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Office of Inspector General

Semiannual Report to the Congress

OCTOBER 1, 1986 - MARCH 31, 1987

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INSPECTOR GENERAL

The following highlights are examples of OIG recommendations during the 6-month period to achieve improved quality of care and program management and cost savings. The items are explained in more detail in the text on the referenced pages.

- Profits of $5.1 billion earned by hospitals during the second year of the prospective payment system (PPS) further substantiate the need to rebase Medicare PPS rates using audited cost data. (See page 1.)

- More than $.5 billion can be saved by using a prospective payment system to pay the States for the Federal share of AFDC, Medicaid and Food Stamp administrative costs. This also would increase State flexibility in running these programs. (See page 38.)

- Medicare beneficiaries enrolled in health maintenance organizations (HMOs) need to receive better information about their HMO coverage. Specifically, HCFA should require HMOs to provide beneficiaries with information identifying noncovered services and explaining HMO premiums. (See page 3.)

- The $150 million interim assistance payments process needs to have strengthened SSA controls to protect against employee fraud. (See page 23.)

- About $18.5 million could be saved annually if State Medicaid programs required preadmission testing and elective surgery to be performed on the same day. (See page 13.)

- An estimated $4.7 million could be saved annually with installation of mandatory and optional Medicare prepayment edits. (See page 2 and 3.)

- Annual savings of $3 million could be realized if HCFA required Medicare carriers to recover overpayments of fees-for-services rendered to Medicare beneficiaries enrolled in HMOs. (See page 4.)

The following three chapters provide detail on the aforementioned highlights and other OIG accomplishments.

- The Health Care Financing Administration (HCFA), with a fiscal year 1987 budget of $98.3 billion, administers the Medicare and Medicaid programs.

- The Social Security Administration (SSA), with a fiscal year 1987 budget of $220.4 billion, administers the Old Age, Survivors and Disability Insurance (OASDI); Supplemental Security Income (SSI); and Part B of the Black Lung programs.

- Grants and Internal Systems (GIS), with its combined fiscal year budget of $29.2 billion, includes the Public Health Service (PHS), the Office of Human Development Services (OHDS) and the Family Support Administration (FSA)--as well as overall departmental management and Government-wide issues.

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HEALTH CARE FINANCING ADMINISTRATION

Chapter I

HEALTH CARE FINANCING ADMINISTRATION

STATISTICAL ACCOMPLISHMENTS

Savings to the Medicare and Medicaid programs of $2 billion were realized during the first half of fiscal year 1987 as a result of Office of Inspector General (OIG) recommendations being implemented. An additional $20.5 million in fines, savings, restitutions and settlements were realized as a result of investigations. Also, $91.9 million of savings and recoveries could result from OIG reviews completed during this period.

Two hundred forty-one (241) health providers and suppliers were convicted for defrauding the Medicare and Medicaid programs as a result of investigations by the OIG and the Medicaid fraud control units (MFCUs). Additionally, 175 individuals and entities were "kicked out" of the health care programs, or were otherwise sanctioned, for fraud or abuse.

PROGRAM OVERVIEW

The Health Care Financing Administration (HCFA) administers the Medicare and Medicaid programs which provide health care payments for more than 51 million of the nation's poor, elderly and disabled. For FY 1987, it is estimated that Federal expenditures for these programs will amount to $98.3 billion: $71.6 billion for Medicare, which is financed by the Federal Hospital Insurance and Supplementary Medical Insurance trust funds; and $26.7 billion for Medicaid, which is financed from Federal and State general revenues.

MEDICARE HOSPITAL PROFITS

Concerns over the financial impact of the Medicare prospective payment system (PPS) on hospital operations and, correspondingly, on the sufficiency of resources to provide quality care, prompted OIG reviews of hospital profits under PPS. Our finding that hospitals' second year PPS profits have increased to $5.1 billion further substantiates our previous recommendations to rebase Medicare PPS rates using more accurate, audited cost data. Since 1985, OIG reports have consistently pointed out that PPS rates need to be rebased because the rates are based on hospital operating costs which are overstated.

The OIG's original analysis of more than 2,000 hospital cost reports for the first year under PPS (1984), representing about 39 percent of

participating hospitals, found that hospital inpatient operating costs used to establish PPS rates inappropriately included costs for capital, direct medical education, exempt units and unallowable costs. The OIG recommended that HCFA seek legislative authority to rebase PPS rates (after full transition to a 100 percent Federal rate) using more accurate, audited cost information.

The OIG's follow-up analysis of statistically representative hospital cost data for the second year under PPS showed that (1) 80 percent of hospitals sampled continued to earn PPS profits, and (2) profits increased. (Profit is the difference between a hospital's reported Medicare inpatient revenue and Medicare inpatient costs.) Additionally, while average profits increased from 1984 to 1985 the average number of discharges decreased from 1,811 per hospital in 1984 to 1,709 in 1985. The following chart shows the amount and rate of Medicare profit (on average), for the 4,912 hospitals included in our analysis.

AVERAGE HOSPITAL PROFIT UNDER PPS

	1984	1985
Profit Rate	14.18%	15.27%
Per Hospital	$939,207	$1,037,314
Hospitals in Study	$4.6 billion	$5.1 billion

Current OIG findings reinforce our conclusion that large Medicare profits occurred, in part, because the PPS Federal rate was based on overstated hospital inpatient operating costs. We again recommended that HCFA seek congressional authority, if deemed necessary, to recompute PPS rates using more accurate and current audited cost information, and rebase the rates after full transition to a 100 percent Federal rate. Pending actions on these recommendations, HCFA should consider PPS profits made by hospitals in recommending the level of increases in PPS rates during annual updates. The OIG's report is currently with HCFA for consideration. The results of our review were also reported to the Congress in testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, on February 27, 1987.

MEDICARE CARRIERS

During this period, OIG studies identified problems with certain of the private insurance carriers which administer the Medicare Supplementary Medical Insurance program (Part B) in fulfilling their contractual responsibilities. Part B covers payment for physician, home health, and other services. The carriers are responsible for promptly and accurately

paying claims and for assuring that such payments are reasonable and made for services which are actually rendered, covered by Medicare and medically necessary. The following examples illustrate situations where carriers did not adequately fulfill these responsibilities.

- The OIG concluded that an estimated $4.7 million could be saved annually if one Medicare carrier installed three HCFA-mandated and four optional prepayment edit screens. The mandated edits are designed to identify unallowable oxygen supplies associated with rented durable medical equipment (DME), payments for noncovered DME for institutionalized beneficiaries, and duplicate payments for surgical procedures that can only be performed once (e.g., gall bladder removal). The four optional edits relate to unnecessary services for oxygen equipment, CAT scans, ophthalmic scans and prosthetic lenses.

