings records. Some of the violations are based on deceptive use of SSNs, as discussed earlier in this chapter. Others, however, are based merely on concealment of marriage, death or other circumstances of the beneficiaries, as indicated in the following cases.

- A Pennsylvania attorney was sentenced to 12 months incarceration and 2 years supervised release for embezzling SSA benefits intended for a deceased client. He prepared and probated the client's will, and afterward forged his name on checks to obtain benefit funds electronically deposited to the client's account. He was ordered to make restitution to SSA of

\$35,116, plus a \$50 special assessment. He had been convicted and jailed previously for embezzling money from clients. (3-90-00339-6)

- After SSA was unable to verify the existence of a centenarian beneficiary, an investigation revealed that she had returned to her native Czechoslovakia in 1964, where she died in 1967. The postmistress of the post office which served the woman's Pennsylvania home had redirected her Social Security checks to her own address. Later she got an SSN in the woman's name and had the checks deposited directly into a joint account. She also used her name to defraud Pennsylvania's rent rebate program. The postmistress was sentenced to 10 months in prison. (3-89-00400-6)
- In Maryland, a woman was convicted and sentenced for Social Security and welfare fraud. She failed to report her husband's death, continuing to receive and use his Social Security benefits. In turn, she failed to report the benefits to the State and was overpaid in public assistance benefits, 50 percent of which came from Department funds. She was sentenced to 5 years probation and ordered to pay \$7,500 in overpayment and restitution. (3-92-00417-2)
- In Virginia, a woman who cashed her deceased father's benefit checks was sentenced to 4 years probation and ordered to make restitution of \$24,450. Rather than order her to perform community service, the judge told her to get a second job to pay off the restitution. (3-90-00414-6)
- For a year following his mother's death, a Texas man cashed her Social Security benefits checks through his postal credit union account. His story was that she was too ill to come in and handle the funds herself. He signed a pre-trial diversion agreement to repay \$5,566 within 12 months. (6-92-00003-6)
- A Louisiana woman who was representative payee for her brother failed to tell SSA that her brother was incarcerated from August 1988 till February 1991. She was sentenced to 4 months home confinement and required to make restitution of \$10,580. (6-91-00218-6)
- An Iowa woman was sentenced after a jury found her guilty of concealing a daughter's marriage with the intent to fraudulently continue receiving Social Security benefits on behalf of the daughter. Evidence showed that the woman was present at the daughter's 1988 wedding. The payee was sentenced to 5 months incarceration, 5 months home detention with work release and 2 years of supervised release during which she must make arrangements for restitution of more than \$10,000. (5-80-00643-6)

- An Iowa man was sentenced to 5 months probation and ordered to pay \$4,980 restitution for defrauding the SSI program. He applied for benefits in 1984, claiming blindness and unemployment after being hit on the head with a baseball bat during a barroom brawl. He pled guilty to fraud after learning that an investigator made videotapes of him working in a local warehouse unloading semi-tractor trailers, driving a forklift, and reading computer invoices, as well as driving his car on public streets. (5-BI-00123-6)

Sale of Restricted Information

As a result of a nationwide investigation by OIG and other Federal law enforcement agencies, approximately 30 persons have been convicted thus far for peddling restricted information such as SSA employment and earnings records, and National Crime Information Center (NCIC) criminal histories.

- An Air Force security officer was sentenced in New Jersey for the illegal sale of Government criminal record information. As security officer he had access to NCIC. On the side he also ran an information brokering company out of Cheyenne, Wyoming. The officer pled guilty to selling NCIC records to a company in New Jersey. Noting that his indictment meant the permanent loss of military pension after 19 years of service, the judge sentenced him to 4 months home detention, 4 years probation, 100 hours of community service and a court assessment of \$75. (2-90-00072-6)
- A former 17-year SSA employee assigned to an Arizona office was also sentenced for her part in an unauthorized disclosure scheme in which she sold confidential information obtained through some 600 queries of SSA files. She was sentenced to 6 months home detention and 3 years probation. (4-90-00527-6)

State Reverse Offset Laws for Disability Benefits

The Social Security Act required that Social Security disability benefits be reduced or offset because of workers' compensation (WC) payments, but allowed the States to enact "reverse offset" laws. With these laws, the States could reduce or offset WC payments because of Social Security payments. The Budget Reconciliation Act of 1981 eliminated the reverse offset provisions for all States which had not already enacted them, and also required that Social Security disability benefits be reduced by public disability benefit (PDB) payments.

Sixteen States and Puerto Rico have reverse offset laws. The OIG found that these reverse offset laws cost the Social Security trust fund \$40.5 million annually between 1986 and 1988; they inappropriately shift financial burdens from employers, insurance companies and States to the Social Security trust fund; and they cause undue administrative complexity for SSA.

The OIG recommended that SSA seek legislation rescinding reverse offset laws and requiring a reduction of Social Security disability benefits because of WC and PDB payments in all States. In its response to the draft report, SSA agreed in principle, but it wanted to defer action pending further study of the impact on affected States and Social Security beneficiaries, and program savings which might result. The SSA is now in the process of reviewing and commenting on the final report. (OEI-06-89-00902)

Collection of Supplemental Security Income Overpayments

The OIG performed this audit to follow up on an earlier review (CIN: A-09-87-00045) which found that FOs had not been timely in resolving certain SSI overpayment cases. The OIG determined that the corrective actions taken by SSA had reduced the backlog of these cases to 59 percent of the inventory that existed in 1986. This was accomplished by giving additional management attention to timely processing of the SSI overpayment workload. However, OIG found that there remains an inventory of these cases totaling approximately \$1.8 million, which represents an ongoing level of debt and results in avoidable carrying costs of about \$64,000 annually. This was due to SSA's limited resources and the higher priority of other workloads. The OIG believes that SSA needs to reduce the number of older cases within this group which comprise about half the cases in the current inventory. The SSA agreed with OIG's recommendation. (CIN: A-09-92-00081)

Public Health Service

Chapter IV

PUBLIC HEALTH SERVICE

Overview of Program Area and Office of Inspector General Activities

The activities conducted and supported by the Public Health Service (PHS) represent this country's primary defense against acute and chronic diseases and disabilities. The PHS's programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. The PHS encompasses: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed food, drugs, cosmetics and medical devices; Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support through financial assistance the development of our future generation of health care providers; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Health Care Policy and Research (AHCPR), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), previously the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), to assist States in refining and expanding treatment and prevention services. The PHS will spend more than \$19.4 billion in Fiscal Year (FY) 1993.

In the past 5 years, the Office of Inspector General (OIG) has significantly increased its oversight of PHS programs and activities. The OIG has concentrated on a variety of issues such as biomedical research funding, substance abuse, Indian health services, drug approval processes and community health center programs. The OIG has also looked at the regulation of drugs, foods and devices, and explored the potential for improving these activities through user fees. The OIG has conducted audits of colleges and universities which annually receive substantial funding from the Department. The OIG continues to examine several PHS-wide policies and procedures to determine whether proper controls are in place to guard against fraud, waste and abuse. These activities include property management, travel approval, preaward and recipient capability audits, and evaluation of PHS' information resource management activities. This oversight work has provided

valuable recommendations to program managers for strengthening the integrity of PHS policies and procedures.

Enhancing Utilization of Nonphysician Health Care Providers

Performance Measure

To meet the demands that any national health care reform undoubtedly will place on the existing delivery system, using our resources more effectively will be critical. In that light, OIG conducted a study to assess the potential for utilizing nonphysician providers in more productive ways. The OIG found that, in different kinds of settings, health care organizations are utilizing nonphysician providers in new ways to address concerns about cost, access and quality. Despite the promise that these approaches hold, OIG identified significant barriers that constrain their widespread adoption, including: professional territorialism, licensure restrictions, educational isolation, physician resistance and institutional inertia.

The OIG concluded that PHS, operating under authorities in the Health Professions Education Act, has an opportunity to strengthen its national leadership in encouraging more productive use of personnel. The PHS could act as a catalyst to bring to the forefront a more extensive examination of how nonphysician health care providers can help increase access and control costs without sacrificing quality. The report suggests specific ways in which PHS might take advantage of this opportunity. (OEI-01-90-02070; OEI-01-90-02071)

Exclusions for Health Education Assistance Loan Defaults

The PHS administers the Health Education Assistance Loan (HEAL) program, which loans money to students seeking an education in a health-related field of study. Students are expected to repay the loans once they have graduated and begun earning money. Some, however, continue to ignore their indebtedness even though they are reminded by PHS in an attempt to collect. Although these cases were in the past referred to the Department of Justice for action, even civil judgments were often ignored. As a result, the Government failed to recoup millions of dollars from medical professionals who were in a position to afford repayment.

In recent years, the Social Security Act has authorized the Secretary to exclude from Medicare and State health care programs health care professionals who default on their student loans. These enforcement authorities have been delegated to OIG. In mid-1992, PHS began referring cases under these authorities to OIG. Since then, more than 300 cases have been referred involving people who, despite repeated efforts by PHS, have ignored their obligation to repay their HEAL debts.

Under the Social Security Act, defaulting individuals may enter into settlement agreements with PHS and OIG whereby the exclusion is stayed while they repay their debt. If an

individual defaults on the settlement, the exclusion takes effect and remains in effect until the entire debt is repaid, and he/she cannot appeal this action.

By the end of this reporting period, 11 individuals had taken advantage of this opportunity and entered into settlement agreements. Their debts have ranged from approximately \$7,000 to over \$100,000. The amount of the money being repaid through this arrangement totals more than three quarters of a million dollars. Since a number of settlement agreements are under negotiation, and new negotiations are constantly being undertaken, this figure continues to rise. The following cases are examples of actions taken during this reporting period:

- A Michigan psychiatrist was excluded indefinitely from Medicare and any State health care program. He not only failed to repay his loans, which with interest amounted to more than \$275,000, but also made no payments against the judgment obtained by the Department of Justice for repayment of this debt. (H-93-46204-4)
- Also in Michigan, a podiatrist was excluded indefinitely for failure to repay her loan of \$70,000 or even to agree to offset her Medicare earnings to pay the debt. (H-93-40512-4)
- Program exclusions against a Florida chiropractor were stayed after he agreed to pay at least \$250 a month on his loan. When the chiropractor received a sanction notice of the exclusions because of his loan default, he immediately executed a consent agreement. (H-93-40163-4)
- An Ohio dentist appealed his exclusion to an administrative law judge (ALJ). The ALJ ruled that neither he nor the Departmental Appeals Board had authority to hear appeals on the mandatory exclusion. He also ruled that all reasonable steps had been taken to get repayment of the debt, that PHS was not obligated to offer the dentist employment to repay the debt (as he had requested), and that the dentist should be excluded until not in default or until PHS was satisfied that the debt had been resolved. (H-92-40167-4)

Spit Tobacco and Youth: Additional Analysis

Performance Measure

In an earlier report on the use of spit tobacco by youth (OEI-06-92-00500), OIG strongly urged the Department, the Federal Trade Commission and the Department of the Treasury to reexamine national tobacco control policy, including higher excise taxes, on spit tobacco. In this supplemental report, OIG concludes that the Federal excise tax on spit tobacco is disproportionately low compared to the cigarette tax, and that raising spit tobacco prices through excise taxes is a promising strategy for discouraging use by youth. The OIG

presents several options for increasing the excise tax on spit tobacco and, depending on the approach used, estimates that Federal revenues ranging from \$221 million to \$2 billion annually can be generated through such action. (OEI-06-92-00501)

National Institutes of Health Management and Service and Supply Funds

Performance Measure

The NIH Management and Service and Supply Funds finance a variety of centralized research support and administrative activities for the operation of numerous NIH programs and facilities, and reported FY 1992 revenues totaling \$606 million. The OIG audited the funds in accordance with Chief Financial Officers (CFO) Act requirements, but issued a disclaimer of opinion for reasons explained below.

The OIG reported problems involving accountability over personal property and inventories which impact on the entire NIH organization. Accounts payable balances did not adequately reflect amounts actually owed, which was compounded by the absence of adequate support documentation for related expenditures. The OIG believes that these weaknesses meet the criteria to be reported under the Federal Managers' Financial Integrity Act (FMFIA) as a material weakness.

Other significant internal control deficiencies noted included inadequate: capitalization of costs associated with a lease of computer equipment and development of automated systems; reconciliation of general ledger cash accounts with the Department of the Treasury's records; procedures relating to processing and recording disbursements; personnel training and written guidance for assigned accounting personnel; and security over accounting system application software and data files.

The NIH management agreed that the inventory deficiencies were material weaknesses but did not agree that the weakness in the area of accounts payable was material. A board of survey, initiated to improve property management, generated a series of recommendations in that area. (CIN: A-15-93-00008)

National Institutes of Health Risk Assessment Procedures

At NIH's request, OIG evaluated its draft risk assessment procedures. The NIH planned to incorporate those procedures as training materials and policy for NIH functional managers and management control coordinators.

The OIG recommended that NIH revise its draft procedures to include an improved definition of risk assessment, and to ensure that NIH assessors gain an understanding of the following risk assessment steps: analyze inherent risk; analyze the general control environment; perform preliminary evaluation of controls; perform overall risk assessment; document and report risk assessment; and plan subsequent actions.

The NIH concurred with the OIG recommendations and reportedly made numerous changes to their draft risk assessment procedures. The revised NIH procedures were forwarded to the Office of the Assistant Secretary for Health (OASH) for approval. The OIG plans to again review the proposed procedures manual before finalization, once it has been accepted by OASH. (CIN: A-15-93-00039)

National Institutes of Health Management and Fraud Problems

The NIH has been cooperative in assisting OIG in criminal investigations. It has been less responsive to OIG's referrals of complaints for inquiry and action. A review of complaint referrals from 1991 through 1993 showed that NIH has not assigned anyone to conduct inquiries in 74 percent of complaints referred 6 or more months ago. Seven of these complaints were referred over 1 year ago, and 5 were referred 3 years ago.

In 1990, 1991 and 1992, PHS reported deficiencies in NIH's inventory records as a material weakness under FMFIA after more than 18,000 inventory items worth over \$80.5 million could not be found. A General Accounting Office (GAO) report issued in July 1993 stated that problems still exist within the NIH inventory. The report states that: GAO is 99 percent certain that at least 10 percent of 18,203 inventory items previously listed as missing, but later located, are missing again; an inventory conducted by NIH found that over 53,000 items worth approximately \$168 million were never recorded in its inventory; and some of the items not recorded in the inventory may now be missing.

Internal Control Procedures: New York Medical College

During 1990, a joint effort by OIG, the Federal Bureau of Investigation, State and county agencies, and the New York Medical College (NYMC) disclosed that the manager of NYMC's grant accounting and accounts payable department systematically misappropriated \$917,990 in Federal funds and \$676,430 in college funds. The manager was sentenced to 2 to 6 years in prison, and the misappropriated funds were recovered through restitution and insurance claims.

To preclude further problems, NYMC strengthened the internal controls by: separating the duties in the accounts payable department; instituting a code of conduct; strengthening controls over the disbursement of checks; augmenting controls over the approval of all general ledger entries; conducting reconciliation of subsidiary ledgers to the general ledger; and establishing an internal audit function. In a current review, OIG found that NYMC had revised its internal control structure and implemented controls to ensure that similar misappropriations do not occur. (CIN: A-02-93-02503)

Revitalizing the Community Support Program

Performance Measure

At PHS' request, OIG conducted a study of the Community Support program (CSP) to assist the Center for Mental Health Services in identifying future directions for the program. The OIG found that CSP has helped change attitudes about serving persons with severe mental illnesses, but has not spurred widespread development of comprehensive community-based services for them. To promote the development of such services in States, OIG recommended that the Center develop a strategic plan focused on implementation of community-based services; broaden its constituency; expand technical assistance; and strengthen evaluation in CSP demonstrations. The PHS concurred with the recommendations and is taking steps to implement them. (OEI-05-92-00120)

Community Health Representative Program

Performance Measure

The IHS Community Health Representative (CHR) program is based on the concept that indigenous community members, trained in the basic skills of health care provision, disease control and prevention can successfully effect change in community acceptance and utilization of health care resources. In FY 1992, IHS spent \$39 million for 1,544 CHRs in 260 programs.

In one report, OIG discusses some of the problems noted in the program. The OIG found that most respondents are not familiar with the goal and objectives of the CHR program and there is widespread disagreement about the appropriate role for CHRs. Also, transport is a major unresolved issue in the program. It is a disproportionately large CHR activity, but respondents disagreed on whether it is a desirable or legitimate CHR activity. Many believed that it should be better defined or limited. Others felt that this was what tribes expected and wanted CHRs to do.

In a companion report, OIG describes the major factors identified by the more than 400 respondents which make the CHR programs effective and discusses how these factors might be used to judge the effectiveness of a CHR program. The factors are: agreement on the role of the CHR; integration into the health care system; tribal support and direction; and IHS support and direction.

