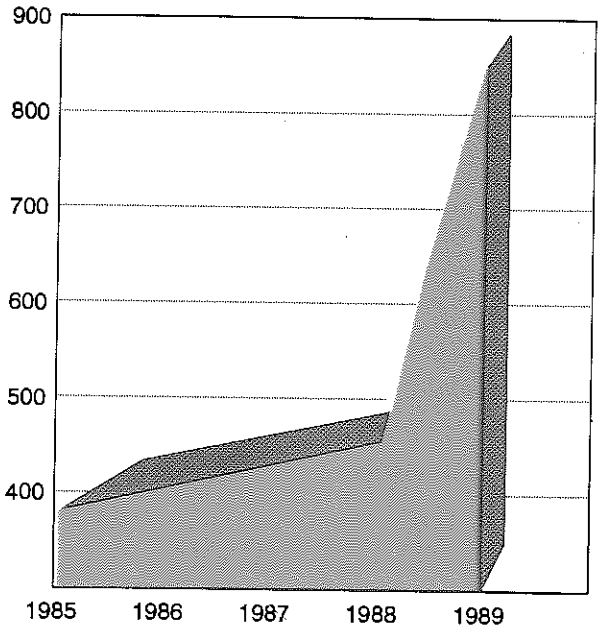
Department of Health and Human Services

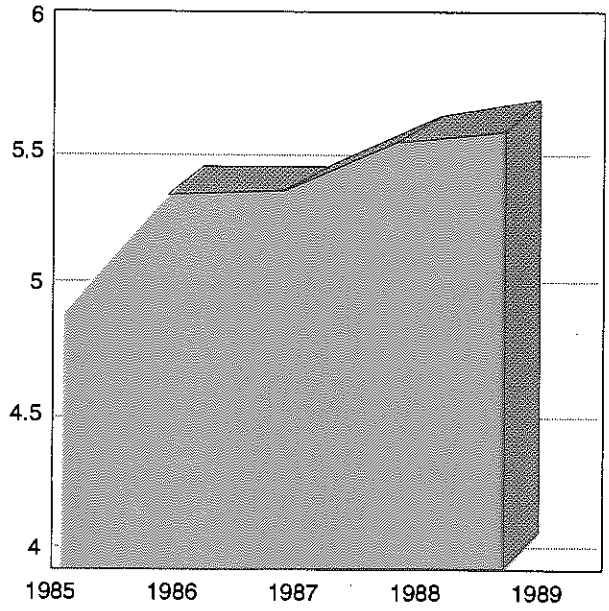
Richard P. Kusserow
Inspector General

OFFICE OF INSPECTOR GENERAL

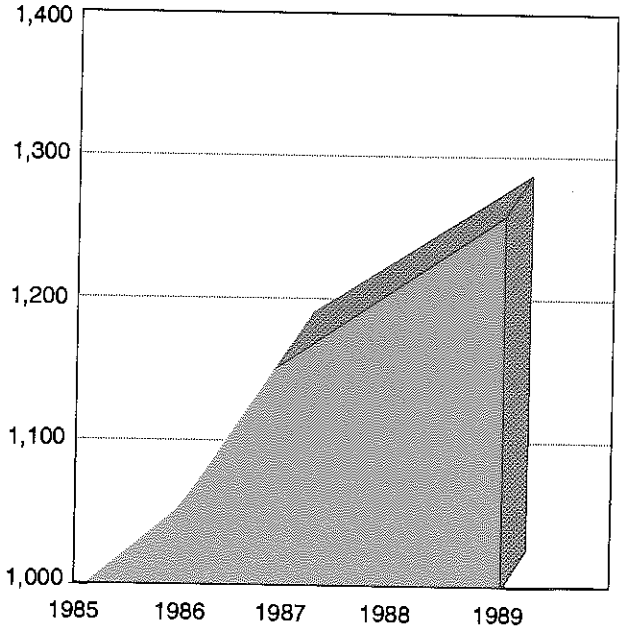
SANCTIONS EFFECTED



SAVINGS ($ BILLIONS)



SUCCESSFUL PROSECUTIONS



SEMIANNUAL REPORT

April 1, 1989 - September 30, 1989

STATUTORY AND ADMINISTRATIVE RESPONSIBILITIES

Effective April 1989, statutory authority for the Office of Inspector General was transferred from Public Law 94-505 to Public Law 95-452, as amended. The law 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 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
A-21	Cost Principles for Educational Institutions
A-25	User Charges
A-50	Audit Follow-up
A-70	Policies and Guidelines for Federal Credit Programs
A-73	Audit of Federal Operations and Programs
A-76	Performance of Commercial Activities
A-87	Cost Principles for State and Local Governments
A-88	Indirect Cost Rates, Audit, and Audit Follow-up at Educational Institutions
A-102	Uniform Administrative Requirements for Assistance to State and Local Governments
A-110	Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations
A-122	Cost Principles for Nonprofit Organizations
A-123	Internal Controls
A-128	Audits of State and Local Governments
A-129	Managing Federal Credit Programs
GAO	"Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

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

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

Title 21, United States Code, sections 331, 333 and 1175, the Federal Food, Drug and Cosmetics Act

Title 26, United States Code, section 7213

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

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

Title 42, United States Code, sections 1320 a-7, 1320 c-5, 13951, 1395m, 1395u, 1395dd, 1395ss and 1396b

Title 31, United States Code, section 3802

FOREWORD

It is my pleasure to submit this semiannual report on the activities of the Department's Office of Inspector General (OIG) for the 6-month period which ended on September 30, 1989. This Semiannual Report of the U.S. Department of Health and Human Services (HHS) OIG is being issued in accordance with the provisions of the Inspector General Act of 1978 (Public Law 95-452), as amended.

Since the inception of OIG, staff have worked to improve the efficiency and management of the Department's programs, to convict numerous individuals for serious violations of Federal criminal laws and to ensure that beneficiaries of the Department's programs receive a high quality of care and service.

The OIG is responsible for oversight of departmental management activities and has been actively involved in the Department's program to ensure effective internal controls. The OIG's role has been to identify material weaknesses in internal control systems, to advise top management on internal control issues, to test the Department's process for evaluating internal controls and to review the Department's annual report to the President and the Congress on the status of internal control systems. In addition, OIG participates in coordinating Government-wide activities to reduce fraud, waste and abuse and to improve management processes.

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

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

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

- *The Public Health Service (PHS) promotes biomedical research, disease cure and prevention, safety and efficacy of marketed food, drugs and medical devices and other activities designed to ensure the general health and safety of American citizens.*

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

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

The OIG is divided into three components - the Office of Audit, the Office of Investigations, and the Office of Analysis and Inspections. The Office of Audit (OA) is responsible for conducting audit services for HHS and overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent evaluations of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.

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

The Office of Analysis and Inspections (OAI) engages in short term evaluations and inspections that focus on issues of concern to the Department, the Congress and the public. The findings and recommendations contained in the inspections generate rapid, accurate and up-to-date information on efficiency, vulnerability and effectiveness of departmental programs.

In Fiscal Year 1989, OIG obtained over $5.6 billion in settlements, fines, restitutions, receivables and savings from its activities and implementation of its recommendations. In this period, a total of 1,278 individuals and entities were convicted for engaging in crimes against HHS programs and 846 health care providers and suppliers or their employees were administratively sanctioned.

During this fiscal year, OIG has devoted considerable effort to evaluating the effectiveness of the Medicare Catastrophic Coverage Act (Public Law 100-360), which represents the most sweeping change in Medicare since the inception of the program in 1965. In addition, OIG has been monitoring implementation of the Family Support Act (Public Law 100-485) to assess the effectiveness of the various programs established by this welfare reform legislation.

One of the highest priorities of the Department is to protect the health and welfare of all Americans. Pursuant to a commitment to the Congress, OIG established a separate division headed by a Deputy Assistant Inspector General for Audit to concentrate on this priority as well

as to exercise greater oversight of the agencies of the Public Health Service, including the Food and Drug Administration (FDA); the Indian Health Service (IHS); the Centers for Disease Control (CDC); the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); the Health Resources and Services Administration (HRSA); the Agency for Toxic Substances and Disease Registry (ATSDR); the National Institutes of Health (NIH); and the offices of the Assistant Secretary for Health. At the request of the FDA Commissioner, OIG is examining the generic drug review program to identify and make recommendations regarding weaknesses that could result in preferential treatment to certain firms.

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed regulations and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. In carrying out our responsibilities under Section 4(a), OIG reviewed 95 of the Department's regulations under development and 194 legislative proposals. During this process, OIG used as the primary basis for our comments the reviews, investigative experience and recommendations highlighted in this and previous semiannual reports.

For example, in the 1988 report "Medicare Certified Ambulatory Surgical Centers, Cataract Surgery Costs and Related Issues," OIG recommended that HCFA establish a reimbursement cap of $200 for an intraocular lens implant procedure performed by an ambulatory surgical center. This reimbursement cap will be established in final regulations.

In the 1989 report "Misconduct in Scientific Research," OIG recommended that the Secretary provide a more formalized and centralized process for dealing with scientific misconduct investigations and recommended that the Public Health Service expedite the publication of final regulations on the responsibilities of institutions for dealing with and reporting possible misconduct in science. Based on these recommendations the PHS strengthened the final rule which was published during this reporting period.

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

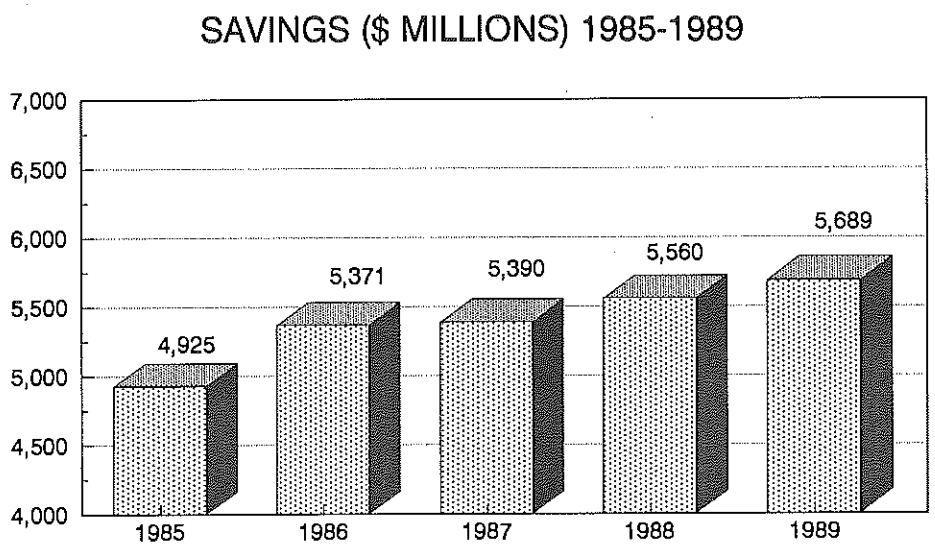
This report documents OIG's ongoing efforts to eliminate fraud, waste and abuse in the Department's programs. Our accomplishments would not have been possible without the cooperation and support of departmental officials and members of the Congress. We look forward to continuing to work with these individuals to help meet the expanding challenges of HHS.

Richard P. Kusserow

Inspector General

REPORT HIGHLIGHTS

Monetary Benefits - Over the last 5-year budget cycle, $26.9 billion dollars in settlements, fines, restitutions, receivables and savings have resulted from Office of Inspector General (OIG) activities and implementation of OIG recommendations.



The following items highlight monetary benefits resulting from OIG activities and implementation of OIG recommendations made during the second half of the fiscal year:

- The Family Support Administration will save $570 million by requiring the States to periodically review child support orders and revise them on the basis of an absent parent's ability to pay. (Appendix A)
- Medicare will save $465 million as a result of the establishment of a reasonable payment rate for a new drug. (Appendix A)
- By eliminating Medicare payments for unnecessary assistant surgeon services, Medicare will save $312 million. (Appendix A)
- Over $11 million was recovered after OIG determined that the State of West Virginia used an illegal basis to claim matching Medicaid funds. (Appendix C)

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

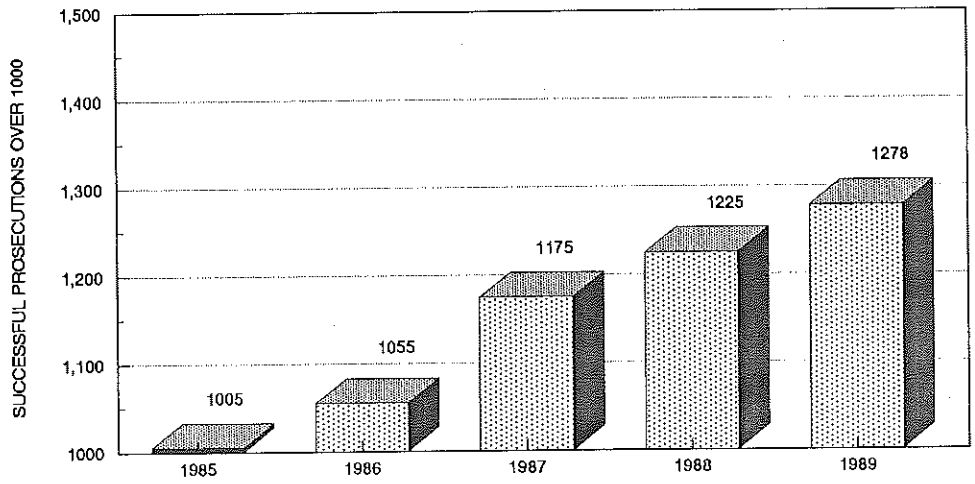
- The OIG estimates that acceleration of large employers' payroll tax deposits could generate as much as $15.5 billion over a 5-year period for the U.S. Treasury and the Social Security and Medicare trust funds. (Page 49)
- Restructuring Federal Supplemental Security Income benefits on the basis of a recipient's living arrangements could generate savings of about $1.4 billion over 5 years. (Page 59)
- The Social Security Administration (SSA) could save over $1 billion in the next 20 years by allowing recovery of delinquent overpayments at the higher of the amount of interest income lost to the trust funds or the value lost to the trust funds due to inflation. (Page 48)
- By amending regulations regarding reimbursement for anesthesia services, the Health Care Financing Administration (HCFA) could reduce allowable charges by more than $347 million over 5 years by paying only for expended services. Further, by instituting rounding-down of payments for such services, HCFA could reduce charges by $695 million for a 5-year period. (Page 37)
- Medicare could save an estimated $544 million over 5 years by developing separate dialysis rates for independent and hospital facilities. (Page 34)
- As a result of coding errors on which basis reimbursement to hospitals is made under the prospective payment system, OIG estimates that the Medicare program loses $474.3 million annually. (Page 29)
- The OIG estimates that the Social Security trust funds incurred losses of approximately $330 million as a result of inadequate reimbursement by the Department of the Treasury to SSA for unnegotiated checks. (Page 51)
- By withholding income tax refunds due former overpaid beneficiaries, SSA could recoup approximately $303.2 million in outstanding debts over a 5-year period. (Page 49)
- The OIG found that an appropriate reduction in the size of a proposed hospital facility in New Mexico could result in construction cost savings of $14.2 million and related staffing cost savings of $3.2 million annually. (Page 69)

Internal Control Review - The Federal Managers' Financial Integrity Act (FMFIA) requires Federal agency heads to establish a continuous process for the evaluation and improvement of the internal administrative, accounting and financial control systems for which they are responsible, and to report annually to the President and the Congress on the status of their internal control and accounting systems.

In Fiscal Year (FY) 1989, OIG identified 19 significant weaknesses in the Department's internal control systems. Chapter I discusses OIG's role in the Department's FMFIA program. In addition, Chapters I through VI outline individual weaknesses.

Successful Judicial Prosecutions - As a result of investigations by OIG over the past 5 fiscal years, numerous individuals and entities were successfully prosecuted for engaging in crimes against the Department of Health and Human Services' programs as illustrated below.

SUCCESSFUL PROSECUTIONS 1985 - 1989



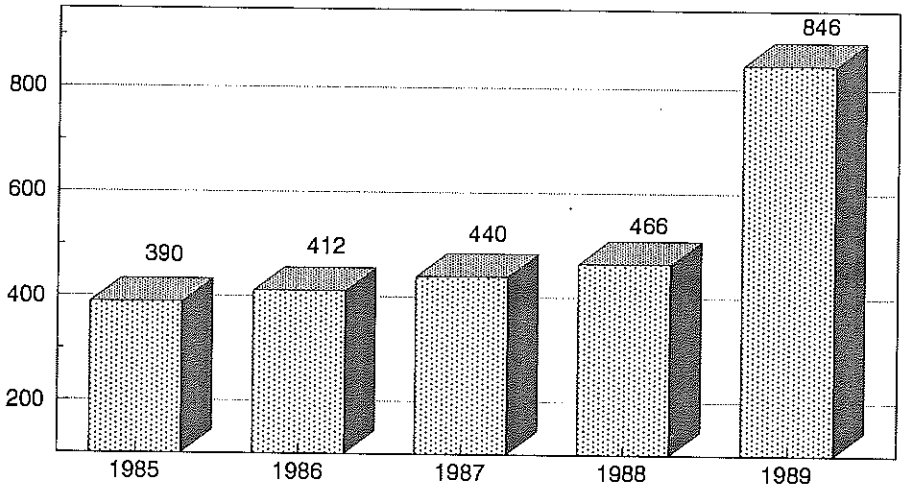
The following items highlight OIG investigative activities during the second half of 1989:

- Convictions resulting from investigations of Medicare and Medicaid fraud by OIG and federally supported State Medicaid Fraud Control Units totaled 322, with financial recoveries and savings of more than $40 million.
- Investigations of fraud and corruption in the generic drug approval process of the Food and Drug Administration (FDA) have resulted to date in conviction of three FDA officials, three generic drug industry representatives and two generic drug manufacturers.
- One State had to repay $3 million it had improperly claimed as Medicaid reimbursement for one of its hospitals.
- The owner of two durable medical equipment corporations in New York was sentenced to 3 years in jail, and more than $1.7 million had to be forfeited in fines and recoveries.

- About $90,000 has been collected from doctors who accepted kickbacks from a Pennsylvania diagnostic laboratory, in response to demand letters that they refund the money to avoid civil liabilities.
- Four persons were given prison sentences and fines in a fraudulent scheme in which Medicaid vouchers were misused and forged for taxi fares in the District of Columbia.
- A physician and his wife had to repay $97,000 they had illegally obtained from SSA by his faking neurological and brain disorders.
- Another man had to repay $32,600 he had embezzled in Supplemental Security Income benefits obtained on behalf of an alien working for him.

Administrative Sanctions - Since FY 1985, numerous health care providers and suppliers or their employees were administratively sanctioned for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries.

ADMINISTRATIVE SANCTIONS EFFECTED 1985 - 1989



The following items highlight OIG administrative sanctions imposed during the second half of the fiscal year:

- A total of 548 persons or entities were administratively sanctioned, through exclusion or monetary penalties, for defrauding Medicare, Medicaid, or other health care payers, or for providing substandard care or excessive services.

- Three hospitals were penalized a total of $130,000 for inappropriately transferring to other hospitals patients with emergency medical conditions or in active labor.
- Under civil monetary penalty authorities, 59 providers were assessed more than $10 million in fines and penalties for filing false Medicare or Medicaid claims.
- One hundred twenty health care providers were excluded from program participation under the Medicare and Medicaid Patient and Program Protection Act on the basis of program-related convictions.
- Seventeen persons were excluded from the programs because of convictions related to controlled substance abuse.
- Six providers were sanctioned upon the recommendation of peer review organizations on the basis of failure to meet professional standards of quality of care or for performing unnecessary services.

Nonmonetary Findings - The following items pertaining to quality of care and the welfare of beneficiaries highlight OIG findings, recommendations and activities during the second 6 months of the fiscal year:

- As part of HCFA's responsibility to implement the prescription drug benefit under the Medicare Catastrophic Coverage Act, the OIG urged HCFA to plan into their proposed electronic point-of-sale system, a comprehensive drug utilization review program to improve quality of care, avoid unnecessary Medicare and personal expenditures and maintain program integrity. (Page 17)
- The OIG recommended that HCFA request a delay in implementing the Medicare prescription drug benefit portion of the Medicare Catastrophic Coverage Act because of significant problems in the design and procurement of the point-of-sale system that will be installed at pharmacies and other drug dispensers. (Page 18)
- The OIG proposed that HCFA pursue legislative and regulatory changes to require entities billing Medicare to disclose the names of their physician-owners and investors. (Page 20)
- The OIG recommended that the Federation of State Medical Boards and the National Association of Boards of Pharmacy assist the States in promoting stronger, more effective regulation of physician drug dispensing. (Page 21)
- In light of the greater than average risk of poor quality care in cases of itinerant surgery, OIG proposed that rural physicians and hospital administrators institute procedures to provide an opportunity for a second surgical opinion, ensure an adequate preoperative workup and improve postoperative communication between the itinerant surgeon and the attending physician. (Page 30)

- The OIG recommended that SSA implement improved controls over the validation procedure used to review software to detect, calculate and process Social Security overpayments. (Page 51)
- The OIG proposed that within the Public Health Service, the Secretary provide for independent oversight and develop a formalized, centralized process to deal with instances of scientific misconduct. (Page 67)

TABLE OF CONTENTS

page

CHAPTER I HHS AND GOVERNMENT-WIDE OVERSIGHT

CHAPTER II HEALTH CARE FINANCING ADMINISTRATION

CHAPTER III SOCIAL SECURITY ADMINISTRATION

CHAPTER IV PUBLIC HEALTH SERVICE

CHAPTER V FAMILY SUPPORT ADMINISTRATION

CHAPTER VI OFFICE OF HUMAN DEVELOPMENT SERVICES

HHS AND GOVERNMENT-WIDE OVERSIGHT

CHAPTER I

HHS AND GOVERNMENT-WIDE OVERSIGHT

INTRODUCTION

This chapter is devoted to Office of Inspector General (OIG) departmental management and Government-wide responsibilities. The OIG's oversight of departmental management activities, including accounting and payroll, consists of reviews of the implementation of the Federal Managers' Financial Integrity Act, debt management activities, grants and contracts and audit resolution. Special reviews requested by the Secretary, the Congress and other departmental policy makers are also conducted. Reviews are directed at ways to strengthen all areas of departmental management.

The OIG has oversight responsibility for audits conducted of Government grantees by nonfederal auditors, principally public accounting firms and State audit organizations. As a result of the Office of Management and Budget (OMB) assignment of audit oversight responsibilities under OMB Circulars A-73, A-87, A-88, A-110 and A-128, OIG is responsible for audits of about 50 percent of all Federal funds awarded to State and local governments, hospitals, colleges and universities, and nonprofit organizations.

The OIG's Government-wide responsibilities include participation in the President's Council on Integrity and Efficiency (PCIE) which was established in 1981 to coordinate Government-wide activities to reduce waste and fraud and improve management processes. The OIG's role typically involves participation on task forces which address developing programmatic or management approaches where the potential for fraud, abuse or mismanagement has been identified.

THE FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

The key process for assuring effective management control systems was established by Public Law 97-255, the Federal Managers' Financial Integrity Act of 1982 (FMFIA). The FMFIA was enacted in response to growing congressional concern over the lack of adequate financial, accounting and internal control systems in Federal agencies.

The FMFIA requires Federal agency heads to establish a continuous process for the evaluation and improvement of the internal administrative, accounting and financial control systems for

which they are responsible and to report annually to the President and the Congress on the status of their internal control and accounting systems.

The FMFIA program, as established by law and reinforced by OMB Circular A-123, sets forth the process under the responsibility of management. At the end of each calendar year, each Secretary or agency head prepares an assurance letter to the President and the Congress setting forth all material weaknesses identified during the course of the year and the plan of action to correct the internal control failures.

Although the Inspector General's role is not specified in the statute, OIG has been actively involved in the Department's FMFIA program because effective internal control systems are a primary mechanism for preventing and detecting fraud, waste and abuse. The OIG role in the Department's program includes:

- identifying material weaknesses in internal controls or material nonconformances in accounting systems as an integral part of OIG reviews of Department activities;
- following up to monitor corrective action taken regarding weaknesses identified by OIG, the General Accounting Office (GAO) and the Operating Divisions of the Department;
- advising top management on internal control issues;
- testing the Department's process for evaluating internal controls; and
- reviewing the Department's FMFIA annual report to the President and the Congress on the status of internal controls.

It was a primary intent of FMFIA that identification of material weaknesses arise from internal control reviews performed by program managers. The role of the auditor was to supplement management's review findings and provide technical assistance. The OIG is concerned that Inspector General auditors continue to dominate in the identification of material weaknesses.

On June 27, 1989, the Director, OMB, requested that each Department undertake a fresh assessment of its FMFIA programs to assure that weaknesses are identified early and effective corrective actions are taken promptly. The Inspector General briefed the Secretary and the Assistant Secretary for Management and Budget on the OIG's FMFIA work and the challenges encountered in efforts to improve the Department's programs. The Inspector General emphasized the concept of issuing early warnings to inform components of all weaknesses identified so that vulnerabilities do not continue for years. Further, the Inspector General urged that the Department monitor the process very closely to ensure that the Operating and Staff Divisions are fulfilling their FMFIA responsibilities as intended by the Congress.

The Department's new management team has instituted an innovative process to improve and maintain adherence to both the letter and spirit of the law in implementing FMFIA. They created the Council on Management Oversight to ensure the integrity of the FMFIA and audit follow-up programs. The Council is chaired by the Deputy Assistant Secretary, Finance. Other members include the Department's Audit Director from OIG and the Deputy Assistant Secretary, Budget. The Council has held hearings on all Operating Divisions of the Department. Each component within the Department has provided evidence of how they are operating under FMFIA. They have described the nature and results of their internal control reviews, including the identification of material weaknesses and the formulation of proposed action plans to correct those weaknesses.

The Council evaluates the components' FMFIA efforts and acts as a dispute resolution body where there are differences of opinion as to the diligence and completeness of those efforts, or the proper identification and correction of material weaknesses.

During FY 1989, OIG identified 19 significant weaknesses which were reported to management and are now undergoing review for a determination as to whether or not they are material, as well as what corrective action plans are appropriate. The following indicates the distribution of the program weaknesses identified, with reference as to where they may be found in our semiannual report:

Office of the Secretary (OS)	1	(page 3)
Health Care Financing Administration (HCFA)	8	(page 15)
Social Security Administration (SSA)	4	(page 47)
Public Health Service (PHS)	4	(page 64)
Family Support Administration (FSA)	1	(page 72)
Office of Human Development Services (HDS)	1	(page 80)

INTERNAL CONTROL REVIEW

The following is a significant weakness identified by OIG in FY 1989 under the overall jurisdiction of the Office of the Secretary (OS):

- The OIG found that invalid figures are contained in the unliquidated obligation ("M" account) balances throughout most of the Department, specifically HCFA, FSA, PHS, and OS/HDS. The Department did not review and validate, on an annual basis, the items carried in "M" accounts as required by Department of the Treasury and HHS policy. As a result, the Department of the Treasury Form 2108 reports prepared by Operating and Staff Divisions and sent to Treasury, OMB and the Congress, contain erroneous information regarding the actual level of unliquidated obligations in the Department.

RESOLVING AUDIT RECOMMENDATIONS

The tables below summarize the Department's actions on OIG recommendations to recover funds or to put them to better use.

A. Questioned Costs

The following chart summarizes the Department's responses to OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs which are challenged because of a violation of law, regulation, grant, etc. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and the Inspector General Act Amendments of 1988 (Public Law 100-504). In addition, the chart provides information on management decisions as required by the Inspector General Act Amendments of 1988 (Public Law 100-504).

TABLE I
OFFICE OF INSPECTOR GENERAL
REPORTS WITH QUESTIONED COSTS

		Number	Dollar Value (in thousands)	
			Questioned	Unsupported
A.	For which no management decision had been made by the commencement of the reporting period	218	$98,032	$4,294
B.	Which were issued during the reporting period	286	202,575	42,215
	Subtotals (A + B)	504	$300,607	$46,509
Less:				
C.	For which a management decision was made during the reporting period:	209	$133,920	$6,828
	(i) dollar value of disallowed costs[1]		123,053	932
	(ii) dollar value of costs not disallowed		10,867	5,896
D.	For which no management decision had been made by the end of the reporting period	295	$166,687	$39,681
E.	Reports for which no management decisions was made within six months of issuance[2]	1	149	0

1 See Appendix B

2 A site visit was required by PHS Program Officials to gather information necessary to resolve reported recommendations. (CIN: A-03-88-00351)

B. Funds Put to Better Use

The following chart summarizes reports which include recommendations that funds be put to better use through cost avoidances, budget savings, etc. Legislative and programmatic actions on OIG recommendations are detailed in Appendix A.

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

		Number	Dollar Value (in thousands)
A.	For which no management decision had been made by the commencement of the reporting period	32	$1,415,118
B.	Which were issued during the reporting period	33	5,787,143
	Subtotals (A + B)	65	$7,202,261
Less			
C.	For which a managemnt decision was made during the reporting period:		
	(i) dollar value of recommendations that were agreed to by management	12[1]	$2,002,795
	(ii) dollar value of recommmendations that were not agreed to by management	1	21,400
	Subtotals (i + ii)	13	$2,024,195
D.	For which no management decision had been made by the end of the reporting period	52	$5,178,066
E.	Prior management decisions implemented in the period (See Appendix A)		$3,094,800

[1] Includes 4 reports in which the OIG and management disagreed on the dollar value of estimated savings.