  The HCFA and carrier officials concurred with OIG's recommendations that the mandated screens be installed and that the carrier consider implementing the four optional screens. In addition, the carrier will recoup all improper payments made to date.

- On the basis of an allegation that a Medicare carrier in New York had waived without good cause, a large overpayment to an internist, an investigation was undertaken. Interviews and review of the records indicated the waiver to have been inappropriate. A letter to HCFA prompted its direction to the carrier to collect the $80,600 overpayment. (2-86-00089-9)

87-1-1

Blue Shield of Western New York

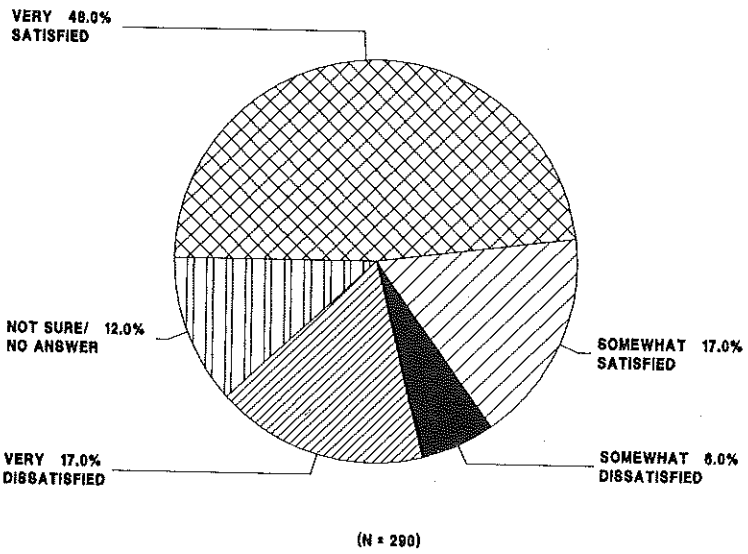
HEALTH MAINTENANCE ORGANIZATION SERVICE DELIVERY EVALUATION

As a result of findings from an ongoing series of HMO evaluations which pointed out the need to help Medicare beneficiaries make more informed decisions in their selection of an HMO, the OIG recommended that HCFA require HMOs to provide information on services not covered by Medicare and to advise Medicare beneficiaries who join HMOs that a monthly premium is being paid on their behalf.

In the first of these evaluations, OIG interviewed a sample of beneficiaries in International Medical Centers of Florida, the HMO with the largest Medicare enrollment in the nation, to determine their attitudes about medical care they received from the HMO. Those who expressed dissatisfaction complained about difficulties in getting specialist care and payment for services received out of the HMO service area. In spite of the problems, most Medicare beneficiaries remained

members of the HMO because it was "free." They paid no deductibles or coinsurance and were unaware that Medicare made monthly payments to the HMO on their behalf.

BENEFICIARY SATISFACTION WITH THE HMO



The HCFA concurred on the notification recommendations and noted it had strengthened the notice of enrollment to new HMO members.

MEDICARE HEALTH MAINTENANCE ORGANIZATIONS: DUPLICATE FEE-FOR-SERVICE PAYMENTS

The HCFA will pay $3 million annually in duplicate fee-for-service payments (for services from outside providers) on behalf of beneficiaries enrolled in risk-based HMOs unless its use of tolerance levels is eliminated. Carriers are required to include edits in claims processing systems that will reject fee-for-service claims for Medicare beneficiaries enrolled in risk-based HMOs. The HCFA conducts postpayment reviews of payment records to ensure that such edits are working; however, payment records are returned to carriers for recovery action only if a specified tolerance level is exceeded.

The OIG's reviews of selected carriers found that about $530,000 in duplicate fee-for-service payments were made on behalf of beneficiaries enrolled in risk-based HMOs, but payments were not recovered because HCFA's tolerance level was not exceeded. The OIG recommended that the tolerance level be eliminated and that carriers be required to recover all overpayments for fee-for-service payments for Medicare HMO enrollees. The HCFA agreed and is acting on our recommendations.

PART B PREMIUMS

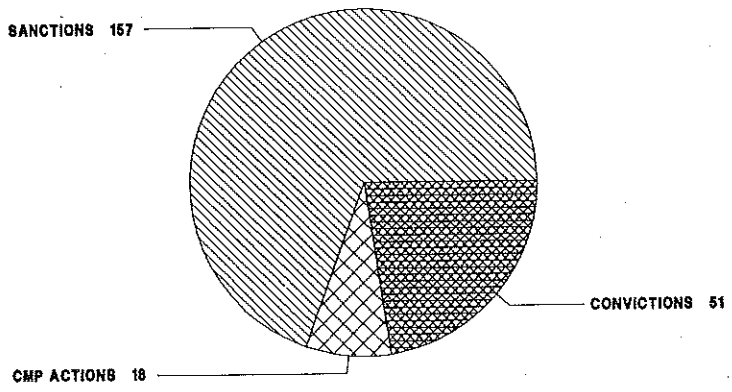
The trust funds could be incurring a yearly loss of as much as $2.4 million as a result of HCFA not billing civil service annuitants for Medicare Part B premiums. The OIG's Government-wide review of premium collection procedures for civil service annuitants showed that as many as 14,700 annuitants enrolled in Part B were not billed for premiums. The OIG also found that more than 4,300 annuitants subject to the late enrollment surcharge were not being billed, resulting in a possible loss of $3.8 million to the trust funds by 1990.

The HCFA previously identified both problems but was not successful in correcting them. The HCFA agreed with OIG's recommendations to closely coordinate with the Office of Personnel Management and the Social Security Administration to resolve the two issues discussed in our report, and to initiate recovery action from civil service annuitants who did not pay their premiums or paid the wrong amount.

INVESTIGATIVE AUTHORITIES

The OIG has statutorily based authorities which permit several avenues of pursuit of those who violate the Department's health care programs. Remedies for fraud or the provision of substandard care can take the form of criminal prosecution, monetary penalties and exclusion from the Medicare and Medicaid programs. During this period, the OIG was responsible for a total of 226 actions against wrongdoers.

JUDICIAL & ADMINISTRATIVE ACTIONS



FRAUD CONVICTIONS

Conviction of individual health care practitioners and suppliers for fraud most commonly results from prosecution related to the filing of false claims against the Medicare program, as illustrated in the following cases.