The OIG recommended that PHS and tribes thoroughly reexamine the CHR program and decide whether to retain it in its current form, revise it to become a transport program or abolish it. Should they retain the program, OIG recommended that they develop a national strategy to revitalize it. Among a number of implementation actions being taken as a result of the studies, IHS guidelines and goals for the program are now outlined in the IHS manual, which states that tribal CHR programs will be evaluated on a triennial basis. The IHS is conducting surveys in select tribal communities to collect information which will assist in improving program performance indicators and in developing a program evaluation instrument. (OEI-05-91-01070; OEI-05-91-01071)

Three years ago, IHS was declared a high risk area by the Office of Management and Budget (OMB). In December 1992, OMB reclassified IHS's high risk rating to "significant progress," meaning that IHS had taken considerable action to address its weaknesses. Although investigations continue to be initiated, primarily in the area of employee mismanagement, fraud and misconduct, there has been a significant decrease in the number of cases opened during the last year.

However, some of IHS's responses to OIG referrals of complaints and investigative results continue to be slow. No administrative action has been reported on investigative results referred 3 1/2 years ago concerning mismanagement and misconduct of high-level officials and employees at one area office. The OIG is also still awaiting responses to four complaint referrals made in 1992. Furthermore, no official response has been received on one OIG-referred Early Alert Report (EAR) on a potential material weakness involving Buy Indian Contracts. This EAR was issued in 1991.

National Practitioner Data Bank: Usefulness to State Licensing Boards

The primary users of the National Practitioner Data Bank are hospitals, which are required by law to query the data bank about practitioners at the time they apply for hospital privileges and at least every 2 years thereafter. State licensing boards are permitted to query the data bank, but are under no mandate to do so.

The OIG found that few licensing boards have opted to query. Among their reasons for not querying is that they already receive much of the information sent to the data bank. However, the results of OIG's study suggest that boards may be underestimating the value of such queries. Two-thirds of the responses that nine boards received in response to queries were considered useful, and several responses provided information that the boards did not already have. Boards might make the best use of the data bank by querying in cases where information from out of State is needed, because boards are less likely to be sent information routinely from out of State sources. While the universe of matches was limited in size, OIG believes that this study provides meaningful insight into the data bank's utility. (OEI-01-90-00523)

Licensure of Out-of-State Dentists

The OIG found that 22 States require out-of-State dentists to take and pass a clinical examination prior to granting them a dental license. The remaining States typically grant a license to such dentists on the basis of their existing credentials. This inspection report explains the rationales and consequences associated with current State practices in licensing out-of-State dentists. It concludes by identifying two closely related issues that may be of greater significance to the public than licensure by credentials: the minimal degree to which States currently assess the continued competency of practicing dentists, and the questionable

performance of many State dental boards in carrying out their enforcement and disciplinary responsibilities.

The OIG suggests that if State governments and private organizations focus constructively on these issues, support for licensure by credentials could increase and the public could receive increased protection for the nearly \$40 billion a year it is spending on dental services provided by about 145,000 dentists. (OEI-01-92-00820)

State Dental Boards and Dental Discipline

This OIG study concluded that there is a strong basis for questioning the capacity of State dental boards to carry out their disciplinary responsibilities. They have insufficient resources to devote to investigations; lack comprehensive reporting laws to help them identify dentists warranting investigations; make limited use of disciplinary action clearinghouses; and discipline dentists to widely varying degrees. The OIG suggested that State governments help the boards improve their investigatory capacity, and that PHS assist them in this effort by providing financial support for the development of a self-assessment instrument. The PHS has provided such support to State medical boards, and has helped stimulate assessments of the capacity and performance of these boards. (OEI-01-92-00821)

Costs Incurred under Acquired Immunodeficiency Syndrome Cooperative Agreements

In response to a congressional request, OIG reviewed the distribution and use of Federal acquired immunodeficiency syndrome (AIDS) education funds for two awards to the State of Florida by CDC during FY 1989. Neither of the awards limited the percentage of funds which could be used for administrative purposes. The OIG found that, of the total expenditures of nearly \$10.7 million for both awards, over \$4.2 million (40 percent) was expended for administration and \$6.4 million was expended for providing direct services to the targeted populations. Based on these results, OIG is expanding its review to other States to determine if their spending patterns are similar. Moreover, in January 1993, PHS requested CDC to perform and report in 3 months on a study of the proportion of its AIDS grant funding that is expended for administrative costs. These reviews will be coordinated to ensure consistency in review methodology and the broadest possible coverage of the issue.

Precedents exist for limiting the percentage of funds which may be expended for administrative costs. The OIG believes that such a limitation may be required for AIDS grants if the results of its Florida review are typical of the spending patterns in other States. (CIN: A-04-91-04027)

Bribery of Food and Drug Inspectors

Over the past couple of years, FDA, with the assistance of OIG, has trained its inspectors in all its district offices in recognizing and handling approaches that lead to offers of bribes. During this reporting period, alert inspectors' actions led to two persons being sentenced and a third being indicted in separate incidents in New York. In each case the owner of the facilities being inspected offered the FDA employee money or other favors in exchange for not reporting unapproved sales or substandard conditions. Each of the inspectors reported the offer.

- A man who imported surgical instruments from Pakistan was sentenced to 3 years probation and fined \$15,000 for paying an FDA inspector, who assumed the cover of a corrupt FDA employee, to release his products. In two consensually monitored meetings, the importer paid the inspector a total of \$4,400 for releasing cartons of disposable instruments and dissecting instruments which he admitted to selling to his dealer without obtaining FDA premarket approval. (2-92-00268-3)
- An importer and wholesale distributor of specialized food products was sentenced to 2 years probation, ordered to pay a \$5,000 fine toward the cost of probation and supervision, and assessed \$50. After an FDA inspector and two coworkers found contaminated and vermin-infested food on his company's premises, the importer gave him \$1,000 and \$200 to each of the others not to report the findings. The inspector reported the bribe, and the importer was arrested after a consensually monitored conversation. (2-92-00772-3)
- Another importer who saw that an inspector's tests for lead in his imported foodstuffs were positive offered airline tickets for his entire family of four to a destination of his choosing, anywhere in the world. When the inspector returned later, the importer gave him \$1,000 to overlook violations and establish a long-term relationship. The importer was arrested and indicted. (2-93-00350-3)

Food and Drug Administration's Headquarters Imprest Fund

Prompted by FDA's discovery of a former employee's fraud, the Commissioner of Food and Drugs requested that OIG review the internal controls relating to the operation of the headquarters imprest fund (HQIF), a cash-based fund maintained at a fixed amount for the purpose of providing FDA headquarters employees with funds for travel advances, reimbursement for local travel and small purchases, and emergency salary advances. In June 1992, as part of the FMFIA process, PHS declared a material weakness regarding FDA's imprest fund operations.

The OIG found that, although FDA had taken measures to improve HQIF operations, additional safeguards should be implemented before the material weakness can be considered corrected. Because operating this fund poses an unnecessary continuing vulnerability for FDA, OIG recommended that the agency eliminate the HQIF and proposed alternative methods for making advances and payments. The PHS concurred with OIG's recommendations and described actions underway or planned to implement them. (CIN: A-15-92-00019)

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

Performance Measure

The OIG performed a financial audit of FDA's Revolving Fund for Certification and Other Services FY 1992 financial statements as required by the CFO Act. The Fund accounts for receipts and expenses related to FDA's certifying the safety and effectiveness of insulin, and the safety of color additives in foods, drugs, cosmetics and medical devices. Manufacturers of insulin and color additives pay a fee to cover the cost of FDA's certification services. In FY 1992, over \$4.5 million was collected from manufacturers.

The financial statements were found to present fairly, in all material respects, the financial position, operations and cash flows of the Fund. However, the audit identified deficiencies in the internal control structure of the accounting system in the areas of input and processing controls, allocation of overhead, and proprietary and budgetary accounting. (CIN: A-15-93-00007)

Identification of Program Management Control Areas for Evaluation under The Federal Managers' Financial Integrity Act

The OIG found that PHS policies and procedures did not assure that all programs and missions were identified for management control reviews as required by FMFIA. The OIG identified programs that were not subjected to the management oversight intended by this law. An effective segmentation process should provide reasonable assurance that all major management control areas have been addressed and control weaknesses identified for corrective action. The OIG recommended bringing PHS into full compliance with FMFIA by requiring agency management control officers to identify and document all PHS programs and their related objectives, missions and legislation. The OIG also recommended that the PHS management control plan be routinely updated to reflect changes in program responsibilities. Management subsequently developed a process to ensure comprehensive FMFIA coverage of its programs. (CIN: A-15-93-00013)

Public Health Service's Service and Supply Fund: Fiscal Year 1992

Performance Measure

The CFO Act of 1990 required that OIG ensure that certain funds—revolving funds, trust funds and funds with substantial commercial activity—prepare financial statements and have them audited. In accordance with the CFO Act, OIG contracted with an independent public accountant to audit PHS's Service and Supply Fund,

Auditors disclaimed an opinion on the financial statements and identified the following issues in their report on internal controls and compliance with laws and regulations: property, plant and equipment records lack sufficient information to verify that they are reasonably stated, and the Fund's procedures for accounting for property are insufficient; the Fund does not bill for service revenue rendered in the fourth quarter until the first quarter of the subsequent year, in violation of the Department's requirement to follow the accrual method of accounting; and there was an absence of proper procedures to ensure that information (or output) in the financial reporting system were correct, and reconciliations were not being performed timely. Further, auditors indicated concerns in the areas of fund balance with the Department of the Treasury, inventory, equity, accounts receivable, capital leases and source documentation.

The auditor's opinion report and the report on internal controls and compliance with laws and regulation are included in the CFO report, which was issued in August 1993. (CIN: A-15-93-00010)

Use of Superfund Monies

The Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, requires the Inspector General of each Federal organization with Superfund responsibilities to conduct audits of payments, obligations, reimbursements or other uses of the Superfund.

A. National Institute of Environmental Health Sciences

This OIG audit disclosed that, with the exception of minor irregularities due to clerical errors, the National Institute of Environmental Health Sciences generally administered the fund in accordance with Superfund legislation. However, OIG noted internal control weaknesses involving grantee audits, budget preparation and reimbursement billings. (CIN: A-04-92-04103)

B. Agency for Toxic Substances and Disease Registry

This OIG audit identified deficiencies in the Agency for Toxic Substances and Disease Registry's timekeeping and payroll functions. A discrepancy was identified in the Department of Health and Human Services' accounting manual concerning operating divisions' responsibility for developing and implementing a system of internal controls to

assure that grant recipients only withdraw cash as it is needed to meet expenditures incurred under the grant. The OIG recommended that PHS work with the Assistant Secretary for Management and Budget concerning the accounting manual discrepancy. (CIN: A-15-92-00010)

**Administration
for Children
and Families,
and Administration
on Aging**

Chapter V

ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. Expenditures for the ACF programs are expected to total \$26.4 billion for Fiscal Year (FY) 1993. The major programs include: Aid to Families with Dependent Children (AFDC), Child Support Enforcement (CSE), Child Care, Job Opportunities and Basic Skills (JOBS) training, Head Start, Foster Care, Adoption Assistance and Refugee Resettlement.

The Family Support Act of 1988 provides a comprehensive restructuring of the welfare system to reduce long term dependency on welfare programs. The last phase of the Act is slated for implementation in 1995. The Office of Inspector General (OIG) identifies opportunities to improve Federal and State management of delivery of program services and monitors the implementation of the Act. The OIG also reviews the cost-effectiveness of the various social services and assistance programs, including determining whether authorized services are rendered to eligible recipients at the lowest cost.

Further, OIG reviews the Department's programs that serve children, and has issued several reports in this area. Overall, OIG has found that there are significant barriers to effective coordination and service delivery among these programs, including Head Start, Foster Care and Adoption Assistance, and the CSE programs. Although the Department has made changes and appears to be on the right course, improvements are needed to better target these services to the needs of children. The OIG reports have focused on ways to increase the efficient use of the program dollar, and how to better coordinate program implementation between the Federal and State/local governments.

Federal funding of the Administration on Aging (AoA), which reports directly to the Secretary, is about \$900 million annually. The AoA awards grants to States for establishment of comprehensive community-based systems that assist the elderly in maintaining their independence and in remaining in their homes as long as possible. The

assistance is targeted to the socially and economically disadvantaged, especially the low-income minority elderly, and includes supportive services, nutrition services, education and training, low-cost transportation and housing, and health services.

The OIG has reported opportunities for program improvements to target the neediest for services; expand available financial resources; upgrade data collection and reporting; and enhance program oversight. Also, OIG is monitoring the effectiveness of actions being taken to identify and correct material weaknesses under the Federal Managers' Financial Integrity Act.

Head Start Expansion

Performance Measure

The OIG prepared two reports in a series on Head Start expansion. One study used file reviews and selected performance indicators to assess the impact of expansion on grantees.

OIG PERFORMANCE INDICATORS

Percent of children medically screened

Percent of children receiving the needed medical treatment

Percent of children receiving dental exams

Percent of children receiving the needed dental treatment

Percent of children fully immunized

Program provides nutritious meals and snacks

Percent of children for whom the teacher has entered in the child's folder observational comments at least once a month

Average class size

Percent of families for whom a family needs assessment has been completed

Percent of families with identified needs for whom the Head Start program has attempted to meet these needs

Percent of parents volunteering at least 50 hours per year

Percent of full enrollment

Average vacancy time

Program is not at fiscal or program high risk

Child-to-staff (teaching, social service, health, parent involvement, total) ratio

Number of volunteer trainings and parent workshops

Average number of contacts with each parent

Average daily attendance

While OIG did not find any statistically significant difference in grantee performance as a result of expansion, it did find that the level of performance as measured by the indicators was considerably lower than that reported by grantees and published by ACF. Because of inadequate record keeping, the lack of specificity in the Head Start performance standards

and the fact that many grantees disregard ACF policy guidance, OIG was unable to determine if the program and performance data weaknesses identified reflect serious deficiencies in the quality of services provided by Head Start. The OIG recommended that the Secretary convene a task force to conduct a formal and thorough review of the management of the Head Start program.

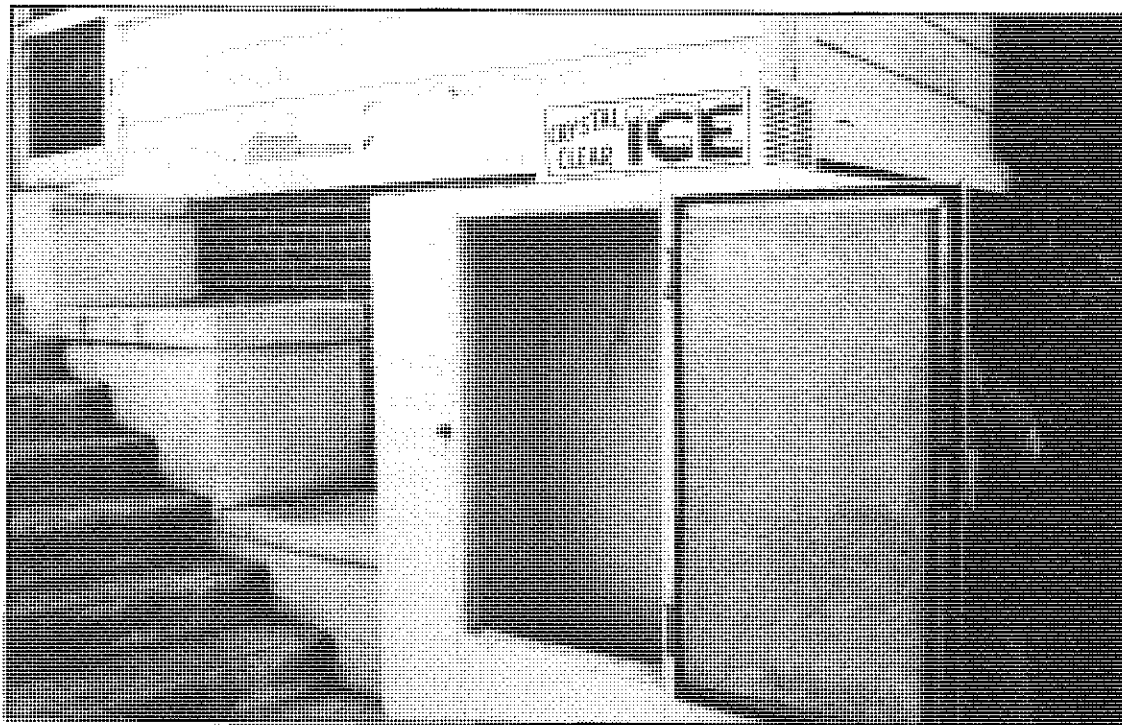
In a companion report, OIG discussed the results of interviews with grantees and ACF staff. Grantees described increased demands on staff and concerns about their ability to provide quality services to families while expanding. They reported problems in such areas as child enrollment, facility acquisition, staffing, transportation and social services. While grantees stated that they were able to overcome most of these problems, they are concerned that some of these problems may become insurmountable if they are not addressed in future expansions. The OIG recommended that ACF develop regional expertise and offer grantees better assistance with facilities; develop strategic and long-range plans to handle future expansions better; and improve its training and technical assistance and reevaluate the effectiveness of its technical assistance contracts.