GOVERNMENTAL ACCOUNTING

Based on leads developed from its nonfederal audit work, OIG continues to identify excessive administrative charges to Federal programs, totaling $31.4 million in this reporting period.

A. Self-Insurance Funds

The OMB Circular A-87 sets forth principles for determining allowable costs of federally-assisted programs, and states that "... no provision for profit or other increment above cost is intended." Several OIG reviews revealed that States had overcharged Federal programs for insurance coverage.

Michigan had an excess reserve balance of $83.1 million in its self-insurance funds as of September 30, 1986 (Federal share $16.1 million). Oregon had accumulated a surplus of $19.7 million in its self-insurance fund as of June 30, 1987 (Federal share $1.9 million). (CIN: A-05-88-00082, CIN: A-10-88-00012)

B. FICA Sick Pay Credits

The OIG continued its reviews of Federal Insurance Contributions Act (FICA) refunds. Amendments to the Social Security Act provide that payments made for sickness or accident disability are considered wages for Social Security purposes.

The OIG found that Rhode Island received FICA tax credits of approximately $3.3 million but had not refunded to the Federal Government its share of nearly $114,400. (CIN: A-01-89-02003)

Colorado claimed FICA tax credits of approximately $2.4 millon on behalf of employees on personal sick leave from 1977 to 1981. An OIG review disclosed that the State did not credit any of the employer's share to the Federal Government; the Federal share was calculated to be almost $104,400. (CIN: A-08-88-00137)

Virginia received a FICA tax credit of $9.5 million for the period 1979 through 1981. The Federal share of the refund amounted to $205,000. (CIN: A-03-88-00451)

Iowa claimed FICA tax credits of $2 million for the period July 1, 1978 to December 31, 1980. Of this amount, $1 million was retained by the State. The OIG concluded that nearly $283,300 of the retained amount should have been refunded to the Federal Government. (CIN: A-07-88-00136)

Indiana claimed FICA tax credits of $14.3 million for the period April 1, 1979 to December 31, 1981. Of this amount, $7 million was retained by the State; the Federal share of the retained amount was calculated at over $636,300. (CIN: A-05-88-00034)

C. Capital Lease Costs

The OMB Circular A-87 states that interest in any form is an unallowable charge to the Federal Government. The OIG found several States that were not excluding the interest portion of capital lease costs and were otherwise improperly charging lease costs.

The OIG found that payments made under capital leases entered into by two Maryland agencies included interest costs of an estimated $151,600 to the Federal Government. The OIG report proposed that Maryland establish accounting procedures to properly account for capital leases. It also recommended that the State refund the interest costs charged to the Federal Government. (CIN: A-03-88-01457)

Texas improperly charged Federal programs with interest expense on capital leases totaling $1.6 million (Federal share $900,000). The OIG recommended that the State reimburse Federal programs and establish procedures to prevent future occurrences of this type. (CIN: A-06-87-00065)

D. Internal Service Fund for Data Processing

During the period July 1, 1984 through June 30, 1987, Wyoming Data Services Division (DSD) overcharged Federal programs a total of $2.2 million.

The overcharges resulted from the application of inflated billing rates and the inclusion of unallowable depreciation costs. The DSD had included depreciation costs for equipment items that were idle or no longer in their inventory. Additionally, the DSD claimed depreciation on a 3-year schedule rather than on its stated policy of 5 years.

The OIG recommended that Wyoming reimburse the Federal programs $2.2 million for the data services overcharges. (CIN: A-08-87-00064)

E. Training and Administrative Costs

During the period October 1, 1981 through September 30, 1985, a State agency claimed about $509 million (Federal share) in training and administrative costs. An OIG report pointed out that about $8.5 million of the costs were ineligible for reimbursement. That amount included $3.1 million in personal care service costs not included in the State's approved title XX plan; $3.5 million in family service worker costs not claimed until after expiration of the 2-year limit; $1 million in capital lease payments that exceeded allowable depreciation costs; $300,000 in computer equipment costs improperly allocated; and $600,000 in computer equipment costs for which the State did not obtain the required Federal approvals. In addition to proposing financial adjustments, OIG made procedural recommendations to correct the related deficiencies and improve internal controls.

The State generally did not concur in the recommended financial adjustments. Although they agreed with the facts presented in the findings, they contended that there were extenuating circumstances and that most of the costs would have been allowable had proper approvals been obtained. The Federal awarding agencies, however, concurred with the audit recommendations. (CIN: A-05-86-60500).

F. Cooperative Administrative Support Units

The OIG completed a series of four inspection reports on the Cooperative Administrative Support Unit (CASU) program which is sponsored by the President's Council on Management Improvement. Under this program, agencies cooperatively combine resources and share common administrative services in order to reduce costs and improve service quality.

The OIG found that users are very satisfied with their CASU services. However, CASU users and local officials are uncertain about the extent of cost savings and desire more implementation support from the national CASU staff. The OIG recommended that the national CASU staff establish an effective mechanism to identify and track cost savings and provide more assistance to CASUs attempting to become fully operational. The CASU officials concurred with these recommendations. (OAI-06-89-00860, OAI-06-89-00861, OAI-06-89-00862, OAI-06-89-00863)

G. Cost Allocation Plan

An OIG review of Virginia Department of Social Services (VSS) cost allocation plan for the period July 1, 1985 to September 30, 1987 identified $330,000 in excess direct costs charged to Federal programs. The excess was due to VSS charging the total purchase price of computer equipment costing nearly $353,700 directly to Federal programs in violation of Federal regulations. The OIG recommended that Virginia make a financial adjustment of $330,000 to the Federal programs. (CIN: A-03-88-01454)

PAYMENT MANAGEMENT SYSTEM

At the request of the Division of Federal Assistance Financing (DFAF) within the Department's Office of the Assistant Secretary for Management and Budget (ASMB), OIG conducted an audit of general operating procedures and electronic data processing controls in the payment management system (PMS). The PMS is a computerized system used by the Department to authorize disbursement of over $52 million annually to about 6,500 grantees.

The audit report concluded that, while an array of controls was in place in DFAF, two material internal control weaknesses existed in the PMS. As a result, funds of about $24 million in the accounts of inactive grantees were susceptible to diversion, which might remain undetected for an extended period of time. Other areas of weakness were identified in the report and several recommendations were made to strengthen internal controls. The DFAF generally concurred with the findings and initiated a number of corrective actions in a timely manner. (CIN: A-12-87-02663)

NONFEDERAL AUDITS

Approximately half of Federal funds awarded to State and local governments and colleges and universities come from HHS programs. The OIG is assigned cognizance at 99 percent of all colleges and universities. The OMB has assigned HHS audit cognizance of 22 State and 919 local governments. A major portion of this oversight responsibility is accomplished by relying on audit work performed by certified public accountants and State audit organizations. The OIG analyzes audit reports for indicators of grantee noncompliance with Federal regulations, initiates audit resolution procedures on reported recommendations and maintains a quality control review process to identify substandard audit work.

The OIG also continues an active role in the implementation of the Single Audit Act. A major component of OIG's workload has been to assist State and local governments and their auditors with planning and performing single audits.

The OIG has a special interest and concern regarding compliance with the Single Audit Act because of the magnitude of HHS funding to State and local governments. The Department provides about $50 billion a year to State and local governments. All but 3 of the 50 States receive more funds from HHS than from any other department.

A. Local Government Compliance

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

B. Quality Control

To ensure that all audits meet generally accepted Government auditing standards, uniform procedures are used to review nonfederal audit reports. During this reporting period, OIG reviewed and processed 2,013 nonfederal audit reports containing $59.4 million in recommended cost recoveries. The reports also identified many opportunities for improving management operations. The following table summarizes these results:

Reports issued without changes or with minor changes	1,667
Reports issued with major changes	277
Reports with significant inadequacies	69
Total audit reports processed	2,013

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

AUDIT ASSISTANCE TO SMALL FEDERAL AGENCIES

Until the Inspector General Act Amendments of 1988 (Public Law 100-504) created "mini-Inspectors General" for 33 designated entities, small Federal agencies typically did not have Inspectors General and many of the agencies did not have audit capability. Recognizing the vulnerability of these circumstances, OMB required these agencies to obtain audit coverage from existing Inspectors General or certified public accountants under the provisions of OMB Circular A-73, "Audit of Federal Operations and Programs."

For example, OIG audited the financial statements for FY 1987 of one small independent Federal agency with an appropriation of $6.5 million. The agency had no statutory Inspector General, and this was the first year its operations had been audited.

As a result of accounting practices employed by the agency, the Report of Financial Position contained several variances in presentation of account balances. The OIG found that the agency had not capitalized its asset acquisitions since 1985. The agency also incorrectly computed and posted an accrued annual leave balance as of the close of the calendar year instead of the close of the fiscal year. Further, the agency lacked a depreciation policy and as a result, depreciation expenses were not calculated appropriately. Upon completion of the audit, agency officials initiated actions to address each of the problems identified. (CIN: A-12-88-00104)

GOVERNMENT-WIDE ISSUES

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

During FY 1987, OIG launched a major initiative to identify improvements in the accounting process, strengthen Government cost principles and identify cost containment areas that

contribute to Government-wide savings. The cost principles governing the charging of costs by State and local governments have not changed substantially for 20 years.

As a result of the initiative, OIG identified 13 areas in need of improvement in OMB Circular A-87 regarding cost principles. These improvements have a savings potential in excess of $100 million. Proposed revisions to the circular were published in October 1988. The OIG is currently participating in an OMB-sponsored, multiagency task force which is responsible for evaluating public comments on the proposed revisions.

During this reporting period, OIG's ongoing review of State and local governments' application of cost principles identified questionable charges to Federal programs of $32 million.

ASSISTANCE TO OTHER LAW ENFORCEMENT AGENCIES

During this reporting period, OIG referred 823 cases for prosecution to the Department of Justice or State and local jurisdictions. A total of 787 indictments or informations were obtained. (An information is a prosecutive procedure which may be used when grand jury indictment is waived.) Some of these cases involved programs and funds tangentially related to OIG purview. Many Federal, State and local law enforcement and regulatory agencies depend on OIG expertise for assistance in identifying, locating, investigating and prosecuting persons who have improperly used Social Security numbers (SSNs) in a broad range of illegal activities, including bank and credit card frauds, licensing and income tax fraud, welfare fraud, drug trafficking and racketeering as well as fraud in programs such as student loans, food stamps and unemployment compensation. Other agencies also benefit from OIG investigations, such as private health insurers, State Medicaid programs, and drug regulatory entities. Many of the cases in which OIG participates result in monetary fines, recoveries, restitutions or savings for these agencies. During this period, monetary fines, recoveries, restitutions or savings from these cases amounted to approximately $5.5 million for other public or private entities, for a total of $18.4 million for FY 1989.

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 written false statements to a Federal agency. It was modeled after the civil monetary penalty 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.

In April 1988, OIG published final rules for implementing PFCRA. Training sessions on implementation for OIG managers and Department components were held during this reporting period, and guidelines have been drafted for inclusion in OIG's Special Agent Handbook.

Thus far, few cases suitable for processing under PFCRA have been identified. The OIG is still expanding the use of its broad sanctioning and penalty assessment powers in the health care area. In the area of Social Security programs, which comprise the other major portion of OIG's workload, the limited resources of most defrauders mitigate against the effort required to exercise PFCRA authorities. In the remaining OIG oversight area, which consists primarily of grants and contracts, thorny legal questions are mandating careful selection of cases for processing and establishing precedents.

EMPLOYEE FRAUD

The OIG has oversight responsibility for the investigation of allegations of Department employee wrongdoing where it affects internal programs. Most of the approximately 115,800 persons employed full time by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities as illustrated in cases cited in the chapters on specific Department programs.

To assist in the prevention of employee fraud, OIG has prepared "An Ethics Handbook for Employees of the Department of Health and Human Services," which outlines areas of questionable conduct and provides answers concerning what constitutes unethical behavior. The handbook is already being used in training sessions for new Department managers. It and a supplementary videotape, which show examples from actual cases, will be presented to all Department employees.

HEALTH CARE FINANCING ADMINISTRATION

CHAPTER II

HEALTH CARE FINANCING ADMINISTRATION

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

In Fiscal Year (FY) 1989, the Medicare program will provide health care coverage for an estimated 32.6 million individuals. Medicare Part A (hospital insurance) provides, through direct payments for specified use, hospital insurance protection for covered services to persons 65 or older and to certain disabled persons. Financed by the Federal Hospital Insurance trust fund, FY 1989 expenditures for Medicare Part A are estimated to be in excess of $58 billion.

Medicare Part B (supplementary medical insurance) provides, through direct payments for specified use, insurance protection against most of the costs of health care to persons 65 and older and certain disabled persons who elect this coverage. The services covered are medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services, and certain other medical and health services. Financed by participants and general revenues, FY 1989 expenditures for Medicare Part B are expected to exceed $37 billion.

The Medicaid program provides grants to States for medical care for approximately 24 million low-income people. Federal grants are estimated at $34.8 billion in FY 1989. Federal matching rates are determined on the basis of a formula which measures relative per capita income in each State. Eligibility for the Medicaid program is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). States may also cover certain individuals who are not eligible for SSI or AFDC.

The OIG activities which pertain to the health insurance programs administered by the Health Care Financing Administration (HCFA) help curtail health care costs, improve quality of care and reduce the potential for fraud, waste and abuse. Through audits and inspections, OIG recommends change in legislation, regulations and systems to reduce unnecessary expenditures and improve inefficient health care delivery systems.

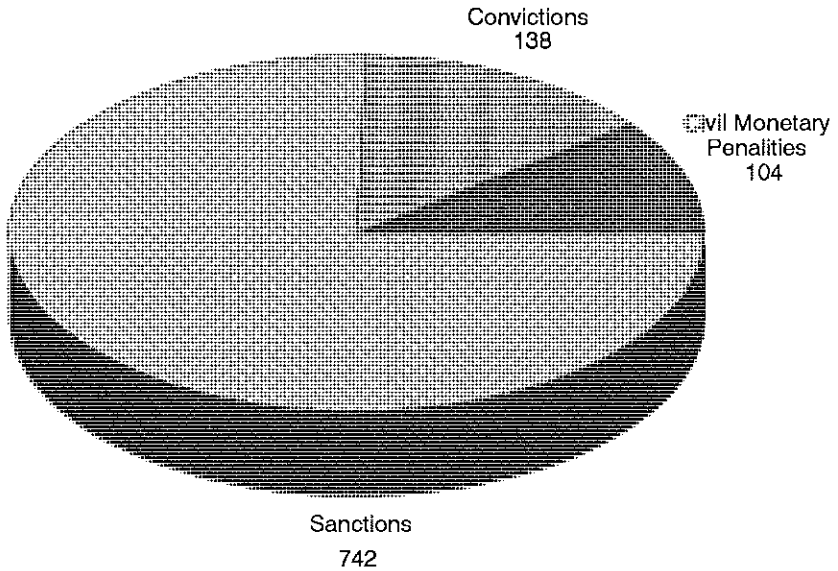
The financial impact of the prospective payment system (PPS) on hospitals, the increases in Part B expenditures, the development and implementation of catastrophic health care policy, and the cost implications of changes in health care technology and delivery will continue to be of

particular interest to OIG. The OIG's reviews identify innovative cost containment techniques, probe for improper cost shifting and validate the adequacy of intermediary audits of hospitals' Medicare cost reports. Reviews detect overutilization of physician and related services and reduce vulnerabilities in payment systems. The OIG also seeks to identify mechanisms to contain increasing Medicaid costs, including monitoring States' collection of overpayments and costs claimed for treating patients residing in institutions for mental diseases and facilities for the mentally retarded.

As a result of actions taken in support of OIG recommendations in the second half of the fiscal year, Medicare and Medicaid will save $1.3 billion (see Appendix A). During this reporting period, OIG identified program areas where legislative action, more efficient management and tightened internal and fiscal controls could result in significant additional savings. An additional $101.7 million in program expenditures were questioned as to their allowability under law, regulations or cost principles. In these instances, recommendations for financial adjustments and appropriate procedural changes were made.

Fraud and abuse of the Medicare and Medicaid programs or their beneficiaries may result in criminal, civil and/or administrative actions against the perpetrators. During this fiscal year, OIG was responsible for a total of 984 successful actions against wrongdoers which resulted in $60.1 million in fines, savings, restitutions and settlements.

HEALTH CARE PROGRAMS
Judicial and Administrative Actions
FY 1989



INTERNAL CONTROL REVIEW

The following are significant weaknesses identified by OIG in FY 1989 when HCFA:

- The procurement process for the multi-carrier drug claims processing system required by Medicare's Catastrophic Coverage Act needs to be improved. Acquisition and program management functions are assigned to the same officials, and these officials do not have the necessary training and experience required for the tasks. The OIG believes that the lack of separation of duties and qualifications represents a significant weakness in the system of internal controls.

- A draft OIG report issued in September 1989 found that Medicare was paying costs that private insurance companies should be paying as primary insurers of Medicare beneficiaries. The OIG reported that insurance companies were not paying as primary payer, but rather were allowing Medicare to pay costs of medical treatment which should have been paid by insurance companies. The review concluded that the absence of complete patient coverage information has caused the Medicare program to pay benefits estimated at $180 million to $900 million annually that are actually the responsibility of other primary payers.

- The OIG issued a report in July 1989 stating that Medicare is probably being billed millions of dollars annually for medically unnecessary seat lift chairs. As a result of the completion of the equipment certificate of need by suppliers rather than by physicians, their internal control mechanism was being circumvented. We found a lack of internal control procedures to assure that only physicians were indeed ordering medically necessary seat lift chairs. This lack of controls permitted suppliers to provide medically unnecessary seat lift chairs to beneficiaries and receive unnecessary payments from Medicare.

- The OIG found excessive and apparently unnecessary variations among the carriers in coverage and pricing decisions involving new technologies. Carriers have inadequate systems for insuring that payments for new technologies decrease in response to decreasing costs for delivering an item or service. The HCFA gives little practical guidance to carriers on coverage and pricing matters. These conditions reflect a major systemic weakness in HCFA's information system and HCFA's ability to collect and disseminate information.

- A draft OIG report issued in September 1989 identified inadequacies in the accounting system which precluded HCFA from identifying significant variations between actual expenditures for certain benefits provided by the Medicare Catastrophic Coverage Act (MCCA) and budget estimates. The HCFA accounting system could not allocate a large FY 1989 budget overrun between the new Medicare skilled nursing facilities (SNFs) benefits added by the MCCA and pre-MCCA SNF services. The allocation is important because pre and post-MCCA services are separately budgeted and financed. The OIG projected a $1 billion FY 1989 overrun of post-MCCA SNF benefits.

- A General Accounting Office (GAO) report identified internal control weaknesses in procedures for reinstating certain Medicaid providers terminated from the program. The GAO concluded that HCFA did not have adequate procedures to assure that terminated Medicaid providers have valid provider agreements before being reinstated into the program. The GAO found that HCFA reimbursed one State $138 million for a reinstated provider that did not have a valid provider agreement, making the disbursement unallowable under program regulations.

- An OIG report was issued in July 1989 which addressed a discrepancy between the Social Security Act and Medicaid regulations involving inpatient psychiatric benefits for children in facilities other than hospitals. The OIG review of payment data showed that in four of eight States, Medicaid funding in excess of $17 million was being provided for children in psychiatric facilities other than hospitals. The OIG is recommending that HCFA modify Medicaid policy to limit this benefit to the hospital setting specified in the Social Security Act.

- An ongoing OIG audit of procurements of Medicare claims processing systems by HCFA has identified violations of both Federal and Department procurement regulations. The HCFA officials who initiated arrangements totaling $15 million for procurements with three contractors did not have contracting authority, in violation of the Federal Acquisition Regulations. Also, the HCFA contracting officers initiated procurements and expenditures totaling $15 million for additional Medicare systems projects with four contractors by means of memoranda of understanding. This is not an authorized method of procurement. The persistence of violations of regulations demonstrates a weakness in internal controls that should be reported under the Federal Managers' Financial Integrity Act.

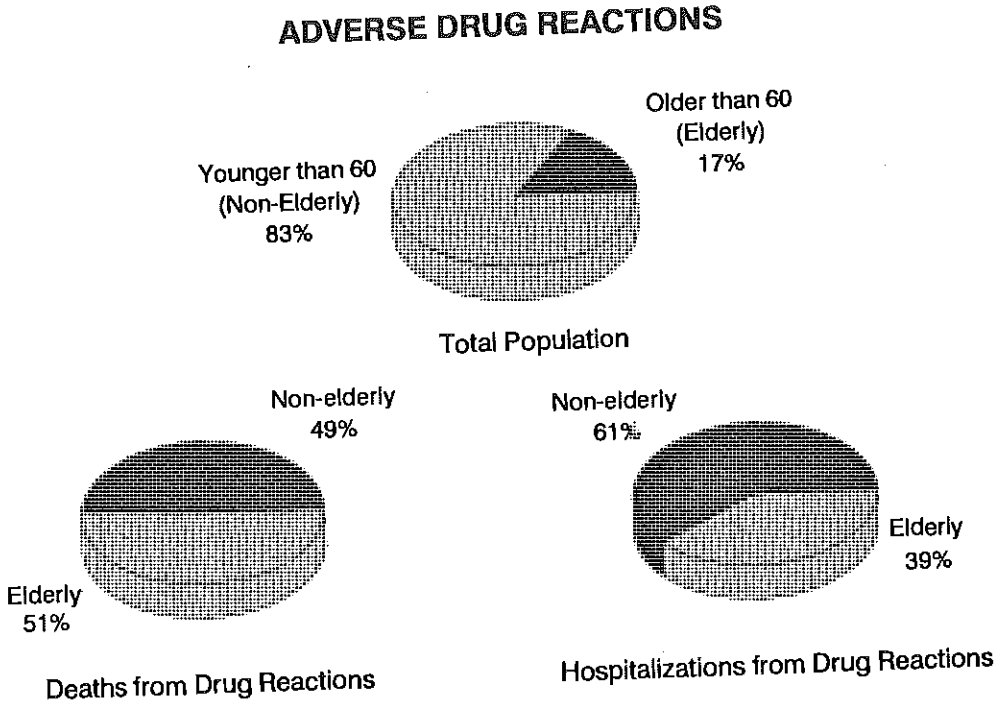
MEDICARE CATASTROPHIC COVERAGE

The MCCA represents the most sweeping change in Medicare since its inception in 1965.

A. Medicare Drug Utilization Review

Under the MCCA, HHS is responsible for establishing a Medicare drug utilization review (DUR) program to identify inappropriate prescribing, dispensing and use of drugs associated with the new benefit. An OIG study examined approaches for developing a high quality Medicare drug utilization review system.

The OIG found a widespread problem of mismedication among the older adult population due to a series of systemic weaknesses in drug prescribing and prescription filling practices. In proportion to the general population, the elderly have a significantly higher ratio of illness and death due to adverse drug reactions than the non-elderly.



The congressional mandate to establish a Medicare DUR program presents a significant opportunity to design and operate a multi-level system to improve quality of care, avoid unnecessary Medicare and personal expenditures and maintain program integrity.

The OIG urged HCFA to plan for the phasing-in of a comprehensive DUR program designed to address each of these areas. Further, OIG recommended that HCFA and the Public Health Service (PHS) develop DUR criteria that will serve as a national standard and made specific recommendations regarding expansion of pharmacology and geriatrics curricula in U.S. medical schools. The OIG also recommended that the Food and Drug Administration expedite publication of final regulations governing approval of drugs to be marketed for the elderly.

The HCFA and PHS did agree with the overall direction set forth for the development of the DUR program. However, HCFA did not agree with the extent of the quality assurance reviews of drug regimens recommended, due to the cost and complexity of such a system. (OAI-01-88-00980)

B. Prescription Drug Claims Processing

The MCCA requires the Secretary to establish an electronic point-of-sale (POS) system for use by participating pharmacies and other drug dispensers in administering the drug benefit. The HCFA must design, procure and implement a fully-tested POS system by January 1, 1991. The POS system will serve as a bill payment and eligibility verification mechanism and as a means for collecting and disseminating drug utilization information.

The OIG evaluated the operational feasibility, cost, procurement schedule and other features of HCFA's evolving plan for implementing the national POS electronic system. The study identified significant problems with HCFA's approach to system design and with the POS procurement schedule. Accordingly, OIG recommended that HCFA request the Congress to delay the implementation date for the Medicare prescription drug benefit by 12 months to January 1, 1992. Such schedule relief would provide HCFA with sufficient time to implement a standard, fully-integrated POS network and to address other issues discussed in the OIG report.

The HCFA disagreed with the recommendation, contending that the mandated implementation date of January 1, 1991 for the POS system is achievable using the HCFA plan as articulated. If the POS system is not functional by that date, HCFA has developed contingency plans under which paper drug bills would be processed until the POS system becomes operational. (CIN: A-14-89-02038)

C. Privacy Implications

Under the electronic POS system, HCFA, its contractors and participating pharmacies will gain access to considerable information about the drug utilization patterns of Medicare beneficiaries. Privacy advocates are concerned that neither the legislation nor HCFA's implementation plans thus far offer adequate assurances that the privacy of beneficiaries will be protected under the new system.

The OIG recommended that HCFA develop standards for the collection and management of data that are consistent with privacy laws and incorporate those standards in the regulations and the criteria to be satisfied by prospective contractors. Further, OIG recommended that HCFA convene a working group of privacy advocates, senior citizen advocates and technical experts to assist in addressing privacy concerns in the development of the electronic system. (OAI-01-89-89170)

D. Supplemental Premium

The MCCA provides that a supplemental premium of up to $800 in the first year be assessed on certain Medicare-eligible beneficiaries. The supplemental premium is to be based on the individual's income tax liability. Since tax-exempt interest is not subject to taxes, there is no supplemental premium on that income. Thus, individuals can shift income to tax-free investments and avoid the premium, causing the program to lose revenue. Further, less affluent and financially sophisticated individuals who do not own tax-free investments will not be afforded the same opportunity to avoid the premium.

The exclusion of tax-exempt interest in figuring the Medicare supplemental premium is not consistent with the Federal Government's taxation of Social Security benefits. In determining how much of beneficiaries' Social Security benefits are subject to taxation, beneficiaries must include tax-exempt income.

The OIG recommended that HCFA propose legislation to amend the Act to require that tax-exempt interest be included in determining an individual's supplemental premium. The savings resulting from this change could be used to lower premiums for all beneficiaries.

The HCFA plans no action on the recommendation, at least during early implementation of the catastrophic program. (CIN: A-09-89-00054)

FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES

New trends in the way health care is delivered in the United States have created a market and impetus for investment in for-profit health care. As physicians have become investors or financial partners in health care entities for which they also generate business through referrals, public examination of the potential conflicts of such arrangements has increased.

The MCCA directed OIG to report to the Congress on physician ownership and compensation. Areas to be studied included the range of such arrangements and the means by which they are marketed to physicians, the potential for these arrangements to lead to inappropriate utilization of such services and the difficulties involved in enforcement actions against arrangements that violate current anti-kickback provisions.

A. Report to the Congress

For the report to the Congress, OIG conducted two surveys of health care providers to determine the prevalence of physician financial involvement with other health care entities and the nature of such arrangements. Claims information from HCFA's Medicare data files for 1987 was used to assess utilization patterns for patients of physician-owners identified in the surveys. In addition, State officials, industry representatives, health care experts and some providers were interviewed or consulted.

The OIG found that many physicians have financial relationships with health care businesses to which they refer patients and that many health care entities are owned by referring physicians. The OIG also found that patients of physician laboratory owners received significantly more services than all Medicare patients in general. The increased utilization of clinical laboratory services alone by patients of physician-owners cost the Medicare program $28 million nationally in 1987.

The OIG recommended that HCFA pursue the necessary legislative and regulatory changes to require entities billing Medicare to disclose the names of their physician-owners and investors to the program, and to require claims submitted by these entities to contain the name and provider number of the referring physician. The report also included six sample options that legislators and administrators might pursue in order to address the issue of higher utilization of services by patients of referring physician-owners and investors.

The HCFA agreed with the recommendations and has taken administrative action to require that claims contain the name and provider number of the ordering or referring physician. (OAI-12-88-01410)

B. State Laws and Regulations

In another study, OIG interviewed State officials regarding their perspectives and experiences in the area of physician ownership. None of the States has an outright ban on physician ownership of a health care entity, though the State of Michigan has prohibited referral of patients to any entity in which the physician has financial interest. Many other States have laws or regulations which prohibit physicians from exploiting patients for financial gain.