87:1.2
Alan S. Klein

- A Michigan chiropractor was sentenced to 10 years in prison and 5 years probation, and ordered to make restitution of more than $300,000 to the Medicare program and a private insurance company. He also had to remunerate the victim assistance program based on his conviction for filing claims for x-rays and spinal manipulations on beneficiaries he never saw. (5-86-00095-9)

87:1.3
Doyle Campbell

- An ophthalmologist in Ohio was convicted on 52 counts of billing Medicare for laser eye surgery he did not perform. Some of the patients for whom he billed were shown not to have had glaucoma, for which the surgery was supposedly needed. Others denied having the eye numbed and a refractory lens placed on it, which is part of the procedure. The doctor's records showed none of the preliminary steps necessary to the surgery, and no follow-up. Expert witnesses saw no evidence that the patients had had the surgery. The doctor received more than $90,000 in unwarranted Medicare payments. He is awaiting trial in State court for similarly defrauding the Medicaid program. (5-84-00059-9)

87:1.4
James Cesar

- An osteopath was sentenced to 2 years in jail, 5 years probation, restitution of $11,426 and 250 hours of community service as the result of the first Medicare prosecution ever brought in Delaware. He was convicted for billing Medicare for arthrocentesis (joint injections) on patients to whom he gave only vitamin B-12 shots. (3-85-00546-9)

87:1.5
Kwoh Cheng Sun

- A Wisconsin physician was sentenced to 60 days in a house of correction, 4 years probation, 910 hours of community service and restitution of more than $6,000. As the result of a joint investigation with the State Medicaid fraud control unit, he was shown to have billed for services which were actually acupuncture procedures. These procedures are not reimbursable by Medicare or Medicaid. (5-83-00331-9)

87:1.6
John E. Rusyak

- A Chicago podiatrist was sentenced to 6 months in a work release program and 5 years probation, and ordered to make restitution of over $17,000 for fraudulently billing Medicare for foot surgery. During the investigation 25 of 29 patients interviewed denied getting any services other than ordinary foot care. (5-83-00159-9)

87:1.7
Gary Deml

- A hospital administrator in Wisconsin was sentenced to 1 year in jail and 6 years probation and had to repay more than $16,000. He also was ordered to perform 500 hours of community service for using

hospital funds for personal pleasures such as a motor home and gambling trips to Las Vegas. The hospital, which received 61 percent of its revenue from Medicare and Medicaid, declared bankruptcy. ~~(5-86-00414~~ (5-86-00414-9)

- A North Carolina man was sentenced to 3 years in prison, followed by 10 years probation, and ordered to repay Medicare-eligible patients he had defrauded. He had claimed that he was affiliated with the Medicare program and convinced patients they were in jeopardy of losing benefits because they had not met their yearly Part B deductible. At least 20 persons had each given him $75. (4-86-01688-9)

87:1.8
Frank Lee Potter

- Five years after an OIG investigation was begun, a civil settlement of $137,800 was obtained against the estate of a Michigan ophthalmologist who died during the investigation. Numerous instances of false Medicare billings were uncovered during the investigation, and a post-death audit by the carrier determined a substantial overpayment. (5-86-21105-9)

87:1.9
John J. Danielski

- Two persons were convicted in "Operation Mr. Hyde," a joint project with the Federal Bureau of Investigation (FBI). This project was established because of concern over Medicare fraud by doctors and chiropractors in south Florida. The doctors signed for treatments actually given patients by the chiropractors, for which Medicare would not otherwise reimburse. In some instances Medicare was billed for treatments not given or for upgraded treatments. (4-83-00285-9)

87:1.10
Edward Altman
Leslie G. Shawn

- A corporation which operated eight foot care centers in Ohio was fined $3,000 and ordered to make restitution of $500,000 in a scheme in which podiatrists performed fake surgery (a simple incision in the skin) or unnecessary surgery. Three podiatrists who cooperated in the case were placed on probation and fined. The corporation remains the defendant in a $10 million civil racketeering case and is the focus of 110 lawsuits. (5-83-00168-6)

87:1.11
Affiliated Foot Care Centers

KICKBACKS

In two States ongoing investigations have resulted in multiple convictions of individuals and organizations involved in elaborate kickback schemes costing the Medicare and Medicaid programs millions of dollars.

- Seventeen convictions have been obtained thus far in "Project Grand Slam," a series of investigations into the New York ambulette industry. Kickback payments as high as $10,000 a month were paid by ambulette company owners to physicians and other health care professionals for referrals of patients for transportation. Also on the

87:1.12
Zoneida Munet
et al

"payroll" were employees of the State Medicaid fiscal agent, who could assure payment of the transportation claims with no questions asked. (2-86-00129-9)(See 2nd half report for case numbers)

87:1.13
~~Shmuskovitch~~
~~Schmuskovitch~~
~~[illegible] Chabra~~
~~et al~~
Smushkevich, D+M,
et al

- In another series of ongoing investigations in California, six persons were convicted in diagnostic testing schemes which involved not only multiple Medicare claims and kickbacks but also potential jeopardy of Medicare patients' health. Patients were frequently misled about the need for such testing and sometimes even failed to get any results of the tests. "Marketers" for small companies approached persons in retirement communities, mobile home parks, benevolent societies, spas--anywhere senior citizens were likely to congregate. They offered "free" comprehensive examinations, playing upon fears of heart attack and stroke. They then billed Medicare or private insurance companies for the tests. They also approached doctors, promising patient referrals for a percentage of Medicare or private insurance reimbursement. At least $2.5 million to $3.5 million in claims are thought to have been submitted thus far. (9-84-01488-9)

SANCTIONS FOR CRIMINAL CONVICTION

Under Section 1128 (a) of the Social Security Act, individuals convicted of defrauding the Medicare and Medicaid programs are subject to suspension from participation in these programs. Sanctions for criminal convictions totaled 124. Following are examples.

- An office manager of a Utah nursing home was suspended from Medicare and Medicaid for 10 years after being convicted of falsely billing Medicaid for the residents' shares of the cost of their care which the residents had already paid.

- After conviction for diverting Medicaid patients' funds to his own use, a co-owner of a nursing home in Maine was barred from participating in Medicare and Medicaid for 8 years.

Edwin Mayer

- A pharmacist in New Jersey was barred from participation for 15 years after being convicted of falsely billing Medicaid regarding the nature, strength and quantity of the drugs he dispensed as well as the number of refills authorized.

OTHER ADMINISTRATIVE SANCTIONS AUTHORITIES

The OIG has other authorities whereby providers who have defrauded the Medicare and Medicaid programs or provided substandard care to patients can be administratively penalized:

- Civil monetary penalties--through which the OIG recoups from providers who have profited from false or fraudulent claims.

- Other administrative sanctions--through which providers or others compensated under Medicare can be excluded from participating in the programs or financially penalized for substandard quality of care to patients, excessive services or lack of required documentation.