The Secretary has initiated a comprehensive examination of the program with a particular emphasis on quality and accountability, convening an Advisory Committee on Head Start Quality and Expansion. This initiative includes: immediately identifying poorly performing grantees, designing corrective actions, providing technical assistance and ensuring that grantees that provide high quality services receive program funds; and conducting an in-depth review of the program with the help of an intellectually diverse expert study panel and using the results to design the Head Start program of the future. (OEI-09-91-00760; OEI-09-91-00762)

Health and Safety Standards at Child Care Facilities

As part of a broad effort to assess risk to the Nation's children in child care facilities, OIG conducted reviews in several States to determine whether providers of child services were in compliance with appropriate Federal, State or local authorities' health and safety standards. The State's monitoring and oversight efforts were also assessed.

The reviews disclosed that additional attention is needed to improve health and safety conditions as well as record keeping at the facilities. The facilities visited receive Federal funding from the Social Services Block Grant for Day Care, Head Start and the Foster Care programs. Accompanied by State, county or city inspectors, OIG performed onsite inspections of federally-funded child care providers. The deficiencies identified included unsanitary conditions, fire code violations, playground hazards and toxic chemical accessibility. Day care facilities had a higher percentage of deficiencies than Foster Care or Head Start facilities.



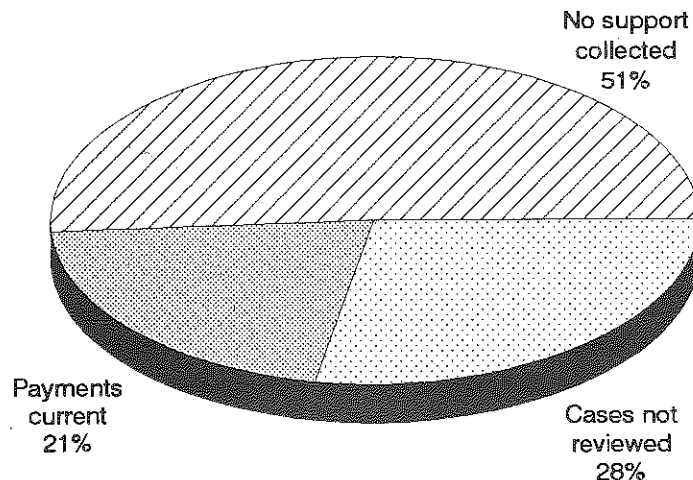
Inoperable ice case accessible to children at foster care institution

Reviews were conducted in the States of North Carolina, Wisconsin and Nevada. The deficiencies noted parallel those previously reported in Delaware, Virginia, Pennsylvania and Native American Head Start facilities. The States generally concurred with OIG's recommendations. However, Nevada disagreed that it should give close and continuous supervision to new caregivers until the results of the background investigations were obtained. (CIN: A-12-92-00044; CIN: A-05-92-00103; CIN: A-09-92-00103)

Child Support and the Military

In an earlier report (CIN: A-12-89-00154), OIG identified 42,000 military personnel in arrears on their child support payments totaling over \$176 million. In a current review, OIG found that States did not collect child support payments in more than half of the sample military cases.

**NO CHILD SUPPORT COLLECTED
(360 Cases)**



Projected national savings to the AFDC and Medicaid programs, if court orders for child support were established and/or enforced in these cases, total \$54.1 million. The OIG determined that locating absent parents is the greatest barrier and that CSE staff have not been properly trained to handle military cases. Military finance centers identified causes for delay in the processing of wage withholding orders, such as the lack of standardized forms for submission of wage withholding orders.

The OIG recommended that OCSE provide technical support to State CSE offices to improve Social Security number (SSN) identification; evaluate the usefulness of information available through the Federal Parent Locator Service and provide necessary assistance to local CSE offices searching for military absent parent SSNs; continue to promote the "Child Support Enforcement in the Military" handbook; and establish and require the use of a standard form and a checklist for submission of wage withholding requests to the Defense Finance and Accounting Service Centers. Further, OIG proposed that ACF and the Social Security Administration (SSA) collaborate to develop a better mechanism to assist CSE staff in obtaining SSNs for absent parents, with safeguards to protect individual privacy and the integrity of the Social Security system. The ACF and SSA agreed with the OIG recommendations, and ACF has since taken a number of actions to address the recommendations. (OEI-07-90-02250)

Job Opportunities and Basic Skills Program

A. On-the-Job Training

Better monitoring and information gathering is needed for a State to determine if the objectives of the JOBS program are being met. One State agency reviewed generally was not monitoring or evaluating the success of the on-the-job (OJT) component of its JOBS program. Records were not maintained to show how many recipients had been placed in the program, whether they attended and completed training and whether they were placed in jobs for which they were trained. Additionally, OIG identified \$40,000 (Federal share \$24,000) in unallowable expenditures.

The OIG recommended that ACF encourage States to establish and implement procedures for determining the success of participants and the OJT program, and ensure that OJT and other components of JOBS are being effectively monitored in all States. The ACF concurred and promptly issued an information memorandum to States regarding the need to have adequate program tracking, record keeping and monitoring in place. The ACF also plans to follow up and to ensure that States maintain adequate controls. (CIN: A-05-93-00019)

B. Child Care and Other Supportive Service Costs

The OIG conducted audits of four States (Arkansas, Florida, Louisiana and New Jersey) to determine the eligibility of participants and the allowability of costs claimed for Federal financial participation (FFP). The audits disclosed that payments totaling nearly \$2.5 million (\$1.4 million Federal share) were made for ineligible participants and almost \$1.4 million in excess FFP because costs were claimed at the wrong matching rate.

Additionally, controls established by the States were inadequate and resulted in the following types of improper payments: child care and other supportive service payments were made without adequate documentation and for ineligible participants; the child care or other supportive service payment was improperly calculated; the transitional child care co-payment was either not deducted or was incorrectly calculated; and child care payments were made prior to the provider being certified as an approved vendor.

The OIG recommended financial adjustments and procedural changes. The States generally concurred with the procedural changes. However, some States did not fully agree with making financial adjustments. (CIN: A-02-91-03508; CIN: A-04-91-00028; CIN: A-06-92-00024; CIN: A-06-92-00031)

C. Youth and Minor Parents

The OIG conducted an audit to determine if the State of Georgia's procedures are adequate for implementing and enforcing the educational requirements for youth and minor parents in

the JOBS program and if these parents are participating in JOBS activities. The review disclosed instances where: county offices did not obtain documentation to ensure that youth and minor parents complete their education; financial sanctions were either not being applied or were not being applied timely; employment plans were not completed and maintained; participants' progress in educational and training activities was not monitored timely or documented, and reassessments were not performed within required time frames; and county offices did not correctly apply exemption criteria and errors were made in target group coding. Officials attributed these problems to case managers' huge workloads. Additionally, potential overpayments for child care were not being identified and procedures to prevent duplication of Federal funds for supportive services, such as transportation and meals, were inadequate.

The State agreed with OIG's recommendation that it review and take appropriate action to reduce caseloads to a more manageable level, properly apply sanctions, and develop procedures for identifying and preventing child care overpayments and duplication of services. Also, OIG suggested that ACF encourage all States to examine their programs for similar problems and provide appropriate guidance or technical assistance which would help improve services to youth and minor parents in JOBS. (CIN: A-04-93-00057; CIN: A-12-92-00035)

D. Program Monitoring and Technical Assistance

The OIG found that, despite changes stemming from the complexities of the JOBS program and the rapid pace of implementation, ACF succeeded in promptly issuing regulations and providing initial technical assistance and guidance. However, some improvements were needed in monitoring, technical assistance, program guidance and management information. The OIG made recommendations to improve the field review process and data collection; reassess States' technical assistance needs; systematically validate and analyze program data; and routinely distribute management information to interested groups. (OEI-07-92-00380)

Aid to Families with Dependent Children Preeligibility Verification Measures

The OIG determined that the 1988 Family Support Act requirement that States establish preeligibility fraud detection measures had little effect on State activities for preventing inappropriate AFDC payments. Further, 12 States in FY 1990 and 18 in FY 1991 did not evaluate the effectiveness of their preeligibility verification measures as required. The OIG recommended that ACF: revise its evaluation reporting requirements so that they will apply to all types of preeligibility verification measures; ensure that States periodically evaluate and report on their preeligibility programs; conduct or sponsor its own independent evaluation of State preeligibility programs; and provide information on effective preeligibility verification measures to States. The ACF agreed with all but the first recommendation. It prefers to use State demonstration projects as a vehicle for evaluating verification measures. (OEI-04-91-00100)

Welfare Fraud

Welfare assistance provided under the AFDC, Medicaid, Food Stamp and general assistance programs is based on State determinations of eligibility. As a result, welfare fraud is usually perpetrated by providing false information about one's circumstances, such as claiming a nonexistent dependent child or concealing income which would render the applicant ineligible. Suspected fraud is discovered through a variety of mechanisms, ranging from disclosure by a disgruntled acquaintance or relative to computer matches of welfare lists against worker's compensation rolls or income tax returns.

The following cases are examples of some of OIG's activities in the area of welfare fraud:

- A California man was sentenced to 120 days in jail and restitution of \$20,170 for welfare fraud and perjury. As an interpreter, he collected \$14,000 in fees from seven Laotian refugees he assisted in applying for Social Security benefits (about 50 percent of their first or retroactive checks) without reporting the money to the AFDC program. He also must serve 5 years probation, attend a theft awareness class, perform 600 hours of community service and surrender his \$20,000 van to his attorney to defray legal expenses. (9-91-00005-6)
- In Utah, three women were sentenced for defrauding public assistance programs of a total of nearly \$80,000. One had to serve 30 days in jail and pay full restitution and a \$1,000 fine for concealing a marriage, two homes, 18 vehicles and a \$40,000 motor home while she received assistance. Another also concealed marriage and assets, and the third claimed a sister as a dependent. These two also had to pay restitution, and one had to spend 60 days in electronic home confinement. The OIG worked the cases jointly with the new Utah State Medicaid Fraud Control Unit, to give its agents guidance in investigating Medicaid fraud. (8-92-00454-2, 8-92-00455-2 and 8-91-00290-6)
- An Ohio task force consisting of OIG and Postal Inspection Service agents and representatives from the county law enforcement, county human services and State auditor's offices began a welfare investigative project in December 1992. Thus far, over 60 persons have been indicted for defrauding the AFDC, general assistance, home energy assistance and medical assistance programs of more than \$300,000. 7

Office of Community Services Grants

The OIG conducted a follow-up to earlier audits of four grants awarded by the Office of Community Services (OCS) to assess the ACF's handling of disallowances and OCS oversight of grantee actions in implementing procedural recommendations. The OIG

determined that ACF had not demanded or recorded some monetary disallowances, and that OCS oversight of grantee actions on non-monetary recommendations needs improvements. The OIG recommended that ACF: track implementation of recommendations made to grantees; follow up with grantees to ensure that effective actions are taken; send properly worded demand letters containing appeal provisions and specifying interest rates for unpaid balances; provide 30-day follow-ups until collections are complete; and close out grants in a timely, accurate manner. The ACF agreed with the recommendations. (CIN: A-12-92-00043)

Independent Living Program Funds

In its review of funds awarded under the Independent Living Program (ILP), OIG determined that ACF's internal controls were inadequate to safeguard ILP funds from unauthorized expenditure and to prevent States from violating the spending cutoff dates established by legislation. As a result of this weakness, \$16.7 million of the \$135 million of ILP funds awarded to States in FYs 1987 through 1989 was either spent or at risk of being spent after the spending cutoff dates. The OIG recommended that ACF take action to recover \$2.2 million spent in violation of grant terms, to strengthen its internal controls and to safeguard the \$16.7 million that remained at risk. Further, OIG proposed that ACF advise the Department of this significant program weakness in internal controls, and develop and implement a corrective action plan. Although ACF did not concur with the recommendations, actions have been completed, initiated or planned to correct the problems and management control weaknesses cited in the report. (CIN: A-03-91-00552)

Low Income Home Energy Assistance Program: Puerto Rico

At ACF's request, OIG performed two reviews of the Low Income Home Energy Assistance Program's (LIHEAP's) weatherization program in Puerto Rico to determine fund accountability, recipient eligibility and implementation of the home repair program.

Puerto Rico contracted with the Instituto de Servicios Comunes (INSEC) to implement the weatherization program. Contrary to Puerto Rico's internal regulations, a lump-sum cash transfer of \$3.3 million was made to INSEC by Puerto Rico without considering the immediate cash needs of the program. Further, some of these funds were used for purposes unrelated to weatherization. The balance was deposited into saving certificates, one certificate with an institution which was not authorized by Puerto Rico as a depository of public funds. Eventually, the transferred funds and earned interest were returned to the program. In addition, Puerto Rico did not have procedures to ensure that INSEC complied with Puerto Rico's approved procurement practices, and obtained the required prior approval for subcontracting of program functions and activities. Puerto Rico authorized payments for new construction rather than just for home repairs as required by the LIHEAP statute, and did not enforce collection procedures in cases in which recipients sold program materials.

Puerto Rico agreed with OIG's findings and recommendations regarding fund accountability but did not agree with those regarding the implementation of the home repair program. (CIN: A-02-92-02010; CIN: A-02-92-02013)

State Cost-Benefit Analysis Reports for State Automated Data Processing Systems

The Office of Management and Budget (OMB) raised concerns about the escalating costs of implementing automated data processing (ADP) systems in States. The OIG participated in a joint OMB-led study designed to review the current Federal-State relationship, assess State cost-benefit estimating and determine the extent to which the Federal ADP investment is contributing to reducing welfare dependency.

Although ACF requires the submission of annual cost-benefit reports, ACF did not have reports for OIG's review from three States that were required to submit them. The OIG found no procedures for: tracking the receipt of States' cost-benefit reports; contacting States that fail to submit reports in a timely manner; and analyzing, evaluating and critiquing State submissions. In OIG's opinion, while some of the reports submitted by the States contained useful management information, they failed to accurately account for all costs and benefits, and did not make the required comparison between estimated and actual costs and benefits to date. Moreover, OIG could not find documentation that ACF staff had analyzed the reports sufficiently to detect the shortcomings observed. In its response to the draft report, ACF generally agreed with the findings and offered suggestions to be included in the final recommendations. (CIN: A-12-92-00038)

Older Americans Act: State Implementation

Performance Measure

Five final reports and an action plan resulted from a joint OIG/AoA effort to assess State implementation of Title III of the Older Americans Act (OAA). The OIG undertook this effort, at AoA's request, to allow AoA to strengthen its stewardship of OAA and provide the Commissioner with up-to-date information on implementation of Title III.

The OIG found that States are in general compliance with most of the stewardship, targeting, nutrition, ombudsman and financial management requirements of Title III. There are, however, a number of requirements and programmatic areas that need attention from the States and area agencies. The AoA developed an action plan to address those needs. As a result of this effort, AoA will increase its direct guidance to States on the OAA and related laws and regulations; provide additional training in key programmatic and skill areas; and conduct periodic, standardized reviews of State and area agency implementation of title III and the new title VII programs. (OEI-02-91-01512; OEI-02-91-01513; OEI-02-91-01514; OEI-02-91-01515; OEI-02-91-01516; OEI-02-91-01517)

General Oversight

CHAPTER VI

GENERAL OVERSIGHT

Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities other than financial management (which is discussed in Chapter 1). The Office of the Secretary (OS) will spend \$153 million in Fiscal Year (FY) 1993 to provide overall direction for departmental activities as well as common services such as personnel, accounting and payroll to the individual operating divisions. Central to these activities is the development of the Department of Health and Human Services' (HHS') budget and its execution, as well as the related activities of establishing and monitoring departmental policy for debt collection, cash management, payment of HHS grants and contracts and procurements. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

The OIG has oversight responsibility for these staff division activities at the departmental level. Another major responsibility flows from the Office of Management and Budget's (OMB's) assignment to OIG to audit the majority of the Federal funds awarded to the major research schools, 104 State and local government cost allocation plans, and separate indirect cost plans of about 1,000 State agencies and local governments. In addition, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations.

The OIG's FY 1993 work in departmental management and Governmentwide oversight focuses principally on financial management and managers' accountability for resources entrusted (discussed in Chapter 1), standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance.

Nonfederal Audits

The OMB Circulars A-128 and A-133 establish the audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under the Circulars, these entities are required to have an annual organizationwide audit of all Federal money they receive.

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In FY 1993, OIG's National External Audit Review Center (located in Kansas City) reviewed almost 3,500 reports that covered over \$785 billion in audited costs. Federal dollars covered by these audits totaled \$156 billion, about \$70 billion of which was HHS money.