Most respondents indicated that they were unable to effectively monitor for compliance with existing laws due to limited resources. Several States are currently in the process of reviewing the practice of physician ownership and self-referral. (OAI-12-88-01412)

C. Perspectives of Health Care Professionals

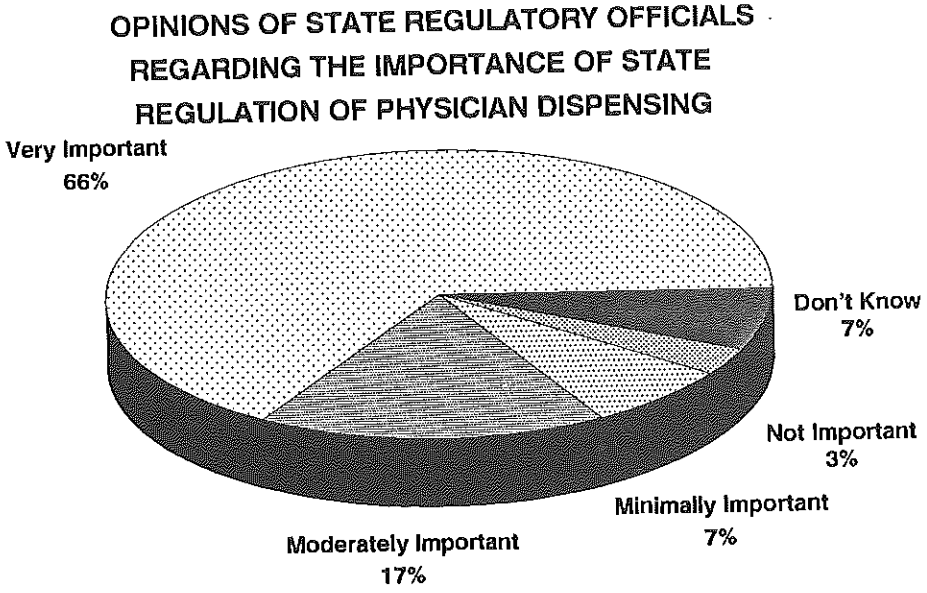
The OIG also conducted interviews with health care professionals and regulatory agencies concerning physician ownership. The majority of State officials, nonphysician owners and health

care association representatives argued that physician ownership and self-referral have a negative impact on the competitiveness of the health care market since physicians control both supply and demand in such circumstances. Physician owners argued that competition is heightened since there are more health care entities from which to choose. Some respondents were concerned that the practice might increase health care costs and diminish quality since, without competition, providers would have no incentive to control costs and maintain quality care. While the majority of physician owners and State Board representatives argued against congressional action, most others were in favor of some kind of congressional intervention. (OAI-12-88-01411)

PHYSICIAN DRUG DISPENSING

The OIG conducted an inspection to determine the nature and extent of current State regulation of physician drug dispensing and to explore the effectiveness of various State approaches to the practice.

The OIG found that the incidence of physician dispensing nationwide is low but increasing. Although nearly all States have some type of regulation over physician drug dispensing, generally these regulations are much less restrictive than those governing pharmacists. Considerable support exists among State regulatory officials for further regulation of physician drug dispensing, as illustrated below.



The OIG recommended that the Federation of State Medical Boards and the National Association of Boards of Pharmacy assist the States in promoting stronger, more effective regulation of physician drug dispensing.

The Assistant Secretary for Planning and Evaluation, PHS and HCFA were all in general agreement that the States continue to assume primary responsibility for regulating physician dispensing of drugs. The PHS, however, disagreed with the need for stronger regulation in this area. (OAI-01-88-00590)

OPHTHALMOLOGY/OPTOMETRY RELATIONSHIPS IN CATARACT SURGERY

At HCFA's request, OIG conducted a study to determine the extent to which ophthalmologists delegate postoperative care to optometrists and the incidence of optometrists being reimbursed for postoperative care already billed by the ophthalmologists as part of a global fee.

The OIG found that the number of postoperative days encompassed by the global fee varies by carrier, as does the percentage of the global fee allocated to surgery versus postoperative care. As a result, in some cases Medicare is making additional payments for postoperative care which would be included in the global fee by other carriers. The report also noted that ophthalmologists who refer cataract surgery patients to optometrists for postoperative care receive a higher percentage of their surgical referrals from optometrists than do those who do all postoperative care themselves.

The OIG recommended that HCFA develop national guidelines covering the number of postoperative days which may be included in a global fee and the percentage allocation of a global fee to surgery and postoperative care. The report also urged that HCFA require the peer review organizations (PROs) to work with their State Boards of Optometry to establish protocols for postoperative cataract surgical care. The HCFA plans to address the issue of carrier variances in the structure and payment of global packages. The HCFA indicated that requiring PROs to establish protocols for postoperative care is beyond the current PRO scope of work. (OAI-07-88-00460)

MEDICARE AS SECONDARY PAYER

At HCFA's request, OIG is currently reviewing the Medicare as secondary payer (MSP) program, both on a nationwide level and a contractor specific level. The Medicare program initially paid for most services provided to beneficiaries. Beginning in 1980, the Congress began enacting legislation that made Medicare the secondary payer in certain cases. By 1987, legislative changes had been enacted that made Medicare the secondary payer to employer group health plans (EGHPs) for those Medicare beneficiaries who are working aged, disabled and/or have end stage renal disease.

The HCFA and its intermediaries and carriers have experienced difficulties in identifying beneficiaries with other health insurance. Despite HCFA's efforts to improve the collection of

information on primary payer insurance of Medicare beneficiaries, more needs to be done to better identify primary payers other than Medicare and reduce the Medicare overpayments estimated at $400 million to $900 million per year from unidentified cases.

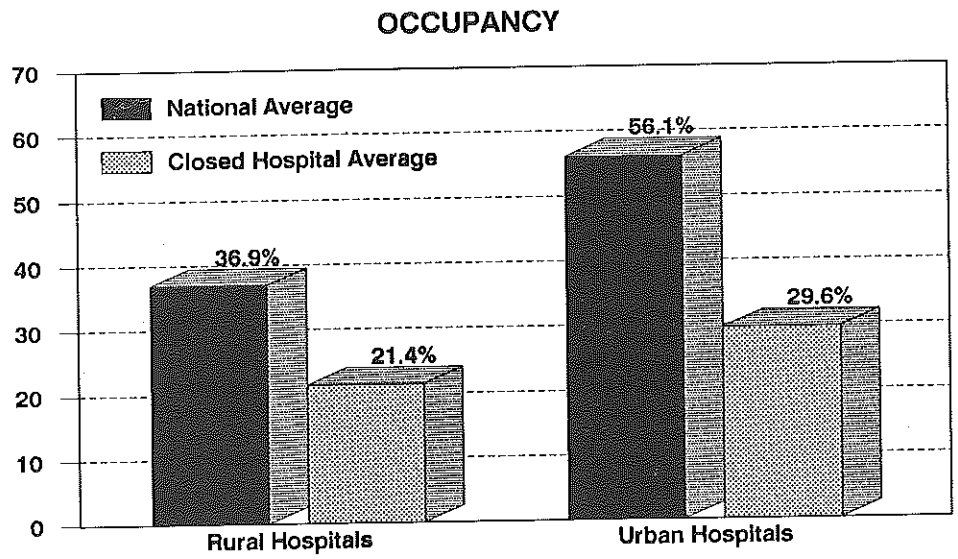
The absence of adequate internal controls to assure the collection of timely and accurate information on those insurers liable as primary payers and to prevent significant Medicare overpayments is a material internal control weakness which should be reported to the President and the Congress under the FMFIA.

The OIG recommended that HCFA make additional necessary procedural changes and seek legislative changes to assist in identifying beneficiaries covered under an EGHP. (CIN: A-09-89-00100)

HOSPITAL CLOSURES

In the past few years, the closure of general, acute care hospitals has generated increasing public and congressional concern. Numerous questions have been raised about the reasons for and the effects of hospital closure, as well as the implications for public policy.

An OIG inspection found that in 1987 there were 69 closures of general, acute care hospitals across the country and that rural and urban hospitals closed in roughly equal proportion to their numbers nationally. Hospitals that closed were small and occupancy rates for both rural and urban hospitals that closed were much lower than the national averages as illustrated below.



There was no single factor or event which accounted for the closures; rather, a set of factors relating to hospital financing gradually diminished the hospitals' viability. These factors included declining revenues due to fewer admissions, lower third-party reimbursement rates, more uncompensated care and rising operating costs. The report concluded that few patients were affected by these closures as emergency services and inpatient care were accessible in other nearby facilities. (OAI-04-89-00740)

RURAL HOSPITALS

Rural hospitals are perceived to be more at financial risk than urban hospitals under the Medicare prospective payment system (PPS) due to their lower payment rates. The OIG developed a financial profile of rural hospitals participating in PPS to determine the extent to which they have earned profits or incurred losses in recent years from Medicare and total hospital operations and the reasons for financial success or failure.

The study showed that the average rural hospital realized a profit from overall activities during 1985, 1986 and 1987; but their Medicare profit margins decreased from 7 percent in 1985 to a negative 2.4 percent in 1987. On the average, rural hospitals losing money under the PPS received about the same amount of 1987 Medicare revenues per discharge as profitable rural hospitals, but they incurred costs per discharge of $500 to $650 more than these hospitals. These data indicate that unprofitable rural hospitals incur losses because they are unable to control costs. The OIG concluded that profitable rural hospitals have higher occupancy rates, have fewer staff and keep Medicare patients in the hospital for shorter periods than similar unprofitable rural hospitals. (CIN: A-07-89-00215)

HOSPITAL PATIENT DUMPING

Under section 1867(d) of the Social Security Act, OIG has responsibility for sanctioning hospitals with emergency departments that fail to provide, within the capability of the hospital, an appropriate medical screening, examination, and stabilizing treatment, or inappropriately transfer or discharge individuals with emergency medical conditions and women in active labor.

Hospitals that fail to comply with these provisions may be terminated or suspended from the Medicare program, and hospitals and responsible physicians who knowingly violate them are subject to a civil monetary penalty of up to $50,000 for each violation.

- In one patient-dumping case settled during this reporting period, a Maryland hospital paid $10,000 after a doctor refused to admit a 5-year-old girl who had been bitten in the face by a dog, telling her parents to take her to another hospital. The doctor's employment at the hospital was terminated.
- An administrative law judge upheld the imposition of a penalty against a Texas doctor who had inappropriately transferred a woman in labor with an emergency

medical condition. He falsely certified that the benefits of transfer outweighed the risks, despite the concerns of the attending nurses, and transferred the woman to another hospital 170 miles away. The penalty was set at $20,000.

SANCTION AUTHORITIES

During this reporting period, OIG imposed 548 sanctions, in the form of exclusions or monetary penalties, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries.

A. Patient and Program Protection Sanctions

The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health, and Block Grants to States for Social Services programs. Exclusions can now be made for conviction of fraud against a private health insurer, obstruction of an investigation and controlled substance abuse, as well as for revocation or surrender of a health care license. Exclusion is mandatory for those convicted of program-related crimes or patient abuse. The following cases are examples of some of the sanctions imposed during this reporting period:

- In a precedent-setting action, OIG excluded a Pennsylvania physician for 5 years from the Medicare and Medicaid programs for refusing to turn over payment records to a Medicare carrier. The doctor was repeatedly uncooperative in supplying information to the carrier to justify $89,000 received in payment on 25 cases.
- A clinic operator was excluded for a 15-year period after being convicted of billing Medicaid over $300,000 for services not rendered.
- As a result of his conviction for embezzling over $1.2 million from a community health center, an accountant was excluded for 20 years.
- A personal care attendant was excluded for 25 years for sexually abusing a mentally incompetent patient.
- A 10-year exclusion was imposed on a physician convicted of intent to illegally distribute controlled substances.

In addition, the Ninth Circuit Court upheld the Medicaid program exclusion of a California physician. In 1980, he was excluded for 5 years on the basis of providing care which did not meet recognized quality standards. After an administrative law judge modified the exclusion to 3 years, the doctor appealed unsuccessfully to the Appeals Council, the District Court and, finally, the Circuit Court.

B. Civil Monetary Penalty Settlements

Under the civil monetary penalty (CMP) authorities enacted by the Congress, health care providers may be assessed thousands of dollars in fines and penalties for each false item claimed against Medicare and Medicaid. The following cases are examples of some of the more significant settlements made during the past 6 months:

- A medical device manufacturer in Florida paid a $5.6 million civil settlement with the Department of Justice, HHS and the Department of Veterans Affairs. The agreement resolves the company's potential liability under the False Claims Act based on allegations that between 1980 and 1985 it manufactured and distributed defective pacemakers. The company has divested itself of its pacemaker division and no longer makes, distributes or sells pacemakers or related products.

- More than $2 million was recovered from several Illinois hospitals which had billed both Part A and Part B of the Medicare program for the same services.

- A physician who repeatedly violated the physician fee freeze provisions of the Deficit Reduction Act of 1984 by overcharging Medicare beneficiaries paid a CMP of $40,000.

- A dentist who billed the Medicaid program for services that were not provided entered into a joint State and OIG settlement agreement whereby he is to pay civil penalties of $100,000. The settlement agreement further provided that the dentist would be permanently excluded from participation in the Medicare and Medicaid programs.

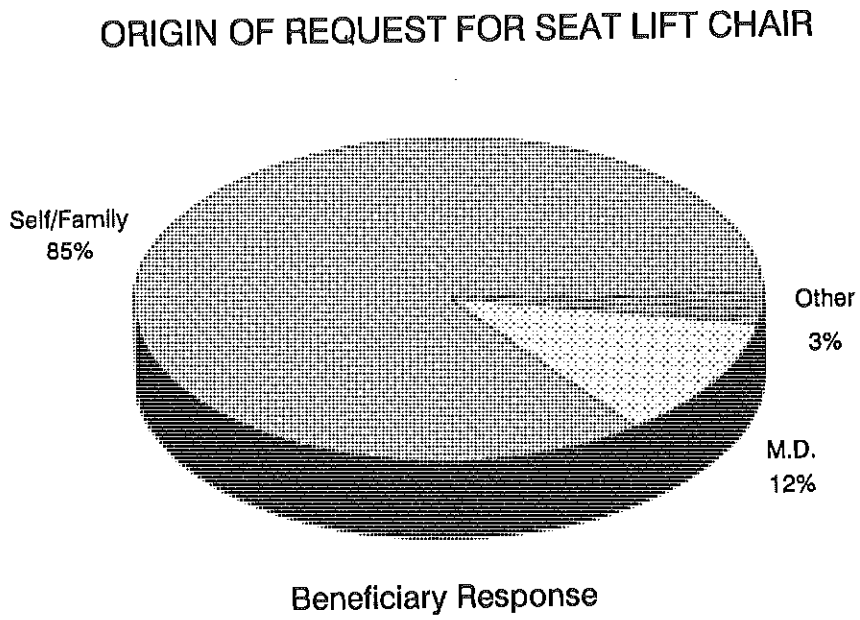
- An OIG investigation of an ophthalmologist disclosed that he was billing Medicare for services that he did not render. The ophthalmologist entered into a global criminal and civil settlement agreement in which he agreed to be excluded from participation in the Medicare and Medicaid programs for a period of 3 years and to pay civil penalty of $190,000.

SEAT LIFT CHAIRS

For some time, the rapidly increasing number of Medicare claims for seat lift chairs (SLCs), the aggressive marketing techniques used by suppliers and the incidence of related fraud have been a source of concern to OIG. Projects investigating fraud in the industry have resulted in recoveries and savings of more than $25 million over the past 3 years. During this period, one case alone resulted in recoveries of more than $1.78 million. An OIG inspection and audit have raised basic questions about whether SLCs should be covered by Medicare at all, and, if so, under what circumstances.

A. Coverage as Durable Medical Equipment

In an inspection focusing on Medicare coverage of SLCs, OIG found that a large number of beneficiaries contacted for the study had initiated the request for the SLC themselves, having learned about them through mass media marketing.



Most beneficiaries indicated that the chairs were used primarily for non medical purposes, making them inappropriate for coverage as durable medical equipment (DME). Further, the study found that physicians were often authorizing the SLCs under pressure from both beneficiaries and suppliers, rather than as part of an existing course of treatment.

The OIG recommended that HCFA reconsider whether SLCs meet the definition of DME and take immediate actions to assure that current coverage requirements for SLCs are enforced. The HCFA has taken steps to ensure more effective evaluation of current SLC claims and has developed a proposed rule which would withdraw Medicare coverage for SLCs. (OAI-02-88-00100)

B. Payments by Carriers

An OIG audit of Medicare payments for SLCs made by a carrier that processed a large volume of SLC claims concluded that the carrier had complied with Medicare requirements in screening claims prior to payment. However, many SLCs paid for were not medically necessary and were not being used by beneficiaries as part of their medical treatment. The OIG found that the

acceptance of supplier, rather than physician, initiated statements of medical necessity and the suppliers' aggressive marketing techniques significantly increased claims and Medicare payments for SLCs.

The OIG recommended that HCFA require physicians to initiate the order for a SLC and provide evidence of its medical necessity. A Texas carrier adopted this procedure and reduced payments for SLCs from approximately $7.3 million to $10,700 annually. The HCFA should also require carriers to only process claims for beneficiaries in their servicing area. Further, OIG recommended legislation to reduce payment levels for SLCs and to apply sanctions for ordering unnecessary medical equipment.

The HCFA will issue revised instructions that incorporate innovative practices used by carriers. However, since HCFA is conducting a review of carrier jurisdiction issues for all Part B services and supplies, it does not support the OIG recommendations at this time. (CIN: A-05-87-00138)

MEDICARE COVERAGE OF POWER-OPERATED VEHICLES

An OIG inspection was conducted to determine the impact of beneficiary-oriented marketing of power-operated vehicles (POVs) on Medicare reimbursement and to review the appropriateness of Medicare payment. The OIG found that direct marketing of POVs to beneficiaries is generating demand and that Medicare should not have paid a majority of claims for reimbursement for POVs in 1986.

The OIG recommended that HCFA ensure that carriers implement the Medicare requirements that each POV claim be reviewed by medical staff; that only certain specialties authorize these claims; and that suppliers have written orders from a physician before delivery of the item to the patient. The HCFA concurred with the recommendations and has prepared procedural revisions to implement them. (OAI-02-88-01110)

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS

The transcutaneous electrical nerve stimulator (TENS) device is a low-voltage electrical impulse generator which is used to control pain. Medicare covers long term use of TENS when it provides significant therapeutic benefit to patients with chronic pain and short term use for acute postoperative pain. Medicare reimbursement for these devices has increased substantially over the past few years.

An OIG inspection to identify vulnerabilities in Medicare reimbursement for TENS found that one-third of the claims for beneficiaries contacted were inappropriately reimbursed, resulting in an estimated loss of $4.3 million to Medicare. The OIG recommended that HCFA prohibit payment unless the supplier receives a written order from the physician prior to delivering the

device to the patient. The HCFA concurred with the recommendations and has taken action to implement them. (OAI-02-88-00060)

FRAUD INVOLVING DURABLE MEDICAL EQUIPMENT

Medicare frequently pays for DME such as oxygen equipment, wheelchairs, SLCs, TENS, home dialysis systems and other medically necessary equipment that physicians prescribe for home use. The following cases are examples of actions resolved during this reporting period involving DME suppliers who defrauded the Medicare and Medicaid programs:

- An Illinois chiropractor had to pay $137,800 in fines and restitution for illegal sales of hundreds of TENS units billed to Medicare at about $500 each. He had paid other chiropractors and physicians to certify that they had examined the Medicare beneficiaries and to prescribe the units.
- In California, the owner of a DME company was convicted for paying kickbacks ranging from $120 to $150 for every patient referred to his company for a TENS unit.
- The owner of an Arkansas DME company was sentenced to 90 days in jail, fined $7,000 and ordered to pay restitution of $3,000 for defrauding Medicare and Medicaid. He devised a scheme whereby his company and four nursing homes received payment for beds the homes already owned.

DRG ASSIGNMENT ERRORS

Under PPS, hospitals file a claim with Medicare upon discharge of the covered patient and are reimbursed at predetermined fixed rates. At discharge, the attending physician attests to the principal diagnosis, any secondary diagnosis and the procedures performed. The hospital's medical records department then translates this into numeric codes and prepares a claim. It is on this basis that a diagnosis rated group (DRG) for reimbursement is assigned. Each DRG has a relative weight. The greater the relative weight, the higher the expected cost of treatment and, therefore, the greater the reimbursement.

The OIG conducted a series of inspections on selected DRGs (DRGs 79, 87, 89, 121, 129, 154, 296, 416 and 468) which are particularly vulnerable to manipulation and miscoding due to their high reimbursement rates and their nonspecific diagnostic criteria. These inspections found coding errors of various types for each of these DRGs. Most of the coding errors resulted in significantly higher payments to the hospitals. As a result of these coding errors, projected Medicare losses are estimated at $474.3 million annually.

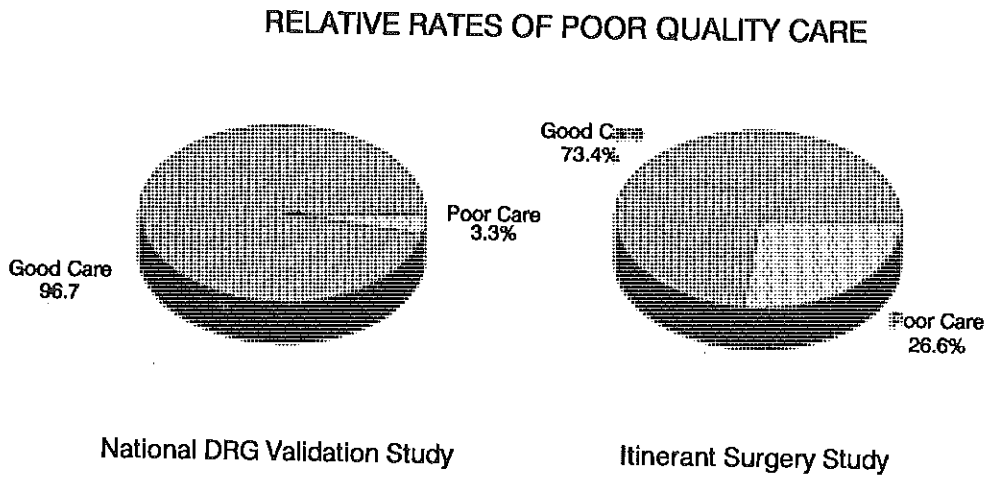
The OIG recommended that HCFA direct the PROs to educate hospitals and physicians about proper coding of these DRGs. The HCFA concurred and has conducted a national training session for all PROs in correctly coding DRGs and has revised coding instructions in an

American Hospital Association publication on coding. (OAI-12-88-01100; OAI-12-88-01140; OAI-12-88-01150; OAI-12-88-01190; OAI-12-88-01160; OAI-12-88-01200; OAI-12-88-01210; OAI-12-88-01180; OAI-12-88-01170)

ITINERANT SURGERY

An OIG inspection focused on the quality of care in cases of inpatient itinerant surgery, which is the practice of surgery by a physician residing in one area who travels to small rural hospitals in other areas to perform surgery.

The OIG found that some rural hospitals make extensive use of itinerant surgery as a cost-effective means of providing necessary services which might not otherwise be available in some rural areas. The study concluded that there is a greater than average risk of poor quality care in itinerant surgery as compared to the overall rate of such care identified by OIG in an earlier national DRG validation study.



In addition, a review of medical records and payment histories found that in nearly 64 percent of the cases the itinerant surgeons did not provide postoperative care, but did bill Medicare a global fee which included the cost of such care.

The OIG recommended that rural physicians and hospital administrators institute procedures to provide the patient an opportunity for a second surgical opinion; ensure an adequate preoperative workup; and improve postoperative communication between the itinerant surgeon and the attending physician. The OIG outlined a means for recovering identified overpayments and for

eliminating future overpayments in instances of postoperative care billed, but not provided, by itinerant surgeons.

The HCFA was in general agreement with the report findings and is taking action to implement the majority of the OIG recommendations. (OAI-07-88-00850)

SHORT HOSPITALIZATIONS

The OIG studied short hospital stays (1 to 3 days) to determine whether short-stay patients were being admitted and discharged appropriately and whether the quality of care they received was adequate. Of the more than 7,000 Medicare discharges reviewed, 18 percent involved short hospitalizations. The short hospitalization group had a 20 percent unnecessary admission rate as compared to a 10 percent rate for the study group as a whole, and these cost the Medicare program approximately $217 million in 1985. Most patients unnecessarily admitted did require medical attention, but not in an acute care setting.

The study report identified those DRGs within which there was the greatest likelihood of an unnecessary admission. Based on these findings and those contained in an earlier report on unnecessary admissions (OAI-09-88-00880), OIG recommended that HCFA include specific DRGs for admission reviews in their proposed pilot studies on short hospital stays. The HCFA concurred with the recommendations. (OAI-05-88-00730)

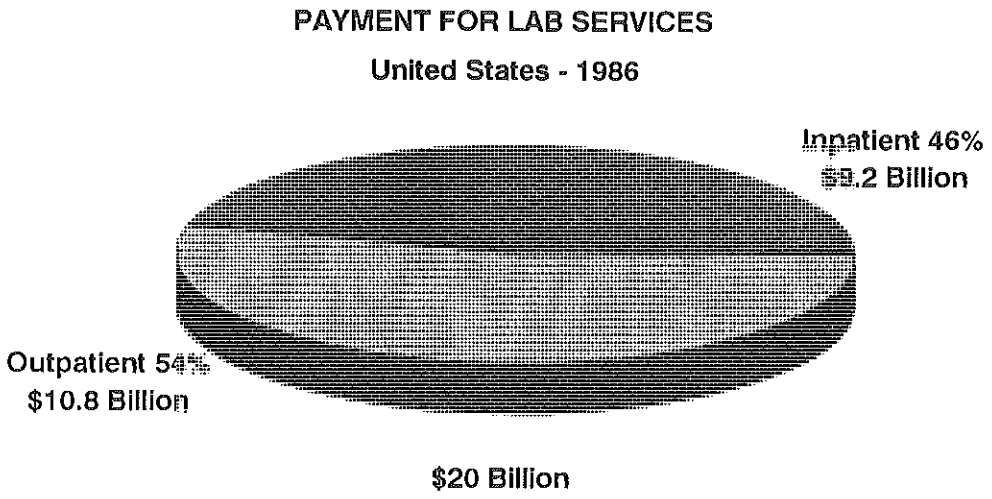
REIMBURSEMENT FOR ONE-DAY HOSPITAL STAYS

The OIG conducted a review to evaluate the propriety of PPS reimbursement for 1-day admissions not requiring an overnight stay. Many of those admissions reviewed were for patient observation after outpatient or emergency services, cancelled surgeries or acute care stays of doubtful necessity.

The OIG recommended that HCFA seek legislation to pay for inpatient services not requiring an overnight stay as outpatient services or propose a legislative change to pay for these services at the lower of actual charges or the DRG amount. If this change were implemented, Medicare could save at least $118 million annually or $590 million over 5 years and reduce beneficiary out-of-pocket expenditures in most cases. The HCFA disagreed with the recommendation and stated that intensified review of 1-day admissions by the PROs will address the problem of medically unnecessary admissions. The OIG continues to believe that the reimbursement methodology for admissions not requiring an overnight stay should be changed. (CIN: A-05-89-00055)

REIMBURSEMENT FOR LABORATORY SERVICES

Payments for all laboratory services in the United States are estimated to be $20 billion annually. Fifty-four percent of that amount is spent on outpatient services.



The OIG studied the effects on Medicare program costs of adopting a national fee schedule for the payment of outpatient laboratory services for Medicare beneficiaries. Currently, the amount Medicare pays for specific outpatient laboratory services is the lowest of three rates: the amount billed by the laboratory, the amount indicated on a carrier-wide fee schedule (the "area rate") or the national limitation for the billed service (the median of all the area rates).

Under the Omnibus Budget Reconciliation Act (OBRA) of 1987, area rates will be discontinued in 1990 and reimbursement will be made according to a uniform national fee schedule. The effect of implementation of such a schedule will depend on the level at which that schedule sets reimbursement. The study concluded that implementation of a national fee schedule set at the current national limitation rates could be very costly, with an increase in Medicare expenditures of $82 million in 1990 for the 62 most frequently reimbursed tests. The total cost for all Medicare laboratory tests would be much higher.

The OIG recommended that HCFA request that the Congress repeal the requirement to base laboratory reimbursement on a national fee schedule beginning in 1990. The HCFA concurred with the OIG recommendation but indicated that they believed it could be implemented administratively. They are in the process of preparing implementing regulations to be effective January 1, 1991. The HCFA estimates savings of $190 million annually. (OAI-04-88-01080)

QUALITY ASSURANCE IN PHYSICIAN OFFICE LABORATORIES

The OIG issued a report as a follow-up to last spring's inspection entitled "Quality Assurance in Physician Office Laboratories" (OAI-05-88-00300). The Clinical Laboratory Improvement Amendments (CLIA) of 1988, which adopted most of the recommendations in that report, were enacted as freestanding provisions to the Public Health Service Act. However, provisions of OBRA 1987, with which some of the CLIA provisions were in conflict, were neither repealed nor amended. Thus, implementation of both OBRA 1987 and CLIA 1988 could result in laboratories being held to two different sets of standards and requirements.

The OIG recommended that the CLIA standards be implemented. The HCFA and PHS should take the necessary administrative measures to ensure that uniform requirements apply under the PHS and Medicare programs for interim laboratory sanctions, registration fees, application processes and deemed status for approved accreditation agencies. The OIG urged that HCFA seek a technical amendment to OBRA 1987 to make the Medicare requirements consistent with the CLIA/PHS requirements. (OAI-05-88-00331)

CLINICAL LABORATORY TEST REIMBURSEMENT

Based on a review to compare Medicare laboratory payment rates to the prices available in a competitive market place, OIG found that Medicare paid, on average, nearly twice the price charged to physicians. The differences between what Medicare paid and the physician prices were most pronounced for profiles, which are standardized test packages ordered as a group.

The OIG recommended that HCFA seek legislation to bring the Medicare payment rates for clinical tests in line with the prices which laboratories charge physicians; develop policies and procedures to insure that the program benefits from reduced prices when profiles are ordered for Medicare patients; and work with carriers to further streamline the processing of Medicare claims for laboratory services. (CIN: A-09-89-00031)

LABORATORY SERVICES FRAUD

Fraud in the laboratory services sector of the health care industry commonly involves billing for a greater number or complexity of tests than those actually performed. While laboratory owners can most easily accomplish this deception, physicians have been known to capitalize on it as well. The following examples illustrate cases successfully concluded during this period.