CIVIL MONETARY PENALTIES

The $5.7 million obtained under the OIG's civil monetary penalties (CMP) authorities is evidence that they continue to be effective in the recoupment of funds lost through fraudulent Medicare and Medicaid claims. Important judicial support has been established for imposition of the penalties. For example, a Federal Court of Appeals upheld the constitutionality of the CMP statute and confirmed the OIG imposition of a penalty of almost $1.8 million against a Florida chiropractor and his wife for filing 2,702 fraudulent Medicare claims. Even though the penalty was more than 70 times greater than the actual damages sustained by the Government, the Court found it reasonable and appropriate in view of the aggravating circumstances.

In addition to the significant recoveries they avail, CMP authorities are sometimes the only remedy and deterrent against those willing to gamble that crowded court dockets minimize their chances of facing criminal prosecution. The following examples, which include some cases not involving prosecutions, illustrate the range of health care providers against whom CMP authorities were exercised.

- The California-based Paracelsus Healthcare Corporation pled guilty to mail fraud and had to pay the Government $4.5 million in fines, restitutions and interest, plus contribute $200,000 in hospital and medical expenses for care of the poor, to satisfy criminal and CMP liabilities. An investigation of only 1 of the 26 hospitals Paracelsus operates showed it had included numerous unallowable expenses in Medicare cost reports, and had failed to disclose related-party transactions. The nonallowable expenses included golf tournaments, country club dues, gifts to physicians, limousines and charter jets, political contributions, expenses for foreign acquisitions and expenses for unsuccessful domestic acquisitions. (9-85-00803-9) 87:1.14

- A hospital paid $250,000 in restitution, penalties and assessments for claims associated with numerous, medically unnecessary pacemaker operations by a cardiologist. The hospital's review committee had had

87:1.15
Kent County Memorial Hospital (Felix Balusco)

ample evidence of lack of medical necessity before the operations took place. The cardiologist previously was prosecuted, convicted and sanctioned as the result of a criminal investigation. [1-86-30377-9]

87:1.16
Advacare, Inc.

- A durable medical equipment supplier paid $300,000 in penalties and restitution for billing Medicare for equipment provided to nursing home residents. The cost of the equipment had been included in Medicare reimbursement to the nursing homes. [5-86-30311-9]

87:1.17
Valley Eye Clinic and Dp Surgery Center Charles C. Denton

- An ophthalmologist entered into a CMP settlement for $175,000 after having filed numerous claims for laser therapy treatments, which are not reimbursable by the Medicare program for ambulatory surgical facilities. ~~Charles C. Denton (Harlingen, Texas)~~ [6-86-30481-9]

87:1.18
Rochester Genessee Orthopedic Group

- An orthopedic surgery group paid $149,000 for billing Medicare for emergency room services which had been performed by physician assistants. Services performed by physician assistants are not reimbursable unless performed under the direct personal supervision of a physician. [2-86-30078-9]

87:1.19
Steven Romanowski (Allstate Ambulance

- An ambulance company owner paid $57,000 in restitution, penalties and interest for mail fraud in connection with a scheme to bill Medicare for nonreimbursable services. The terms of the owner's probation required restitution and resolution of other civil liabilities. The OIG expanded the investigation and found 118 instances in which the owner had misrepresented patients as being nonambulatory. [2-83-00045-9]

87:1.20
Emilio Solernon

- A physician agreed to pay almost $47,000 in fines and penalties for concocting a scheme with an optician to submit fraudulent claims to the Medicare and Medicaid programs for fictitious or medically unnecessary services. [4-84-00450-9]

87:1.21
Cesar L. Ruiz

- As the result of a joint investigation with a State Medicaid fraud control unit, a psychiatrist had to pay the Medicare and Medicaid programs more than $30,000 in penalties, interest, restitution and investigative costs for submitting 59 claims for fictitious psychiatric hospital visits. [4-86-30036-9]

- An administrative law judge sustained a penalty of $76,000 against a psychologist for filing 71 false Medicaid claims. In some instances he

had billed for psychotherapy sessions when he had merely dispensed vitamins and nutritional supplements. In other instances he had rendered no services at all. [I-86-30287-9]

87:1.22 Jimmy Scott

SANCTIONS FOR SUBSTANDARD OR UNNECESSARY CARE

The OIG sanctioned 31 health care providers upon evidence of unnecessary services or failure to meet professionally recognized standards of care, as determined by a professional review organization (PRO). The PROs cited the following deficiencies on the part of providers:

—congestive heart failure inadequately treated or untreated;

—delay in evaluating the patient, ordering and evaluating tests, and obtaining surgical consultation in a life-threatening situation;

—failure to treat kidney failure;

—failure to evaluate significant medical problems;

—premature decision to withdraw life support;

—improper management of a drug for heart disease;

—ordering medication in inappropriate dosages, without consideration of side effects;

—failure to properly treat massive post-operative bleeding from surgical site;

—failure to treat infection;

—heart attack not properly evaluated and managed;

—administration of inappropriate intravenous fluids;

—transfusion of incompatible blood;

—failure to attempt resuscitation; and

—premature discharge.

More than 120 patients were involved in the cases in which the PROs recommended sanctions. Twenty-seven of these patients died. The following examples illustrate some of the sanctions imposed.

- A monetary penalty was imposed on a North Carolina physician because he prematurely discharged a Medicare patient. The patient was uncommunicative, required restraints and was maintained on tube feedings, yet he was sent to his residence with only a neighbor to check on him and administer his feedings. Two days later he was readmitted to the hospital with pneumonia.

- A Texas physician was excluded from Medicare participation for 4 years after the PRO found that in ten cases his care did not meet professional standards of quality. Among the problems cited was failure to properly evaluate and treat severe medical conditions.

PATIENT AND PROGRAM PROTECTION ACT

The Office of Inspector General has made several legislative recommendations which are incorporated in the Medicare and Medicaid Patient and Program Protection Act of 1987 (H.R.1444 and S.661). If passed, this legislation would strengthen the OIG's authority to protect the integrity of the Medicare and Medicaid programs. These additional authorities, which would authorize the OIG to exclude certain practitioners who have committed crimes or lost their licenses, is intended to fill in gaps in the current ability of the Department to protect Medicare, Medicaid and other program beneficiaries from incompetent practitioners and from receiving inappropriate care.

The legislation would broaden the protections in existing law. For example, it would require a minimum exclusion of 5 years for individuals or entities convicted of program-related crimes, and mandate the exclusion of any individual or entity convicted of a crime related to patient neglect or abuse. It would give the OIG authority to exclude any individual or entity convicted of certain crimes related to: the provision of health services, financial integrity, the obstruction of certain investigations, or controlled substance violations. Anyone whose license had been revoked or suspended by any State licensing authority also would be excluded.