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

A. Office of Inspector General's Proactive Role

The OIG has taken the following steps in the nonfederal area to ensure adequate coverage of the Department's programs and provide for greater utilization of the data provided:

- Through evaluation and summarization of reported data, OIG is able to provide both basic audit coverage and analyses of trends that could indicate systemic problems within HHS' programs. These systemic problems are brought to the attention of departmental management to improve program administration.
- To ensure audit quality, OIG maintains a quality control program (discussed below) and has taken steps to ensure that adequate guidance is available to the nonfederal auditor.
- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number and through training. During the past 6 months, over 1,500 individuals were provided with technical assistance through OIG's toll free number. In addition, training was provided to certified public accountant societies, State auditor staff, Public Health Service (PHS) program staff, Administration for Children and Families grantees and the National Education Institute on issues related to Circulars A-128 and A-133.
- In August, OIG co-hosted a statewide Single Audit workshop in Kansas City with the Mid-America Intergovernmental Audit Forum. Over 100 State auditors, independent public accountants and Federal departmental officials attended a 2-day session which covered numerous topics, including: OMB Circulars; cash management; indirect costs; audit resolution; Medicaid; foster care; Alcohol, Drug Abuse and Mental Health

block grants; education, labor and transportation programs; universities; and other subjects.

- The OIG also has been heavily involved in the President's Council on Integrity and Efficiency task force on the Single Audit Act and the American Institute of Certified Public Accountants audit.

B. Quality Control

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

Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and issued 1,933 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	1,054
Reports issued with major changes	99
Reports with significant inadequacies	<u>780</u>
Total audit reports processed	1,933

The 1,933 audit reports discussed above included recommendations for HHS cost recoveries totaling \$22.9 million as well as many for improving management operations. In addition, areas were identified for follow-up by OIG auditors.

Resolving Office of Inspector General Recommendations

The tables and schedules below summarize actions taken on OIG recommendations to recover funds or to put them to better use.

A. Questioned Costs

The following chart summarizes the Department's responses to OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs which are challenged because of a violation of law, regulation, grant, etc. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and the Inspector General Act Amendments of 1988.

TABLE I OFFICE OF INSPECTOR GENERAL REPORTS WITH QUESTIONED COSTS			
	<u>Number</u>	<u>Dollar Value</u> (in thousands)	
		<u>Questioned</u>	<u>Unsupported</u>
A. For which no management decision had been made by the commencement of the reporting period ¹	427	\$662,339	\$17,825
B. Which were issued during the reporting period ²	<u>360</u>	<u>\$113,745</u>	<u>\$6,531</u>
Subtotals (A + B)	787	\$776,084	\$24,356
Less:			
C. For which a management decision was made during the reporting period ³ :	376	\$143,398	\$6,646
(i) dollar value of disallowed costs		\$134,057	\$4,815
(ii) dollar value of costs not disallowed		\$9,341	\$1,831
D. For which no management decision had been made by the end of the reporting period	411	\$632,686	\$17,710
E. Reports for which no management decision was made within 6 months of issuance ⁴	87	\$494,766	\$11,302
See Appendix D for footnotes.			

B. Funds Put to Better Use

The following chart summarizes reports which include recommendations that funds be put to better use through cost avoidances, budget savings, etc.

TABLE II
OFFICE OF INSPECTOR GENERAL REPORTS
WITH RECOMMENDATIONS THAT FUNDS BE PUT TO BETTER USE

	<u>Number</u>	<u>Dollar Value</u> (in thousands)
A. For which no management decision had been made by the commencement of the reporting period ¹	99	\$2,360,371
B. Which were issued during the reporting period	<u>40</u>	<u>\$1,192,105</u>
Subtotals (A + B)	139	\$3,552,476
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management ^{2,3}		
(a) based on proposed management action	54	\$282,624
(b) based on proposed legislative action ⁴	<u>8</u>	<u>\$485,000</u>
Subtotals (a+b)	62	\$767,624
(ii) dollar value of recommendations that were not agreed to by management	<u>19</u>	<u>\$754,995</u>
Subtotals (i + ii)	81	\$1,522,619
D. For which no management decision had been made by the end of the reporting period ⁵	58	\$2,029,857

See Appendix D for footnotes.

Legislative and Regulatory Review and Regulatory Development

A. Review Functions

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. During this reporting period, OIG reviewed 124 of the Department's regulations under development and 30 departmental legislative proposals.

In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigative and legislative experience and recommendations highlighted in this and previous semiannual reports. Recommendations made by OIG for legislative and regulatory change can be found throughout this semiannual report.

B. Legislative and Regulatory Development Functions

The OIG also develops a variety of legislative proposals and sanction regulations for the civil money penalty (CMP) and exclusion authorities which the Inspector General administers. During this reporting period, OIG submitted for consideration five separate legislative proposals developed as a result of its experience with administering existing statutory authorities and the need to develop alternative sanctioning approaches.

During this same reporting period, OIG prepared and published final regulations that established two new safe harbors, and amended one existing safe harbor, to provide protection for certain managed health care plans, such as health maintenance organizations and preferred provider organizations, that offer incentives to enrollees or that enter into negotiated reduction agreements with contract health care providers. The OIG also prepared and published a notice of proposed rulemaking which proposed eight additional payment and business practices for safe harbor protection. Five of these proposed safe harbors are particularly important to rural health care providers: investment interests in rural areas; investment interests in ambulatory surgical centers; practitioner recruitment; obstetrical malpractice insurance subsidies; and rural hospital purchase of practice as part of a practitioner recruitment program. The remaining three proposed safe harbors are: investment interests in group practices composed exclusively of active investors; referral agreements for specialty services; and cooperative hospital service organizations.

The OIG continues its development of several other regulations related to the safe harbor provisions under the Medicare and State health care programs' anti-kickback statute, and various rulemaking efforts related to expanding and revising its CMP and peer review organization sanctions authorities.

C. Congressional Testimony and Hearings

The OIG also maintains an active involvement in the congressional hearing process and the preparation and provision of congressional testimony. During this 6-month period, OIG participated in the oversight hearings for the Medicare and Medicaid programs before the House Committee on the Judiciary and the House Ways and Means Committee. In addition, OIG participated in extensive discussions relating to durable medical equipment before the Senate Appropriations Committee, Subcommittee on HHS, Labor and Education. During this same period, OIG also prepared and presented testimony on kickbacks and self-referrals before the Ways and Means Committee, and testimony related to hospital capital costs before the Energy and Commerce Committee, Subcommittee on Oversight and Investigations.

The OIG continues to track all relevant congressional hearings and pending legislation related to a wide range of HHS issues.

Working Capital Fund: Fiscal Year 1992

Performance Measure

The OIG, in conjunction with a public accounting firm under contract with OIG, audited the Working Capital Fund (Fund) of the Office of the Secretary in accordance with the provisions of the Chief Financial Officers Act of 1990 and OMB guidance. Certain internal control structure weaknesses were reported. The Fund did not perform adequate physical inventory of its property and equipment, nor did it perform complete and timely cash account reconciliations. Also, the Fund needs to improve communications and supervision related to the Fund's accounting operations and improve procedural controls over computer software program changes. The Fund concurred with recommendations for corrective actions. (CIN: A-17-93-00007)

Hospital Cost Principles for Federally Sponsored Research Activities

In response to disclosures of the charging of unallowable and unallocable costs to federally sponsored research activities, OMB, in October 1991, revised its Circular A-21 regarding cost principles applicable to federally sponsored research at colleges and universities. Recent OIG reviews of general and administrative and fringe benefit costs under the Medicare program at hospitals revealed the potential for similar claiming of reimbursement for unallowable, unreasonable and unallocable general and administrative costs under federally sponsored research. Accordingly, OIG reviewed HHS-established cost principles for federally sponsored research activities (known as OASC-3) to determine whether they were outdated and whether Circular A-21 should be extended to all research hospitals.

The OIG determined that the OASC-3, which has not been revised in nearly 2 decades, does not always provide clear guidance for determining what types of costs should be allowed and how costs should be allocated. This results in hospitals' interpretations expanding the

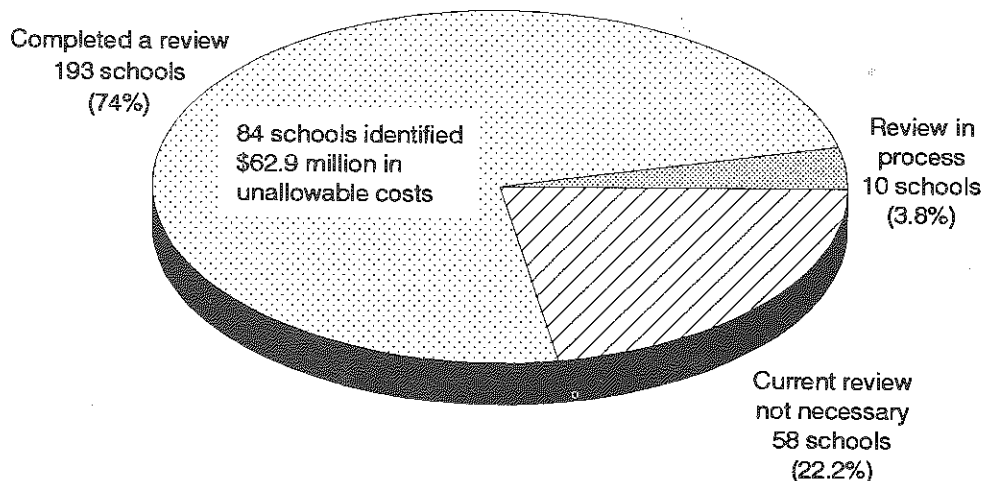
types and amounts of costs which might be included in their indirect cost rate proposals. The OIG recommended that the Assistant Secretary for Management and Budget (ASMB) modernize and strengthen the hospital cost principles by either revising OASC-3, where applicable, to be consistent with Circular A-21, or working with OMB to extend Circular A-21 coverage to all hospitals. The ASMB generally concurred with the recommendations. (CIN: A-01-92-01528)

Internal Indirect Cost Reviews Performed by Colleges and Universities

As part of a continuing joint effort, OIG and ASMB requested that major colleges and universities under HHS cognizance conduct internal reviews of their current procedures (self-scrubs) to ensure that only allowable costs are included in the indirect costs allocated to Federal research.

As illustrated below, OIG found that 193 of the 261 major schools under HHS cognizance had completed self-scrubs as of January 31, 1993 and had identified unallowable costs totaling \$62.9 million. (This did not include \$20.4 previously identified by OIG at 14 schools.) Of the remaining schools, 10 self-scrubs were in process and, for 58 schools, they were unnecessary at this time.

RESULTS OF SELF-SCRUBS



Based on past experience, OIG estimated that approximately 10 percent of the total unallowable cost was allocated to Federal research. The withdrawal of these costs from

allocations to Federal research, therefore, reduces indirect cost rates at various schools from one-tenth of 1 percent to as much as 4 percent. (CIN: A-01-91-04016)

Reimbursement to Educational Institutions and Nonprofit Organizations

The OIG reported that the Financial Accounting Standards Board Statement No. 106 (FASB 106) could materially increase postretirement benefit (PRB) costs claimed for reimbursement by schools and nonprofit organizations conducting federally sponsored research. The FASB 106 changed the treatment of PRB costs from the cash basis to the accrual basis of accounting. Currently, OMB Circulars A-21 and A-122, Cost Principles for Education Institutions and Cost Principles for Nonprofit Organizations, do not state whether the accrued portion of PRB expenses should be recognized as a reimbursable cost. Without guidance as to whether accrued expenses should be charged, scarce Federal research funds may be used to reimburse unfunded PRB costs.

The OIG recommended that ASMB work with OMB to revise applicable cost principles to include PRB costs, and advise HHS negotiators to pay special attention to PRB costs when reviewing fringe benefit rates for schools and nonprofit organizations. The ASMB concurs with the OIG recommendations and intends to incorporate appropriate provisions in OMB Circular A-21 and A-122. In the interim, ASMB has discussed this issue with departmental negotiators and will issue written instructions in the near future. (CIN: A-01-93-04000)

Governmental Accounting

A. Compilation of Reports Issued on Cost Allocation Plans

Each year, State and local governmental entities receive over \$200 billion in Federal grant funds and an equal amount in Federal contract funds. The OIG estimates that at least \$20 billion is related to administrative costs, much of which cuts across all Federal agencies. The OIG is continuing its efforts to look for options to improve the accounting process, strengthen government cost principles and identify cost containment measures that could provide greater flexibility for States and local governments and increase governmentwide efficiency.

As a part of this effort, OIG prepared a compilation of cost accounting issues at State and local governments identified and reported on by OIG since FY 1988. It highlights nine areas in which reports have been issued: internal service funds; self-insurance funds; pensions; unfunded actuarial liabilities; equipment capital leases; Federal Insurance Contributions Act sick pay credits; statewide cost allocation plans; State sales tax; and payroll tax deposits. The report summarizes the results of 51 issued audit reports containing recommendations for improvements, as well as cost containment recommendations totaling

over \$360 million dollars relating to Federal costs principles and one relating to improved payroll tax deposits. (CIN: A-12-93-00052)

B. Collections and Credit Procedures: New York State

The OIG determined that, as a result of the inaccurate reporting of collections and credits for both the Medicaid and Refugee Resettlement programs for the period April 1, 1988 through March 31, 1991, New York received nearly \$14.9 million in excess Federal reimbursement. Further, OIG identified procedural weaknesses in the operation of the State's internal control structure which adversely affected its ability to account for and report on all collections and credits due the Federal Government. New York disagreed with the findings. The Health Care Financing Administration (HCFA) withheld concurrence pending review of additional documentation to be provided by the State. (CIN: A-02-92-02001)

Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome: Nursing Home Discrimination Complaints

The OIG found that The Office for Civil Rights (OCR) handled more than half of the 615 nursing home complaints filed with all public agencies from 1986 through 1991. Most of the remaining cases were handled by State government agencies, and few local agencies were involved. The majority of the 401 complaint cases reviewed by OIG for this inspection involved corrective actions and took an average of 6 months to resolve. The OIG determined that, in general, the complaint system is difficult to use. Public information does not specifically address nursing home discrimination against persons with human immunodeficiency virus or acquired immune deficiency syndrome (AIDS); the investigating agencies are difficult to identify; and those in a position to file complaints are reluctant to do so.

The OIG recommended that OCR: lead a departmental initiative with HCFA, PHS and the Administration on Aging to improve public information about the occurrence of discrimination and where to file complaints; offer technical assistance to State and local governments; and meet its 3-month timeframe for resolving AIDS-related complaints. (OEI-03-91-00960)

Healthy Difference: Information Dissemination

This report provided information about the dissemination strategy of a departmentwide health promotion initiative and data bases used by agencies for mailing out information. In a survey of Healthy Difference recipients, OIG found that over half reported that they did not receive the materials. Further, OIG determined that the data bases provided by the agencies to mail out the Healthy Difference materials cannot be reliably used to disseminate a departmentwide initiative or for evaluation purposes. The OIG recommended that the Assistant Secretary for Public Affairs and ASMB develop guidelines to ensure the accuracy in agency-operated data base systems used to disseminate information. (OEI-12-91-01430)

National Archives Review

The President's Council on Integrity and Efficiency requested that OIG examine possible management problems at the National Archives, including the selection and activities of the Archives' Inspector General, and disclosures of contract bid information by management. The study found significant management and personnel problems with both the Archives top management and with the Inspector General, since departed. (OEI-12-93-00030)

Employee Fraud and Misconduct

The OIG has oversight responsibility for the investigation of allegations of Department employee wrongdoing where it affects internal programs. Most of the thousands of persons employed full time by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities as illustrated in the following cases:

- Three wage-grade Social Security Administration (SSA) employees who were arrested in Maryland, along with another person, for selling cocaine or marijuana to undercover agents pled guilty to drug distribution. Over a 3-month period, the agents purchased drugs on 9 occasions, sometimes on Government property and some with a total of \$1,675 in confidential funds from OIG. The employees were sentenced to several months in the county detention center, probation and community service. Informants have identified other SSA employees as using drugs during work hours on Government property. (3-92-00104-6)
- A former PHS Regional Health Administrator in California, who was also an Assistant Surgeon General (two-star Admiral) in the PHS Commissioned Corps, was sentenced for defrauding the Government. He was sentenced to 5 years probation, 4 months in a halfway house and 4 months home detention with electronic monitoring. He was ordered to pay \$12,950 in restitution, a \$5,000 fine and a \$150 special assessment. He was also ordered to perform 1,000 hours of community service and participate in a mental health program for 5 years as directed by his probation officer. He and seven subordinate PHS managers were involved in a scheme to defraud the Government with respect to travel vouchers and frequent flyer awards. The criminal case on each of the eight individuals charged has been adjudicated in court, and PHS has imposed disciplinary action. None of the commissioned officers involved remains on active duty, and the civil service employees involved were placed on new assignments subsequent to the imposition of administrative and criminal sanctions. (9-90-00557-4)
- A Supplemental Security Income claims representative in Iowa was sentenced to 1 year supervised probation and fined \$400 for unauthorized

access to Government electronic data. He used the SSA data system to obtain confidential information on family members, other SSA employees, acquaintances, former girlfriends and a number of young women for personal reasons. (5-B2-00287-6)

- A technician at the National Institutes of Health (NIH) stole 2.9 grams of cocaine from the laboratory in which he worked, for recreational use. He was terminated from his position, sentenced to 12 months probation and ordered to pay a \$50 special assessment fee. (W-92-00042-4)

Criminal Prosecutions

During this semiannual reporting period, OIG investigations resulted in 633 successful criminal actions. Also during this period, 893 cases were presented for prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors in 714 cases.