- The owner of a laboratory in Illinois was ordered to repay $24,000 he had obtained fraudulently. He claimed the single drawing fee of $5 for services to 50 patients a day, when he should have charged the multiple patient rate of $3 each. He also billed for drawings when the only tests were urinalyses.

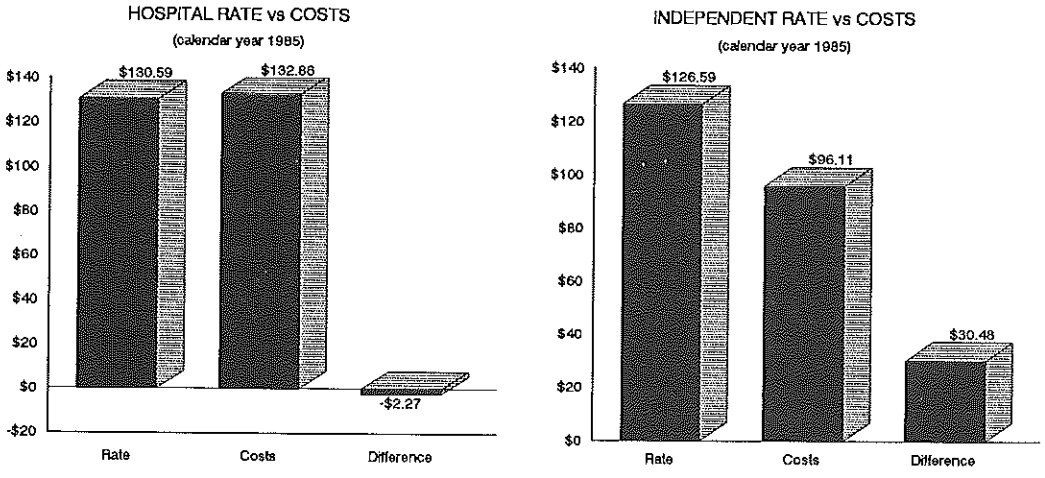
- A West Virginia doctor pled guilty to billing Medicare for tests actually performed by a laboratory service, some of which he also billed to Blue Cross. He billed Medicare $450 for each series of tests he claimed to have performed in his office. The laboratory charged him only $18 for each and nothing at all for tests to indigents. The doctor agreed to pay full restitution of $12,200 to Medicare, $750 to Blue Cross, $150 to the State workers' compensation program and $8,000 to OIG for investigation costs. He also agreed to pay all tax liabilities he incurred by not reporting cash payments to his office.

- Last year, more than $500,000 was collected from 334 physicians in the Philadelphia area who had accepted kickbacks from four diagnostic laboratories for referring patients. The money was collected as the result of letters sent by the United States Attorney demanding repayments in settlement of civil liabilities. In a second phase of this civil kickback recovery project, demand letters were issued to 50 physicians who received payments for referring patients to another vascular diagnostic company. Thus far, about $90,000 has been collected.

DIALYSIS REIMBURSEMENT RATES

The HCFA sets reimbursement rates for dialysis services under PPS, which differentiates between independent and hospital providers. The average rate is established by combining independent and hospital facilities' costs. Adjustments are then made in the hospitals' rate to reflect their higher costs. However, no corresponding downward adjustments are made to the independents' rate to reflect their lower costs.

DIALYSIS REIMBURSEMENT RATES VERSUS COSTS



The OIG determined that by developing separate dialysis rates for independent and hospital facilities providing such services, the Medicare program could save an estimated $544 million over 5 years. The HCFA did not agree with the report findings and believed that implementation of the OIG recommendation could increase expenditures and have an adverse effect on quality of and access to care. The OIG continues to believe that the rate setting methodology requires immediate change. (CIN: A-01-87-00500)

PHYSICIANS' SERVICES IN OUTPATIENT SETTINGS

Medicare regulations provide that payments for physicians' services of the type routinely furnished in physicians' offices, which are furnished in outpatient hospital settings, will be limited to 60 percent of the area prevailing charge by non-specialists in office practice. Under the regulations, each carrier is to identify the physicians' services that are subject to the 60 percent limitation. An OIG audit of the Medicare carriers' implementation and HCFA's monitorship of the 60 percent limitation found a wide variance among carriers in the types and numbers of procedures they subjected to the limitation.

The OIG developed a list of 315 physician procedures that all carriers should consider subjecting to the 60 percent limit. If the limit were applied to these 315 physician procedures, Part B expenditures would be reduced by an estimated $111 million over 5 years.

The HCFA expressed concern about the wide disparity among carriers in implementing the 60 percent limitation. However, HCFA believes the present variance exists because of different levels of attention to this requirement among carriers. The OIG recommended that HCFA take the lead and assure that carriers are consistently applying the limitation to all physicians' services in outpatient settings. (CIN: A-07-86-62041)

DUALLY ELIGIBLE VETERANS

The Department of Veterans Affairs (VA) authorizes payments for medical services to certain veterans, some of whom are also eligible under the Medicare program. The OIG reviewed the costs of cardiac surgical services provided to Medicare eligible veterans at three hospitals and determined that costs for cardiac surgical services authorized by the VA were inappropriately billed to Medicare contractors. The study disclosed that Medicare paid $3.2 million for cardiac surgical services that were the financial responsibility of the VA.

The OIG recommended that the Medicare contractors recover the inappropriate payments made for services to veterans who were the financial responsibility of the VA and instruct Medicare providers not to bill Medicare for services authorized by the VA. (CIN: A-04-88-02049)

PRACTICING WITHOUT A LICENSE

Physicians who practice medicine without a license and bill Medicare not only illegally obtain program funds but also pose a threat to unwitting patients. As a result of OIG investigations during this reporting period, the following sentences were given for practicing without a license.

- A nursing home administrator was given a suspended prison sentence and ordered to pay restitution to his victims, including the Medicaid and Medicare programs, for forgery and practicing psychology without a license. He had altered the valid license renewal form of a legitimate psychologist to appear as if it were issued in his own name. He then rendered purported psychological services under a business name to patients in a number of nursing homes.

- A Virginia physician and his son were each sentenced to 3 years probation. The father must also perform 200 hours of community service for allowing his son, who had no medical license, to cover his practice when he was out of town. The son was fined $5,000 for seeing patients and writing prescriptions, in violation of Medicare, Medicaid, and Civilian Health and Medical Plan of the Uniformed Services programs rules.

- In California, a man was sentenced in a county court to 3 years probation and a fine of $1,175 for posing as a physician in an "industrial medicine" group. He had used another physician's billing number and had given pre-employment physicals, supplied medication and performed minor operations without a license.

ENDOSCOPIC EXAMINATIONS

Endoscopic examinations of the lower gastrointestinal (GI) tract are among the most frequently performed procedures paid for by Medicare. The OIG reviewed the records of 237 patients who had been reimbursed for endoscopic examination of the lower GI tract in 1986 and found that over 27 percent of the procedures were not appropriate for Medicare reimbursement as they were performed for noncovered examinations. Medicare made inappropriate payments of this type in excess of $39 million in 1986. The study concluded that the incorrect payments were made as a result of inaccurate diagnostic information which had been provided on the claims forms.

The OIG recommended that HCFA have its carriers provide information to the medical community regarding the coverage limits and documentation for such procedures and give increased attention to these procedures in their postoperative reviews. The HCFA concurred with the OIG recommendations. (OAI-02-88-00090)

MEDICARE PAYMENTS FOR ANESTHESIA SERVICES

The OIG concluded that by changing the current and/or proposed regulations regarding reimbursement for anesthesia services, HCFA could reduce allowable charges by over $69 million a year or $347.5 million over a 5-year period. Further, by following other HHS programs where rounding-down is required, HCFA could reduce charges by $139 million annually and $695 million over 5 years.

Current Medicare regulations require that fractional time units of anesthesiologists rendering services to Medicare beneficiaries be rounded up to the next whole time unit for Medicare payment purposes. An earlier OIG audit using 1986 data estimated that this rounding provision caused the Medicare system and its beneficiaries to pay over $35 million annually for unexpended anesthesiologist time. Regulations, contemplated for implementation in 1989, provide that certified registered nurse anesthetists (CRNAs) will also be able to directly bill Medicare and that the same rounding of time provision will be applicable to them as to anesthesiologists. Using 1988 data, OIG currently projects that allowable charges for effort not expended will come to over $52 million a year for anesthesiologists and over $17 million a year for CRNAs.

The OIG obtained comments from the American Society of Anesthesiologists (ASA) on the issues addressed in this report. The ASA generally concurred with the report findings. They stated that they could accept any of the various reimbursement approaches proposed and agreed that payment should only be made for efforts expended. (CIN: A-07-89-00193)

MEDICAL DIRECTION OF ANESTHESIA

Billings for medical direction of anesthesia by a surgeon are permissible under current regulations as a means of reimbursement for services furnished by CRNAs in their employ. An OIG review performed in Florida showed the need for a limitation on medical direction provided to CRNAs.

A regulatory change proposed by HCFA would establish a fee schedule to reimburse surgeons for the services of CRNAs in their employ, allow direct payments to CRNAs, and eliminate the need for "medical direction" payments to surgeons. The OIG recommended that the proposed regulation that establishes a fee schedule for direct payments to CRNAs also contain a provision that surgeons no longer be reimbursed for the medical direction they furnish anesthetists during surgery. Inclusion of these instructions in the text, as well as in the preamble to the regulations, would help eliminate confusion in the implementation of reimbursement policies. (CIN: A-04-89-02081)

MEDICAL TRANSPORTATION FRAUD

The OIG continues to obtain convictions of ambulance companies and their officers for Medicare and Medicaid fraud. During this reporting period, convictions were also obtained from an ongoing investigation of the use of Medicaid patient transportation vouchers by the taxi industry:

- In Pennsylvania, the president of a community ambulance association was sentenced to 6 months in jail and ordered to make restitution of $1,000 a month, up to a total of $53,000 he had embezzled. He had diverted Medicare, private insurer and membership funds to his own bank account and used the money to pay personal bills and gambling debts.
- The owner of an Arkansas ambulance company and his office manager were convicted of Medicare fraud. They altered trip sheets to show destinations as hospitals rather than doctors' offices. They also inflated mileage charges by charging station to station rather than actual "loaded" miles.
- An Oregon ambulance company and its owner had to repay $10,000 claimed from Medicare and $11,700 in fines because they had already been reimbursed by Medicaid.
- Four persons were given prison sentences in an ongoing investigation by OIG into the fraudulent use of Medicaid vouchers for taxi fares in the District of Columbia. A former hospital employee had stolen vouchers and sold them to taxi drivers who turned them in for reimbursement. A total of 30 months in jail time and more than $20,000 in fines and restitution were ordered.

MEDICAID CREDIT BALANCES

The law and regulations provide that Medicaid payments may be made only when there is no third party liable for payment of services. Where Medicaid and a third party make payments, or where the Medicaid payment is in excess of the amount due or there is a duplicate Medicaid payment, a credit balance is created. An OIG inspection disclosed potential Medicaid credit balances of over $34 million nationwide, with a Federal share of over $20 million.

The OIG found that hospitals were often not reporting credit balances to Medicaid in a timely manner and that State agencies and fiscal agents were not recovering those balances in a timely manner. The OIG recommended that HCFA take action to recover or adjust the identified credit balances and that they establish and enforce time frames for reporting and recovering such balances.

The HCFA generally agreed with the OIG findings. They disagreed with the recommendation to establish time frames for refunds. The HCFA indicated that section 9512 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) is more stringent than the OIG recommendation and should ensure faster recoupment of the Federal portion of these funds. This provision

requires State Medicaid agencies to refund any overpayments, including credit balances, as soon as they are identified. The OIG continues to believe that the establishment of time frames would help ensure prompt recovery of these Medicaid funds. (OAI-07-88-00470)

TRANSFER OF ASSETS IN THE MEDICAID PROGRAM

A recent review of Medicaid estate recoveries (OAI-09-86-00078) disclosed reports of widespread asset sheltering by applicants and their attorneys across the country and the existence of many available legal shelters. In the first of a series of follow-up studies, OIG examined whether asset shelters, including property transfers, play a significant role in qualifying people for Medicaid long-term care benefits in the State of Washington.

The study found that, in 58 percent of the Washington Medicaid nursing home cases involving individuals who were initially denied assistance because they exceeded the resource eligibility threshold, those individuals became eligible within a few months by transferring or sheltering their assets. It also concluded that advice on how to qualify for Medicaid nursing home benefits by such means is widely available and that financial abuse of the elderly is common in such situations.

In view of these findings which reinforced those of the study on estate recoveries, OIG reiterated the recommendations from that earlier report, including one on strengthening the transfer of asset rules. In addition, OIG proposed that the Washington State Medicaid agency improve case record documentation to assure that asset values and dispositions are properly recorded in all cases. The OIG plans to conduct a national inspection of Medicaid asset shelters to determine their impact on States other than Washington. (OAI-09-88-01340)

IMPROPER STATE CLAIMS FOR FEDERAL MEDICAID FUNDS

The costs of the Medicaid program are shared by the Federal and State governments. However, the law and regulations stipulate that the Federal Government will share in care and treatment costs only when certain criteria are satisfied.

A. California: Short/Doyle Program

An OIG audit determined that California overstated actual expenditures by about $3.5 million for FY 1983 under the Short/Doyle program, a component of the California Medicaid program serving the mentally ill which is operated by the various counties in California. The counties bill the Department of Mental Health for their Short/Doyle costs, and these in turn are passed on to the Department of Health Services which submits claims for Federal cost sharing to HCFA.

In connection with a review of Short/Doyle Medi-Cal costs for FY 1986, a second audit report disclosed another overclaim in excess of $2.3 million. In prior audits, OIG reported on similar

sentenced for stealing more than $16 million from the Medicaid program by submitting false claims. His was the largest fraud by a single Medicaid provider ever prosecuted in the United States. He was sentenced in absentia to 7 to 21 years in prison, and a bench warrant was issued for his arrest. His two sons were also given terms of 5 to 25 years, and the family-owned corporation was convicted of felony larceny and ordered to make $32 million in restitution.

- The highest Medicaid-paid optometrist in Tennessee was sentenced to 3 years incarceration and ordered to pay $120,000 in restitution and fines for falsely billing the Medicaid program. The optometrist bused Medicaid-eligible people to his clinic for examinations and, once he had their Medicaid numbers, billed Medicaid for glasses not issued and services not rendered. Each year he rebilled Medicaid under many of these numbers.
- A New York ophthalmologist working as a general practitioner in a poor neighborhood was sentenced to 1 year in jail for conspiracy and false filings against the Medicaid program. He had been suspended from the program in 1986 for false billings, but had continued to bill under another physician's name.

MEDICAID LABORATORY FEE SCHEDULE

The OIG conducted an audit to determine if State agencies utilized the appropriate fee schedules in claiming FFP under Medicaid for outpatient clinical diagnostic laboratory services performed by physicians, independent laboratories or hospitals.

Under the Deficit Reduction Act of 1984 (DEFRA), FFP is not available to the extent a State pays more for outpatient laboratory services than the amount Medicare recognizes for such services. The OIG identified FFP of approximately $2.2 million in outpatient laboratory services that were inappropriately claimed by the State Medicaid agencies.

The OIG recommended that HCFA ensure that all States either use the Medicare fee schedule or demonstrate that their current payment level for such services is lower than that amount; take action to initiate recovery of overpayments in those States where the DEFRA provisions were not implemented timely; and follow up to ensure that corrective actions have been taken. The HCFA agreed with the findings and recommendations and instructed their regional offices to implement the OIG proposals. The overpayments have been recovered. (CIN: A-01-87-00008)

MEDICAID ABORTIONS

Since 1977, the "Hyde Amendment" has prohibited the use of HHS funds to pay for abortions except where the life of the mother would be endangered if the fetus were carried to term.

A follow-up review showed that the majority of recommendations made by OIG in earlier reports were adopted by HCFA and have been fully implemented. However, the OIG report highlights several proposals which remain unresolved, including recommendations that HCFA issue guidance to States to assist them in determining which services are properly "abortion-related services" and in excluding those expenses from FFP; adopt a policy requiring a reasonable allocation of costs for multiple procedures; and not rely solely on physician certifications that the life of the mother would be endangered if a fetus were carried to term. The HCFA is implementing a procedure to "look behind" all physician certifications to the underlying medical records to substantiate the claims. (CIN: A-02-89-01022)

MEDICAID PROVIDER AGREEMENTS

An OIG audit of Indiana's Medicaid certification and provider agreement activities involving skilled nursing facilities (SNF) and intermediate care facilities (ICF) disclosed substantial noncompliance with requirements of the Medicaid program.

The OIG reviewed 352 SNFs and ICFs in the State and identified those Medicaid providers that operated without effective certification for varying periods of time between June 1, 1982 and September 30, 1984. The State made payments of about $41.9 million (Federal share) to the providers in this period for services rendered to Medicaid recipients during times when invalid provider agreements were in use.

The report recommended that the State make a financial adjustment of $41.9 million; assure that the survey agency conducts recertification surveys as required for participation in the Medicaid program; and follow proper procedures to establish time-limited agreements with each SNF and ICF provider. The HCFA officials concurred with the findings and recommendations. (CIN: A-05-86-60150)

STATE MEDICAID FRAUD CONTROL UNITS

During FY 1988, Medicaid health care provider payments exceeded $48.7 billion. These payments represent a 270 percent increase over the $18 billion expended in 1978. Medicaid Fraud Control Units (MFCUs) are currently responsible for investigating fraud in more than 91 percent of all Medicaid health care provider payments.

With the recent certification of a MFCU in Oklahoma, 39 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 1989, OIG administered $48.5 million in grants to the MFCUs and conducted 16 State recertifications and technical assistance visits. During this period, the MFCUs reported 260 convictions and $8 million in fines, restitutions and overpayments collected.

LABOR AND MOVING SERVICES

At HCFA's request, OIG performed an audit of contractor billings for daily labor and moving services in the Baltimore/Washington metropolitan area. The HCFA alleged that there were probable contractual irregularities in work hours billed to HCFA and that the contract was not being properly monitored.

The OIG audit confirmed both alleged problems, identifying questionable time charges to HCFA totaling nearly $5,500 for four individuals. The OIG also identified serious internal control weaknesses in contract administration. The individuals and the questionable billings were referred to the OIG Office of Investigations for further review.

The OIG recommended that HCFA implement a job order system to provide management with control over daily labor and moving services and designate one person as project officer to monitor the contractor's daily activities and certify invoices for payment. The HCFA agreed to institute a job order system to account for its daily labor and moving services. The HCFA also agreed to a number of other corrective actions, including modifying the existing contract to add security provisions for screening job applicants and finding a new contractor as soon as possible. (CIN: A-14-89-02035)

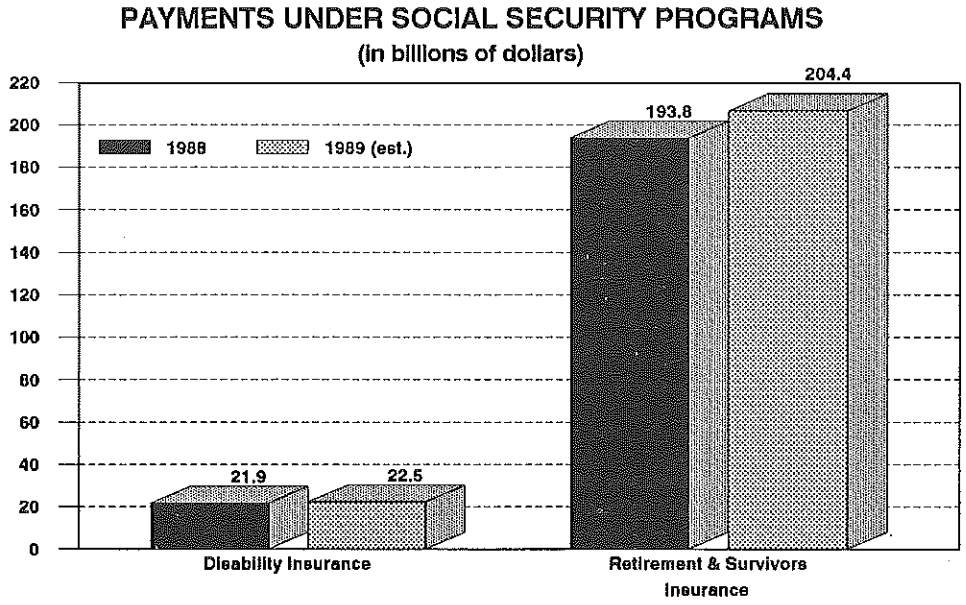
SOCIAL SECURITY ADMINISTRATION

CHAPTER III

SOCIAL SECURITY ADMINISTRATION

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

Fifty-four years ago, the Social Security Act established a national insurance system that would be financed through payroll taxes on workers and employers and would pay benefits to workers in their old age. The national Retirement, Survivors, and Disability Insurance (RSDI) program, popularly called Social Security, is the largest of the Social Security Administration (SSA) programs. In FY 1989, SSA will pay almost $227 billion in these benefits to 38.9 million beneficiaries. The program is financed almost entirely through payroll taxes paid by employees, their employers and the self-employed. Benefits are distributed to retired and disabled workers, spouses, certain divorced spouses, children and disabled children of retired and disabled workers. Benefits are also provided to widows and widowers, certain surviving divorced spouses, children, and dependent parents of deceased-worker beneficiaries.

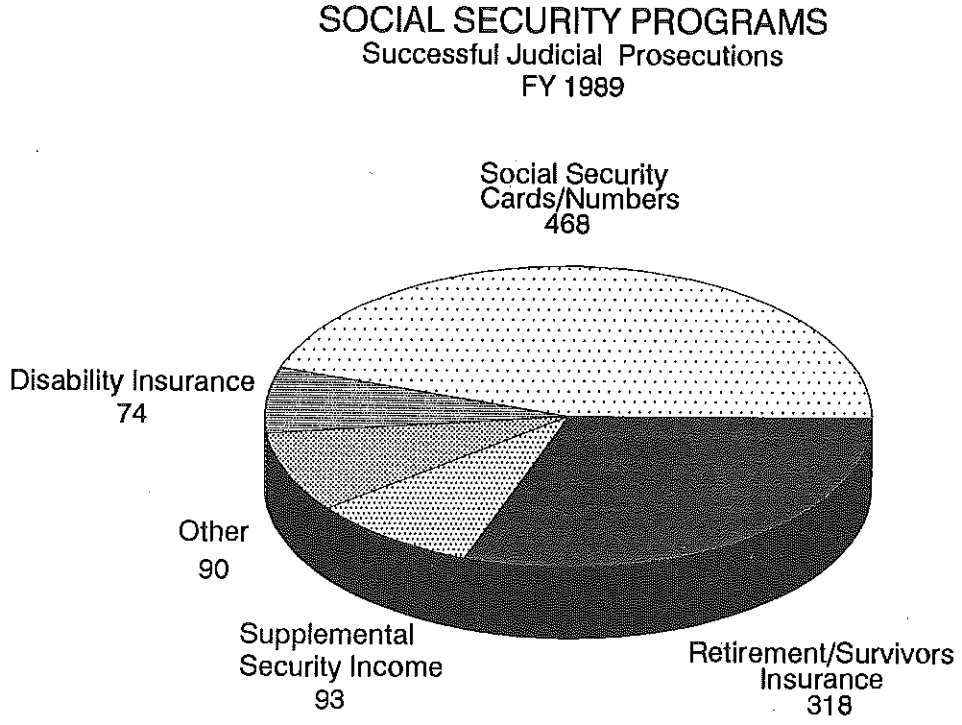


The Supplemental Security Income (SSI) program is a federally administered, means-tested assistance program that provides a nationally uniform, federally-funded floor of income for the aged, blind and disabled. Beginning January 1974, SSI replaced State and county run assistance programs for the aged, blind and disabled that were funded by a mix of Federal and State money.

Federalization of assistance for these categories permitted the establishment of uniform eligibility criteria. In FY 1989, SSA will pay SSI benefits totaling $11.4 billion.

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

The OIG is currently undertaking a number of important initiatives with respect to SSA programs and operations. Prior OIG activities which resulted in substantial benefits include evaluations of SSA's financial statements; suggestions for important legislative and regulatory changes; and recommendations for more efficient and effective operations, reductions and/or recoveries of RSDI and SSI overpayments, and other improvements in SSA's operations and internal controls. The OIG legislative and programmatic recommendations resulting from prior reviews could, if implemented, save billions of dollars. As illustrated in the chart below, investigations resulted in a total of 1,043 convictions during this fiscal year.



INTERNAL CONTROL REVIEW

The following are significant weaknesses identified by OIG in FY 1989 within SSA:

- The OIG identified inadequacies in the separation of duties in SSA's automated claims system (MCS). The process as reviewed, allows one SSA employee to take, develop, adjudicate and effect payment on a claim without an independent review or verification of the claimants' identity or eligibility information. Also, SSA has not established sufficient controls to compensate for the lack of separation of duties. Since over ten thousand employees have the ability to control all aspects of claims processing via MCS, the absence of separation of duties or compensating controls constitutes a significant weakness.

- An OIG audit disclosed control weaknesses in the administration and configuration of SSA computer operating systems. We performed an audit to assess how effectively SSA uses operating system features to control access to their computer systems, programs and data. The OIG identified weaknesses in procedures and controls for using these operating systems features. Poorly protected operating system features could allow knowledgable programmers to issue instructions to bypass SSA security software and run unauthorized programs or manipulate normal processing.

- The OIG found inadequate controls over resolving the results of the reconciliation of differences in wage amounts reported by employees to SSA and the Internal Revenue Service (IRS). Reconciliation efforts significantly reduced the initial reporting difference of $56 billion, but as much as $33.2 billion remains unresolved. The SSA does not have an information system which identifies the amount of new wages which were recorded to individuals' earnings records as a result of the reconciliation process. Consequently, SSA cannot estimate how much of the unresolved differences constitute unrecorded earnings. This leaves the correct amount of wages to be credited for credit of taxes in the Social Security trust funds in doubt. The amount to be credited could vary by as much as $2 billion depending on whether the IRS or SSA wage figures are used.

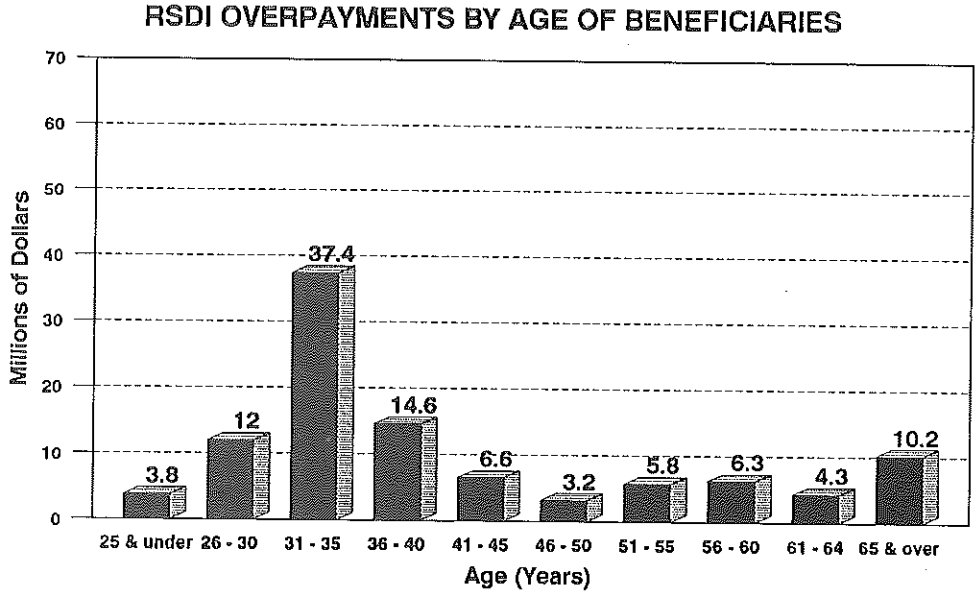
- Inadequate controls to estimate and document SSA year-end obligations were identified by OIG. Our review disclosed that no comparison is being performed between estimated and actual obligation amounts, the process for estimating year-end obligations is not timely, and proper documentation to support reductions to obligation amounts does not exist.

VALUE LOST

An OIG inspection found that SSA will lose more than $470 million in interest to the trust funds by not having its outstanding debt of $94 million to invest until debtors become reentitled to benefits. Moreover, the trust funds will lose over $1 billion in value during the next 20 years due to the addition of an estimated $625 million in delinquent debts from 1988 through 1997.

When an overpayment of Social Security benefits is detected, SSA requests repayment or offsets it against any current benefits. If eligibility for monthly benefits has ceased, however, and collection efforts prove to be unproductive, SSA terminates recovery actions. If the debtor becomes reentitled to monthly benefits, the overpayment will be recovered from those payments.

The OIG study determined that older debtors form a small part of the overpayment rolls, and the majority of younger debtors have the resources to repay their debts, the average of which was under $400.



The OIG recommended that SSA institute a policy change to allow recovery of delinquent overpayments at the higher of the amount of interest income lost to the trust funds or the value

lost to the trust funds due to inflation. The SSA did not believe that it had the statutory authority to implement the OIG recommendation, but proposed to pursue a legislative initiative to allow use of the provisions of the Debt Collection Act against nonbeneficiary debtors. (OAI-03-88-00680)

INCOME TAX REFUND OFFSET

The OIG determined that withholding income tax refunds due former overpaid Social Security beneficiaries could result in recovery of approximately $303.2 million over a 5-year period, with most of the recovery occurring in the first 2 years.