NURSING HOMES

As part of its oversight of the Medicaid program, OIG found that one State claimed $2.6 million in excess Federal sharing for unallowable costs reported by a State-owned and operated nursing facility. The unallowable costs were for: housing State department of corrections prison inmates; operating a nursing school, providing meals and staff housing to selected employees, providing barber and beauty services, and providing grounds maintenance and nursing administration. The HCFA generally concurred with OIG's recommendation calling for a financial adjustment and procedural changes to ensure that future cost reports include only allowable costs.

LESS-THAN-EFFECTIVE DRUGS

The OIG found one State that continued to pay for drugs beyond the 30-day grace period following publication by the Food and Drug Administration (FDA) in the *Federal Register* that the drugs were less than effective. Payments continued to be made by the State because: (1) the *Federal Register* arrived late, (2) the State inappropriately relied on sources other than the *Federal Register* for notification of less-than-effective drugs, and (3) State law required a 60-day notification prior to discontinuing payments for such drugs. The HCFA concurred with our recommendations for a financial adjustment totaling about $500,000 and procedural changes to ensure that all less-than-effective drugs are removed from the State drug formulary, and that future additions to FDA's list are processed timely. The HCFA is currently updating its Medicaid manual to reflect the February 10, 1987 FDA list.

PREADMISSION TESTING FOR SURGERY

Savings of about $18.5 million in Federal funds could be saved annually if 30 additional States (i.e., those without hospital prospective payment systems) implemented same-day surgery and preadmission testing programs. This estimate is based on OIG findings that only one State without a prospective payment system required preadmission testing of Medicaid patients and admission on the day of an elective surgery. This State saved an estimated $11 million annually.

The OIG recommended that HCFA provide guidance and encourage State Medicaid agencies to develop programs in these two areas. The HCFA agreed with the finding but did not concur with the recommendations because it is developing regulations requiring States to adopt second surgical opinion programs (SSOPs) for selective surgeries. The OIG pointed out, however, that SSOPs focus on the necessity of surgery and not on preventing premature admissions. Our final report is with HCFA for consideration.

ABORTION SERVICES

The OIG continues to find States claiming Federal sharing in the costs of abortion-related services that are not allowable under the Medicaid program. Federal sharing is available to pay claims for abortion-related services only when a physician has certified that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term. The State Medicaid agency must have the certification on hand before paying the physician's claim for the abortion procedure, or the claims of other providers for abortion-related services.

One State improperly claimed over $1 million in hospital and other ancillary costs for abortion services that were not certified by the physician as being necessitated by life-endangering situations. The cause

was attributed to a computer editing problem. The OIG recommended that a financial adjustment be made and procedural changes be implemented to ensure that all ineligible abortion costs are identified and excluded from claims for Federal sharing. Both State and HCFA officials agreed with OIG's recommendations.

Another State claimed nearly $1.4 million in Federal funds for independent laboratory services related to abortions which are ineligible for Federal sharing. The OIG recommended a financial adjustment of $1.4 million and procedural changes to ensure that laboratory services related to unallowable abortions are excluded from the State's claims for Federal sharing. We were advised that the State will voluntarily refund the $1.4 million in unallowable expenditures.

OVERPAYMENTS The OIG continues to find that States are not promptly crediting the Federal Government for its share of identified Medicaid overpayments. In one State, for example, the Federal Government had not been credited with about $4.5 million for overpayments made to nursing homes on behalf of Medicaid beneficiaries. These overpayments were identified through routine State agency settlement procedures. Federal regulations require States to adjust the Federal account when overpayments to Medicaid providers are identified rather than when recovered. The HCFA agreed with our recommended financial adjustment for the amount of identified overpayments.

SINGLE AUDIT The OIG reported to HCFA that nonfederal auditors performing a single audit required by the Single Audit Act identified about $55 million in denied medical claims (i.e., unsupported charges) which the State had not deducted from Medicaid expenditures reported for Federal sharing. The Federal share amounted to about $27.6 million. State auditors recommended an appropriate financial adjustment as well as procedural changes.

On the basis of a desk review and limited quality control review, OIG concluded that the first single audit of this State generally met the requirements of OMB Circular A-102, Attachment P. Accordingly, OIG requested the State's response to the recommendations contained in the single audit report.

In another State, the State agency failed to refund about $1.4 million in identified but uncollected overpayments made on behalf of ineligible

Medicaid recipients. The OIG recommended a financial adjustment and certain procedural changes. The HCFA concurred with OIG's recommendations.

STATE MEDICAID FRAUD CONTROL UNITS

The OIG has oversight responsibility for 36 State Medicaid fraud control units which receive Federal grants to support investigations of fraud in the Medicaid program. During this period the MFCUs reported 190 convictions and more than $4 million in fines, restitutions and overpayments. The following cases are examples of the kinds of cases covered by the MFCUs.

- A gynecologist in Utah had to pay over $13,000 in restitution because of fraudulent practices, including failure to credit the State for payments received from private insurance companies, filing duplicate Medicaid claims and billing the State for multiple surgeries which were incidental to other surgical procedures.

- A former owner-operator of a Minnesota home for the mentally retarded had to relinquish ownership and agree never again to apply for a license to own or operate any type of facility licensed by the State Department of Human Services. He had repeatedly sexually abused a 41-year-old female resident of the home.

- A New York psychiatrist had to make full restitution of $50,000, including interest, for billing Medicaid for far more psychotherapy sessions than he had actually provided to his patients.

- A Delaware pharmacist was sentenced to be incarcerated for 5 1/2 years (suspended for a similar period of probation), ordered to pay the cost of prosecution and fined $1,500 for forgery and filing false claims. Prior to the sentencing he had repaid $10,000 in Medicaid overpayments. His pharmacy was fined $1,000 and also had to pay prosecution costs.

- A former law firm accountant and a Medicaid claims examiner in New York were sentenced for having given and accepted unlawful gratuities in order to get the law firm's Medicaid claims expedited. The examiner accepted more than $800 in gratuities--including cash, Broadway show tickets, and dinner at a noted Manhattan restaurant--for having speeded up payment of the claims. Both the accountant and the claims examiner were each fined $1,000, given 3 years probation and ordered to perform 200 hours of community service.

During this period, the OIG decertified the State of Rhode Island MFCU for failure to comply with program regulations and failure to utilize program resources effectively. The MFCU staff had been used for other than Medicaid-related work, in violation of Federal regulations. Moreover, in 1 year the unit had expended over $427,000 but obtained only one indictment and no convictions or monetary recoveries. Finally, an OIG review showed that compliance problems cited earlier had not been corrected. The grant to the MFCU was therefore terminated.

SOCIAL SECURITY ADMINISTRATION

Chapter II

SOCIAL SECURITY ADMINISTRATION

STATISTICAL ACCOMPLISHMENTS

Savings to the Social Security Administration (SSA) trust funds of $1.2 billion were realized as a result of Office of Inspector General (OIG) recommendations being implemented. A total of 409 convictions and $7.6 million in fines, savings, restitutions and settlements were realized as a result of investigations.