The number of convictions in this period has declined from previous reporting periods. Resource constraints in OIG have resulted in fewer criminal investigators and a growing backlog of cases. In keeping with our commitment to the highest priorities, OIG is reducing investigative coverage in some geographic and program areas. Existing staff are being concentrated in States with the most HHS program dollars and being deployed to work on the most serious program violations.

Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act (PFCRA), passed in October 1986, established administrative penalties for anyone who makes a false claim or a written false statement to a Federal agency. It was loosely modeled after the CMP law for the Medicare and Medicaid programs, which OIG is responsible for enforcing. Under PFCRA, any person who makes a claim or statement to the Department knowing, or having reason to know, that it is false, fictitious or fraudulent may be held liable in an administrative proceeding for a penalty of up to \$5,000 per claim or statement. In addition, that person may be subject to an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims or statements, and for reporting at the end of each fiscal year investigations completed under PFCRA and referred for administrative action.

During FY 1993, the following settlements were made under the PFCRA authorities:

- A principal investigator for an NIH grant at a California university agreed to a \$59,500 PFCRA settlement. The man handled salaries for employees working under the grant. He padded the time sheets of one of the employees and forged his signature on the resulting check. The scam was

uncovered when the employee received a wage and tax statement for \$10,000 more than he actually was paid. (9-90-80119-4)

- In Maryland, two SSA employees entered a settlement agreement under PFCRA after submitting inflated claims for taxi and limousine fares while on a training trip. Employees of SSA's publications management division, the two submitted claims for more than double the actual amount of the fares, and supplied no receipts. Both were suspended without pay by SSA for 14 days, and both refunded the amount of their cash advances that exceeded the allowable reimbursement. Under the PFCRA agreement, each also had to pay \$715. This action was the first use of the PFCRA authorities in a case involving travel fraud by employees against the Department. (3-91-80528-6)
- An Iowa woman who applied for and received surviving spouse's SSA benefits 10 years after she had remarried was permitted on appeal to offset the overpayment with the amount she would have received had she applied on her own record. She agreed to pay \$1,000 to settle PFCRA claims. (8-92-80050-6)
- In Wisconsin, a retiree was convicted and sentenced earlier for defrauding SSA by reporting earnings under his wife's Social Security number (SSN) while he was receiving retirement benefits. This year the company for which he worked, the wife of the company president (who was also the former company bookkeeper), and the retiree's wife agreed to pay a total of \$11,000 in settlement of claims under PFCRA for their part in abetting the deception. (5-89-20016-6)

Cooperation with Other Law Enforcement Agencies

Many Federal, State, and local law enforcement and regulatory agencies depend on OIG expertise for assistance in identifying, locating, investigating and prosecuting individuals who have improperly used SSNs in a broad range of illegal activities, including bank and credit card fraud, licensing and income tax fraud, welfare fraud, drug trafficking and racketeering, as well as fraud in programs such as student loans, food stamps and unemployment compensation. Other agencies also benefit from OIG investigations, such as private health insurers, State Medicaid programs and drug regulatory entities. Many of these cases in which OIG participates result in monetary fines, recoveries, restitution or savings for the other agencies. During this period, the monies accruing from these cases amounted to approximately \$12.6 million for other public or private entities.

Appendices

APPENDIX A

Implemented Office of Inspector General Recommendations to Put Funds to Better Use April 1993 through September 1993

The following schedule is a quantification of actions taken in response to OIG recommendations to prevent unnecessary obligations for expenditures of agency funds or to improve agency systems and operations. The amounts shown represent funds or resources that will be used more efficiently as a result of documented measures taken by the Congress or by management to implement OIG recommendations, including: actual reductions in unnecessary budget outlays; deobligations of funds; reductions in costs incurred or preaward grant reductions from agency programs or operations; and reduction and/or withdrawal of the Federal portion of interest subsidy costs on loans or loan guarantees, or insurance of bonds. Total savings during this period amounted to \$3,091.6 million.

OIG Recommendation	Status	Savings in Millions
Health Care Financing Administration		
Medicare Laboratory Reimbursements: The Medicare fee schedule allowances for clinical laboratory tests should be brought in line with the prices physicians are paying for tests purchased from independent laboratories. (OAI-02-89-01910; CIN: A-09-89-00031)	Section 4154 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 reduced the national cap to 88 percent of the median of all fee schedules and limited the annual fee schedule increase for clinical laboratory tests to 2 percent for 1991, 1992 and 1993.	\$270
Intraocular Lenses in Ambulatory Surgical Centers and Hospitals: In a 1988 report, OIG recommended that the Health Care Financing Administration (HCFA) establish a national Part B reimbursement cap of \$200, with a handling fee not to exceed 10 percent, for any intraocular lens (IOL) billed to Medicare. After later studies found that IOLs were available for lesser amounts, OIG issued a report in June 1990 recommending that Medicare pay a flat \$150 for all IOLs. (OEI-07-89-01664; OAI-07-89-01662; OAI-07-89-01661; OAI-07-89-01660; OAI-09-88-00490; OAI-85-IX-046)	Section 4063 of OBRA 1987 mandated a reduction in payment rates for IOL implants. On February 8, 1990, final regulations were published in the Federal Register (55 FR 4526 No. 27). Section 4151(c)(3) of OBRA 1990 maintains the \$200 IOL allowance provided for in the regulations as part of the ambulatory surgical center payment amount, through December 31, 1992.	135
Anesthesia Services: Medicare should pay only the fractional time units for anesthesiologists and certified registered nurse anesthetists rather than rounding up to the nearest whole unit. (CIN: A-07-89-00193; CIN: A-07-88-00080)	Section 6106 of OBRA 1989 specified that anesthesia time units are to be based on actual time and not rounded up.	55
Coverage of Conventional Eyewear: Exclude Medicare coverage of conventional eyewear following cataract surgery. (CIN: A-04-88-02039)	Section 4153 of OBRA 1990 limited Medicare coverage of eyeglasses following cataract surgery to one pair of glasses.	50
Payment Rates for Drug Epogen: Reimbursement for Epogen should be based on units administered rather than a flat rate. (CIN: A-01-90-00512)	Section 4201(c) of OBRA 1990 based the payment rate for Epogen on 1,000 units rounded to the nearest 100 units.	40

OIG Recommendation	Status	Savings in Millions
Conversion Factors Used in the Anesthesia Payment Formula:		
The HCFA should adjust the area-specific conversion factors now used to conversion factors which correlate to geographic multipliers. (CIN: A-07-90-00296)	Section 4103(a) of OBRA 1990 required the Secretary to estimate a national weighted average conversion factor and reduce it by 7 percent.	\$40
Institutions for Mental Diseases:		
The HCFA should seek recovery of unallowable costs claimed by State agencies for Federal financial participation in the care and treatment provided to individuals between 22 and 64 years of age in institutions for mental diseases. (CIN: A-05-92-00024)	The HCFA has initiated recoveries of the unallowable costs and has issued a directive to State agencies to establish internal controls to prevent future unallowable reimbursements.	29.5
Third Party Liability - Indiana:		
The State should make a financial adjustment on the quarterly HCFA-64 report in the amount of \$15.1 million (Federal share) for third party collections. (CIN: A-05-91-00052)	Appropriate financial adjustment was made on the HCFA-64 report.	15.1
Coronary Artery Bypass Graft Surgery:		
The HCFA should negotiate all-inclusive payment prices with selected surgeons and medical centers for providing coronary artery bypass graft surgery to Medicare beneficiaries. A preferred provider option should be considered. Since legislation would be required, a demonstration project should be considered. (OEI-09-86-00076)	Seven hospitals participated in HCFA's pilot heart surgery project, beginning in 1989 for 3 years.	13.7
Low Cost Ultrasound:		
The HCFA should prohibit payment for tests conducted with pocket dopplers, and advocate revisions in procedure codes and reimbursement rates to reflect the different levels of sophistication and quality of the diagnostic information provided. (OEI-03-88-01401; OEI-03-91-00460; OEI-03-91-00461)	The HCFA issued an instruction prohibiting separate payment for tests conducted with pocket dopplers and revised the Physician's Procedural Coding handbook to revise imaging codes for hand-held ultrasound devices.	5.7
Liver Biopsies:		
The HCFA should ensure that payment for all biopsies can be made correctly by recommending that the coding structures be changed so that all biopsies, particularly open needle biopsies, can be properly classified. Further, HCFA should ensure that carriers adjust payment for open biopsies performed in the course of more major procedures. (OEI-12-88-00900; OEI-12-88-00901)	The HCFA made necessary changes to the Physician's Current Procedural Terminology Manual, and will exclude payment for open biopsies which are performed during the course of major surgery.	1.2

OIG Recommendation	Status	Savings in Millions
Social Security Administration		
Social Security Coverage for State and Local Government Employees: Require mandatory Social Security coverage for all noncovered State and local government employees who are not participating in a public employees' retirement system. (CIN: A-02-86-62604)	Section 11332 of OBRA 1990 extends Social Security coverage to most State and local employees not participating in a public employee retirement system. The effective date is July 1, 1991.	\$2,300
General Oversight		
General Administrative Indirect Costs at Colleges and Universities: The Assistant Secretary for Management and Budget (ASMB) should work with the Office of Management and Budget (OMB) to further revise OMB Circular A-21, Cost Principles for Educational Institutions, to clarify the definitions of allowable and allocable costs, clarify certain costs already considered unallowable and add additional categories of unallowable costs. Further, ASMB should continue to provide assistance to colleges and universities where possible regarding implementation of the circular and appropriately implement the 26 percent cap on administrative costs. (CIN: A-01-91-04008)	The ASMB is implementing the 26 percent cap on administrative costs and has estimated that this will reduce indirect costs and make up to \$104 million available for funding on Federal research projects.	104
Preaward Audits: The OIG reviewed contract proposals and contract extensions and provided contracting officials at HCFA and the Public Health Service with reports documenting questioned costs and unsupported costs. (Various CINs)	Contracting officials used OIG recommendations to negotiate contracts at significantly lower rates than originally proposed.	32.4

APPENDIX B

Unimplemented Office of Inspector General Recommendations to Put Funds to Better Use

This schedule represents potential annual savings or one-time recoveries which could be realized if Office of Inspector General (OIG) recommendations were enacted by the Congress and the Administration through legislative or regulatory action, or policy determinations by management. It should be noted, however, that the Congress normally develops savings over a budget cycle which results in far greater dollar impact statements. Savings are based on preliminary OIG estimates and reflect economic assumptions which are subject to change. The magnitude of the savings may also increase or decrease as some of the proposals could have interactive effects if enacted together.

OIG Recommendation	Status	Savings in Millions
HEALTH CARE FINANCING ADMINISTRATION		
Medicare Secondary Payer: Definition Expansion Savings		
Extend the Medicare secondary payer (MSP) provision to include end stage renal disease (ESRD) beneficiaries without limitation. Also, seek legislation making Medicare the secondary payer for all retirees of exempt State and local government agencies, if legislation requiring Medicare coverage and hospital insurance contributions for all State and local government employees, including those hired prior to April 1, 1986, is not enacted. (CIN: A-09-88-00072; CIN: A-10-86-62016)	In the 102nd Congress, H.R. 11 (as passed by the Senate) contained a provision to extend the MSP ESRD provision from 18 to 24 months. However, this provision was not enacted. The proposal to include under Medicare all State and local government employees hired before April 1, 1986 has been included in previous Presidential budgets. Although this proposal was not enacted, OIG continues to advocate this legislation. As an alternative, the Health Care Financing Administration (HCFA) could seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies.	\$2,070
Laboratory Roll-In:		
Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)	The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.	1,100
Indirect Medical Education:		
As an interim measure, reduce the indirect medical education (IME) adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether any adjustment factor is warranted for all teaching hospitals. (CIN: A-07-88-00111)	While the past administration sponsored several legislative proposals to reduce the adjustment factor, none were enacted. The OIG continues to recommend that HCFA reduce the IME adjustment factor to the level supported by empirical data.	1,045

OIG Recommendation	Status	Savings in Millions
Medicare Secondary Payer: Retroactive Recoveries The HCFA should ensure that contractors' resources are sufficient and instruct contractors to recover improper primary payments; ensure that contractors take sufficient action to preclude the loss of backlogged MSP cases (claims where contractors are more than one quarter behind in sending a demand letter) because the recovery period lapsed; implement financial management systems to ensure all overpayments are accurately recorded; and pursue alternative strategies such as contingency contracts, demonstration and incentive programs, or fund collection activities from recovery proceeds. (CIN: A-01-90-00509; CIN: A-01-91-00525; CIN: A-04-91-02004; CIN: A-04-92-02037; CIN: A-04-92-02057; OEI-07-89-01683)	During Fiscal Year (FY) 1992, HCFA provided the contractors an additional \$20 million in administrative funding to reduce the MSP backlog, but the backlog continues. The HCFA has also developed an MSP overpayment tracking system. However, it is not considered a financial management system. In addition, the Department submitted an FY 1994 legislative proposal to establish a payment safeguards revolving fund to provide smoother and more certain funding levels which could result in more consistent and efficient contractor MSP operations. The HCFA submitted a legislative proposal that would establish a cost recovery fund for carriers.	\$961.6
Medicare Secondary Payer: Prospective Savings The HCFA should revise the justification for an FY 1990 legislative proposal, which would require insurance companies, underwriters and third-party administrators to periodically submit employer group health policy (EGHP) coverage data directly to HCFA, and resubmit it for FY 1994; require that employers report EGHP coverage on the Wage and Tax Statement (W-2); revise all Medicare claims forms to require a positive or negative response pertaining to other health insurance coverage; request that the Social Security Administration (SSA) maintain beneficiary spousal information in its master beneficiary record system for use by HCFA; establish a national data bank system containing primary insurance information; assure compliance with all carrier first claim development procedures and collect health insurance information for disabled beneficiaries during the required disability waiting period. (CIN: A-09-89-00100; CIN: A-09-91-00103; OEI-07-90-00760; OEI-07-90-00763)	The HCFA is considering these recommendations and supports the establishment of a national clearinghouse of health insurance information as an alternative. It has taken some measures to prevent mistaken Medicare payments, such as: the initial enrollment questionnaire, the common working file and the implementation of the Internal Revenue Service (IRS)/HCFA/SSA data match project. Corrective action plans have not been implemented on some of OIG's recommendations. Even though the Omnibus Budget Reconciliation Act (OBRA) 1993 includes many MSP provisions, including extending the data match through 1998 and establishing a health claims clearinghouse for all employers who are required to file a Form W-2, OIG continues to recommend that HCFA resubmit the legislative proposal that would require employers and insurance companies to report MSP information directly to HCFA on a quarterly basis. The OIG also continues to recommend that HCFA identify and maintain spousal information.	900

OIG Recommendation	Status	Savings in Millions
Reduce Hospital Capital Costs: Seek legislative authority to continue mandated reductions in capital payments beyond FY 1995. The HCFA should determine the extent of the capital reductions that are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070)	The HCFA did not agree that there were inappropriate cost elements in payment rates, but agreed that there is some validity to OIG's position on excess capacity. The OBRA 1993 reduces the Federal rate for capital payments by 7.4 percent and extends the 10 percent reduction for capital costs for outpatient hospital services through 1998. The OIG continues to recommend that HCFA determine the extent of the capital reductions to fully account for hospitals' excess bed capacity and report that percentage to the Congress.	\$800
Clinical Laboratory Tests: Seek legislation to set the fee schedules at amounts comparable to what physicians are paying laboratories for the same tests; develop policies and procedures to ensure that profiles are more appropriately reimbursed; and work with contractors to simplify the processing of bills from laboratories. (CIN: A-09-89-00031)	The President's FY 1993 budget and legislative program contained a proposal to reduce the cap for reimbursing clinical lab tests to 76 percent of the median of all the fee schedules. However, this proposal was not enacted. The OIG continues to recommend that HCFA seek similar legislation reform for FY 1994.	426
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt policy. The OIG presented an analysis of four options for HCFA to consider including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals which are profitable, and the inclusion of a bad debt factor in the diagnosis-related group (DRG) rates. (CIN: A-14-90-00339)	While HCFA has not submitted a legislative proposal, OIG continues to believe that legislation is needed.	400
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality. (CIN: A-05-89-00055; CIN: A-05-92-00006)	The HCFA proposed to implement OIG's recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. As a final measure, HCFA may submit a legislative proposal to remove these stays from the usual DRG payment methodology.	210