An OIG inspection compared a sample of overpayment records to tax return information for 1983 and 1984. The study found that more than half of the former beneficiaries had reported taxable income in the 2 sample years; a significant number had income exceeding $25,000 and several had income exceeding $50,000.

The SSA is in the process of resolving a number of systems, operational and legal issues associated with implementation of withholding income tax refunds. The SSA intends to submit this item as a legislative proposal for 1991 and anticipates implementation in 1991 for the 1990 tax year. (OAI-12-88-01290)

PAYROLL TAX DEPOSITS

The OIG proposed acceleration of payroll tax deposits of large employers to 1 banking day after disbursement of wages. Currently, large employers have from 3 to 11 days to deposit payroll taxes after disbursement of wages. The OIG estimated that this proposal could generate as much as $15.5 billion over a 5-year period for the U.S. Treasury and the Social Security and Medicare trust funds. The savings would result from a shifting of $12.1 billion into earlier fiscal years and $3.4 billion in earned interest.

The SSA generally concurred with the OIG recommendation while the Department of the Treasury (Treasury) opposed the proposal, expressing concern that accelerating payroll taxes would present a significant administrative burden to, and be unfavorably received by, employers. In addition, Treasury officials are not sure how much revenue would be generated if payroll tax deposits were accelerated. (CIN: A-09-89-00075)

SOCIAL SECURITY CLIENT SATISFACTION: FISCAL YEAR 1989

This survey was conducted to determine the level of client satisfaction with services provided by SSA. The sample consisted of 6,000 randomly selected individuals who had contact with a Social Security office during the last week of October or the first week of November 1988.

Based on a response rate of over 80 percent, OIG found that satisfaction with services provided by Social Security continues to be high, but is somewhat lower than previously reported. Other major findings of the survey were that nearly two-thirds of the respondents favor using the telephone to conduct future Social Security business; reducing office waiting time would further improve client satisfaction; and at least two-thirds of the respondents had seen, heard or read public service announcements about Social Security. (OAI-12-89-00420)

AGE ATTAINMENT

The OIG assessed the programmatic and financial impacts of using the common law definition of age attainment, which was incorporated into the Social Security Act. The audit found that using the common law definition results in inconsistencies for individuals born in the same month. For example, at age 65 an individual born on the 1st of the month is entitled to full retirement benefits and Medicare coverage 1 month before individuals born on any other day of the same month. These inconsistencies, based on 1986 SSA data, cost the SSA and Medicare trust funds about $21.4 million annually, or $107 million over 5 years.

The OIG recommended that SSA and the Health Care Financing Administration jointly sponsor legislation to define age attainment as occurring on an individual's birthday in order to establish consistent periods of entitlement for persons born in the same calendar month. The SSA did not agree with OIG's observations. In response to the OIG report, SSA replied that its analysis indicated that administrative costs, staff allocations and other considerations would outweigh the estimated savings. (CIN: A-09-89-00073)

ACCOUNTING FOR PENALTIES AND INTEREST ON FICA TAXES

The OIG issued a report on the equity of the simplified method of accounting for tax receipts which is provided for by the Social Security Act. The OIG estimates that the trust funds could be losing hundreds of millions of dollars annually because of an imbalance which appears to have developed between the value of penalties and interest retained by IRS and the higher receipts accruing to the trust funds.

Due to the absence of reliable documentation, OIG could not confirm its observations. Accordingly, OIG recommended that SSA's Chief Financial Officer pursue the matter with IRS. If an inequity does in fact exist, then legislation should be proposed to correct the problem. The SSA concurred with the recommendation and will make the necessary contacts with IRS. (CIN: A-13-86-62640)

DEBT MANAGEMENT SYSTEM

The OIG conducted a review of SSA's efforts to enhance and standardize processing in the post-entitlement software which detects, calculates and processes RSDI overpayments. The study found that generally the enhancements were successfully completed, but certain problems were noted. The procedures used to validate the software changes were inadequate to assure that they were completed correctly. Overly ambitious target dates caused SSA to circumvent normal review and validation procedures in order to meet deadlines. The SSA concurred with the OIG findings and agreed to implement improved controls over the validation process for future software releases and to reevaluate future deadlines for debt management system releases. (CIN: A-13-89-00010)

COMPLIANCE WITH RSDI DEBT COLLECTION POLICIES

Social Security debtors are typically former students, spouses or disability beneficiaries who were overpaid because they failed to notify SSA of an event which affected their eligibility. If SSA's collection actions have not been successful, SSA terminates collection activity until the debtor becomes reentitled to RSDI benefits.

An OIG audit found that between January 1, 1983 and March 31, 1986, debts of about $101 million were placed in terminated collection status before all required collection actions were taken. The OIG recommended that SSA strengthen its oversight of all debt collection activity so that quality assurance or supervisory activity review is required prior to terminating collection.

While SSA believed that OIG's results might reflect a failure by technicians to properly document the folder rather than a failure to attempt collection, they did agree to take measures to ensure the appropriateness of debt collection termination decisions in the future. Accordingly, they established both a quality assurance procedure and a supervisory review procedure to guarantee that overpayment cases are properly developed and documented. (CIN: A-03-87-02600)

UNNEGOTIATED CHECKS

The OIG estimates that the Social Security trust funds may have incurred losses of approximately $330 million as a result of inadequate reimbursement by Treasury to SSA for unnegotiated checks. Under the Social Security Act, Treasury is required to return to the trust funds the amounts of uncashed Social Security checks plus interest. As of May 1987, Treasury had made transfers totaling over $836 million, presumably representing reimbursement to the trust funds for all unnegotiated benefit checks issued from 1940 through October 1986.

An OIG audit disclosed deficiencies in the unnegotiated check data used to compute the transfer amounts and questioned the accuracy of those amounts. The OIG recommended that SSA

officials contact officials at Treasury to resolve the identified discrepancies and to obtain appropriate adjustment to the trust funds, including principal and interest, for any missing unnegotiated checks which should have been considered in determining the transfer amounts. The SSA was in general agreement with the OIG recommendations. (CIN: A-04-87-03004)

PAYMENTS AFTER DEATH

Eligibility for RSDI benefits ceases at death; SSA is then responsible for terminating deceased beneficiaries from payment rolls and requesting Treasury to recover any benefits paid after the beneficiaries' deaths. The SSA must control payments issued after death to ensure that the payments are recovered and returned to the trust funds. A 1985 audit (ACN: 04-52601) concluded that SSA had ineffective financial management controls over 1981 and 1982 payments made to beneficiaries after death and that SSA could realize significant savings by implementing actions to control and manage such payments.

A follow-up audit showed that SSA has implemented some of OIG's earlier recommendations, and, consequently, some savings to the trust funds have been realized. However, the OIG estimates that, by not implementing those recommendations fully, SSA, in a 1-year period, lost accountability over approximately $95 million in payments made after death. In addition, the audit report recommended that SSA more closely monitor the resolution of audit findings to assure that corrective actions are actually taken. The SSA agreed to implement the current recommendations and estimated savings at $20 million. (CIN: A-04-87-03007)

RECLAMATION OF INCORRECT ELECTRONIC FUND TRANSFER PAYMENTS

The objective of this OIG review was to determine whether systems were in place to ensure that the trust funds receive proper credit for all electronic fund transfer (direct deposit) payments identified by SSA as having been incorrectly made to RSDI beneficiaries. The OIG approximates that SSA requests Treasury to recover more than $480 million in incorrect payments each year. While the precise amount of incorrect payments made through direct deposit was not determined, it was estimated that the volume would be sizeable since half of all RSDI payments are made in this manner.

The audit disclosed that some incorrect direct deposit payments identified by SSA were not reclaimed and credited to the trust funds by Treasury. The OIG concluded that this was due to reclamation processing deficiencies in both SSA and Treasury, limited recovery efforts by Treasury, the absence of an accounts receivable system to control incorrect payments in SSA and an overall lack of understanding between SSA and Treasury regarding their respective roles in the reclamation process.

The OIG recommended that SSA establish an accounts receivable system, improve collection procedures and negotiate an agreement with Treasury to clearly establish the functions of each Department in the reclamation process. The SSA was in general agreement with the OIG findings. (CIN: A-01-87-02003)

UNDELIVERABLE NOTICES

Each month, SSA authorizes Treasury to electronically transfer about $8.4 billion in payments directly to the bank accounts of 18 million Social Security beneficiaries. As one means of detecting unreported deaths, SSA uses statements of earnings that are mailed to direct deposit beneficiaries and returned as undeliverable.

Of the 190 deaths identified in the sample of 802 beneficiaries with undeliverable notices in both 1982 and 1986, the system failed to detect 135 unreported deaths. Eighty-eight of these deaths occurred prior to 1983 and should have been detected by at least one of the six undeliverable notice alerts due to have been generated prior to the OIG review. Payments after death totaled $2.7 million. Of that amount, $1.8 million remains in beneficiary bank accounts.

The OIG report recommended additional controls to ensure that all undeliverable notices are processed and that alerts generated to obtain an address or determine whether or not the beneficiary is deceased are worked. The report also proposed that financial institutions provide SSA with information that indicates whether or not the beneficiary is deceased. The SSA generally agreed with the OIG recommendations. (CIN: A-13-88-00035)

DECEASED BENEFICIARIES

Benefits may continue to be sent to a deceased beneficiary because the person's death goes unreported to SSA or because relatives or friends deliberately conceal it from SSA. Deliberate concealment of death to use such benefits constitutes fraud against SSA programs. Since the success of OIG's computer matching project Spectre in the early 1980s, matches of State death records against SSA beneficiary rolls have become a required mechanism for detecting this kind of fraud.

These matches result in a continuing investigative workload for OIG. During this reporting period, for example, the OIG office in Ohio completed a joint project with the United States Secret Service in following up on 22 cases in which SSA and other Federal benefits payments to deceased beneficiaries were being converted to illegal use. This endeavor resulted in 23 convictions and a total of $589,000 ordered restitutions and fines. The following cases are representative of those successfully concluded during this project.

- A man had to serve 5 years probation and repay more than $31,300 of his deceased mother's benefits he had usurped. He was also advised that he owed the IRS for these benefits, plus penalties and interest.
- A woman who had used her deceased father's SSA, Black Lung, and Railroad Retirement benefits from 1983 through 1987 had to serve 6 months in a community detention program and complete 4 1/2 years probation. She also had to participate in mental health and drug and alcohol counseling and make restitution of $56,600.
- An artist was ordered to find employment or enter an employment training program so that he could repay $12,600 he had used of his deceased mother's benefits over a period of 28 months.

FRAUDULENT SOCIAL SECURITY NUMBERS

Along with birth certificates and drivers' licenses, the Social Security number (SSN) or card is a foundation document in creating false identifications. These identifications are then used by individuals to perpetrate crimes involving billions of dollars. Crimes involving the sale and use of fraudulent SSNs are illustrated in the following examples of cases resolved during this reporting period:

- In Georgia, a woman was sentenced to 4 years in jail and restitution of $13,700 for mail fraud and fraudulent use of SSNs to obtain unemployment benefits. Over a 20-month period she had submitted 82 unemployment insurance claims for herself and others, when all were gainfully employed. The case was jointly investigated with the Department of Labor.
- A woman in Ohio was sentenced to 2 years in prison, consecutive to sentences received under prior convictions, for grand theft through the use of false names and SSNs. She used the false identities to obtain Government assistance benefits, hide from law enforcement officials and negotiate thousands of dollars in bad checks.
- A woman was sentenced in Illinois to 1 year and 1 day in jail and 5 years probation after pleading guilty to selling counterfeit Social Security cards. The attorney prosecuting the case argued for a severe sentence because of two prior convictions, one for attempting to smuggle illegal aliens into the United States and the other for arranging sham marriages for illegal aliens. The judge agreed, citing the woman's disregard for the law.

As in the preceding example, many cases also involve the use of fraudulent SSNs in the commission of crimes not directly related to Department programs. The following cases illustrate the range of such cases:

- A Virginia man was sentenced to 47 years in prison after pleading guilty to using fraudulent SSNs in the purchase of firearms. The firearms were transported by bus to New York, where they were sold to drug dealers. The man had used false SSNs to obtain identification from the State Division of Motor Vehicles, which in turn was used in buying the guns. The case was investigated jointly by OIG and the Bureau of Alcohol, Tobacco and Firearms.

- Four persons were convicted in New Jersey on charges related to using false SSNs and fictitious companies to obtain millions of dollars from loans and stock sales. One man was sentenced to 10 years in prison for conspiracy and misuse of a SSN. His brother and two others were each given a year imprisonment upon conviction of lesser charges. The four used a defunct computer technology company, a fictitious accounting firm and false SSNs to obtain amounts ranging from a bank loan of $500,000 to $1 million in the sale of company stock.

- In Tennessee, a man was sentenced to 60 years in prison, with a minimum parole date of 20 years, after pleading guilty to the 1984 murder of a woman in the Great Smokey Mountains National Park. The man and his wife had been arrested in Mississippi on charges of using false SSNs after being featured three times on "America's Most Wanted" television program. An 11-year fugitive from justice, the man was also wanted on rape charges in Florida and West Virginia. He was sentenced to 5 years on the SSN charge to be served concurrently with the 60-year sentence. His wife was given 5 years probation.

DISABILITY BENEFITS FRAUD

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

- A physician and his former wife pled guilty in Florida to conspiracy and making false statements to obtain disability benefits. The couple are to repay the $97,000 they obtained illegally from SSA. After an accident in Virginia in 1980, the man used his medical knowledge to apply for benefits for himself, his wife and two children, claiming neurological and brain injuries. While drawing disability benefits, he went to school, worked in a county health unit and hospital emergency room, and divorced, remarried and redivorced his wife. The investigation was conducted jointly with agents from the Federal Bureau of Investigation.

- In Indiana, a man was sentenced to 4 years probation and restitution of more than $34,000 for concealing his work as a minister in Washington, D.C. and Indianapolis in order to receive benefits.
- A contractor for a multimillion dollar project in New York was ordered to repay $102,605 in illegally acquired disability payments.

UNVERIFIED PUERTO RICO BIRTH DOCUMENTS

An applicant for a SSN is required to present a record of his or her birth at the time of application. The OIG conducted an inspection to determine the extent to which SSNs were improperly issued on the basis of apparently fraudulent Puerto Rico birth documents and the impact of these issuances on selected federally-funded programs.

Between 1983 and 1985, SSA issued nearly 8,000 SSNs to U.S. citizens age 18 or older who listed Puerto Rico as their place of birth on the SSN application form. Over 29 percent of these SSNs were issued from Social Security offices in the continental United States. For 17 percent of the 403 individuals whose SSNs were selected for the study sample, there were no corresponding birth records found on file at the Puerto Rico Demographic Registry.

The OIG report recommended that SSA verify every Puerto Rico birth record that is presented as evidence to a Social Security office in the continental U.S. by an applicant for a SSN. While the inspection found that the suspect SSNs in the study were used minimally to secure government benefits, the percentage of unverifiable records was considered significant, given the potential for fraud and abuse. The SSA disagreed with the OIG recommendations. They believe that their current procedures effectively deal with Puerto Rico birth documents. (OAI-09-89-01310)

SYSTEMS MODERNIZATION

Computer modernization efforts at SSA have been the subject of much congressional criticism and General Accounting Office and OIG activity since 1982. Although modernization efforts have not lived up to original expectations and serious obstacles remain, progress has been made. The SSA has upgraded its computer processing capability, telecommunications network and data base capabilities. In addition, some success has been achieved in software engineering and in computer capacity planning.

Although SSA has made much progress in correcting weaknesses related to systems modernization, OIG reported serious weaknesses in controls in accounting for payments after death and separation of duties controls over processing claims for Social Security benefits.

The OIG recommended that SSA advise the Department to report the weaknesses as required by the Federal Managers' Financial Integrity Act through the Secretary to the President and the

Congress. The SSA should also continue its efforts to improve capacity management, as well as emphasize the design of internal controls in new systems. The SSA agreed to report the lack of separation of duties in the modernized claims system as a material weakness and to take corrective action. Controls over accounting for payments after death was reported by SSA as a material weakness in FY 1988 and corrective action is underway. (CIN: A-13-89-00014)

EARNINGS ENFORCEMENT

The OIG released a management advisory report to alert SSA to a breakdown in that part of the earnings enforcement process that identifies excludable earnings. The OIG found that SSA field offices use this process as a corrective action measure rather than as a preventive tool as was intended.

The OIG suggested that SSA re-educate field office personnel on the purpose of the earnings enforcement process and authorize field offices to directly input and transmit the excludable income information to the central office earnings record center rather than sending it through the program service centers. (OAI-07-89-00930)

MICROCOMPUTERS

The OIG conducted an audit of the acquisition and use of microcomputers by SSA under the microcomputers for operation project (MOP). The review concluded that MOP was a successful project, with SSA staff effectively utilizing their microcomputers. It also found that, in general, adequate training and maintenance were being provided and that SSA's security arrangements for sensitive data were satisfactory.

The audit did, however, identify some areas where improvement is needed. To reduce the impact of a lengthy procurement process, OIG recommended that SSA pursue an indefinite quantity contract for its next major purchase of microcomputer systems. The OIG also proposed that SSA take additional measures to ensure that each microcomputer is adequately tested before being accepted. Further, OIG recommended that SSA continue to pursue and use the customized microcomputer tutorial computer security training package developed by the Office of Information Resources Management, Office of the Assistant Secretary for Management and Budget, to increase security awareness for users. The SSA concurred and has already undertaken a procurement action that incorporates these recommendations for office automation. (CIN: A-13-88-00036)

REPAYMENT OF SSA MORTGAGES

The OIG estimates that immediate repayment of three mortgages by SSA could save the trust funds $148 million. This was the conclusion of a follow-up review focusing on the advisability

of early repayment of the mortgages on SSA program service center buildings in Chicago, Illinois; Philadelphia, Pennsylvania; and Richmond, California.

The SSA agreed in principle with the findings of an earlier audit report which had recommended full repayment, but qualified their commitment to implement the recommendation. Since that time, SSA has retired about one-half of the mortgage balances, stating that if opportunities arise in the future to liquidate more of the purchase contract balance, they will do so.

The OIG determined that an immediate lump-sum payment of the $41.2 million balance would result in savings of approximately $148 million over the remaining life of the mortgages. Stated in terms of present value, the savings would be over $48 million. Further, OIG believes that immediate repayment of the mortgages falls well within trust fund capability. The OIG therefore recommends that SSA budget for full repayment of the remaining mortgage balances. The SSA agreed with the thrust of the recommendation, but due to deficit reduction targets, did not request additional funding for FY 1990. (CIN: A-09-88-00131)

EXPANDING TIP REPORTING REQUIREMENTS

The OIG proposed expansion of the tip reporting requirements for Federal income tax purposes to include other industries with significant levels of tip income, thereby equitably distributing the income tax burden and generating as much as $570 million in tax revenue over the next 5 years. Currently, only large food and beverage establishments are required to report sales and tip information to IRS.

A 1985 survey conducted for IRS indicated that while 27 percent of tips were attributable to the beverage industry, another 23 percent were reported in about 90 different service categories; the remaining 50 percent were in the barber and beauty shops and taxicab industries. Based on these findings, OIG recommended that SSA advocate legislation to revise the tip reporting requirements to include barber and beauty shops and taxi companies. The audit report estimated an increase in revenue of $234 million to the Social Security trust funds, and $57 million to the Medicare trust funds over a 5-year period if the proposal is implemented. The balance of the $570 million, or $279 million, would accrue to the general funds. The SSA deferred to the Department of the Treasury regarding this recommendation. (CIN: A-09-89-00072)

HEARINGS TRAVEL COSTS

The OIG issued a management advisory report which addressed the potential vulnerability of current provisions of the 1986 Pulido regulations. These regulations govern reimbursement of travel costs for claimant representatives who attend disability or Medicare hearings before administrative law judges (ALJs). The OIG found that the current statute appears to contain a significant vulnerability for abuse or misuse of the Social Security trust funds and potentially for Medicare funding as well.

The OIG recommended that SSA submit a legislative proposal to restrict reimbursement travel expenses of legal counsel and other representatives to the maximum allowable cost of travel within the designated hearing office service area. The OIG further proposed that the Office of Hearings and Appeals monitor and analyze travel costs to ALJ hearings. (OAI-06-89-00850)

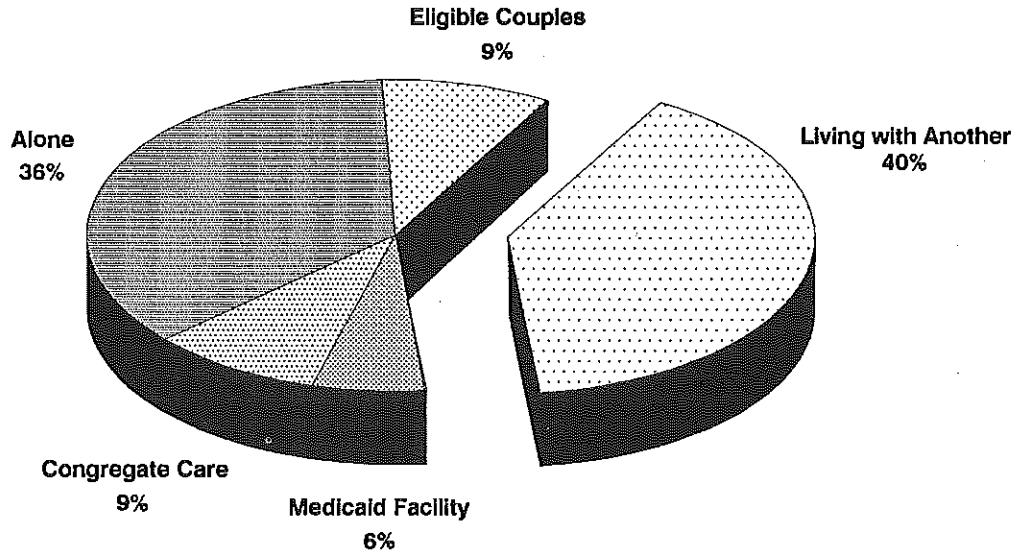
RESTRUCTURING SSI BENEFITS

An OIG report concluded that legislation to restructure Federal SSI benefits on the basis of a recipient's living arrangements could promote benefit equity, simplify program operations and generate net savings of about $1.4 billion over the next 5 years.

Under current law, SSI recipients living with their eligible spouses are subject to a 25 percent reduction in their Federal benefit rate. In addition, the law requires the valuation of in-kind support and maintenance (ISM) in the form of food, clothing or shelter, which may result in a one-third reduction in the Federal benefit rate when SSI recipients live in the household of another person. In FY 1984, about 40 percent of SSI recipients lived with a person other than an eligible spouse.

SSI RECIPIENT LIVING ARRANGEMENTS FY 1984

(1.4 Million People)



Extending the 25 percent reduction in benefit rate to all SSI recipients living with another person would reduce program costs and allow SSA to eliminate ISM, which has been identified as one of the most complex, time-consuming and error-prone aspects of the SSI program. The SSA did not agree to support this proposal because it would result in benefit reductions for about 2.1 million recipients. (CIN: A-10-89-00008)

SSI BENEFITS FRAUD

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

- A 65-year-old woman in Wisconsin was sentenced to 4 months in prison after pleading guilty to making false statements to SSA in order to obtain SSI benefits. She was also ordered to repay $17,600. In 1984 and 1985, she claimed she had less than $1,500 in resources. In 1984, however, she held certificates of deposit totaling about $26,000 and in 1985 she had $21,500 in certificates of deposit and $8,800 in a savings account.

- In California, a computer match of SSI rolls and earnings records turned up a man who had been receiving substantial wages for 3 years from a computer firm for which he worked. He had to repay $14,500. Another California man, discovered through a similar computer match, was found to have concealed wages for more than 6 years and had to repay more than $34,000.

- In Missouri, an unusual SSI case involved both concealment and embezzlement. A man and his former wife had applied for a Social Security card for an alien working for them. When the woman became temporarily disabled, they applied for SSI benefits for her. From 1975 through 1988 they kept most of the money while she continued to work for them. The man had to repay $32,600 he had embezzled in SSI benefits and complete 100 hours of community service within the first 30 months of a 5-year probation. His former wife could not be prosecuted because the statute of limitations had expired on her part of the crime.

DISABILITY DETERMINATION PROGRAM

The OIG reviews federally-assisted State programs to determine if costs claimed are in excess of allowable amounts. One such program is the Social Security disability determination program (DDP).

A. Improper Charges

The OIG determined that over a 10-year period Arkansas improperly charged the DDP over $2 million for rental costs for office space furnished by the Arkansas State Building Services

(ASBS) agency without the costs being included or approved in Arkansas' statewide cost allocation plans (SCAP) as required.

The OIG recommended that Arkansas revise the SCAP submitted after July 1, 1977 to include rental costs charged to the State agency by ASBS, and obtain HHS' review and approval of the costs. Based on the results of the HHS review, the State should be required to make the necessary financial adjustments for the unallowable costs charged to the DDP during the period July 1, 1977 to September 30, 1987 and after September 30, 1987. The State generally did not agree with the findings and recommendations. However, SSA agreed and advised that necessary actions would be taken to recover overclaimed DDP funds. (CIN: A-06-87-00076)

B. Interest Earned

The OIG determined that New York State eamed interest on premature letter of credit draw downs for employee retirement contributions related to DDP during the period April 1, 1980 through September 30, 1983. In addition, OIG noted that the interest was not credited to the Federal Government but was used for State purposes.

The OIG calculated that the State earned over $2 million in interest on premature letter of credit draw downs related to the DDP. As a result, OIG recommended that SSA require New York State to refund that amount to the Federal Government for the interest earned. (CIN: A-02-89-01007)

PUBLIC HEALTH SERVICE

CHAPTER IV

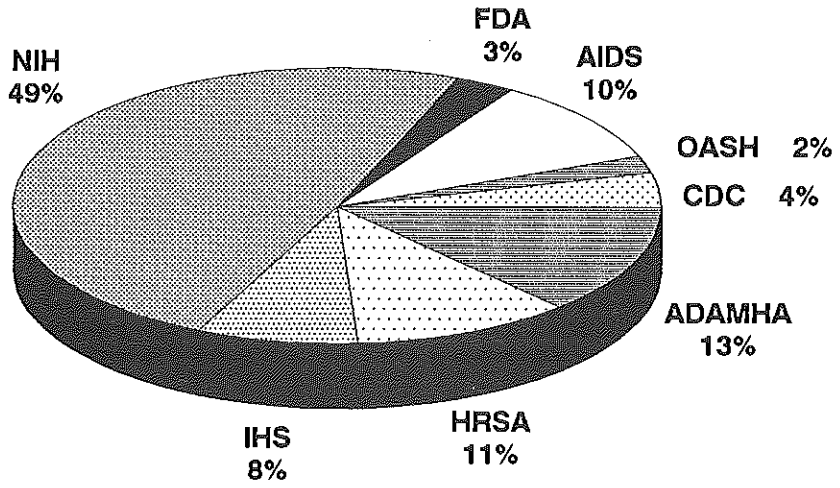
PUBLIC HEALTH SERVICE

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

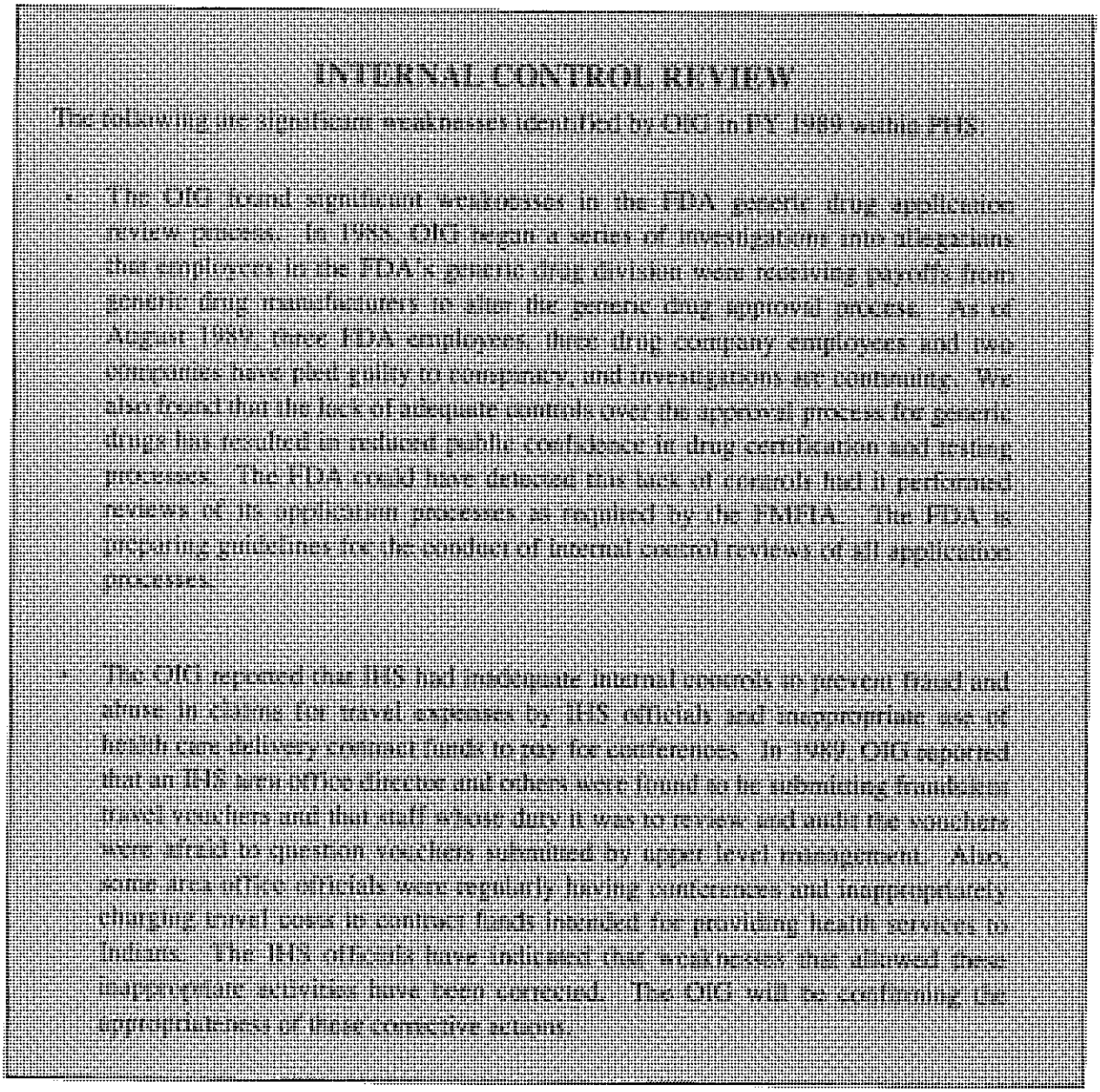
The activities conducted and supported by the Public Health Service (PHS) represent this country's primary defense against acute and chronic diseases and disabilities. The PHS's programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. The PHS encompasses: National Institutes of Health (NIH) to advance our knowledge through research; Food and Drug Administration (FDA) to assure safe and effective marketed food, drugs and medical devices; Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) to assist States in uncovering the physiological and behavioral bases for understanding, preventing and treating mental illnesses and alcohol and substance abuse; Centers for Disease Control (CDC) to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA) to support through financial assistance, the development of our future generation of health care providers; Indian Health Service (IHS) to improve the health status of Native Americans; and Agency for Toxic Substances and Disease Registry (ATSDR) to address issues related to Superfund toxic waste sites. The PHS will spend approximately $13.4 billion in FY 1989.