PROGRAM OVERVIEW

The SSA administers the Old-Age, Survivors and Disability Insurance (OASDI), and Supplemental Security Income (SSI) programs, and Part B of the Black Lung program. In fiscal year 1987 SSA will pay OASDI benefits estimated at $202.7 billion from trust funds financed principally from payroll taxes. Annual benefits paid under the needs-based SSI program and Part B of the Black Lung program will total an estimated $10 billion and $1 billion, respectively. Both of these programs are financed from general revenues.

INCARCERATED FELONS

In a series of studies the OIG is looking at abuses of the 1980 and 1983 Social Security Amendments that require suspension of Title II benefits to incarcerated felons. The rationale for suspension of benefits is that minimal needs of incarcerated felons are provided for with public funds.

- The OIG identified five States where incarcerated felons in county jails were receiving Title II benefits. These felons were not being detected because SSA was not contacting local and State authorities on an ongoing basis to obtain data necessary to identify and suspend benefits. We estimate that during the 20-month period covered by our review over $435,000 in Title II benefits were paid to jailed felons. The OIG recommended that established procedures be followed, and that SSA study more efficient methods of identifying the county felon population. The SSA has acted to enforce procedural requirements and will explore system changes in conjunction with OIG's forthcoming report concerning felons in Federal and State prisons.

The following cases provide specific examples of incarcerated felons fraudulently obtaining benefits.

87:1.23
Kanmanie Clyde Jenkins

- A Wisconsin man had to make restitution and serve another year in prison after being convicted for the third time since 1976 for obtaining benefits while he was incarcerated. During periods when he was not in prison he lied on benefit entitlement reviews. If he was in prison at the time, his girlfriend would arrange for reviews. (5-85-00991-6)

87:1.24
Dennis L. Spedding

- In California a man serving a 3-year prison term was sentenced to a consecutive 1-year term for failing to tell SSA he was imprisoned and no longer entitled to benefits. He also had lied on benefit entitlement reviews in periods he was out of prison. (9-84-00219-6)

87:1.25
Rose Palcemaschio

- A New York woman was convicted for collecting more than $20,000 in benefits for her son who was in prison. For 4 years she had presented false documentation to SSA in order to obtain the illegal benefits. (2-85-01370-6)

FALSE IDENTIFICATION AND SOCIAL SECURITY NUMBERS

False identification is a multi-billion dollar problem affecting both Government and business. In 1976 a Federal advisory committee estimated that crimes involving false identification cost the American public and business $15 billion annually. In 1982, a Senate subcommittee updated that figure to $24 billion. The Social Security number (SSN) or card is a key foundation document in creating false identification. A significant part of the OIG's work load is devoted to combating the incidence of bought, falsified and stolen SSNs.

ILLEGAL ALIENS

The sale of SSNs to illegal aliens appears to remain unabated. Especially in areas having a large alien population, a booming business exists, as illustrated in the following examples.

87:1.26
Joseph Tagnipes et al

- In an ongoing investigation of the illegal sale of SSNs to Filipino nationals, 12 persons have been convicted, including three SSA employees. District office contract guards and others served as go-betweens with the employees and sellers. The employees were paid $40 to $50 for each legitimate SSN they provided, which was then sold to an alien for as much as $450. Thousands of SSNs were sold. (9-83-00219-6)

87:1.27
Jose & Javier Romero et al (Marie Callender Restaurants)

- Acting on a referral from the Immigration and Naturalization Service (INS) on a case of two illegal aliens suspected of having false SSNs, the OIG obtained 10 convictions for SSN violations on the part of corporate officers, managers and employees of a group of restaurants in Utah. At the instruction of the officers and managers, each illegal

alien employee reported regular work hours under one name and SSN, and overtime work hours under another. In this way the employers avoided paying overtime compensation. (8-86-00580-6)

- In New York three persons were convicted of selling counterfeit Social Security cards and INS documents to illegal aliens for $800 a set. One was given a year in prison, a second 3 years probation with psychiatric treatment a condition of probation, and a third 2 years probation. All three were fined. The case was worked jointly with INS. (2-86-00050-6)

87:1.28
Marylou McFarlin et al

- A man in Detroit was sentenced to 1 year and a day in prison for selling blank birth certificates for $40 each and blank Social Security cards for $30 each to illegal aliens or persons wishing to create a false identity. (5-86-00079-6)

87:1.29
Fleming Ivy

- In North Carolina a Nigerian national was sentenced to 6 years imprisonment for using false identification, including SSNs, to obtain credit with several department stores and defrauding them of an estimated $47,000. A search of his living quarters turned up 22 credit cards in 10 names, 35 handwritten SSNs, 170 blank credit card applications, and documentation for 55 complete identities. A wide range of valuable goods was also found including electronic equipment, hundreds of records, tapes and videocassettes, 70 designer suits and 35 pairs of Italian shoes. (4-86-01571-6)

87:1.30
Adeyboyeda Roland Ademiluyi

- The OIG discovered that SSA's practice of displaying the Department seal on the throwaway portion of the Social Security card form left the SSN cards vulnerable to counterfeiting. To correct this, the OIG recommended that SSA delete the seal from the reverse side of the SSN card form when it is reprinted. The SSA agreed with this recommendation and also indicated that they would take steps to avoid this vulnerability when designing future documents.

  The vulnerability was discovered through the prosecution of an individual who was selling counterfeit SSN cards. Although the SSN card portion of the form is tamper resistant and its seal difficult to reproduce because of multiple colors, overprinting, and other protections, the seal on the reverse of the form is not so protected. It is printed in the same scale as the seal on the Social Security card and is isolated from the printed message on the form. Consequently, it can easily be photographed, reproduced by a counterfeiter and used to create false cards.

CREDIT CARD AND BANK CHECK FRAUD

The use of fraudulent SSNs has a significant impact on the entire credit system of the United States. Industry sources estimate that credit card fraud alone cost the industry more than $700 million in 1985. Because of its responsibilities for assuring the integrity of the SSN system, the OIG frequently assists the Federal Bureau of Investigation, Secret Service and other Federal law enforcement agencies in myriad investigations which otherwise would not be within its program purview. The following cases are examples of some of these investigations in which the OIG was involved.