OIG Recommendation	Status	Savings in Millions
Adjust Physician Fee Schedule Payments Based on Site of Service Differentials: Seek legislative authority to expand the reimbursement limitation to physician services provided in additional settings and to expand the definition of services routinely performed in physicians' offices to include a high volume criterion. (CIN: A-05-92-00007)	The HCFA does not concur with OIG's high volume criterion, stating that the expense component of physician payments is statutorily defined. The HCFA is evaluating payments under the physician fee schedule to determine if adjustments should be made for services furnished in additional settings.	\$176.9
Conventional Eye Wear: Exclude conventional eye wear from Medicare coverage for beneficiaries receiving intraocular lens (IOL) implants. (CIN: A-04-88-02039)	The OIG's proposal was partially implemented with the passage of Section 4153 of OBRA 1990 which limits coverage to one pair of eyeglasses following cataract surgery with an IOL implant. However, OIG continues to recommend that HCFA seek legislation to exclude all conventional eyeglasses following certain cataract surgery.	158
Outpatient Surgery - Cataract Quality of Care Costs and Unnecessary Endoscopies: The HCFA should reduce the incidence of payments for medically unnecessary and poor quality cataract surgeries, upper gastrointestinal endoscopies and colonoscopies through a combination of efforts by PROs and carriers, including targeted review of certain providers. (OEI-09-88-01005; OEI-09-88-01006)	The HCFA has developed a new strategy for PROs which is intended to reduce poor quality and unnecessary care across the board.	106.1
Reduce Medicare Payments for Hospital Outpatient Department Services: Establish a legislative initiative to reduce the current payments for services in outpatient departments to bring them more in line with ambulatory service center (ASC) approval payments. Pay outpatient departments the ASC-approved rate or adjust hospital payments by a uniform percentage. (CIN: A-14-89-00221; OEI-09-88-01003)	The HCFA developed a legislative proposal which was contained in the FY 1992 President's budget. However, the proposal was not passed and HCFA believes that such a proposal will not be passed in the future. The OIG continues to believe that its recommendation is valid.	90
Inpatient Psychiatric Care Limits: Develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (CIN: A-06-86-62045)	The Department considered an FY 1993 legislative proposal recommending that the 190-day lifetime limit to psychiatric admissions be extended to general hospitals. However, the proposal was not included as part of the President's FY 1993 budget. The OIG continues to recommend that HCFA seek legislation to correct the problem.	47.6

OIG Recommendation	Status	Savings in Millions
Recover Medicare Payments Made for Beneficiaries Eligible for Other Government Health Insurance: Recoup past unauthorized payments and prevent future improper payments. With respect to past unauthorized payments, send letters to each Uniformed Services Treatment Facility (USTF) requesting that each refund all Medicare payments received on behalf of USTF patients. With respect to preventing future improper payments, send a letter to each USTF clarifying existing policy that Medicare should not pay for care provided to a patient eligible for the USTF program. (CIN: A-14-90-00325)	The HCFA is currently in the process of preparing a claim to the Department of Defense (DOD) to recoup past incorrect payments. Legislation requires that DOD and the Department of Health and Human Services' OIG audit the claimed amount. The OIG will also evaluate the effectiveness of HCFA's actions to reduce/preclude future incorrect payments.	\$40
Monitored Anesthesia The HCFA should study the appropriateness of paying the same amount for monitored anesthesia care and general anesthesia in view of the fact that other insurers are more restrictive than Medicare. (OEI-02-89-00050)	The HCFA does not concur with this recommendation.	28
Further Reduce Medicare's End-Stage Renal Disease Rates: Reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)	The HCFA agreed that ESRD facilities have become more efficient in their operations and that the composite payment rate should reflect the costs of outpatient maintenance dialysis treatment in an efficiently operated renal facility. However, OBRA 1990 prohibited HCFA from changing the ESRD composite rates. The HCFA should seek legislation to reduce payment rates to reflect the current market value.	22
Establish Mandatory Prepayment Edit Screens for Medicare and Medicaid: The HCFA should move swiftly with the process of establishing mandatory prepayment edit screens for the Medicare and Medicaid programs. (CIN: A-03-91-00019)	The HCFA believes that the OIG approach does not consider the carriers' responsibility to establish Medicare coverage and payment policy when there is no national HCFA policy. The OIG disagrees. Good internal control procedures would require basic edit checks to ensure that the procedure codes are not manipulated.	12.9

OIG Recommendation	Status	Savings in Millions
SOCIAL SECURITY ADMINISTRATION		
Close Loopholes Affecting the Federal Insurance Contribution Act Wage Base: Require that salary reduction agreements established under Internal Revenue Code cafeteria plans be included in the definition of wages for Federal Insurance Contribution Act (FICA) purposes. (CIN: A-05-86-62602)	Although SSA generally supported expansion of the FICA wage base, it did not believe that it was appropriate to seek legislation at this time. The HCFA said that it will give the proposal further consideration should the Administration decide to examine ways to expand the tax base.	\$1,247
Lodging Compensation: Include permanent lodging compensation for FICA coverage. (CIN: A-09-90-00050)	The SSA did not support the recommendation since it results in different Social Security and IRS treatment of the value of employer-supplied lodging and the IRS indicated the proposal could be difficult to administer. The OIG pointed out that other similar provisions are currently being administered.	221
Expand Mandatory Tip Reporting Requirements: Expand the requirements for mandatory reporting of tip income to include other types of businesses where tipping is a common practice. (CIN: A-09-89-00072)	Although SSA supports OIG's efforts to expand tip reporting requirements, it believes that any proposal to change the requirements would be within the jurisdiction of IRS. The IRS has not supported this proposal.	134
Recover Value Lost to the Trust Funds from Past Due Debts: Institute a policy change to allow recovery for each delinquent overpayment at the higher of the interest income lost to the trust funds or the value lost to the trust funds due to inflation. (OAI-03-88-00680)	The SSA disagrees with the proposed method of recovery in the absence of a clear legislative mandate. The OIG remains convinced that the recommendation is appropriate.	112
First Month of Eligibility: The SSA should submit a legislative proposal establishing a consistent definition of eligibility for age-based retirement and survivor payments. (OEI-12-89-01260)	The SSA did not agree with the recommendation and thought that it should be supported with a stronger rationale.	40

OIG Recommendation	Status	Savings in Millions
Overpayments to Supplemental Security Income Recipients: (CIN: A-07-91-00376)	The SSA concurred that improved reporting by nursing homes to SSA of admissions of Supplemental Security Income beneficiaries could prevent overpayments and that nursing homes should report this information directly to SSA. However, SSA believed that appropriate regulations should be pursued through HCFA. The HCFA did not concur since it did not believe the recommendation should be pursued via a Medicaid regulation. The OIG, SSA and HCFA are attempting to reach a consensus as to how to implement the recommendation.	\$22
Develop Cost Standards for Disability Determination Services: The SSA should adopt the reimbursement method for laboratory fees used by Medicare for use by the disability determination services (DDSS). (OAI-06-88-00820)	The SSA had been considering a proposed rulemaking which would apply the Medicare laboratory fee schedule for use by DDSs, but deferred action until more experience was gained using a new consultative examination regulation. However, recent feedback on the regulation indicates that there is not enough information to implement the Medicare fee schedule. Moreover, due to budget and resource limitations, SSA plans to defer action on this recommendation until the issue is addressed in the health care reform bill.	15.3
Unreported Workers' Compensation: The SSA should expedite current negotiations and consider expansion of information exchange agreements with several States. A pilot exchange should be conducted to determine the most efficient method of obtaining workers' compensation (WC) information. If the pilot proves to be cost-effective, SSA should seek legislation to require States to identify WC recipients. (OEI-06-89-00900)	The SSA is negotiating with a State for a pilot WC information exchange agreement to determine the efficacy of legislation to require States to provide SSA with WC information.	11.7

OIG Recommendation	Status	Savings in Millions
Revise Criteria for Waiving Overpayments: The SSA should seek a regulatory or combined regulatory/statutory change to the current waiver policy so that waivers are not granted to individuals under 59 years of age. These individuals would still be entitled to consideration of their financial condition using the current criteria for financial hardship. However, if SSA determines that the individual's current financial condition does not permit repayment, the collection effort would be suspended or terminated rather than waived. This would allow SSA to seek recovery if and when a debtor is financially able to repay the debt. (CIN: A-05-90-00034)	The SSA did not concur. It questioned the cost-effectiveness and equity of the proposal.	\$9
Collect Nonresident Alien Taxes: Use SSA's automated systems to identify retroactive nonresident alien taxes due and develop procedures to facilitate collection by the automated system. (CIN: A-13-90-00041)	The SSA replied that it agreed with OIG's recommendation. The SSA is designing the needed automated systems. Changes and implementation are scheduled for FY 1994. The SSA indicated that these cases would not be worked until the process is automated.	7.7
Recover Supplemental Security Income Benefits through Income Tax Refund Offset: Take administrative action to recover certain Supplemental Security Income (SSI) overpayments through income tax refunds. (OAI-12-86-00065)	The SSA has implemented tax refund offset to recover Retirement, Survivors and Disability Insurance overpayments. In consideration of the potential for a relatively small collection of delinquent debt and other priority demands for available resources, SSA has postponed implementation of tax refund offset for SSI debt until 1995.	6
New Cards for New Brides: The SSA should actively pursue the acquisition of computerized marriage records from States having this capability. (OEI-06-90-00820)	The SSA agreed with this concept, but will study quantitative and cost issues before agreeing to implement.	5.5

OIG Recommendation	Status	Savings in Millions
PUBLIC HEALTH SERVICE		
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to various functions performed by the Food and Drug Administration (FDA), possibly including premarket review and approval for drugs and devices, inspections of additional manufacturing facilities, and inspections of food processors and establishments. (OEI-12-90-02020; CIN: A-12-88-00004)	The President's FY 1993 budget included a provision to assess fees totaling \$200 million, which were intended to recover the cost of certain Food and Drug Administration (FDA) activities, such as processing premarket applications and registering manufacturers and regulated products. The Prescription Drug User Fee Act of 1992 only covers application and registration fees for prescription drugs. This concept may be extended to other products that FDA regulates, such as foods and medical devices.	\$200
Recover Grant Funds Awarded for the Construction of Community Mental Health Centers: The Substance Abuse and Mental Health Services Administration (SAMHSA) should initiate recovery action on grants awarded in excess of \$6.8 million (Federal share for 13 grants) from 9 grantees not providing essential and below-cost or free services, and determine whether an additional \$235,000 plus interest can be recovered from one grantee. (CIN: A-05-91-00050)	The SAMHSA is scheduling visits to all community mental health center grantees over the next several years to determine if grantees are complying with waiver conditions and are now providing all essential services.	7
Reduce Unneeded Health Care under Urban Indian Health Programs: Promptly implement procedures to comply with legislative requirements regarding annual evaluations of individual urban Indian health projects, and the evaluation of ongoing and future proposals for direct health care services for urban Indians. Eliminate or reduce direct health care services provided in areas where the services duplicate services already accessible in the community and where the extent of Indian utilization does not support the need for Indian Health Service (IHS) services. (CIN: A-09-86-63001)	The Public Health service concurs but has not completed corrective action. The IHS will be developing an instructional manual during the fourth quarter of FY 1993 that will be used to assess the need for direct care services in urban areas where there may be duplication or low utilization.	5.6

OIG Recommendation	Status	Savings in Millions
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Reducing Federal Financial Participation: The Administration for Children and Families (ACF) should consult with the Congress on modifications to the Federal Medical Assistance Percentages formula which would result in distributions of Federal funds that would more closely reflect per-capita-income relationships. (CIN: A-06-90-00056)	The ACF did not agree with the recommendation.	\$1,100
Limit Federal Participation in States' Costs for Administering the Foster Care Program: Limit Federal participation in Foster Care administrative costs through one of the following actions: limit future increases in administrative costs to no more than 10 percent per year; fund administrative activities via a single block grant with future increases based on the consumer price index; limit administrative costs to a percentage of maintenance payments; or restrict, through legislation, the filing period for retroactive claims, namely require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. (CIN: A-07-90-00274)	The ACF agreed that the issues identified are worthy of further examination. Options presented in the report include legislative changes; modifying the methodology for conducting administrative cost reviews; and requiring States to uniformly identify and account for administrative costs. The 102nd Congress did not act on the proposed legislation to combine the administrative and training authorities under title IV-E to a new capped entitlement program. No additional proposals have been submitted at this time.	340
Reduce Incentive Payments and Base Them on States' Performance: Base incentive payments on the States' demonstrated ability to meet Federal child support enforcement (CSE) requirements and performance objectives. Also, consider OIG recommended options to reduce financial incentives realized by States that would result in a more equitable cost sharing with the Federal Government. These options are: limiting incentives to a break-even point where a State's share of Aid to Families with Dependent Children collections plus incentive equal the State's share of CSE costs; eliminating incentives to poor performing States; and reducing the Federal share of administrative costs. (CIN: A-09-91-00147; CIN: A-09-91-00034)	The ACF proposed for legislative action a new incentive plan, but has not agreed with OIG-recommended options. The ACF proposal requires the incentive funds to be reinvested in child welfare programs instead of just the CSE program. The OIG plans to assess ACF's proposed plan to determine whether it is equitable.	277
Limit Period of Emergency Assistance to 30 Days: Revise current emergency assistance regulations to limit benefits to one period of 30 consecutive days or less in 12 consecutive months. (CIN: A-01-87-02301)	The 102nd Congress did not act on this legislation prior to adjournment. No additional proposals have been submitted at this time.	22

OIG Recommendation	Status	Savings in Millions
Low Income Home Energy Assistance Program - Duplication of Benefits: The ACF should continue its effort to seek a change in the Low Income Home Energy Assistance Program (LIHEAP) statute that will explicitly allow States to consider other home energy assistance received by applicants before LIHEAP grants are made. (CIN: A-04-90-00005)	The ACF agreed and submitted a legislative proposal. The ACF is planning to resubmit the proposal as part of its FY 1994 legislative package.	\$14.4
GENERAL OVERSIGHT		
Disallow Interest Charges on Unfunded Liabilities of Government Pension Plans: The Office of Management and Budget (OMB) should revise Circular A-87 limiting Federal sharing of actuarially determined pension costs, including amortization of unfunded liabilities, to situations where the State and local governmental unit is funding such cost through an actuarially sound plan. Interest cost caused by late funding should not be allowed. (CIN: A-09-87-00031)	Because of the sensitivity and financial impact of the proposed changes on the State and local governmental entities, OMB has expended considerable effort working with State and local interest groups prior to issuance as a draft proposed rule change. The OIG continues to recommend that OMB clarify the rule relating to pensions by finalizing revisions to Circular A-87.	1,300
Accelerate Federal Grantees' Deposits of Payroll Taxes: Require recipients of Federal funds to deposit payroll taxes on the same day Federal funds are drawn down to meet payroll needs. (CIN: A-12-88-00110)	The recommendations are being considered by OMB in its initiative to develop cost containment proposals. Corrective action is pending implementation of the Cash Management Reform Act.	103.4
Recover Federal Share of Excess Reserves in Self-Insurance Funds: The OMB should revise Circular A-87 to tighten standards for charging of self-insurance funds to Federal programs and improve reporting by the States on fund operations, condition and funds flow. (CIN: A-04-90-00018; CIN: A-05-88-00082; CIN: A-02-88-02010; CIN: A-04-88-00061; CIN: A-03-91-01450; CIN: A-04-90-00019; CIN: A-04-91-00023; CIN: A-04-88-00060; CIN: A-04-90-00020; CIN: A-10-86-86-60450; CIN: A-03-91-14562; CIN: A-03-92-00603; CIN: A-04-91-00024)	The OMB has developed changes to its cost principles that will tighten the standards and improve reporting on self-insurance funds. The OMB will seek and consider public comments before finalizing revisions to Circular A-87. The OIG continues to recommend that OMB clarify all rules on self-insurance funds by finalizing revisions to Circular A-87 cost principles.	76

OIG Recommendation	Status	Savings in Millions
Disallow State Sales Tax Charged to Federal Programs: The OMB should review Circular A-87 to disallow payment of self-assessed State sales tax as charged to Federal programs. (CIN: A-04-87-00040)	The OMB has developed a change to Circular A-87 cost principles that will disallow payment of self-assessed sales and similar taxes as an allowable cost to Federal programs. The OMB will seek public comments and make changes as appropriate. The OIG continues to recommend that OMB clarify the rules relating to charging of State sales taxes by finalizing revisions to Circular A-87.	\$54

APPENDIX C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

OIG Recommendation	Status
HEALTH CARE FINANCING ADMINISTRATION	
Kidney Acquisition Cost: The Health Care Financing Administration (HCFA) should establish uniform fiscal oversight of the organ acquisition costs of all Medicare artificial organ procurement organizations. (OEI-01-88-01331)	The HCFA largely disagrees with this recommendation. Further resolution of this issue is being pursued.
Medicare Carrier Assessment of New Technologies: The HCFA should foster greater consistency among carriers in their coverage and pricing decisions, by providing carriers with selective access to comparative information on new technologies, reviewing carrier performance and working with the Public Health Service (PHS) to disseminate information on new health care technologies. (OEI-01-88-00010)	The HCFA indicated that it recognized the problems with the carrier assessment of new technologies and had taken steps to correct the problems. The OIG plans to conduct a follow-up study to determine if effective actions have been completed.
Carrier Maintenance of Provider Numbers: The HCFA should establish adequate safeguards for detection of abusive providers. (OEI-06-89-00870)	The HCFA is taking steps to address the problems identified in the report, which OIG will monitor. The HCFA agreed to issue a modification to the Medicare Carrier Manual which will clearly state that carriers have a responsibility to ensure the integrity of provider numbers and that only those practitioners and providers with legal authority to practice are given and may retain provider numbers. Further, it will require carriers to: stay abreast of changes in relevant laws and regulations concerning medical practice requirements; make every reasonable effort to receive, on an ongoing basis, information from State licensing authorities and other appropriate bodies about the currency of licenses; and maintain provider number applications for at least 6 years after deactivation of the number.
Independent Physiological Laboratories: The HCFA should increase its monitoring of independent physiological laboratories (IPLs), including determining what testing is appropriate in IPLs, and establishing a regulatory or certification program to promote stronger quality assurance in IPLs. (OEI-03-88-01400)	Although it will not pursue the actions outlined in the recommendations, HCFA is studying data from Medicare carriers and its regional offices to determine if it is necessary to regulate or set standards for these laboratories.