DISTRIBUTION OF PHS RESOURCES

(FY 1989 Budget $13.4 Billion)



This year, OIG is continuing to respond to commitments made to the Secretary, the Congress and the Assistant Secretary for Health to increase oversight of PHS programs and activities. A separate PHS audit division was created to concentrate on issues within PHS such as Acquired Immune Deficiency Syndrome (AIDS), medical effectiveness, substance abuse, biomedical research and scientific misconduct. In addition, since the majority of contract and grant funding provided by HHS to colleges and universities is awarded by PHS, responsibility for audits of these institutions was transferred to the new division effective June 1, 1989. The division will provide the resources to conduct internal and external reviews promoting: effective and efficient program operations; compliance with laws and regulations; financial accountability; as well as prevention and detection of fraud, waste and abuse. The OIG is currently conducting reviews addressing problems of congressional and departmental interest in the public health area.

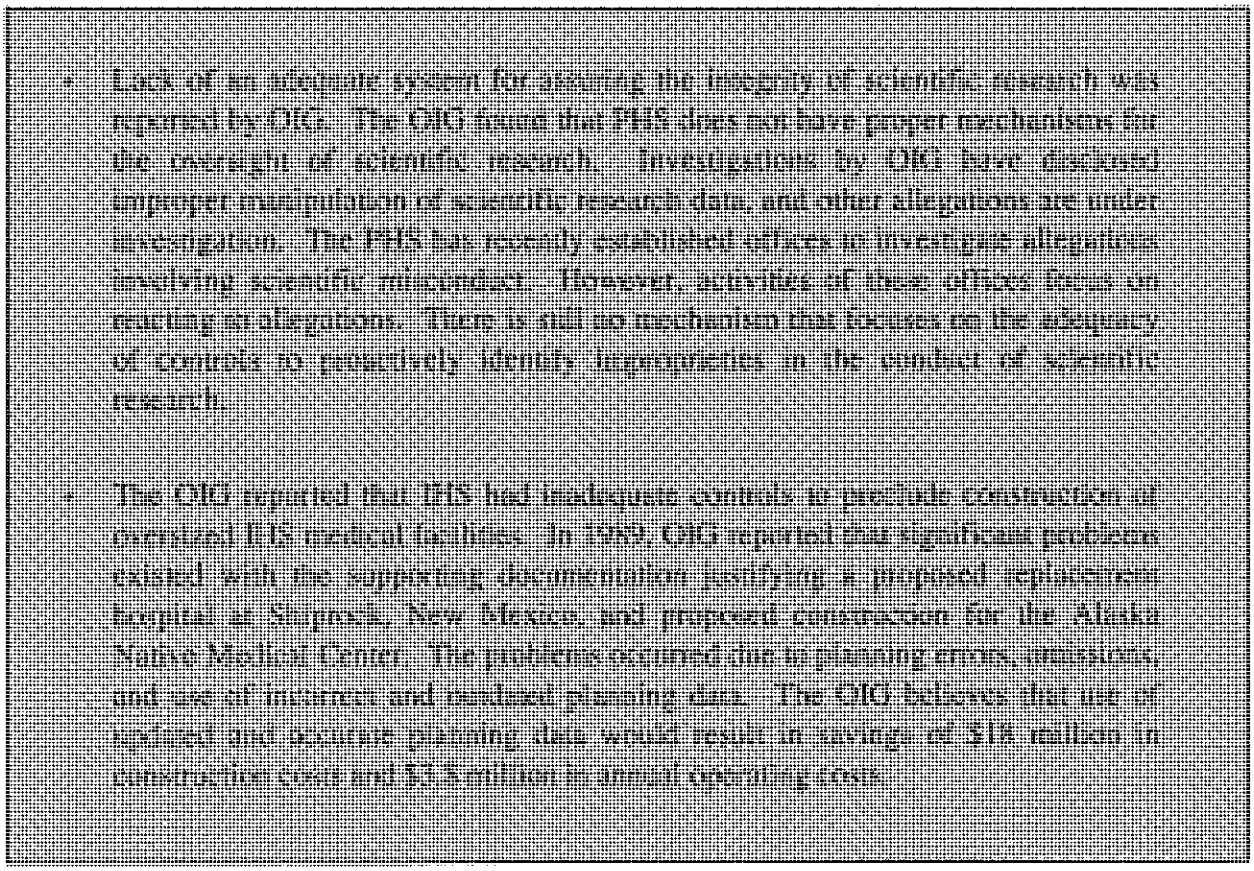


INTERNAL CONTROL REVIEW

The following are significant weaknesses identified by OIG in FY 1989 within PHS:

- The OIG found significant weaknesses in the FDA generic drug application review process. In 1989, OIG began a series of investigations into allegations that employees in the FDA's generic drug division were receiving payoffs from generic drug manufacturers to alter the generic drug approval process. As of August 1989, three FDA employees, three drug company employees and two companies have pled guilty to conspiracy, and investigations are continuing. We also found that the lack of adequate controls over the approval process for generic drugs has resulted in reduced public confidence in drug certification and testing processes. The FDA could have detected this lack of controls had it performed reviews of its application processes as required by the FMFIA. The FDA is preparing guidelines for the conduct of internal control reviews of all application processes.

- The OIG reported that HHS had inadequate internal controls to prevent fraud and abuse in claims for travel expenses by HHS officials and inappropriate use of health care delivery contract funds to pay for conferences. In 1989, OIG reported that an HHS area office director and others were found to be submitting fraudulent travel vouchers and that staff whose duty it was to review and audit the vouchers were afraid to question vouchers submitted by upper level management. Also, some area office officials were regularly having conferences and inappropriately charging travel costs to contract funds intended for providing health services to Indians. The HHS officials have indicated that weaknesses that allowed these inappropriate activities have been corrected. The OIG will be confirming the appropriateness of these corrective actions.



- Lack of an adequate system for assuring the integrity of scientific research was reported by OIG. The OIG found that PHS does not have proper mechanisms for the oversight of scientific research. Investigations by OIG have disclosed improper manipulation of scientific research data, and other allegations are under investigation. The PHS has recently established offices to investigate allegations involving scientific misconduct. However, activities of these offices focus on reacting to allegations. There is still no mechanism that focuses on the adequacy of controls to proactively identify irregularities in the conduct of scientific research.

- The OIG reported that IHS had inadequate controls to preclude construction of oversized IHS medical facilities. In 1992, OIG reported that significant problems existed with the supporting documentation justifying a proposed replacement hospital at Shiprock, New Mexico, and proposed construction for the Alaska Native Medical Center. The problems occurred due to planning errors, omissions, and use of incorrect and outdated planning data. The OIG believes that use of updated and accurate planning data would result in savings of $18 million in construction costs and $3.5 million in annual operating costs.

FRAUD IN GENERIC DRUG APPROVAL

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

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

Questions of jurisdiction were raised which threatened to hamper OIG felony investigations in this area. On the basis of a Department of Justice opinion that the Department of Labor has no authority to investigate criminal violations where there are no perceived program interests, a U.S. Attorney has ordered that all OIG investigations into false statements related to drug approvals be held in abeyance. To resolve this problem, the Secretary delegated to the Inspector General authority to conduct felony investigations under the Federal Food, Drug and Cosmetic Act. Currently, OIG, FDA and Justice are working closely together on generic drug problems and cases.

GENERIC DRUG APPROVAL PROCESS

The OIG's management advisory report, "Vulnerabilities in the Food and Drug Administration's Generic Drug Approval Process," discusses material weaknesses in the internal controls of the generic drug review process. On June 29, 1988, the Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, of the United States House of Representatives, alleged that favoritism and preferential treatment existed in the generic drug approval process. The OIG review showed that FDA does not have adequate internal controls over the abbreviated new drug application (ANDA) review process to guarantee its integrity. This lack of controls made the ANDA review process susceptible to manipulation and preferential treatment.

The OIG recommended a number of actions needed to improve the internal controls in the application review process. In addition, OIG urged that PHS report these problems as an internal control weakness under the FMFIA and take action to correct these weaknesses. (CIN: A-15-89-00051)

SCIENTIFIC MISCONDUCT

The PHS relies heavily on private contractors and grantees to conduct much of the basic scientific research needed to make advances in protecting and enhancing the health and well-being of the citizenry and to prevent and cure disease. The integrity of this research is vital, and the researchers must abide by proper study protocols to ensure the validity of future drugs and treatments. Several cases of falsified data and findings have received recent media attention, some involving PHS programs, which have heightened OIG and congressional concern about scientific misconduct. In a related case, the New Jersey medical licensing board permanently suspended the license to practice of a doctor who was the former head of rheumatology and a board member of a New Jersey medical center. The action followed the doctor's conviction for falsifying drug study data while under contract to a variety of manufacturers who were submitting this data to FDA in support of new drug applications.

NIH POLICIES ON MISCONDUCT

In light of such concerns, OIG conducted an inspection to determine the extent to which NIH and its grantee institutions have developed and implemented policies and procedures to prevent, detect and handle cases of scientific misconduct.

The study found that there was no central locus of responsibility and accountability within the Department to deal with scientific misconduct. The NIH had been slow to establish an official plan for dealing with such misconduct and investigations were handled on an ad hoc basis, resulting in inconsistencies. Further, the study determined that only 22 percent of grantee institutions had policies and procedures in place for handling alleged instances of scientific misconduct.

The OIG recommended that the Secretary provide for independent oversight and develop a formalized, centralized process to deal with scientific misconduct. The OIG urged completion and publication of a final regulation on the responsibilities of PHS awardee and applicant institutions for handling and reporting cases of misconduct in science. This would facilitate the development of procedures by grantee institutions.

The PHS expressed general agreement with the OIG recommendations. They recently established two new offices to set PHS policies on misconduct; to oversee the activities of PHS research activities; to oversee investigations into alleged scientific misconduct within grantee institutions; and to conduct investigations as necessary. In addition, PHS has published a final rule on the responsibilities of applicant institutions for dealing with possible misconduct in science. (OAI-88-07-00420)

STRATEGIES TO REDUCE INFANT MORTALITY

The OIG issued a management advisory report to share insights gained during an evaluation of the Healthy Baby program in Boston, Massachusetts. This report discusses eight sets of recommendations governing the management and implementation of programs designed to reduce the incidence of low birth weight and infant mortality.

The OIG found that effective management and implementation strategies are necessary complements to broadly based local initiatives and sound program design. The strategies presented are most relevant to local policy-makers who are involved in infant mortality prevention programs. However, they are also of value to the Department, especially PHS, in its role of providing national leadership in the effort to reduce infant mortality. The recommendations focus on targeting and outreach, risk assessment, referral, clinical services, early and intensive nonclinical services, policy management, operations management and community involvement. (OAI-01-88-01421)

NIH PROCUREMENT

In response to a request from the House Committee on Appropriations, OIG performed a follow-up review to assess the status of NIH's efforts to correct procurement deficiencies identified in earlier OIG, Office of Assistant Secretary for Management and Budget (ASMB) and PHS study reports. The earlier OIG report noted that NIH was not obtaining all possible vendor discounts, did not have a system that was designed to take full advantage of its purchasing power, and in general could achieve greater economies and efficiencies in the purchasing of small dollar items. Purchases through NIH's principal small purchasing system, DELPRO, amounting to $178 million in FY 1988, include equipment, supplies and services costing less than $25,000, which are used to support in-house research efforts and related activities.

Based on prior OIG, ASMB and PHS recommendations, NIH developed a corrective action plan to address four critical procurement areas: vendor discounts, regulatory compliance, the organization of ordering personnel and warehouse stocking and buying decisions. The review found that NIH was generally implementing the plan according to its scheduled time frames. However, OIG concluded that modifying certain parts of the plan and expediting the implementation of these changes could result in additional economies being achieved. The PHS was in general agreement with OIG's recommendations for acceleration of actions and modifications to the corrective action plan. (CIN: A-15-89-00006)

In a subsequent report done at the request of the Chairman, Senate Subcommittee on Labor, Health and Human Services and Education, Committee on Appropriations, the OIG estimated that NIH could save between $10 million and $15.3 million annually when current procurement reforms are implemented in its DELPRO small purchasing system. In addition, the OIG estimated savings of $3.6 million and $5.9 million annually in NIH's other two systems through which it makes small purchases: centralized procurement and decentralized purchasing. (CIN: A-15-89-00036)

DEFECTIVE PLASMAPHERESIS EQUIPMENT

The OIG investigated allegations of defects in plasmapheresis equipment, subject to FDA regulation, which is used to extract plasma from other blood components. An FDA field investigator claimed that certain FDA-approved equipment used at plasmapheresis centers was defective and placed employees and donors at risk of exposure to the human immunodeficiency virus, hepatitis B virus, and other infectious agents. An FDA health hazards evaluation committee determined that the equipment did not create a public health hazard, but recommended that FDA notify the manufacturer to include improved directions for use on equipment labels to prevent spillage of untested blood plasma.

The investigator further stated that FDA did not take prompt action to correct the problems with the equipment. The OIG found that this allegation was substantially correct. From the time the

problems were first reported, FDA took 9 months to make its determination and 7 more months to instruct the manufacturer to take corrective action.

The OIG report recommended that FDA amend its procedures for inspections of plasmapheresis centers to include an evaluation by field investigators of the performance of blood collection and processing equipment. It also urged that FDA take immediate action to improve its response time to reports of potentially hazardous situations involving the use of such equipment. The FDA agreed with the recommendations and has initiated corrective action. (CIN: A-12-88-00009)

IHS CONSTRUCTION PROGRAM

An OIG review of two proposed replacement hospitals in Shiprock, New Mexico and Anchorage, Alaska concluded that the size and configuration of the facilities should be reduced, resulting in a savings of $18 million in construction funds and $3.8 million in staff costs.

A. Replacement Hospital: Shiprock, New Mexico

The OIG found that the project justification materials did not demonstrate that the proposed 75-bed replacement facility was the most efficient means of providing medical services. The IHS should update the 1981 Navajo Inpatient Acute Care Health Delivery Plan and complete a valid comparison between the cost of providing needed services at the proposed Shiprock facility and the cost of obtaining the services through contracts with private sector providers. If a new facility can then be justified, available documentation would support one substantially smaller than that proposed. The OIG found that the proposed facility should be reduced by almost 57,000 gross square feet, with a cost saving of $14.2 million, and that related staffing costs could be reduced by approximately $3.2 million annually. (CIN: A-06-88-00008)

B. Replacement Hospital: Anchorage, Alaska

An OIG review disclosed opportunities for reducing the size of the proposed replacement facility by about 11,300 gross square feet and 8 beds, at estimated savings of about $3.8 million in construction costs.

If the OIG recommendations for reducing the size of the facility are implemented, annual staffing costs for the facility could be reduced by about 17 full-time equivalent positions, with annual savings of about $0.6 million. (CIN: A-09-89-00096)

EMPLOYEE FRAUD

Weaknesses in employee travel controls, particularly in IHS, resulted in the conviction of several PHS employees during this period, as illustrated in the following cases:

- A former area director for IHS in Minnesota was sentenced to 1 year and 1 day in prison and full restitution of $22,000 he obtained through travel voucher fraud.

- Two former IHS employees in Wisconsin have been sentenced to 60 and 45 days in jail, respectively, without release privileges, for submitting falsified hotel receipts for reimbursement of expenses they had not incurred. One of the two also had to pay restitution of $2,150, a $1,000 fine and a $100 assessment, and donate 100 hours in community service.
- A public health advisor with the CDC received a suspended sentence and had to serve 3 years probation and 100 hours of community service for travel voucher fraud. Transferred from South Carolina to Arizona, he falsified expenses for en route and temporary quarters accommodations and services. He also lost his Federal position.

INDIRECT COST SAVINGS

At the request of HHS' Division of Cost Allocation (DCA), OIG provided audit support in analyzing and negotiating indirect cost rates at the University of California, Los Angeles (UCLA). Through the combined efforts of these two organizations, UCLA's indirect cost rate was reduced by 14.5 percent for four fiscal years ending June 30, 1993. The result of this reduction is a total savings of $72 million, of which OIG's contribution accounted for $37.6 million. (CIN: A-09-89-00061, CIN: A-09-89-00068)

FAMILY SUPPORT ADMINISTRATION

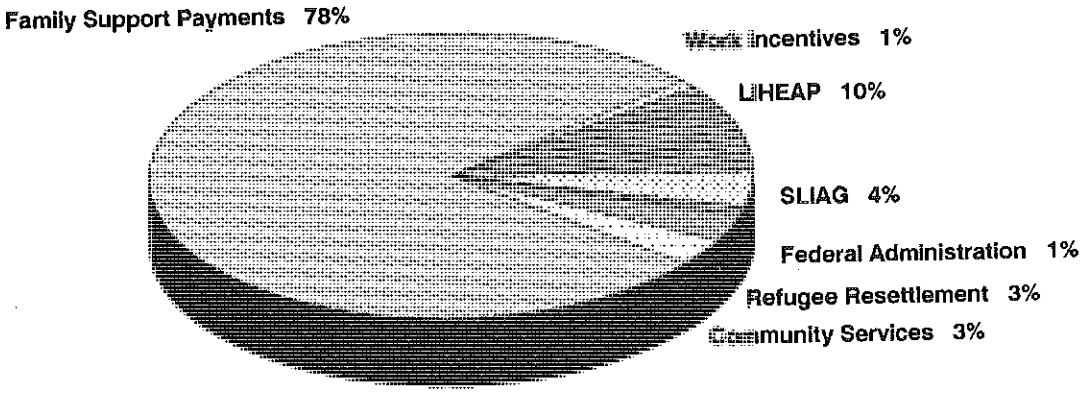
CHAPTER V

FAMILY SUPPORT ADMINISTRATION

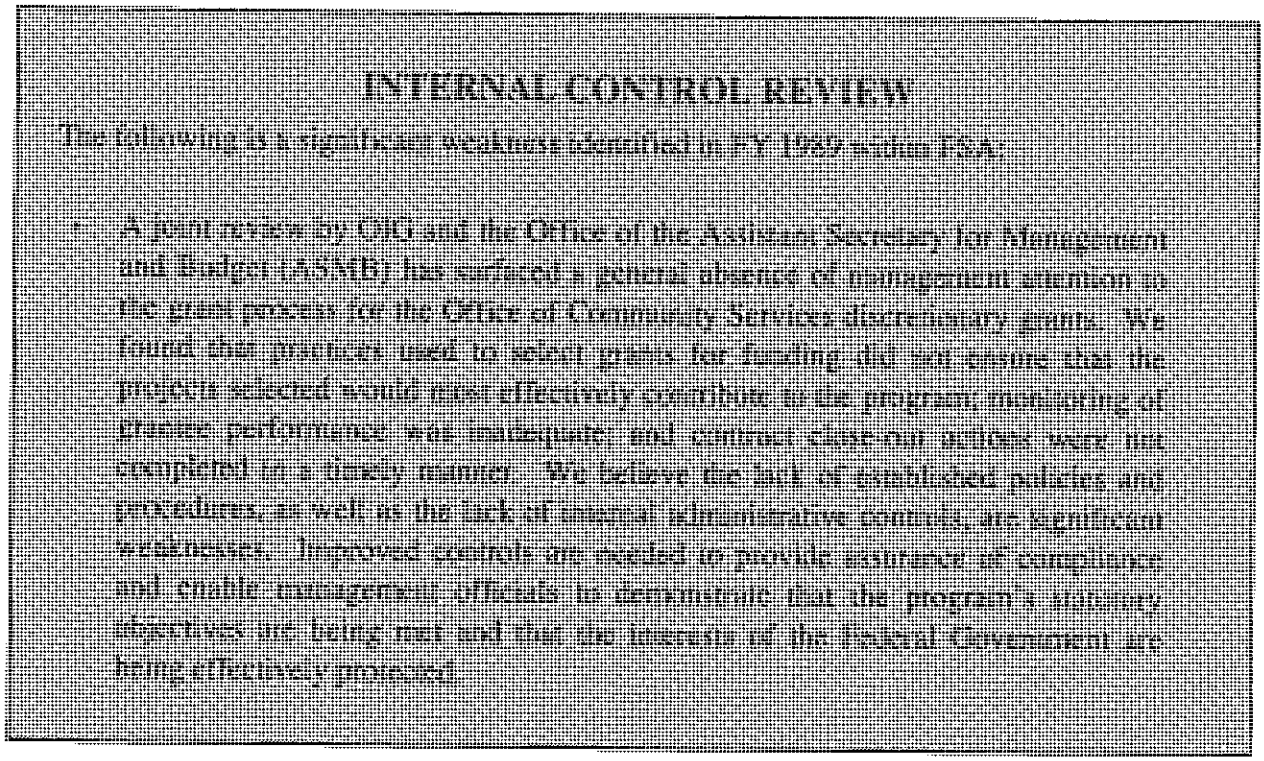
OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

The Family Support Administration (FSA) provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. Aid to Families with Dependent Children (AFDC) is a cooperative program among Federal, State and local governments which reaches 3.8 million families consisting of 11 million individuals each month. The Child Support Enforcement (CSE) program provides grants to States to enforce obligations of absent parents to support their children by locating absent parents, establishing paternity when necessary, and establishing and enforcing child support orders. The Low Income Home Energy Assistance program (LIHEAP) provides block grants to the States to help offset the increased cost of fuel for recipients of AFDC, food stamps or supplemental security income, as well as certain other individuals. Other programs include Emergency Assistance, Refugee and Entrant Assistance, Community Services and Work Incentive programs. The FSA is also responsible for the State Legalization Impact Assistance Grants (SLIAG) program, created by the Immigration Reform and Control Act (Public Law 99-603). Expenditures for FSA programs will total $13.9 billion for FY 1989.

DISTRIBUTION OF FSA RESOURCES
(FY 1989 Budget $13.9 Billion)



The OIG performs audits to review recipient eligibility, determine the fairness of program benefits, and evaluate the economy and efficiency of operations. Implementation of the Family Support Act of 1988 (Public Law 100-485) is one of the Department's highest priorities. The OIG will be actively involved in monitoring that implementation to detect fraud, waste and mismanagement of Government monies. Included in these efforts will be an assessment of the effectiveness of the new Job Opportunity and Basic Skills (JOBS) program intended to assist welfare recipients in achieving self-sufficiency. In addition, OIG will undertake several inspections and audits to review implementation of the strengthened CSE provisions of the Act, designed to help meet the costs of the new child care, training and other components of welfare reform. During this reporting period, OIG recommended recovery of $5.4 million in questionable grantee charges. Programmatic savings totaled $804.1 million.



CHILD SUPPORT ENFORCEMENT: WAGE WITHHOLDING

The 1988 Family Support Act emphasizes the need to improve child support collection activities and requires immediate wage withholding action by the States. To determine the extent of increased collections possible at the Federal level if immediate wage withholding were in place in all States, OIG performed a statistical match of Federal employee data from the Office of

Personnel Management, the United States Postal Service, and the Department of Defense with CSE tax intercept data.

Preliminary data disclosed approximately 70,000 Federal employees (civilian and military) in arrears on child support payments totaling $269.4 million. Additionally, OIG estimated that child support collections could be increased by as much as $23 million annually.

The OIG recommended that FSA take the lead by making the computer matches available to the States, encouraging the States to make greater efforts to fully utilize State and Federal parent locator services, and implementing immediate wage withholding. (CIN: A-12-89-00127)

CHILD SUPPORT ENFORCEMENT: NON-AFDC CASES

The OIG conducted an inspection to determine if there was a systematic method of identifying those absent parents who were in a position to contribute more to their children's support. Since many single-parent families are living close to the poverty level, the regular payment of child support may be an essential element in avoiding welfare dependency.

This inspection examined ways to increase child support collection for children not receiving AFDC payments and was a follow-up to an earlier study which focused on AFDC cases. It analyzed individual child support enforcement cases and determined absent parents' reported yearly income through a computer match with Social Security Administration (SSA) records.

The OIG found that substantial savings could result from a targeted review of child support cases which remained dormant for long periods. A review of over 3,000 non-AFDC child support cases where there was no support order or where the monthly support payment was $100 or less, and a match to the absent parents' Social Security records showed that 46 percent of the absent parents earned more than $10,000 in 1986.

The OIG recommended that, within legal constraints, States should perform a logical, systematic review of all cases, and, as a minimum, should target those cases where absent parents are earning over $10,000 annually. The FSA agreed that there is great potential for increasing child support collections through the use of systematic case follow-up and subsequent modification of court orders. (OAI-05-88-00340)

SHELTER FOR HOMELESS FAMILIES

In November 1988, the Congress required HHS to conduct a study on the use of AFDC emergency assistance funds for long-term shelter for homeless families. A departmental work group requested that OIG obtain information about alternative sources of funding for temporary housing for homeless families.

The OIG determined that all 6 States included in its survey were taking an aggressive lead in the effort to prevent and relieve homelessness. The States reported a total of 54 programs that were designed to provide shelter or temporary housing for homeless families. Total funding for these programs amounts to $346 million, the majority of which comes from State and local governments and private charities.

The study found that AFDC emergency assistance and special needs funds are particularly important to the efforts of the States involved. However, it also found that the States do have alternatives to the use of AFDC emergency assistance dollars where more than 30 days of benefits are required. There are at least 15 programs that offer shelter benefits in excess of 30 days which are funded by sources other than AFDC, with a median duration of 151 days of benefits.

Accordingly, OIG recommended that regulations stipulating a 30-day limit on AFDC emergency assistance be implemented. In order to allow for possible action by State legislatures necessary to accommodate such a change, OIG proposed a phase-in period not to exceed 2 years. (OAI-07-89-01300)

EMERGENCY ASSISTANCE PAYMENTS: NEW YORK

The OIG conducted a review of payments made to New York State under the Emergency Assistance to Needy Families with Children (EAF) program, which provides temporary financial assistance and social services in emergency situations.

During the period October 1, 1984 through September 30, 1985, New York City claimed approximately $17.6 million ($8.8 million Federal share) in EAF assistance payments. The OIG previously reported (CIN: A-02-87-00003) that about $7.1 million ($3.55 million Federal share) of these amounts were unsupported claims and recommended financial adjustment.

A current review of the balance of the EAF payments revealed that $7.6 million ($3.8 million Federal share) of these claims were ineligible for Federal financial participation (FFP) as a result of noncompliance with Federal program requirements.

The OIG recommended that the State process a financial adjustment of over $3.8 million Federal share. Further, OIG proposed that the State improve future program administration by stricter adherence to EAF program requirements and by strengthening its management system. The FSA generally agreed with the recommendations. (CIN: A-02-88-00002)

REFUGEE RESETTLEMENT

The Refugee Act of 1980 (Public Law 96-212) as amended, provides for the effective resettlement of refugees in the United States. Federal regulations provide for subsidies to designated State agencies to administer the refugee resettlement program (RRP). Federal funds are available to reimburse States for cash, medical assistance and social services provided to eligible refugees who meet requirements in the State in which they reside. The social services are funded under separate discretionary grants awarded by the HHS Office of Refugee Resettlement.

A. Eligibility Periods

The law authorizes Federal reimbursement to the States for 100 percent of cash and medical assistance provided to refugees during the 36-month period immediately following their date of entry into the United States, subject to availability of funds. Because of lack of sufficient funds for 36 months' reimbursement, effective March 1986, the reimbursement period was reduced to 31 months and effective February 1988, it was reduced to 24 months.