- A Virginia man was convicted for defrauding a federally insured bank. As part of his scheme, he used an SSN other than his own. He subsequently produced a letter, which proved to be a fake, trying to show that SSA told him to use the number. After being convicted and while he was awaiting sentencing, he went to an SSA district office and tried to get a new SSN and a letter from SSA stating there had been problems with his SSN for 10 years. He was sentenced to 5 years imprisonment and was ordered to pay $18,000 in fines and restitutions. (W-86-00082-6)

87:1.31
Robert Eugene Bales

- Another Virginia man received 6 months in jail and had to repay $17,000 for using the SSN of a man who had the same name. The man whose SSN he had used continually received calls from banks and other creditors with whom he did no business and owed no money. It took him many months and many letters to correct the information in the various credit reporting data bases. (W-85-00036-6)

87:1.32
William Arthur Cross

- In Georgia, a man and woman approached a person working in an Army post financial office about obtaining a number of blank Government checks. They also wanted him to enter names, addresses and SSNs in the payment system to generate payroll checks, for which they offered to pay him $10,000. The woman was sentenced to 15 years in prison pending psychiatric evaluation. The man fled but was found and also sentenced to 15 years. (4-86-00483-6)

87:1.33
Ibrahim + Tina Muhammed Abdullah

- A Florida woman who owned a travel agency was sentenced to 3 years in prison for falsely using SSNs to get credit cards through which more than $81,000 in cruise and plane tickets were purchased. Her son and daughter, who were part of the scheme, were sentenced to 5 and 3 years, respectively, and the total amounts swindled had to be repaid. (4-86-02030-6)

87:1.34
Gloria Morelli et al

- Nine members of an auto theft ring were convicted in South Carolina for using false SSNs to obtain bank loans to purchase automobiles,

87:1.35
Ralph Douglas et al

selling the automobiles and never paying on the loans. They were given suspended prison and probation sentences of 3 to 5 years each, forced to repay a total of almost $47,000 and ordered to contribute hundreds of hours of community service. (4-86-00155-6)

SOCIAL SECURITY NUMBER FRAUD AND VIOLENT CRIME

Beyond the limits of white-collar crime, fraudulent SSNs are used to conceal drug smuggling, terrorism, murder and arson. The OIG has developed an efficient system of following up on suspicious SSNs which is often critical to identification and prosecution of persons committing violent crimes.

- Timely involvement of the OIG in following up on two suspicious SSNs in south Florida pinpointed two persons who were wanted for murder, grand larceny and drug trafficking in Missouri. A drivers license examiner had become suspicious about a couple who presented birth certificates showing they were in their thirties and had been citizens all their lives, but had SSNs issued less than 3 months earlier. (no OI case opened — S.A. Montalto reported)

- The OIG assisted the FBI in identifying a top organized crime figure who was using a false SSN and was wanted in Italy for the murders of 12 people, including the machine-gunning of 3 people at one location. The OIG identified and located the true owner of the Social Security card. The location of the true owner helped prove at the crime figure's hearing that he was not who he claimed to be. The man is being held for extradition.

REFUGEES CHANGE DATES OF BIRTH TO RECEIVE SUPPLEMENTAL SECURITY INCOME

Refugees entering the U.S. typically do not have documentary evidence of their ages, and their dates of birth are established based on their allegation to the Immigration and Naturalization Service. An OIG investigation revealed that many of these refugees were subsequently changing their dates of birth with the INS to show that they were older than originally alleged in order to qualify for SSI as an aged individual.

It was learned that the INS procedures for changing dates of birth on its records needed to be strengthened. Because SSA relies heavily on INS records as evidence of age for refugees, it was obvious that the lax INS procedures would adversely affect SSA's administration of the SSI program.

The SSA has, on the basis of OIG recommendations, revised their evidence of age procedures and developed new guidelines for field personnel to identify documents which are not acceptable as primary evidence of age.

REPRESENTATIVE PAYEE FRAUD

One of the more odious crimes against SSA programs is the use of one's position as representative payee for helpless beneficiaries to steal their benefits.

87:1.36 Jerry D. Ash

- An Indiana man must repay more than $8,000 plus 10 percent interest a year, and perform 100 hours of community service, for using his mother's benefits while acting as her representative payee. Nursing home officials stated that during the time he took the money his mother's account was insufficient for basic purchases of necessary clothing. (5-85-01356-6)

87:1.37 Ora Sykes

- A Michigan woman used benefits intended for her child after leaving the child with a guardian in Mississippi. She was sentenced to 3 years in a Federal prison where she could get treatment for drug dependency. (5-85-00114-6)

DISABILITY BENEFITS FRAUD

Whether through the use of fraudulent SSNs or otherwise giving false information to SSA, many "disabled" persons conceal a wide variety of work activity to continue receiving benefits.

87:1.38 Keith S. Rose

- A Tennessee man was sentenced to 1 year in prison and ordered to repay $71,000 he obtained in disability payments over 5 years while working in at least five different jobs as a pipefitter or welder. (4-84-00568-6)

87:1.39 Joseph A. Gonzalez

- A man operating an automobile dealership in Puerto Rico was convicted of obtaining $36,000 in disability benefits when it was found that his children, whom he claimed were running the business, were employed full time elsewhere. (2-85-01339-6)

87:1.40 Dorothy L. Martin

- A former county corrections employee in Illinois was put on probation and ordered to repay about $12,000 in disability benefits after it was found she had concealed her work at a community college. (5-85-00320-6)

87:1.41 John B. Markle

- A State alcohol and drug abuse counselor was sentenced to 3 years probation and 300 hours public service, and ordered to repay almost $4,000 received by concealing his work. (5-85-00842-6)

87:1.42 Frank R. Ward

- A California man defrauded both SSA and the Veterans Administration of almost $44,000 in disability payments by working for 7 years under his wife's name and SSN. He was given a suspended sentence, and the monies are being recovered. (9-85-00620-6)

CONCEALMENT OF LEGAL STATUS

Citizens who conceal self-employment, marriage, student status and incarceration may for a time continue receiving benefits. Follow-up on project indicators or the suspicions of alert SSA employees, however, continues to eliminate the types of fraud shown in the following examples.

- An Illinois man owned and managed several businesses but never reported his self-employment to SSA or IRS. He was placed on probation, required to make restitution of almost $5,400 in retirement and survivors benefits to SSA and was ordered to pay taxes and a penalty. (5-85-00138-6)

87:1.43
Lonzo Stafford

- A Michigan woman and her husband had to make restitution of more than $36,500 obtained by repeatedly lying about their marital relationship to continue receiving survivors benefits for two children. They both also received prison terms. (5-86-00130-6)

87:1.44
Barbara + Monte Cole

- Another Michigan woman was sentenced to 3 months imprisonment and 5 years probation, and ordered to make full restitution of almost $16,000 in student benefits. She had falsified and forged student attendance forms. She had even presented an altered birth certificate to prevent SSA from terminating benefits when she reached age 22. (5-84-00251-6)

87:1.45
Cynthia E. Smith

SSI INTERIM ASSISTANCE REIMBURSEMENT PAYMENTS

An investigation identified a scheme by a State employee to use the Interim Assistance Reimbursement (IAR) process to defraud the State of Maryland. This case pointed out the potential for employee fraud in the IAR program and the lack of adequate measures to prevent it. The OIG issued a fraud alert to the State of Maryland and also recommended that SSA immediately take action to ensure that the States carry out their responsibility for sound fiscal controls.