OIG Recommendation	Status
Review of Medicare Bill and Claim Processing - Opportunities for Long Term Improvement: The HCFA should initiate a strategic planning effort to determine the feasibility of further streamlining Medicare operations through standardization, consolidation and system integration. Further, HCFA should include the initiative in its information resources management (IRM) strategic plan submission to the Department. (CIN: A-14-91-02532)	The HCFA was largely in agreement with the recommendations and believes that in several instances it has already taken corrective actions.
Review of HCFA's Implementation of the Project to Redesign Information Systems Management: The HCFA should include in its IRM plan a discussion of how it intends to assign duties of sufficient scope to, and maintain the independence of, its principal IRM official (PIO). Also, the Assistant Secretary for Management and Budget (ASMB) should review HCFA's implementation of recently issued departmental IRM policy, particularly with respect to assignment of PIO duties. (CIN: A-14-91-02533)	The HCFA disagrees because it believes that the duties of the senior IRM official in HCFA are properly assigned within HCFA's organizational structure. The ASMB has issued several IRM policies to improve the planning and management controls of departmental operating division IRM programs.
Improve HCFA's Federal Managers' Financial Integrity Program: The HCFA should enhance the tests used to evaluate the contractors' claims processing internal controls and consider reclassifying risk assessments of internal control areas that are pending material weakness and high risk areas to a high risk rating. (CIN: A-14-91-03413)	The HCFA agreed and has established a contractor claims processing internal control task force. The HCFA believes a moderate risk rating is appropriate for some high risk areas.
Implement Proper Accountability over Billing and Collection of Medicare Drug Rebates: The HCFA should ensure that States implement accounting and internal control systems in accordance with applicable Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current and complete disclosure of drug rebate transactions and provide HCFA with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (CIN: A-06-92-00029)	The HCFA concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The HCFA expects to have regulations in place by January 1994.

SOCIAL SECURITY ADMINISTRATION

False Evidence Submitted to Obtain a Social Security Number:

The Social Security Administration (SSA) should systematically identify all original Social Security number (SSN) applications from U.S.-born applicants over age 24 and require a second level review of such applications. (OEI unnumbered management advisory report, October 1987)

The SSA has implemented a manual control process to verify the evidence submitted for U.S.-born applicants age 18 and older. This process requires management verification and authorization of SSN issuance. Additionally, SSA is making systems changes to allow entry of the reviewing manager's personal identification number to complete these transactions.

OIG Recommendation	Status
Social Security Payments for Vocational Rehabilitation: The SSA should require the States to establish a formal mechanism to screen and enroll those SSA clients who show the greatest potential for successful rehabilitation. (OAI-07-89-00950)	The SSA is reviewing the entire area of vocational rehabilitation referral, and has established a task force with the Rehabilitation Services Administration to jointly develop a framework for better screening mechanisms and a more effective referral process.
Suspended Payments Need to be Resolved Timely: The SSA should, in direct deposit cases where the beneficiary is placed in suspense status, institute stronger controls to ensure that timely action is taken to resolve these suspensions so that SSA can either terminate or reinstate payments. (CIN: A-13-89-00027)	The SSA agreed to proceed with policy and procedural changes.
Modernized Claims System Needs Controls to Compensate for Lack of Separation of Duties: The SSA needs to implement controls in the modernized claims system since employees are authorized to take, develop, adjudicate and effect payment on a claim without any independent review or compensating controls. (CIN: A-13-89-00025)	The SSA generally agreed and has proposed corrective action.
Further Improvements Necessary to 800 Number Telephone System: The SSA should decrease the number and increase the size of telephone centers, make better use of technology and back-up agents to increase handling capacity and accuracy, and initiate a pilot to determine whether the telephone centers could become full service centers. (CIN: A-09-90-00071)	The SSA has referred the issue of the number and size of the telephone centers to a work group for evaluation. It has included evaluation of technological improvements in its service delivery plans and has expanded use of back-up units in its program service centers. The SSA did not support the concept of full service centers for the 800 number system.
Project Clean Data: The SSA should develop, maintain and widely disseminate a software package for detecting invalid SSNs patterned after Project Clean Data. (OEI-12-90-02360)	The SSA agrees with the objective but believes greater use of the enumeration verification system would be more effective. The SSA is conducting a pilot test to assess employer interest and use.
Drug Addicts and Alcoholics: The SSA should work with PHS and HCFA to develop clearer definitions for drug addiction and alcoholism status, treatment and successful rehabilitation. (OEI-02-90-00950)	The SSA agreed that significant improvements are needed in this process and has convened a work group to improve the definitions of drug addiction and alcoholism status, treatment and successful rehabilitation. The SSA has also formed an intercomponent steering committee to address concerns relative to the drug addiction and alcoholism program.
Delayed Notices of Planned Action: Because of the potential cost implications of field office failure to maximize opportunities for overpayment avoidance by using manual notices of planned action in the Supplemental Security Income (SSI) program, OIG recommended that SSA initiate a review to determine the extent of the problem. (OEI-04-90-02160)	The SSA had already planned a comprehensive review of the same subject. The OIG will defer its actions until after the results of SSA's studies are compiled.

OIG Recommendation	Status
Improvements Needed in Processing Delayed Claims: To improve the processing of claims in delayed status, SSA should: emphasize that field personnel follow operating procedures; clarify operating procedures; modify the SSA claims control system to eliminate manual work; identify and review all claims in delayed status more than 6 months; and establish a systematic follow-up control. (CIN: A-06-88-00037)	The SSA generally agreed and stated that changes have been made or are in the process of being made. The SSA has emphasized the importance of operating procedures and clarified them. Planned enhancements to SSA's workload management system will include automated controls for all delayed claims. The SSA agreed to review all cases in delayed status for 6 months or more and will evaluate a systematic follow-up control.
Better Controls Would Help Post More Earnings to Wage-Earners' Accounts: The OIG made 29 recommendations which, if implemented, should substantially improve SSA's capability for correcting name and SSN errors for reported earnings. (CIN: A-13-89-00040)	The SSA agreed with most of the recommendations. It has started to implement some of these as well as other recommendations made by its own work group convened to explore wage reporting problems.
Work Incentives for Disabled SSI Recipients: The Commissioner of SSA should take the lead in organizing efforts to identify and study ways to encourage employers to hire severely disabled workers. (OEI-09-90-00020)	The SSA believes that coordination of agency efforts is a good idea, but that it should not assume the lead for such a Governmentwide effort. However, SSA has initiated several pilots to test different approaches to encourage the disabled workers to return to work.
Wage Certification: The SSA should expeditiously seek congressional guidance on the proper method for certifying wages so that proper revenue amounts are credited to the trust funds. (CIN: A-13-91-00206)	The SSA expects at some future date to replace the interim certification with a final one. The SSA agreed with the importance of determining the most appropriate methodology, and has sought the views of the General Accounting Office, which provided options and methods for consideration.
Supplemental Security Income Accounts Payable: The SSA needs to identify the problems in the SSI accounts payable system, document the causes and integrate the solution into a systemic plan. (CIN: A-13-91-00206)	The SSA agreed to initiate the recommended actions.
Security of Manually Issued Social Security Number Cards: The SSA should reconcile (daily) blank SSN cards dispensed to cards typed and voided, and involve supervisors with the reconciliation and the flow of blank SSN cards. It should also establish tighter controls over the mutilated card process. (CIN: A-13-91-00204)	The SSA agreed with the recommendations and indicated that it has taken corrective action to strengthen the internal controls over the processing and issuance of manually prepared SSN cards.
Telecommunications Management: The SSA should test new telecommunications technology after first identifying those functions where it can have the most impact on reducing costs and improving service. It also needs to monitor procurement and perform a needs assessment regarding video services. (CIN: A-09-91-00105)	The SSA concurred and will continue to work on a sound network strategy and an evaluation of emerging technology. It will focus on optimum utilization in a cost-effective manner.

OIG Recommendation	Status
Central Computing Strategy: The SSA's data systems are highly centralized and need to be protected against down-time or catastrophic failure. (CIN: A-13-89-00041)	The SSA is continuing to evaluate and proceed with distributed data processing alternatives. The back-up and recovery plan, however, was addressed and completed in June 1993 when a contract was awarded. The contract will provide resources to support online and batch systems in the event of a major outage at SSA's National Computer Center.
Death Match Operation: The SSA should: build an appropriate management information system into future death match enhancements to help monitor performance and detect errors; correct and continue to process certain rejected death records; and generate death verification alerts for all suspended beneficiaries so their payments can be terminated. (CIN: A-13-90-00046)	The SSA agreed to address the recommendations in planned systems modification projects.
Accelerate Efforts to Improve the Systems Providing Overpayment Accounting Data in the Debt Management System: The SSA should accelerate efforts to develop a comprehensive plan for replacing Retirement, Survivors and Disability Insurance and Supplemental Security Income (SSI) "back-end" processes (programmatic systems providing overpayment accounting data). (CIN: A-13-92-00216)	The SSA agreed. It is now developing a debt management transition plan, which will document "back-end" processing with the debt management system.
Establish Better Controls to Help Prevent or Detect Duplicate Payments to Attorneys: The SSA should: document a procedure instructing employees to look up attorney fee payments that may have been previously recorded before making any payment; modify the automated system with a control to detect duplicate payments to attorneys; review all potential duplicates identified by OIG for Calendar Year 1991 and begin recovery procedures; and periodically identify and review cases that contain two or more identical attorney fee payments to determine if a duplicate payment was made. (CIN: A-13-92-00219)	The SSA concurred and plans to take corrective action.
Improve the Printing and Mailing of Social Security Cards: The SSA should improve security of Social Security Number (SSN) cards in the loading dock area, better account for each SSN card printed or spoiled, and reduce the number of undeliverable SSN cards. Security and control should be improved in the mailing operation, and improvements should be required of the mailing contractor. (CIN: A-13-90-00047)	The SSA agreed and is taking corrective action.
PUBLIC HEALTH SERVICE	
National Practitioner Data Bank - Controls over Authorized Agents: The PHS should revise Data Bank forms and procedures in order to strengthen controls over authorized agents. (OEI-12-90-00530)	The PHS has prepared, in draft form, revised guidelines for dealing with authorized agents.

OIG Recommendation**Status**

Fully Implement Internal Controls in the Food and Drug Administration's Medical Device 510(k) Review Process:

The OIG recommended that the Food and Drug Administration (FDA) modify its exception report for use on a quarterly basis to detect possible manipulation of the 510(k) process; periodically sample reviewer workload to ensure compliance with the "first-in; first-reviewed" policy; require reviewers to document responses to all items on the review checklist; conduct bioresearch monitoring inspections on devices likely to result in 510(k) submissions; complete postmarket testing of the four devices it selected for review and increase the number sampled for future tests; include in its quality control reviews an independent scientific evaluation of reviewers' 510(k) decisions; and periodically monitor employee compliance with procedures for employee/industry contacts. (CIN: A-03-92-00605)

In a September 2, 1993 status report to OIG, PHS reported that FDA has made significant progress in rectifying deficiencies in this program area, and that it will continue to monitor FDA's efforts until all corrective actions are implemented.

Improve Public Health Service Controls over Technology Transfers and Royalty Income:

The National Institutes of Health (NIH) should improve procedures to properly record patents, account for foreign patent rights and work with the Department of Commerce to monitor licensing and royalty areas. The NIH should also disclose a material internal control weakness in technology transfer and royalty income areas in the next Federal Managers' Financial Integrity Act (FMFIA) report. (CIN: A-01-90-01502)

The NIH partially concurred with OIG's recommendations. It had to reconcile its records related to the status of its patents, make adjustments to its system for training its employees regarding foreign patents and monitoring license agreements. The NIH did not agree that deficiencies in this area constituted a material weakness.

Tighten Controls of the Advance Payment System Used by the Indian Health Service to Advance Cash to Contractors and Grantees:

The PHS should: consider reporting the problems identified in the advance payment system (APS) used by the Indian Health Service (IHS) to advance funds to its contractors and grantees as a material internal control weakness or a material nonconformance under FMFIA; assess the propriety of funds advanced to 16 contractors who commingled IHS funds with their other funds; and evaluate alternatives for improving the current system of advancing funds to IHS contractors and grantees. (CIN: A-06-90-00001)

In a January 27, 1993 status report to OIG, PHS reported that corrective actions have been taken or planned to implement recommendations in the subject report. Among the key actions taken were: the declaration of a material internal control weakness in APS and the decision to transfer the advance payment function from APS to the departmental payment management system (PMS). In addition, IHS has begun the orderly transfer of area office tribal contracts to PMS and expects to complete this process by the end of Calendar Year 1994.

Properly Justify the Acquisition of Computer Equipment and Services at the Centers for Disease Control and Prevention:

The ASMB should suspend the delegation of procurement authority for the Centers for Disease Control and Prevention's (CDC's) planned acquisition until CDC demonstrates the need for and cost benefit of the acquisition; direct PHS to require that CDC document its requirements analysis and the costs and benefits of the planned acquisition of microcomputers; and review the role of PHS in reviewing proposed computer acquisitions. The Assistant Secretary for Health (ASH) should require CDC to document its requirement analysis and the costs and benefits, and review the role of PHS in reviewing the proposed acquisition. (CIN: A-15-92-00016)

The ASMB and ASH agreed with OIG's recommendations. Accordingly, the delegation of procurement authority was withdrawn until CDC resubmitted a revised cost benefit and requirements analysis.

ADMINISTRATION FOR CHILDREN AND FAMILIES**Summarization of Head Start Grantee Audit Findings:**

The Administration for Children and Families (ACF) should increase training and technical assistance to grantees; strengthen procedures regarding grantee monitoring and use of interest bearing accounts, and refunding interest income; implement the new audit requirement for nonprofit organizations administering Federal programs; develop procedures to detect grantees with interfund transfers; reevaluate procedures to ensure that excess cash is not drawn; and obtain evidence that excess balances are collaterally secured when awarding grants. The ACF should also reemphasize that the nonfederal match is properly documented and met; require evidence of current licensing or compliance with all of the facility standards; and emphasize use of sales tax exemptions and timely deposits of tax refunds. (CIN: A-07-91-00425)

The ACF is in general agreement with the recommendations.

Child Support Enforcement Payments - Financial and Program Implications:

Incentives should be based on the States' demonstrated capability to meet Federal child support enforcement (CSE) requirements and performance objectives. In addition, the Office of Child Support Enforcement should continue its efforts to revise the CSE incentive formula to be more equitable for both the States and the Federal Government. The OIG also have recommended various options for legislative changes to increase the effectiveness and efficiency of the CSE program. (CIN: A-09-91-00147)

The ACF agreed with the thrust of the OIG recommendations, indicating it will continue to pursue the adoption of its legislative proposal on performance-based incentives. It was submitted to Congress in February 1992. The ACF submitted a budget proposal to revise the method of calculating incentives. The ACF agreed that the restructuring of incentives would facilitate improvements.

Protect Federal Interest in Real Property Acquired by Grantees:

The ACF should establish a management information system to identify, track and monitor real property purchased with grant funds. The management information system should include the date, type, location and cost of property purchased. (CIN: A-12-90-00020)

The ACF implemented the Office of Community Services grants tracking and monitoring computer system in 1990 to identify, track and monitor real property that was purchased with Federal grant funds. According to ACF's corrective action plan, this material weakness' targeted correction date is Fiscal Year 1993. A corrective action review will be performed within 1 year from completion date.

Improve Management of Community Services Discretionary Grants:

The ACF should: develop grant policies and procedures that implement the Department's grants administration manual; provide adequate oversight of external grant application reviewers and resolve grant application reviewer comments before funding grants; prepare guidelines for selecting grantees for site visits, following up on site visit problems and documenting the visit; process expenditure reports timely to prevent draw down of unobligated balances and expedite recovery of misused grant funds; and obtain and use available audit reports to expedite the review and close-out process to eliminate the backlog of expired and terminated grants. (CIN: A-12-90-00022)

The ACF advised that corrective actions have been or are being taken. However, ACF did not agree with OIG's recommendation to resolve reviewers' comments, stating that there is no requirement to resolve the comments before funding. The ACF is moving to close out the backlog of expired grants and protect the Government's interest.