A series of OIG reviews conducted in several States show that reimbursement for assistance payments continue to be claimed for periods beyond the reimbursement period. The OIG identified total financial adjustments of about $612,300. (CIN: A-05-88-00018; CIN: A-05-88-00020; CIN: A-05-88-00092; CIN: A-05-88-00098)

B. Cash and Medical Assistance Payments

An OIG audit revealed that Pennsylvania received more than $1.2 million of FFP in cash and medical assistance payments made to or for ineligible clients of the RRP and the Unaccompanied Minors Refugee Program (UMRP) during the period October 1, 1985 through June 30, 1988.

The OIG report recommended procedural changes to improve the State management of the RRP and the UMRP. It also recommended that the State make a financial adjustment of $1.2 million for ineligible payments prior to June 30, 1988 and additional financial adjustments for payments to or for ineligible clients after June 30, 1988. The State agreed with the OIG recommendations and has begun implementation. The FSA also agreed with the findings and recommendations. (CIN: A-03-88-00254)

An OIG review in another State disclosed that costs shown on its financial status reports during the period October 1984 through March 1988 overstated the Federal share by approximately $290,300. This overstatement resulted from errors made by the State agency in using an incorrect FFP rate; claiming cash assistance payments as medical costs; and claiming cash assistance for refugees who had exhausted their eligibility. The State concurred with the OIG findings. A revised financial status report was submitted to credit the RRP for the overclaimed costs. (CIN: A-05-88-00092)

C. Social Services

To meet anticipated RRP social service expenditures during the period October 1, 1984 through September 30, 1986, Ohio withdrew Federal funds totaling over $1.8 million under the payment management system (PMS). The State claimed that it incurred costs of approximately $1.4 million for this same period and was unable to account for the $400,000 difference. (CIN: A-05-88-00043)

RENOVATION OF HOMELESS SHELTER

The OIG conducted an audit of costs claimed by the District of Columbia, Department of Human Services (DHS) under a $6.5 million contract according to which they were to perform demolition and renovation work on a homeless shelter.

The audit found that the contractor failed to remit interest earned on excess cash balances totaling nearly $176,500 and charged improper costs of almost $4,300. In addition, about $310,000 was being held in abeyance because of a dispute between contractors.

The OIG recommended that the Office of Community Services (OCS) require DHS to make financial adjustment of over $180,700. Also, there should be a refund of over 90 percent of the interest earned on the Federal funds being held pending resolution of the contract dispute. The OCS concurred with the findings and recommendations including the amounts of disallowed costs and interest income earned on Federal funds invested and those held in escrow. (CIN: A-03-88-03300)

CHILD SUPPORT ENFORCEMENT: INTERSTATE GRANT

The OIG reviewed costs charged to an FSA grant to the State of Texas' Attorney General's Office (TAGO) for the development of an interstate network clearinghouse for child support enforcement cases.

The TAGO charged over $977,000 of expenses to the grant. The OIG recommended disallowance of about $68,900 of salary, fringe benefits and computer hardware costs which did not appear to have been incurred on grant work. The State agreed to repay $3,912 of the recommended disallowance and FSA is determining whether the remainder should be repaid. (CIN: A-06-88-00072)

VERIFICATION OF SSNS IN PUBLIC ASSISTANCE PROGRAMS

The Deficit Reduction Act of 1984 required the States to establish the Income and Eligibility Verification System to share wage and benefit information relating to welfare recipients. The law mandated that the States use the Social Security number (SSN) for record identification and

attempt to verify the SSN with SSA. In 1988, the OIG issued an inspection report evaluating SSA's systems for verifying SSNs and proposing enhancements to those systems. That review found that the primary system for SSN verification has historically failed to verify 15 to 18 percent of the SSNs submitted; however, the system was able to verify more than half of those when a maiden name was substituted for the recipient's current surname. The SSA agreed with OIG's recommendation that the States submit multiple names in their requests for SSN verification.

In a follow-up to that inspection, OIG recommended that FSA instruct State welfare offices to provide multiple records which separately identify the maiden or other secondary surname, as well as the current surname, when requesting SSN verification. In addition, it was suggested that clients whose maiden name is the one which verifies, be asked to contact SSA to update their Social Security records. The FSA agreed with the recommendations and is preparing instructions to implement them. (OAI-12-89-01900)

AFDC FRAUD PROJECTS

One form of welfare assistance, which includes Medicaid, food stamps and AFDC benefits, is based on State determinations of AFDC eligibility. As a result, welfare fraud is usually perpetrated by making false claims about one's circumstances, such as claiming a nonexistent dependent child or concealing income which would render the applicant ineligible. Suspected fraud is discovered through a variety of mechanisms, ranging from disclosure by a disgruntled acquaintance or relative to computer matches of welfare lists against worker compensation rolls or income tax returns. Individual cases of welfare fraud typically involve relatively small amounts of money and little notoriety and, therefore, are relatively low on the agenda of prosecutors. The OIG seeks to make prosecution attractive by grouping several cases for convenience of prosecution and maximum deterrent effect. For example, in central Illinois 61 persons from 31 communities have been indicted, all but two for AFDC or other welfare violations. The indictments were the result of a 14-month project, dubbed "Operation Wel-cheat," conducted with the assistance of the United States Attorney and the Illinois Department of Public Aid.

AFDC STATES' BENEFITS PROJECT

In 1981, OIG initiated a project to assist State and local agencies in California in the prosecution of fraud against Federal and State income maintenance and benefit programs. The project was established in response to the perception on the part of the agencies that successful completion of their cases was frustrated by the amount of time it took to obtain necessary information and documents from Federal agencies. The OIG developed a mechanism for State and local investigators and prosecutors to verify SSNs, get information about Social Security payments and obtain photocopies of the checks. The success of the project led OIG to expand it nationwide in 1983. Close to 15,000 requests for assistance have been received from hundreds of State, county

and municipal jurisdictions. Their reporting to OIG on the outcome of cases is sometimes sporadic, but at least 1,300 convictions and an estimated $12 million in monetary returns have been obtained. At present OIG is processing 400 to 500 requests for assistance each month.

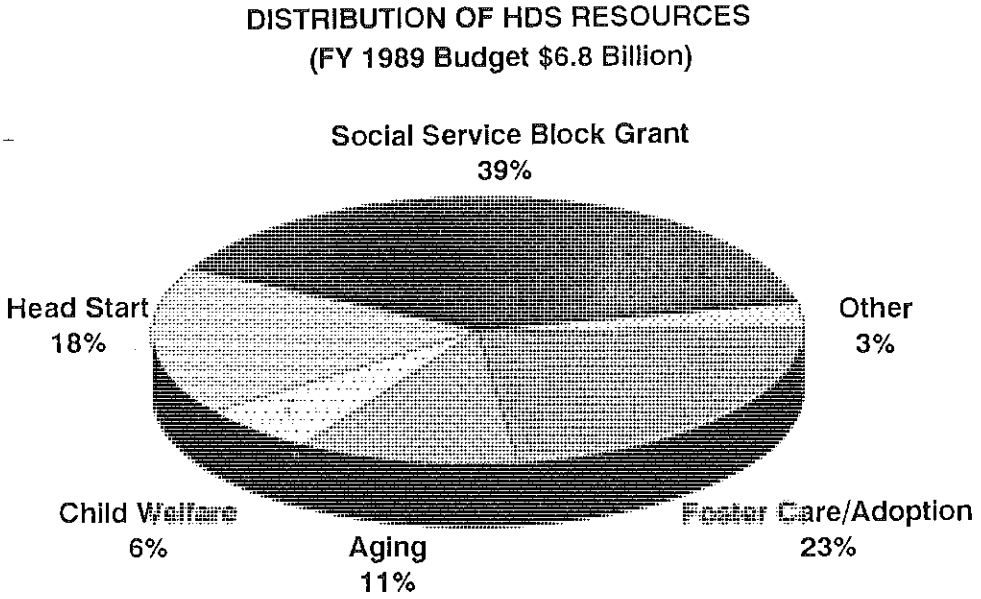
OFFICE OF HUMAN DEVELOPMENT SERVICES

CHAPTER VI

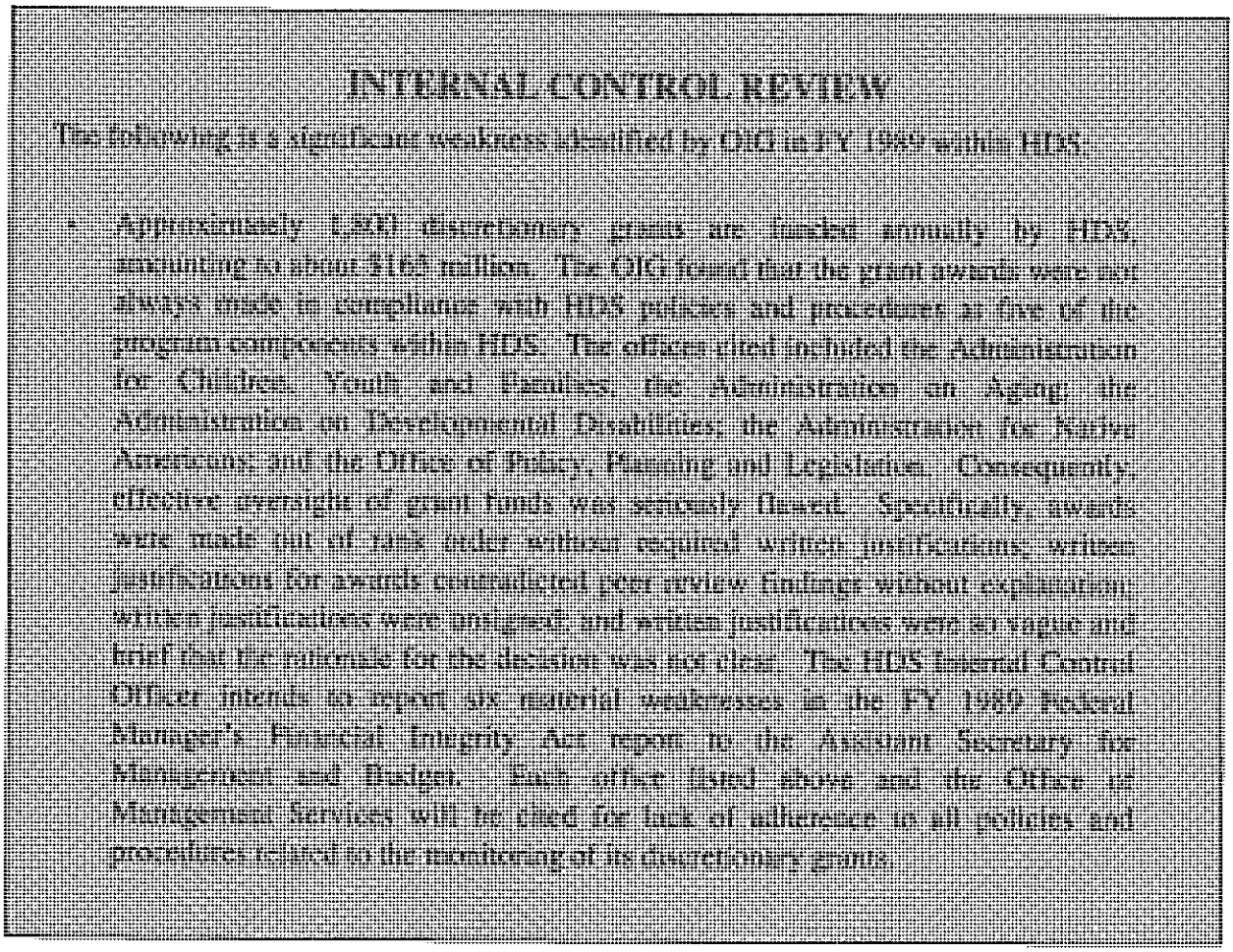
OFFICE OF HUMAN DEVELOPMENT SERVICES

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

The Office of Human Development Services (HDS) oversees a variety of programs that provide social services to the Nation's children, youth and families, disabled, older Americans and Native Americans. Head Start is a $1.2 billion per year program which provides comprehensive health, educational, nutritional, social and other services primarily to pre-school children and their families who are economically disadvantaged. Foster Care and Adoption Assistance is an entitlement program that provides grants to States to assist with the cost of foster care and special needs adoptions maintenance, administrative costs to manage the program, and training for staff. The goal of this program is to strengthen families in which children are at risk, reduce inappropriate use of foster care, and facilitate the placement of hard to place children in permanent adoptive homes when family reunification is not feasible. The programs for the aging provide for supportive centers and services, congregate and home-delivered meals and in-home services for the frail elderly. Expenditures for HDS programs will total $6.8 billion for Fiscal Year (FY) 1989.



During this reporting period, OIG identified questionable grantee charges to HDS programs of over $5.5 million.



INTERNAL CONTROL REVIEW

The following is a significant weakness identified by OIG in FY 1989 within HDS.

- Approximately 1,200 discretionary grants are funded annually by HDS, amounting to about $162 million. The OIG found that the grant awards were not always made in compliance with HDS policies and procedures at five of the program components within HDS. The offices cited included the Administration for Children, Youth and Families, the Administration on Aging, the Administration on Developmental Disabilities, the Administration for Native Americans, and the Office of Policy, Planning and Legislation. Consequently, effective oversight of grant funds was seriously flawed. Specifically, awards were made out of rank order without required written justifications; written justifications for awards contradicted peer review findings without explanation; written justifications were unsigned; and written justifications were so vague and brief that the rationale for the decision was not clear. The HDS Internal Control Officer intends to report six material weaknesses in the FY 1989 Federal Manager's Financial Integrity Act report to the Assistant Secretary for Management and Budget. Each office listed above and the Office of Management Services will be cited for lack of adherence to all policies and procedures related to the monitoring of its discretionary grants.

COORDINATED DISCRETIONARY FUNDS PROGRAM

The OIG conducted a review to determine whether HDS has adequately implemented their stated policy of requiring grantees under the coordinated discretionary funds program (CDP) to demonstrate the potential for self-sufficiency once Federal funding has ended. The CDP combines the discretionary grant programs of the various HDS agencies into a coordinated effort, which is designed to permit more efficient administration of the program. Each fiscal year, HDS publishes a joint request for applications for all its CDP grants in the Federal Register. The applications are rated by a panel of peer reviewers and HDS management staff then select the awardees.

The review found that the HDS policy on self-sufficiency was not being implemented in a uniform manner within HDS and disclosed that HDS has no procedures to determine whether these grantees actually do become self-sufficient after Federal funding ceases. The OIG recommended that HDS take steps to assure that the concept of grantee self-sufficiency receives a consistently high emphasis in the CDP despite changes in HDS leadership. It further urged that there be follow-up procedures to identify those factors which self-sufficient grantees have in common for use by reviewers in screening future grant applications. As a result of the OIG recommendations, HDS is examining their policy on self-sufficiency and the need to establish follow-up procedures. (OAI-04-89-00800)

AUTOMATED DATA PROCESSING OPERATIONS

Based on a review of HDS' automated data processing operations, the OIG estimated that recommended changes would result in annual savings of about $640,000, with a one-time conversion cost of $125,000.

The audit report concluded that HDS should develop and execute plans to move all application systems now on its dedicated computer to a combination of microcomputers and shared HHS mainframe computers. The HDS agreed to move suitable applications to microcomputers but did not agree to shift major data processing work to a shared computer center. In FY 1990, HDS plans to operate its mainframe computer center on a fee-for-service basis and the market forces shall determine the cost-effectiveness of HDS maintaining its mainframe facility versus utilizing an existing HHS shared mainframe computer facility. The OIG continues to believe that such a shift would be the most efficient and economical course. (CIN: A-12-87-00135)

FOSTER CARE MAINTENANCE PAYMENTS

Title IV-E of the Social Security Act provides financial assistance for the care and protection of children in the AFDC program who have been judicially removed from the homes of relatives and placed in approved foster care arrangements. During this reporting period OIG found that Virginia claimed Federal financial participation (FFP) for foster care maintenance payments that did not meet requirements for Federal reimbursement. From a sample of payments made by local social service agencies, OIG determined that the State agency received almost $1.7 million in FFP for payments not eligible for Federal reimbursement during the period October 1, 1984 to September 30, 1986. The OIG recommended that the State agency require local social service agencies to comply with title IV-E requirements; to periodically monitor local agency compliance with these requirements; and to refund the overclaim to the Federal Government.

Some payments were found to be ineligible because they were made without the required documentation of judicial determination. The Office of Attorney General, Commonwealth of Virginia, responded to the report by issuing legal orders to invalidate OIG findings on judicial determinations. The OIG believes that the orders do not invalidate the findings as they alone are

not sufficient evidence that required judicial determinations were actually made. (CIN: A-03-88-00550)

HEAD START

During this period, OIG conducted several audits of the Head Start program which provides comprehensive support and early childhood development services for children of low-income families. Nonfederal auditors examine Head Start grantees on an annual basis.

A. Georgia

A nonfederal audit of a Head Start grantee in Georgia found that the grantee did not comply with the 20 percent nonfederal contribution which was required by the grant award. Also, the fund balance consisted of funds received from HHS grants which had not been expended.

The OIG recommended that the grantee develop and implement controls to ensure that the percentage of matching share incurred is in accordance with the approved grant document and that the more than $125,000 in Federal funds which exceeded the expended amounts be refunded. (CIN: A-04-89-07507)

B. Marshall Islands

An audit of the Marshall Islands Head Start grant resulted in a recommendation that the grantee promptly submit a revised final financial status report (FSR) to exclude over $23,800 claimed for three program accounts in excess of audited costs. A revised final FSR was submitted by the grantee to delete excess costs claimed. (CIN: A-09-89-00512)

C. Puerto Rico

An audit of the Head Start program administered by Puerto Rico's Office of Human Development for the fiscal year ending February 1988 resulted in recommended financial adjustments of about $484,900. The HDS officials concurred. (CIN: A-02-88-05285)

ADOPTION ASSISTANCE

The Adoption Assistance program provides Federal funds to States to subsidize the adoption of children who receive AFDC, SSI or foster care and have special needs. During FY 1985 and FY 1987, the District of Columbia claimed costs of $3.5 million for the title IV-E Adoption Assistance program (FFP $1.75 million). An OIG review showed that $1.9 million of the costs claimed were ineligible for FFP, either because maintenance payments were not made in accordance with title IV-E requirements or administrative costs were improperly allocated to the title IV-E program.

As a result, the District of Columbia received excess FFP of almost $800,000. The OIG made procedural recommendations to assist the District of Columbia in properly administering the title IV-E Adoption Assistance program and recommended financial adjustment of the overclaim. (CIN: A-03-88-00552)

CONSULTANT SERVICES COSTS

An OIG audit disclosed that during 1986 and 1987 one State's legislature directed its Department of Human Services to award a consulting contract with the objective of increasing Federal revenue. The intent was to shift costs from State and other programs with limited funding to the Foster Care program which has open-ended funding.

The OIG concluded that the $239,800 ($119,900 Federal share) expended for the contract was not an allowable charge to the Foster Care program. The costs were not reasonable or necessary for the administration of the Foster Care program nor did they benefit the program. The OIG recommended that the State make reimbursement in the amount of $119,900 and that it comply with requirements for charging costs to the Foster Care program. (CIN: A-07-88-00085)

MULTIPURPOSE SENIOR CITIZEN CENTERS

Multipurpose senior centers (MSC) are funded under title III of the Older Americans Act.

A. Florida

The OIG found several weaknesses in controls over MSCs in Florida. The Florida Department of Health and Rehabilitative Services (HRS) did not have required procedures in place to ensure that the Federal Government would recover its original investment and its share of the increased fair value of the centers. The OIG estimated the Federal share of the total value at $23.9 million.

The OIG recommended that the HRS prepare procedures for local center operators on steps to be taken when centers are sold and action required to return the appropriate share of funds to the Federal Government. (CIN: A-04-88-00073)

B. Illinois

The OIG found several weaknesses in internal controls over the Federal Government's financial interests in MSCs by the Illinois Department on Aging. The Federal share of funding for the centers totals $7.5 million.

The State concurred with the OIG recommendation to maintain accurate, up-to-date records of MSCs funded for facility development and to identify procedures for recovery of the appropriate share of Federal funds when the centers are sold. (CIN: A-05-88-00136)

APPENDICES

APPENDIX A

SAVINGS

APRIL 1989 THROUGH SEPTEMBER 1989

This schedule documents savings to programs resulting from legislative or regulatory actions or policy determinations of management on behalf of OIG recommendations. Legislative items represent funds or resources that will result in budgetary savings over a 5-year period. Programmatic savings are calculated by OIG using departmental figures for the year in which the change was effected or, as appropriate and where so indicated, for a projected 5-year period. Total savings during this reporting period amounted to $3,094.8 million.

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Child Support Enforcement: The FSA should identify those child support cases with no or low support orders and periodically review and establish new orders or modify existing orders based on the absent parent's ability to pay. (OAI-05-87-00034; OAI-05-87-00033; OAI-05-87-00035)	The FSA can now determine an absent parent's ability to pay through contact with IRS. With FSA's encouragement, a number of States have taken action to review their cases, and where appropriate, have established new orders or modified existing ones.	$570
DCA Savings: Reviews and negotiations of indirect cost rates and cost allocation plans conducted by the Department's Division of Cost Allocation (DCA) resulted in savings shown. The OIG provides audit support to the DCA in conducting some of the negotiations.	The DCA has negotiated rates for FY 1989, resulting in the savings shown.	488.2
End Stage Renal Disease Drug: The HCFA should employ techniques developed by OIG to establish a reasonable payment for a new drug which will benefit end stage renal disease (ESRD) patients. (CIN: A-14-89-00218)	The HCFA made use of OIG payment models to determine a reasonable Medicare payment amount.	465*
New Drug Development: The cost of technological improvements, such as the new drug TPA, are adequately reimbursed by DRG amounts. Additional Medicare payment for administering them is unwarranted. (CIN: A-14-89-00325)	The Prospective Payment Assessment Commission estimated that hospitals would incur costs of $78 million each year for administering TPA. The Department announced that Medicare would not authorize payments for TPA over and above DRG rates.	390*
Assistant Surgeon Services: Follow-up on OIG's recommendation to eliminate Medicare payment for unnecessary assistant surgeon services during cataract surgery and other operations. (CIN: A-01-89-00506; ACN: 01-52001)	The COBRA of 1985 excluded Medicare coverage of payments for assistants at surgery for certain cataract operations. The OIG had previously reported savings of $145 million. We are now reporting additional cost savings computed on the basis of a follow-up review.	312
State Investigation of Fraud in the AFDC Program: The FSA should require States to implement a pre-eligibility fraud detection and prevention program. (OAI-04-86-00669)	The Family Support Act of 1988 mandated the establishment of pre-eligibility fraud units in the AFDC program.	230*

* 5-year projection

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Acceleration of Deposits: The OIG recommended that SSA seek legislation to accelerate State and local government deposits by adopting the private sector deposit schedule. (ACN: 13-52601)	Section 9002 of the OBRA 1986 required State and local employers to follow the private sector deposit schedule. The OIG previously reported $1.142 billion in estimated savings that was expected to result from implementation of this recommendation. Based on the latest available data, it now appears these savings were underestimated for years 1987 to 1991.	$ 200
Uncontrolled Payments After Death: The SSA should initiate recovery of the overpayments identified in the report and stop payment actions for incorrect payments issued after the death of the beneficiary. (OAI-12-88-00970)	The SSA concurred with the recommendations and has identified the cases for recovery and issued alerts for the cases requiring recoupment.	149.5
Errors Resulting in Overpayments in the AFDC Program: The SSA should institute enumeration of infants at birth. This would help reduce the number of technical errors which occur in cases where recipients allege that no SSN had been assigned to them. (OAI-04-86-00024)	The SSA has issued policy and procedures to facilitate enumeration at birth. They are implementing an enumeration at birth project with cooperating States wherein parents may obtain an SSN for a newborn child as part of birth registration.	94.5*
PRO Disallowances: Eliminate from contract awards and subsequent contract amendments, unallowable and overstated costs included in peer review organization (PRO) cost proposals.	The HCFA used OIG findings in reducing third cycle/ 1988-1990 PRO contract awards and extensions.	77.2
Audit Assistance: The Department's Division of Cost Allocation should use OIG audit results to negotiate indirect cost rates for the University of California - Los Angeles and the University of Wisconsin - Madison. (CIN: A-09-89-00061; CIN: A-09-89-00068; CIN: A-05-86-67006)	The DCA has negotiated rates based on OIG audits, resulting in the savings shown.	41.1
Miscoding Patient Transfers: Effect on Medicare Payment: The HCFA should develop instructions concerning transfer cases that provide for clear responsibility on the part of the hospital, the intermediary and the PRO for identification and correct payment of transfers. (OAI-06-87-00043)	The HCFA issued new PRO instructions which require that PROs review 25 percent of all readmissions occurring within 31 days from discharge from a PPS hospital. This will identify those hospitals which incorrectly code transfers and cause them to be selected for intensified review.	34.7

* 5-year projection

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Small Purchases at NIH: The NIH should implement reforms in its small purchases system (DELPRO). Additional savings can be obtained by implementing similar reforms in NIH's centralized procurement and decentralized purchasing mechanisms. (CIN: A-15-89-00036)	The NIH has developed a corrective action plan based upon OIG, ASMB and PHS recommendations.	$21.2
Institutions for Mental Disease (IMDs): Costs of care provided to Medicaid patients in Illinois IMDs should be disallowed as they do not meet the criteria to be eligible for Federal financial participation (FFP). (CIN: A-05-89-00023)	Illinois returned improperly claimed FFP for periods covered in the OIG review and for subsequent periods.	12.1
Overpayment Recoveries from Contingently Liable Beneficiaries: The SSA should improve staff compliance with collection procedures and develop a computer application to identify and review overpayments placed in the terminated collection file while other persons received benefits under the same earnings record. (CIN: A-03-89-02701)	The SSA staff was reminded of pertinent collection procedures, a computer application was developed, and a review was conducted which resulted in terminated overpayments being recovered.	4.2
Submitting Secondary Names for Social Security Number Verification: The FSA should instruct State welfare offices to provide multiple records separately identifying the maiden or other secondary name, as well as the primary name, when verifying SSNs via the Enumeration Verification System. (OAI-02-89-01900, OAI-09-86-00068)	The FSA agreed with the recommendation and has initiated action to instruct State public assistance agencies of the revised procedures.	4.1
Access of Foreign Nationals to U.S. Cadaver Organs: The HCFA should issue regulations requiring that kidneys sent to foreign countries or transplanted to non-Medicare recipients be excluded from Medicare payments to an Organ Procurement Agency. (OAI-09-86-00076)	Final regulations implementing the recommendation were published in the Federal Register, Volume 54, Number 23, dated February 6, 1989.	1.0

APPENDIX B

AUDIT RECEIVABLES
APRIL 1989 THROUGH SEPTEMBER 1989

This schedule represents significant examples of the dollar amounts placed in accounts receivable for recoupment during this reporting period as a result of management determinations in favor of audit findings and recommendations. Audit receivables for this period totaled $249.5 million and were comprised of OIG receivables of $123.1 million, a one-time adjustment to OIG receivables of $16.9 million arising from a change in reporting periods in accordance with amendments to the IG Act and HCFA program disallowance receivables of $109.5 million. A complete listing of audit reports and inspection reports issued during this reporting period is available upon request.