OIG Recommendation**Status**

Improve Cash Management of Child Support Collections:

The ACF should require the State and local agencies to: specify that collection and recording procedures be in writing; maintain accurate records and proper segregation of the collection and recording processes; restrict access to the computer systems; increase controls over the receipt forms, blank checks and signature devices; perform follow-up reviews to ensure that all child support agencies are offsetting interest earned on child support collections; negotiate with investment institutions to maximize earnings on deposited child support collections; perform follow-up reviews to determine the status of undistributable child support collections; and ensure that all CSE agencies have adequate systems for establishing, recording, maintaining and reviewing account balances. (CIN: A-12-91-00018)

The ACF generally concurred with the findings and recommendations and indicated that increased efforts would be made to promote adequate internal controls and cash management practices at the State level.

Ensure State Compliance with Health and Safety Regulations at Child Care Facilities:

North Carolina should reevaluate their (federally-required) plan to assure timely, accurate and comprehensive inspections that will assure compliance with State regulations. The plan should assure compliance with fire codes, building codes, sanitation regulations, requirements for background checks on child care providers and day care regulations by accommodating consultant workload. In addition, North Carolina should review regulations and eliminate vagueness, provide technical assistance to providers, provide health and safety information to parents, and ask parents to report conditions that would be harmful to their children. (CIN: A-12-92-00044)

North Carolina generally concurred with the observations noted.

GENERAL OVERSIGHT**Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake:**

The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify the Department of Health and Human Services (HHS) disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to PHS, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040)

The OASH has taken the lead in this area and has met with headquarters operating division emergency preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved.

Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake:

The OASH should issue guidelines to improve disaster planning. The plans of each operating and staff division should spell out lines of communication with each other, and should specify headquarters and regional lines of communication with the Federal Emergency Management Agency. (OEI-09-90-01040)

The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department.

OIG Recommendation

Status

Ensure that New York Allocates Training Costs to Federal Programs for Actual Number of Attendees:

The Department should be more aggressive when approving State plans to ensure that the State (among other actions): allocates future training contracts to programs based on the actual number of participants; maintains documentation which clearly details which programs benefit from future training and, where applicable, allocates training costs to all benefitting programs; and discontinues using third party contributions provided by private contractors to meet its share of training costs. (CIN: A-02-91-02002)

The Department's Division of Cost Allocation (charged with approval of State cost allocation plans) expressed agreement with the findings and recommendations.

APPENDIX D

Notes to Tables I and II

Table I

¹ The opening balance was adjusted to reflect a downward revaluation of recommendations in the amount of \$1.4 million.

² Included in the reports issued during the period are questioned costs totaling \$138,451 and \$11,726 in management decisions to disallow costs attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

³ During the period, revisions to previously reported management decisions included:

CIN: A-02-88-01029	Institutions for Mental Diseases New Jersey: The Departmental Appeals Board did not uphold a previous disallowance of \$4,034,681.
CIN: A-02-86-60252	New York Department of Social Services AFDC Administrative Costs: The Departmental Appeals Board overturned previously disallowed costs of \$9,690,698.
CIN: A-06-87-00076	Arkansas DDS/DHU Administrative Costs: \$2,027,425 in previously disallowed costs were subsequently allowed based on additional information provided by the State.
CIN: A-09-90-00073	Audit of Counties Surplus Pension Reserve: \$67,400,000 reported as questioned costs have been changed to funds put to better use.

Not detailed are additional revisions to previously reported decisions totaling \$24,428,341.

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

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

CIN: A-03-92-00010	National Review of Medical Credit Balances, December 1992, \$270,000,000 (Related recommendation of \$157,000,000 in Table II)
CIN: A-07-90-002062	Review of Asset Reversions from Pension Plan Terminations Occurring after the Implementation of the Prospective Payment System, May 1990, \$92,000,000
CIN: A-01-91-00511	Follow-Up Review Nonphysician Hospital Review, December 1992, \$38,511,916
CIN: A-07-89-00134	Medicare is Losing Millions of Dollars from Terminations of Pension Plans, January 1990, \$27,600,000
CIN: A-12-91-00018	Cash Management by State Child Support Agencies, August 1991, \$13,200,000 (Related recommendation of \$13,800,000 on Table II)
CIN: A-05-91-00050	Community Mental Health Construction Grant Phase I, October 1991, \$6,823,979
CIN: A-07-92-00578	Blue Cross/Blue Shield of Texas Inc. - Unfunded Pension Costs, October 1992, \$6,244,637
CIN: A-03-89-00046	Maryland Blue Cross/Blue Shield Administrative Costs FYs 85-88 Part B, September 1991, \$5,996,278

CIN: A-07-92-00579	Blue Cross/Blue Shield of Michigan Inc. - Unfunded Pension Costs, October 1992, \$2,535,698
CIN: A-05-92-00026	Associated Insurance Co.-Medicare Administrative, February 1992, \$2,530,409
CIN: A-02-91-01006	Blue Shield of Western New York Medicare Adm CTS Porter, September 1991, \$2,379,239
CIN: A-09-89-00162	MSP Nationwide Employer Review, July 1992, \$2,218,824
CIN: A-05-93-19899	Michigan Department of Social Services, November 1992, \$2,104,727
CIN: A-05-90-00090	Blue Cross Blue Shield-Administrative Contract Costs, November 1990, \$1,825,677
CIN: A-09-91-00155	Blackburn Care Home, November 1991, \$1,772,944
CIN: A-03-92-19733	State of Maryland, August 1992, \$1,505,462
CIN: A-03-90-00053	Blue Cross of Virginia Administrative Costs, August 1992, \$1,487,212
CIN: A-01-90-00509	Medicare Secondary Payer Review-AETNA, February 1992, \$1,471,233
CIN: A-03-90-00051	Maryland Blue Cross Blue Shield Administrative Costs Contract Audit, August 1991, \$1,438,414
CIN: A-10-91-00011	Washington Physician Services - Keystone Computer Acquisition, October 1992, \$1,346,681
CIN: A-03-92-16229	State of Pennsylvania, March 1992, \$1,298,072
CIN: A-05-93-19899	Michigan Department of Social Services, November 1992, \$1,030,218
CIN: A-02-93-19670	State of New York, February 1993, \$893,691
CIN: A-05-92-00060	Contractor Audit - Blue Cross Blue Shield Administrative Costs, February 1993, \$879,609
CIN: A-05-91-00136	Community Mutual Ins. Co. Administrative Costs, August 1992, \$720,668
CIN: A-04-91-04029	Audit of O&M AIDS Campaign Contract, May 1992, \$675,750
CIN: A-09-92-04011	University of Arizona Recharge Centers, December 1992, \$652,025
CIN: A-02-91-01004	Seguros Servicio De Salud CPA Gedrich, July 1992, \$575,603
CIN: A-06-92-00017	IHS Creek Contract Closeout Report, May 1992, \$468,217
CIN: A-06-93-00042	Review Administrative Costs - Medicare Parts A&B, Blue Cross Blue Shield Texas, January 1993, \$434,134
CIN: A-03-92-17153	Virginia Department for the Rights of the Disabled, January 1992, \$323,006
CIN: A-09-92-00063	Blue Cross of California Administrative Costs, March 1992, \$310,665
CIN: A-04-91-04067	Review Appropriateness of HRSA's Non-Competitive Award, May 1992, \$274,697
CIN: A-03-92-20250	Virginia Department of the Rights of the Disabled, August 1992, \$261,095
CIN: A-03-92-20033	State of Delaware, August 1992, \$247,609
CIN: A-03-91-14988	Maryland Dept of Health and Mental Hygiene, March 1991, \$243,703
CIN: A-02-92-16749	City of San Juan Puerto Rico, December 1991, \$233,462

CIN: A-09-93-23623	Triangle Project Grant #CS-83-UR-0075, January 1991, \$224,099
CIN: A-05-91-00064	Nationwide Administrative Costs Contract Audit, October 1991, \$211,422
CIN: A-10-92-00005	Washington Physician Services Administrative Cost Audit, February 1992, \$179,891
CIN: A-09-92-06850	Santa Ysabel Band of Mission Indians, September 1992, \$151,081
CIN: A-05-92-00048	Wisconsin Physicians Services, Pension - Medicare Vs. Erisa, October 1992, \$130,577 (Related recommendation of \$2,068,964 on Table II)
CIN: A-09-92-00093	Blue Cross Arizona Administrative Costs, August 1992, \$129,518
CIN: A-01-92-10075	State of Massachusetts, September 1992, \$96,703
CIN: A-03-91-04033	Eye & Ear Institute of Pitt-Core Grant Study, November 1993, \$91,113
CIN: A-03-92-00008	Allied Services for Handicapped G&A Review, January 1993, \$85,848
CIN: A-07-93-19985	State of Kansas, January 1993, \$78,511
CIN: A-06-93-23046	Choctaw Nation of Oklahoma, February 1993, \$77,388
CIN: A-10-92-06767	Spokane Tribe of Indians, August 1992, \$77,312
CIN: A-03-91-02002	Delaware Blue Cross Administrative Costs, October 1991, \$66,858
CIN: A-03-91-16232	UNISYS Inc., September 1991, \$61,754
CIN: A-04-92-19779	Poarch Band of Creek Indians, August 1992, \$59,904
CIN: A-05-92-18671	Two Rivers Head Start, April 1992, \$57,944
CIN: A-06-92-19887	Central Tribes of the Shawnee Area Inc, July 1992, \$57,944
CIN: A-08-93-20755	Oglala Sioux Tribe, October 1992, \$50,637
CIN: A-04-93-22457	Johnnie Ruth Clarke Health Center, Inc., January 1993, \$45,639
CIN: A-06-93-21825	Community Action Council of South Texas, December 1992, \$38,588 (Related recommendation of \$25,194 on Table II)
CIN: A-09-91-00150	Audit of National Practitioner Data Bank, October 1992, \$24,165
CIN: A-10-93-22465	Small Tribes Organization of Western Washington, January 1993, \$23,220
CIN: A-06-92-20334	Pueblo of Jemez, September 1992, \$20,156
CIN: A-10-92-06459	Kenaitze Indian Tribe, June 1992, \$18,678
CIN: A-04-93-20961	Commonwealth of Kentucky, January 1993, \$15,000
CIN: A-10-92-20781	Tulalip Tribes of Washington, September 1992, \$14,525
CIN: A-04-93-22516	Poarch Band Creek Indians, January 1993, \$13,640
CIN: A-09-92-06864	San Juan Southern Paiute Tribe, September 1992, \$10,433
CIN: A-06-92-16588	State of Oklahoma, August 1992, \$9,294
CIN: A-10-93-21881	Enterprise For Progress in the Community, December 1992, \$8,226
CIN: A-06-93-21654	Inter-Tribal Council Inc., November 1992, \$7,745

CIN: A-09-92-20824	Tri-County Migrant Head Start, September 1992, \$7,593
CIN: A-10-93-22136	Confederated Tribes of the Grand Ronde Community, December 1992, \$7,384
CIN: A-09-93-21763	Gila River Indian Community, November 1992, \$5,859
CIN: A-04-93-20876	State of North Carolina, February 1993, \$5,776
CIN: A-04-92-19467	Trinity Child Development Center, October 1992, \$5,701
CIN: A-05-93-21767	University of Wisconsin System, December 1992, \$5,245
CIN: A-06-91-00034	Audit of Collection and Credit Activities at TDHS, January 1992, \$5,081
CIN: A-10-92-06777	Coeur D'Alene Tribe of Idaho, September 1992, \$4,868
CIN: A-08-92-16941	Fort Belknap Indian Community, December 1991, \$4,325
CIN: A-08-93-22280	Crow Creek Sioux Tribe, January 1993, \$4,211
CIN: A-06-93-23107	Osage Nation of Oklahoma, February 1993, \$4,071
CIN: A-07-93-22976	Nebraska Department of Social Services, February 1993, \$3,850
CIN: A-10-92-06884	Washington Statewide, October 1992, \$3,578
CIN: A-03-92-16787	State of West Virginia, June 1992, \$3,547
CIN: A-03-92-00015	Medical College of PA G&A Review, January 1993, \$3,326
CIN: A-10-92-00002	Washington Physicians Services Termination Costs, January 1992, \$3,380 (Related recommendation of \$12,100,000 on Table II)
CIN: A-04-93-22355	Hemophilia of Georgia Inc., January 1993, \$2,077
B. Reports in litigation:	
CIN: A-03-92-00033	Blue Cross of West Virginia Termination, November 1992, \$25,200
CIN:03-91-02004	West Virginia Blue Cross Administrative Costs FYs 85-90 and Termination Cost, November 1992, \$7,556

Table II

¹ The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of \$446.5 million.

² Included are sustained management decisions of funds put to better use of \$894,673 attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

³ The Administration for Children and Families agreed with the recommendation but disagreed with the savings figure of \$54.1 million for OEI-07-90-02250, Child Support and the Military.

⁴ The OIG has reported as "management decisions during the period" those line items in the President's Fiscal Year 1994 budget that relate directly to OIG recommendations contained in issued reports. Management does not report these decisions in its table.

⁵ Management decisions have not been made within 6 months of issuance on 10 reports:

A. Discussions with management are ongoing and it is expected that the following reports will be resolved during the next semiannual reporting period:

CIN: A-06-91-00048 Non-AFDC Application and Users Fees for CSE Services, July 1992, \$385,000,000

CIN: A-04-91-00001	Review RASC Support-Recording, Maintaining, Reconcile, March 1992, \$1,544,849
CIN: A-03-92-03320	Association of American Medical College NIH-OD-92-01, August 1992, \$488,883
CIN: A-06-91-00089	Audit of CN B Accounts to Determine Status of IHS Cash On Hand, April 1992, \$445,890
CIN: A-04-93-22872	Montgomery Community Action Committee, Inc., January 1993, \$106,760
CIN: A-03-92-03315	Thomas Jefferson University Prop. RFP NCI-CN-25406-41, May 1992, \$50,943
CIN: A-06-92-0051	CDC Grant CCH603190-5 Ctr Health Policy Dev SA. Texas, June 1992, \$20,708
CIN: A-10-93-21109	Grant County Community Action Council, October 1992, \$15,020
CIN: A-09-90-07111	Yomba Shoshone Tribe, January 1990, \$12,832
 B. Report in litigation:	
CIN: A-09-91-05300	Kass Management Services, April 1991, \$79,829

APPENDIX E

Reporting Requirements of the Inspector General Act of 1978, as Amended

The specific reporting requirements of the Inspector General Act of 1978, as amended, are listed below with reference to the page in the semiannual report on which each of them is addressed. Where there is no data to report under a particular requirement, this is indicated as "none." A complete listing of Office of Inspector General audit and inspection reports is being furnished to the Congress under separate cover. Copies are available upon request.

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	78
Section 5(a)(1)	Significant problems, abuses and deficiencies	throughout
Section 5(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	throughout
Section 5(a)(3)	Prior significant recommendations on which corrective action has not been completed	appendices B and C
Section 5(a)(4)	Matters referred to prosecutive authorities	84
Section 5(a)(5)	Summary of instances where information was refused	none
Section 5(a)(6)	List of audit reports	under separate cover
Section 5(a)(7)	Summary of significant reports	throughout
Section 5(a)(8)	Statistical table I - reports with questioned costs	76
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	77
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none

ACRONYMS

ACF	Administration for Children and Families
ADP	automated data processing
AFDC	Aid to Families with Dependent Children
AHCPR	Agency for Health Care Policy and Research
AIDS	acquired immunodeficiency syndrome
ALJ	administrative law judge
AoA	Administration on Aging
ASMB	Assistant Secretary for Management and Budget
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control and Prevention
CFO	Chief Financial Officers
CHR	community health representative
CMP	civil monetary penalty
CSE	child support enforcement
CWF	common working file
CY	calendar year
DAB	Departmental Appeals Board
DME	durable medical equipment
DMS	debt management system
DOD	Department of Defense
ESRD	end stage renal disease
FDA	Food and Drug Administration
FFP	Federal financial participation
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEAL	health education assistance loan
HHS	Department of Health and Human Services
HI	health insurance
HRSA	Health Resources and Services Administration
ICF/MR	intermediate care facility for the mentally retarded
IHS	Indian Health Service
ILP	Independent Living Program
IOL	intraocular lens
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance Program
MBR	master beneficiary record
MEF	master earnings file
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
OAA	Older Americans Act
OASH	Office of the Assistant Secretary for Health
OASI	Old Age and Survivors Insurance
OBRA	Omnibus Budget Reconciliation Act
OCR	Office for Civil Rights
OCS	Office of Community Services
OMB	Office of Management and Budget
PCIE	President's Council on Integrity and Efficiency
PFCRA	Program Fraud Civil Remedies Act
PHS	Public Health Service
PPS	prospective payment system
PRO	peer review organization
SAMHSA	Substance Abuse and Mental Health Services Administration
SEI	self-employment income
SMI	supplementary medical insurance
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
TPN	total parenteral nutrition
USTF	uniformed services treatment facility
WC	workers' compensation

DEPARTMENT OF
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