OIG RECEIVABLES	DOLLARS IN MILLIONS
• Interest income not credited back to the self-insurance fund maintained by the State of South Carolina. (CIN: A-04-88-00061)	$ 25.2
• Inspection identified Medicaid credit balances in hospitals which are to be recovered. (OAI-07-88-00470)	20.7
• Medicaid funds claimed without a valid provider agreement by the State of Kansas. (CIN: A-07-88-00105)	15.8
• Unallowable costs claimed for outpatient mental health services in New York. (CIN: A-02-87-01032)	13.1
• Unallowable costs claimed by Michigan under the Public Assistance, Medical Assistance and Social Services Programs. (CIN: A-05-86-60500)	8.5
• Overclaim of Medicaid funds by California under the Short/Doyle program, a special mental health program. (CIN: A-09-88-00133; CIN: A-09-88-00134)	5.8
• Overclaim for reimbursable bad debts under Medicare's end stage renal disease program by National Medical Care, Inc. (CIN: A-01-87-00504; CIN: A-01-88-00500)	4.2
• Improper Medicaid claims for physician and ancillary services by the State of California. (CIN: A-09-88-00060)	2.3
• Reimbursement for Federal Government's portion of FICA tax credit received by the State of Pennsylvania. (CIN: A-03-88-00450)	2.2
• Improperly claimed costs incurred in operating a mental health complex by the State of Wisconsin. (CIN: A-05-88-00004)	2.1
• Interest on premature draw downs by New York State for employee retirement contributions related to the disability determination program. (CIN: A-02-89-01007)	2.0
• Unallowable pass-through costs for indirect medical education charged to the Medicare program in Ohio. (CIN: A-05-88-00114)	1.6
• Overcharge for data processing costs by the State of Wyoming's Data Services Division. CIN: A-08-87-00064)	1.4
• Interest income not offset to interest expense arising from funds borrowed by Harvard University for construction/renovation projects. (CIN: A-01-87-04004)	1.4

- Unallowable costs charged to the Federal Government by the New York University Medical Center. (CIN: A-02-86-67012) 1.2
- Single audit disclosed unallowable charges to HHS programs in Oregon. (CIN: A-10-89-06058) $1.0
- Unallowable interest expense relating to capital lease agreements administered by the State of Texas. (CIN: A-06-87-00065) 0.9
- Single audit disclosed unallowable charges to HHS programs in Missouri. (CIN: A-07-89-06198) 0.8
- Unallowable Medicaid charges claimed by the State of Iowa for consultant service contracts. (CIN: A-07-88-00123) 0.7
- Overclaim of FICA sick pay credits by the State of Indiana. (CIN: A-05-88-00034) 0.6
- Ineligible costs claimed by the State of Ohio under the Refugee Resettlement Program. (CIN: A-05-88-00092) 0.6
- Overclaim of Medicaid charges by the State of Missouri for medical assistance provided to eligible recipients at State-operated facilities. (CIN: A-07-88-00144) 0.5
- Overclaim of administraive costs by the State of Washington related to the Social Security Disability Determination Service and Disability Hearing Unit functions. (CIN: A-10-88-00008) 0.5
- Overpayments of costs by a Medicare carrier. (CIN: A-02-88-01013) 0.5
- Other Audit determinations (under $500,000) 9.5

Total $123.1

CFA PROGRAM DISALLOWANCES	DOLLARS IN MILLIONS

- Unallowable claims for payments made to recipients rather than providers under Medicaid program. $12.2
- Medicaid reimbursements claimed during periods of invalid provider agreements. 18.8
- Medicaid Management Information Systems (MMIS) overhead expenditures not directly attributable to MMIS Cost Center. 5.4
- Overstated Medicaid claims for administrative expenditures. 4.6
- Medicaid payments for ineligible recipients. 10.3

Provider overpayments not credited timely to Medicaid program. 1.8

State charged the Medicaid program unallowable costs in rates for psychiatric centers 5.5

Medicaid payments to providers for individuals whose eligibility was not properly documented. 19.0

Medicaid payments not related to patient care. 15.4

- Overstated Medicaid claims due to not deducting recipient's liability. 2.1
- Nonqualifying contributions were included in Medicaid program claims. 3.2
- Overpayments by Medicaid of States' management system cost 1.1
- Medicaid payments for unallowable malpractice. 6.7
- Medicaid improperly reimbursed estimated costs on eligibility determination for medically needy. 0.8
- Other determinations (under $500,000) 2.6

Total	$109.5

APPENDIX C

INVESTIGATIVE RECEIVABLES
APRIL 1989 THROUGH SEPTEMBER 1989

This schedule represents the dollar amount of fines, savings, restitutions, settlements and recoveries determined through judicial or administrative processes in support of OIG investigative findings. These figures include both actual and ordered recoupments for the Treasury of the United States, the Social Security and Medicare trust funds and departmental programs victimized by fraud and abuse. Receivables of $41.7 million are reported for this period.

Judgments and Settlements

- Florida DME manufacturer sold defective pacemakers. ..... $ 5,600,000
- Missouri group of anesthetists billed Medicare for inadequately supervised nurse anesthetists 450,000
- A former head of rheumatology at a New Jersey medical center falsified Medicare claims for hospital visits never made. 325,000
- Texas laboratory fragmented charges for diagnostic thyroid tests. 318,200
- Texas residential treatment center for emotionally disturbed children billed group sessions as physician services. 300,000
- California ophthalmologist billed for laser eye surgery on consecutive days that was actually performed on the same day 290,000
- Pharmacy of Wisconsin hospital filed false claims. 200,000
- Michigan emergency room physicians billed cardiac monitoring as if it were Holter monitoring. 200,000

Recoveries and Fines

- West Virginia Department of Human Services used illegal basis to claim matching Medicaid funds. 11,047,900
- State improperly claimed Medicaid reimbursement for Kansas hospital 3,971,300
- California hospitals claimed Medicare reimbursement at urban rather than rural hospital rates. 3,525,500
- Illinois hospitals billed Medicare Part A and Part B for the same services. 2,070,800
- Two DME corporations and their owner fraudulently billed Medicare and Medicaid for seat lift chairs 1,787,900
- Reimbursement of overpaid Medicaid funds by Colorado nursing home operators. 600,000
- Ohio oxygen supplier billed Medicare for extra units, larger units and other services not supplied. 352,600

- Pennsylvania home for the aged required "contributions" from prospective Medicaid patients' families. 300,000
- Woman in Utah, arrested for embezzlement, tried to evade taxes by working under husband's SSN. 250,000
- Iowa doctor billed Medicare for unnecessary and duplicate services. 241,000

Other Receivables Which Did Not Meet the $200,000 Threshold for Individual Reporting, Excluding Receivables Credited to Prior Reporting Period: ..... $ 9,869,800

APPENDIX D

PENDING OIG MONETARY FINDINGS
THROUGH SEPTEMBER 1989

This schedule represents over $13.8 billion in potential annual savings or a one-time recovery which could be realized if OIG recommendations were concurred in by the Congress and by the Administration through legislative action or if positive determinations were made by Management in favor of OIG recommendations. It should be noted, however, that the Congress normally develops savings over a full 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
Mandate Medicare Coverage: Medicare Part A coverage should be extended to all State and local government employees. (CIN: A-09-86-62050)	This proposal is included in the President's FY 1990 budget and legislative program.	$1,800
Unfunded Actuarial Liabilities in Pension Plans: The OMB should revise Circular A-87 to disallow the interest expense associated with unfunded actuarial liabilities. (CIN:A-09-87-00031)	The OMB has included part of our recommended changes in its revised Circular A-87.	1,300
Indirect Medical Education: Modify Medicare payments to teaching hospitals by reducing the prospective payment system adjustment factor. (ACN: 14-52018, ACN: 09-62003, CIN: A-09-87-00100, CIN: A-07-88-00101)	The President's FY 1990 budget and legislative program includes a proposal to reduce the IME adjustment factor from 7.75 percent to 4.05 percent.	1,020
National DRG Validation Study-Unnecessary Admissions: The HCFA should strengthen the role of the PROs and reconcile differences between PRO and SuperPRO data to reduce the nearly $1 billion in unnecessary Medicare hospital payments identified in this report. (OAI-09-88-00880)	The HCFA concurred with our recommendations and is taking action to implement them.	938
FICA Wage Base Loopholes: The value of fringe benefits selected under cafeteria plan salary reduction agreements should be included in the definition of wages for FICA purposes. (CIN: A-05-86-62602)	The SSA did not agree to seek legislative changes since it did not believe the Congress would favorably consider changes to cafeteria coverage.	927
Disproportionate Share Payments: Disproportionate share payments to hospitals should be ended without redistributing the funds to the prospective payment system. (CIN: A-04-87-01004)	This legislative proposal was not included in the President's FY 1990 budget proposal.	800

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Hospital DRG Rates: Rebase Medicare hospital PPS rates to correct for inclusion of overstated operating costs. (ACN: 09-62021; CIN: A-08-87-00003)	This proposal has not been included in the President's FY 1990 budget and legislative program. However, this report has been generally available and has been considered by the Congress in setting annual updates to the PPS rates in recent years. A PPS update that is 1.5 percent less than the full market basket will encourage further efficiencies while maintaining high quality health care.	$625
Medicare as Secondary Payer: Extend the Medicare secondary payer (MSP) provisions for ESRD beneficiaries beyond the current 1-year limit. (CIN: A-10-86-62016)	The HCFA disagrees with this proposal and has taken no action on the recommendation.	600
Bridging the Coverage Gap: Require mandatory Social Security coverage for all part-time and temporary State and local government employees not participating in a public employees' retirement system. (CIN: A-02-86-62604)	The proposal was not included in the President's FY 1990 budget and legislative program. A bill recently introduced in the Senate (S.210) would implement our recommendation if enacted.	600
Poor Quality Care - National DRG Validation Study: The HCFA needs to issue regulations to implement the 1985 COBRA provisions giving PROs authority to deny Medicare reimbursement for patients receiving substandard medical care. (OAI-09-88-00880)	The HCFA issued a proposed rule on January 18, 1989 (54 FR 1956).	550
Buy-In Program: Eliminate Federal financial participation in monthly Part B premiums paid by States on behalf of Medicaid recipients eligible for Medicare buy-in program. (ACN: 03-50228; CIN: A-03-86-62019)	The proposal is not included in the President's FY 1990 budget and legislative program.	380
Intraocular Lenses in Ambulatory Surgical Center and Hospitals: The HCFA should establish a national Part B reimbursement cap of $200, with a handling fee not to exceed 10 percent, for any intraocular lens billed to Medicare. (OAI-09-88-00490)	The Department has prepared and submitted final regulations to OMB.	370
Payroll Taxes: Require recipients of Federal funds to deposit payroll taxes at the time Federal funds are drawn down to meet payroll needs. Under this concept, the only basic change in grantee procedures would be in the timing of deposits of payroll taxes. Instead of waiting for a "trigger date," the grantee would deposit payroll taxes almost simultaneously with the Federal cash draw.(CIN: A-12-88-00110)	Our recommendations are being considered by OMB.	360

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Medicaid: Eliminate premium matching rates under Medicaid. (ACN: 03-60223)	The proposal was not included in the President's FY 1990 budget and legislative program.	$360
Medicare Deductibles: Raise the Medicare Part B deductible to $100 and appropriately index it. (ACN: 09-52043)	The proposal was not included in the President's FY 1990 budget and legislative program.	280
Multiple Visits in SNFs: Apply the "multiple visit" concept to Medicare payments for physician visits to patients in skilled nursing homes and hospitals. (ACN: 03-42005)	The HCFA has not adopted the multiple visit concept.	240
Inpatient Psychiatric Care Limits: New limits should be developed to deal with the high cost and changing utilization patterns of inpatient psychiatric services. (CIN: A-06-86-62045)	The proposal is not included in the President's FY 1990 budget and legislative program.	238
Disregard Child Support: Eliminate the $50 child support payment to the AFDC family. (CIN: A-02-86-72606)	The proposal is not included in the President's FY 1990 budget and legislative program.	175
Rounding Medicare Premiums: Round Medicare Part B premiums up to the next higher dollar. (ACN: 09-52008; CIN: A-08-87-00003)	The proposal was not included in the President's FY 1990 budget and legislative program.	175
Physician Office Laboratories: The HCFA should impose a registration fee to fund the laboratory registration and inspection process. (OAI-05-88-00330)	The Department is considering including this provision in the FY 1991 legislative proposals.	173
Medicare Credit Balances: The HCFA should require hospitals to bill the primary insurer and receive payment from that insurer prior to billing Medicare. (OPI-85-040)	The HCFA has prepared legislation to implement this provision. The final regulation has not yet been issued.	165
Foster Care: Limit Federal participation to one of several limitation methods: (1) none in administration and training costs, (2) only in administration and costs based on a percentage of maintenance costs, (3) in program costs using a percentile limitation based on previous costs, or (4) in administration and training costs based on specific fixed dollar amounts. (CIN: A-07-86-60551)	A legislative proposal is currently under consideration within the Department.	147

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Rural Referral Centers: Reimbursement rates to rural referral centers (RRCs) should be based on the relationship of costs of RRCs to costs of urban and other rural hospitals. (CIN: A-09-87-00001)	This proposal is not included in the President's FY 1990 budget and legislative program.	$121
SSI Cross Program Adjustment: The SSA should resubmit its legislative proposal authorizing the adjustment of RSDI payments to recover overpayments from former SSI recipients. (OAI-12-86-00029)	A legislative proposal was included in the Department's FY 1990 legislative program which was submitted to OMB.	120
Medicaid Estate Recovery: The HCFA should institute stronger restrictions against transfer of assets to qualify for assistance; fewer restrictions on the use of liens to secure property for estate recovery; and mandatory estate recovery programs. (OAI-09-88-01340; OAI-09-86-00078)	The Department established a task group which is currently reviewing these issues and formulating policy positions for consideration.	118.5
Ambulatory Surgeries: Increase use of outpatient facilities for elective surgeries under Medicaid. (ACN: 09-50205)	The HCFA is preparing a proposed rule which will encourage the use of outpatient surgery. Implementing regulations are currently scheduled to be published during FY 1990.	110
Elimination of Enhanced Federal Match for Medicaid Family Planning: The 90 percent Federal match for family planning services provided under the Medicaid program should be reduced to the Federal share of payment for medical services. (OAI-1-05-4002-37)	The HCFA included this proposal as part of their FY 1987 proposals. The FY 1990 budget reconciliation package includes a provision for phasing out of the enhanced matching rate in FY 1991 and FY 1992.	110
Crossover Claims: Limit Medicaid "buy-in" payments for Medicare deductible and coinsurance to the Medicaid fee schedule. (ACN: 02-60202)	The proposal is not included in the President's FY 1990 budget and legislative program.	100
Viability of HEAL SLIF Fund: Eliminate the current 8 percent ceiling on insurance premiums over the life of a loan; link insurance premium assessments to risk categories; require a 20 percent cost-sharing by lenders; permit lenders to require co-signers; eliminate Federal guarantee for loan amounts in case of death or disability; and impose a lender's processing fee for default claims filed. (ACN: 12-73276)	The President's FY 1990 budget and legislative program includes proposals to improve long term solvency of the HEAL program.	74.7

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Medicare Physician Consultation Services: A uniform definition for consultation for carriers and physicians should be developed and specific reimbursement criteria regarding initial and follow-up consultations should be adopted. (OAI-02-88-00650)	The HCFA disagreed with the recommendations concerning reimbursement criteria.	$73.6
Shared Living Arrangements: Require that households with multiple AFDC family units be budgeted as a single economic unit for determining the amount of the grant award. (ACN: 09-72615)	The proposal is not included in the President's FY 1990 budget and legislative program.	73.5
Ambulance Claims: Require Medicare carriers to implement effective claims screening procedures to detect noncovered ambulance services. (ACN: 04-62006)	The HCFA is evaluating the need for claims processing improvements at all carriers.	64
Mandatory Secondary Opinion: Mandate that Medicaid beneficiaries obtain second surgical opinions for selected surgeries. (ACN: 03-30211)	The HCFA's regulations had to be delayed until a report required by the Omnibus Budget Reconciliation Act of 1986 was submitted to the Congress. The report was submitted on June 16, 1989. Implementing regulations are currently scheduled to be published during FY 1990.	63
Medicare Round Down: Round down to the next whole dollar Medicare Part B and other payments for Medicare services. (ACN: 03-62006; ACN: 14-52085)	The OIG has submitted a second report; however, this proposal has not been included in the President's FY 1990 budget and legislative program.	63
Intraocular Lens Implant: Exclude conventional eye wear from Medicare coverage for beneficiaries receiving intraocular lens implants. (CIN: A-04-88-02038)	The HCFA is reviewing the issue but has no plans to implement the recommendation.	60
SSI Overpayments - Tax Refund Offsets: The SSA should begin negotiations with IRS to permit income tax refund offset to recover outstanding debts owed by uncooperative former SSI recipients who are under age 65. (OAI-12-86-00065)	The SSA is continuing to negotiate with IRS to establish income tax refund offset.	58
State Sales Tax: Disallow State sales tax charged to Federal programs. (CIN: A-04-86-00040)	The OMB has made sales tax assessed by a governmental unit upon itself an unallowable cost in the proposed revisions of Circular A-87.	54
Overpayments: The SSA needs to recover or otherwise resolve 124,039 incorrect payments or overpayments (amounting to $72.5 million) which were recorded as incorrect payments. (CIN: A-03-86-62600)	The SSA agreed and expects to implement the recommendation in the near future.	53.7

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Financing SSA Buildings (Early Repayment of Loans): Use trust fund monies to liquidate the remaining mortgage balances on the three program service centers' contract method of financing. (CIN: A-09-86-62611)	The SSA has authorized GSA to spend up to $40 million to buy back some outstanding certificates, and will consider further liquidation as funds become available. In the initial year of implementing this proposal, there would be a one time cost.	$48
Medicare Secondary Payer-Employer Group Health Plans: Under the provisions of MSP, HCFA should ensure identification of all Medicare beneficiaries covered by employer group health plans and proper billing for services. (OAI-07-86-00091)	The HCFA concurred with the OIG recommendations and has taken some steps to address the issues and recommendations made in the OIG report.	44.5
User Fees: The OIG identified three premarketing approval functions where FDA has not proposed a user fee. (CIN: A-01-87-02522)	The proposal is included in the President's FY 1990 budget and legislative program.	30.9
Nonphysician Services: Require fiscal intermediaries to implement computer edits to prevent improper payments to hospitals for nonphysician services reimbursed through DRG rates. (CIN: A-01-86-62024)	The HCFA is taking action to improve intermediary systems and recover identified overpayments.	28
Excessive FFP in States' Costs of Provider Survey and Certification Activities: The HCFA should bring the FFP matching rates used for costs of States' survey and certification activities into agreement with the authorizing provisions of the law. (CIN: A-14-88-01000)	The HCFA disagrees with our recommendation. They believe that the FY 1991 implementation of the OBRA 1987 FFP matching provision will settle the issue. The HCFA plaus no action on this recommendation.	20
Medicare as Secondary Payer - End Stage Renal Disease: Under the provisions of MSP, HCFA should ensure identification of all ESRD beneficiaries covered by employer group health plans, and that proper billing for services has been made. (OAI-07-86-00017)	The HCFA concurred with OIG findings and recommendations and issued a Notice of Proposed Rulemaking on June 15, 1989 which addresses most of our recommendations. The HCFA anticipates that the final rule will be issued shortly.	19.6
Premature Admissions: Minimize premature admissions for Medicaid elective surgeries. (CIN: A-09-86-60213)	The HCFA is developing a proposed rule which will encourage the use of preadmission testing and preadmission review systems. Implementing regulations are currently scheduled to be published during FY 1990.	18.5

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Access of Dialysis Patients to Kidney Transplantation: The OIG sent to HCFA a series of recommendations that would help ensure that dialysis patients are afforded a full and fair opportunity to receive a kidney transplant. (OAI-01-86-00107)	Both HCFA and PHS are collaborating with professional societies to develop guidelines for patient transplant suitability.	$18.3
Emergency Assistance to Needy Families (EAF): The FSA should revise the EA regulations to limit EA benefits to one period of 30 consecutive days or less in 12 consecutive months. This would bring the regulations into compliance with the intent of the Congress. (CIN: A-01-87-02301)	The FSA concurred and issued a proposed rule change. Also, the Congress enacted a moratorium on changes to the EAF program which extended through September 30, 1989.	18
Nursing Home Per Diem: Revise Medicare regulations to prohibit suppliers from billiug directly for urological and enteral therapy supplies and require that nursing homes include the cost of such products in their per diem rates.(ACN: 06-42002)	The proposal was not included in the President's FY 1990 budget and legislative program.	17
Medicare as Secondary Payer - Automobile Accident Related Claims: Under the provisions of the MSP program, HCFA should ensure identification of all beneficiaries involved in automobile accidents and covered by auto or liability insurance. (OAI-07-86-00017)	The HCFA concurred with OIG findings and is in general agreement with OIG recommendations.	15.2
Cost Standards for DDSs: Cost and performance standards should be developed for disability case processiug. (OAI-06-88-00820)	Recommendations are being considered by SSA.	14.5
Arterial Bypass Surgery: Eliminate Medicare coverage of extracranial-intracranial bypass surgery. (CIN: A-09-87-00005)	The HCFA agrees and is drafting a proposed regulation to withdraw Medicare coverage of certain ineffective EC/IC surgery.	10.7
Pacemaker Monitoring: Reclassify pacemaker monitoring under Medicare from the current physician-assisted service to the lower-paying routine service. (ACN: 08-52017)	The HCFA issued guidelines as part of studies mandated by the Deficit Reduction Act of 1984, and is exploring alternative approaches to the problem.	6
Multiple Surgical Procedures: All carriers should uniformly limit reimbursement for second surgical procedures to 50 percent of reasonable charges. (CIN: A-03-86-62008)	The HCFA has no plans to establish a national limit for multiple surgical procedures at this time, but has agreed to bring our findings to the attention of the carrier involved.	5.2
Repatriation Program: Evaluate existing internal control procedures and reassess responsibilities for the timely collection of Federal debts. (CIN: A-12-87-03087)	The FSA generally concurred with our findings and recommendations and is taking the necessary corrective actions.	4.8

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Unreported Marriages: The SSA should take appropriate action on cases of unreported beneficiary marriages identified by OIG. (CIN: A-09-87-00052)	The SSA is continuing its recovery efforts on the cases identified in the OIG report. Acquisition of computer marriage records from States is being addressed as part of SSA's strategic plan and the issue is being considered under the "Expanded Automated Data Exchange" project.	$4.2
Oxygen Concentrators: Develop effective measures to prevent overuse of oxygen concentrators. (CIN: A-04-87-02000)	The HCFA agreed and developed a revised certificate of need form to control utilization of oxygen concentrators. Additional measures are being planned.	4
Premium Collection: Improve Medicare Part B premium collection procedures on Civil Service annuitants. (CIN: A-03-86-62009)	The HCFA agrees with this proposal and is in the process of taking corrective action.	2.4
Nonpayment for Broken Consultative Examinations: The SSA should not pay State agencies for consultative examinations that are canceled or otherwise not kept. (CIN: A-01-87-02004)	The SSA developed a regulation to implement the OIG proposal. The proposed rule was published in the Federal Register in October 1988. The SSA has received negative comments from medical providers and has not yet decided whether to proceed with publication of a final regulation.	1.5

APPENDIX E

OIG NONMONETARY FINDINGS THROUGH SEPTEMBER 1989

This schedule represents recent OIG findings and recommendations that resulted in or which, if implemented, would result in substantial benefits. The benefits primarily relate to effectiveness rather than cost-efficiency.

OIG RECOMMENDATION	STATUS
Medicare Reimbursement for At-Home Oxygen Care: The HCFA should issue immediately a uniform medical necessity certification form. Included on this form should be a strong physician attestation statement. This attestation places the responsibility with the physician for the accuracy of the information contained on the certification form. (OAI-04-87-00071)	The HCFA has established a medical necessity certification and attestation statement. These were recently tested in the field and are currently being implemented nationally.
Medical Licensure and Discipline: The HCFA should amend the PRO regulations and the Medicare carrier instructions to require more extensive and timely reporting to State medical boards of cases involving physician misconduct or incompetence. (OAI-01-86-00064)	The HCFA included a regulatory provision to require PROs to report cases or a possible pattern of substandard care to State or Federal licensing bodies. The proposed rule was published on March 16, 1988 (53 FR 8654).
Patient Dumping After COBRA: The HCFA should require hospitals to report suspected cases of dumping as a condition of their participation or as part of their provider agreement. (OAI-12-88-00830)	Regulations were proposed that required hospitals to report violations as part of their provider agreements. The final regulations are currently under development.
False Evidence Submitted to Obtain an SSN: The SSA should systematically identify all original SSN applications from U.S. born applicants over age 24 and require a second level review of such applications. (Notice of Program Vulnerability, October 6, 1987)	The SSA will validate the results of an earlier regional study before committing to a more intense review of selected high risk cases.
Postings To SSA's Master Earning File: The SSA should install a mechanism to prevent the postings of earnings to the master earnings file subsequent to an individual's date of death and create an alert if the SSN is being used by another person subsequent to the death of the account holder. (Management Advisory Report, March 3, 1988)	The SSA agreed and will include these recommendations in the functional requirements for the redesigned master earnings file.
Increase Financial Viability of Rural Hospitals Subject to PPS: The HCFA should consider budget-neutral legislative proposals to assist rural hospitals subject to PPS. (CIN: A-14-88-02506)	The HCFA believes that additional legislative relief is not necessary. They believe that it is prudent to await the impact of current legislation.
Specify in PRO Contracts Excess Profit Clauses-Medicare: The HCFA should consider both PRO and non-PRO business of all prospective PRO contractors when evaluating offerors' estimated costs for future PRO contracts. (ACN: 14-62158)	The HCFA commented that due to the firm fixed-price nature of the contracts, there is no basis for adjusting the contract price based on the PRO's cost experiences.
SSI Payments Under Recently Issued SSNs: The SSA should systematically monitor SSI claims under SSNs that have been issued within 2 years of the SSI application. (Notice of Program Vulnerability, September 27, 1985)	The SSA is implementing a security and integrity system that will require a management review of all new SSI claims with high risk characteristics.

OIG RECOMMENDATION	STATUS
The PRO Program: Sanction Activities: The Department should submit a legislative proposal to amend section 1156 of the PRO statute to strengthen the monetary penalty to $10,000 per violation. (OAI-01-88-00571)	This recommendation is currently under consideration within the Department.
Coding of Physician Services: The HCFA should consult with the American Medical Association to reduce the number of HCPCS codes for office visits. (OAI-04-88-00700)	The HCFA concurred with the OIG recommendation.
Integrity of Medical Evidence: The SSA should institute appropriate procedures to ensure the integrity of medical evidence submitted to support claims for disability benefits. (OAI-03-88-00670)	The SSA is considering the recommendations.
Overpayments in the AFDC Program: The FSA should take appropriate action to reduce errors which lead to overpayments, including rewarding States with error rates below the 3 percent tolerance. (OAI-04-86-00024)	The FSA is deferring action pending the lifting of the moratorium on imposing sanctions based on excessive error rates.
Investigation of Fraud in the AFDC Program: The FSA should consolidate their anti-fraud efforts into one component with high visibility to focus attention on the prevention, deterrence and detection of fraud. (OA1-04-86-00066)	The FSA is considering this recommendation.

APPENDIX F

SUCCESSFUL PROSECUTIONS BY JUDICIAL DISTRICT

FEDERAL DISTRICT	PROSECUTIONS
Region I	
Connecticut	6
Maine	1
Massachusetts	8
New Hampshire	1
Rhode Island	4
Vermont	1
Region II	
New Jersey	26
Eastern New York	19
Northern New York	1
Southern New York	29
Western New York	11
Puerto Rico	2
Region III	
Maryland	4
Eastern Pennsylvania	33
Middle Pennsylvania	4
Western Pennsylvania	2
Eastern Virginia	8
Western Virginia	2
Southern West Virginia	1
Region IV	
Northern Alabama	5
Middle Alabama	5
Southern Alabama	1
Northern Florida	9
Middle Florida	24
Southern Florida	25
Northern Georgia	9
Middle Georgia	2
Eastern Kentucky	4
Western Kentucky	2
Northern Mississippi	4
Southern Mississippi	2
Eastern North Carolina	10
Middle North Carolina	4
Western North Carolina	3
South Carolina	9
Eastern Tennessee	2
Middle Tennessee	2
Western Tennessee	11
Region V	
Northern Illinois	32
Central Illinois	4
Southern Illinois	7
Northern Indiana	13
Southern Indiana	8
Northern Iowa	1
Eastern Michigan	63
Western Michigan	4
Minnesota	21
Northern Ohio	36
Southern Ohio	41
Eastern Wisconsin	9
Western Wisconsin	8
Region VI	
Eastern Arkansas	11
Western Arkansas	8
Eastern Louisiana	18
Middle Louisiana	6
Western Louisiana	6
New Mexico	7
Northern Oklahoma	4
Eastern Oklahoma	1
Western Oklahoma	11
Northern Texas	31
Eastern Texas	1
Southern Texas	93

Western Texas	12
Regions VII and VIII	
Colorado	25
Northern Iowa	4
Southern Iowa	8
Kansas	10
Eastern Missouri	18
Western Missouri	2
Montana	15
Nebraska	7
North Dakota	2
South Dakota	6
Utah	8
Wyoming	2
Regions IX and X	
Arizona	3
Northern California	15
Central California	24
Eastern California	6
Southern California	21
Idaho	2
Nevada	1
Oregon	2
Eastern Washington	1
Western Washington	2
Washington, D.C., Field Office	
District of Columbia	9
Maryland	6
Eastern Virginia	2
State and Local Prosecutions:	325
Grand Total:	**1,278**

ACRONYMS

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
AFDC	Aid to Families with Dependent Children
AIDS	acquired immune deficiency syndrome
ANDA	abbreviated new drug application
ASMB	Assistant Secretary for Management and Budget
CAPD	continuous ambulatory peritoneal dialysis
CASU	cooperative administrative support unit
CBO	Congressional Budget Office
CDP	coordinated discretionary funds program
CLIA	Clinical Laboratory Improvement Act
CMP	civil monetary penalty
COBRA	Consolidated Omnibus Budget Reconciliation Act
CRNA	certified registered nurse anesthetist
CSE	Child Support Enforcement
DCA	Division of Cost Allocation
DDP	disability determination program
DEFRA	Deficit Reduction Act
DFAF	Division of Federal Assistance Financing
DME	durable medical equipment
DRG	diagnosis related group
DUR	drug utilization review
EA	emergency assistance
EGHP	employer group health plan
ESRD	end stage renal disease
FDA	Food and Drug Administration
FFP	Federal financial participation
FICA	Federal Insurance Contribution Act
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GAO	General Accounting Office
HRSA	Health Resources and Services Administration
ICF	intermediate care facility
IHS	Indian Health Service
IMD	institution for mental diseases
IRS	Internal Revenue Service
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance program
MCCA	Medicare Catastrophic Coverage Act
MFCU	Medicaid Fraud Control Unit
MSP	Medicare as secondary payer
NIH	National Institutes of Health
OBRA	Omnibus Budget Reconciliation Act
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
PMS	payment management system
POV	power-operated vehicle
PPS	prospective payment system
PRO	peer review organization
RRP	Refugee Resettlement program
RSDI	Retirement, Survivors & Disability Insurance
SLC	seat lift chair
SLIAG	State Legalization Impact Assistance Grants
SNF	skilled nursing facility
SSI	Supplemental Security Income
SSN	Social Security number
TENS	transcutaneous electrical nerve stimulator

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