Under an agreement with SSA, States make welfare payments to individuals potentially eligible for Supplemental Security Income (SSI) payments pending the adjudication of the SSI claim. When the SSI award is made, SSA reimburses the welfare agency for the amount that would not have been due from welfare because of entitlement to SSI. The SSA concurred with OIG recommendations. The State of Maryland has already taken action to close the vulnerabilities that were exposed by the employee fraud case.

CONVERSION OF BENEFITS AFTER DEATH

In 1983, Congress enacted a law requiring that State vital statistics records be matched against beneficiary rolls for programs under the Social Security Act. The Secretary designated SSA as the repository

agency for the State vital statistics data, authorizing SSA to obtain the data through cooperative agreements with the States and to conduct the matches. Several convictions were obtained both as a result of these matches and as residual cases under investigation before these matches occurred.

87:1.46 Erik Hansen

- In Michigan, the son of a retired university professor was given a 3-month jail term and ordered to repay $26,000 of his deceased mother's benefits. The son had removed benefits deposited to a joint account for 4 years after his mother's death, although he had been the notifying person on the death certificate. (5-85-00031-6)

87:1.47 M. Sidney Glanzman

- An Indiana attorney was convicted for using $13,000 of his mother's benefits after her death, much of it in Atlantic City casinos. In addition to a suspended sentence, he had to pay restitution and more than $1,000 in interest, a $1,000 fine and a $25 special assessment. The court also reported his conviction to the State disciplinary commission for possible revocation or suspension of his license to practice law. (5-85-00760-6)

87:1.48 Marilyn Hays

- A suburban mother in Minnesota who owned an expensive home and three automobiles, and who kept two children in private schools, had to repay more than $10,500 in benefits sent to her children's deceased grandmother which she had converted to her own use. She also received a suspended prison sentence and 3 years probation, plus was ordered to contribute 350 hours of community service. (5-85-01206-6)

87:1.49 Forest Edgar Laterbaugh

- An Ohio man was sentenced to a 1-year suspended jail term and ordered to repay $13,500 he had withdrawn in money orders against his deceased sister's account to purchase goods and services. (5-85-00558-6)

87:1.50 Ione Kielpinski

- A 74-year-old retired bar owner in Wisconsin was sentenced to 3 years probation and restitution of almost $6,000 she had embezzled in benefits erroneously paid to a deceased friend. (5-85-00868-6)

DECEASED BENEFICIARY PROJECTS

In two States convictions were obtained as the result of special matching projects to uncover individuals who had converted to their own use funds mistakenly sent to deceased beneficiaries.

- A Minnesota death match project yielded 12 convictions and about $20,000 in fines and restitutions.

- Project Phoenix in south Florida resulted in four convictions and $60,000 in recoveries.

PAYMENTS TO SANCTIONED PHYSICIANS

A study was performed to determine whether physicians with a record of fraudulent or abusive behavior in HHS health programs were involved in suspect activity involving the SSA disability process. The review did not identify major fraud or abuse. However, the OIG recommended that SSA distribute copies of our report to all State disability determination services (DDS) as a reminder of the need to exclude sanctioned physicians from the disability determination process. We also recommended that all State DDS offices review medical evidence submitted on behalf of debarred physicians to prevent fraudulent entitlement. The SSA has agreed with our recommendations and is taking steps to implement them.

SOCIAL SECURITY ADMINISTRATION EMPLOYEE FRAUD

In a few instances investigations uncovered SSA employees manipulating the system to illegal personal benefit.

- An SSA employee in a Chicago district office who often received checks returned by relatives of deceased beneficiaries struck upon a way to capitalize on his position. By entering in the records death dates a month later than they actually occurred, he concealed his pocketing of the returned checks. His scheme was discovered before he really had a chance to benefit. (5-82-00037-4)

87:1.51
John Bartucci

- An SSA employee in Nebraska redirected checks payable to a legitimate beneficiary to an Iowa post office box under two fictitious names. He created two SSNs under these names and was in the process of transferring the funds to his own account when he was caught. He was sentenced to 1 year in prison, fined $500 and had to pay restitution of $2,513. More than $31,000 was found to be remaining in the account under the fictitious names. (8-85-00374-6)

87:1.52
Austin H. Mason

- A claims representative in Michigan created SSNs and used them to cash bad checks at a food store. He had to repay the store, resign his position, serve 2 years probation and contribute 200 hours of community service work. (5-85-01325-6)

87:1.53
Ronald M. Peterson

FURNITURE ACQUISITION

The OIG review of SSA's furniture pilot program (made at SSA's request) found that costs were generally reasonable and that furniture procured was appropriate. The furniture pilot program is being conducted in selected district and branch offices to explore the use of standardized, more functional modular furniture to improve office space utilization

and to prepare for the coming installation of computer terminals. Now that SSA is at the point of concluding its pilot testing and evaluating results, OIG recommended that SSA consider several factors in making its final determinations, including a reassessment of the need for all offices to be renovated and an exploration of less costly alternatives. The SSA is currently acting on our recommendations.

GRANTS AND INTERNAL SYSTEMS

Chapter III

GRANTS AND INTERNAL SYSTEMS

STATISTICAL ACCOMPLISHMENTS

Savings of $48.3 million were realized to the areas covered by Grants and Internal Systems (GIS) programs as a result of Office of Inspector General (OIG) recommendations being implemented. The OIG obtained 68 convictions and $22 million from investigations of fraud in departmental contracts, grants and internal systems. Over $594.2 million of additional savings and recoveries could result from OIG reviews completed during this period.

PROGRAM OVERVIEW

The GIS reviews cover three operating divisions, the Family Support Administration (FSA), the Public Health Service (PHS), and the Office of Human Development Services (OHDS), as well as HHS internal management; that is, those functions that cut across departmental lines, including procurement, debt collection and employee-related activities. For fiscal year 1987, it is estimated that expenditures for these areas will amount to $29.2 billion. In addition to these diverse programs, which are described in more detail in their respective sections of this chapter, GIS also includes reviews of Government-wide areas, as described in the final section.

Presently, HHS, and specifically OIG, has audit oversight responsibility over 945 State and local governments, 2,800 colleges and universities and thousands of other entities receiving funds from any Federal agency. For assistance, OIG relies on nonfederal auditors to provide basic audit coverage.

To ensure the adequacy of that coverage, OIG reviews and evaluates each nonfederal audit report for adherence to generally accepted governmental auditing standards and for audit findings or leads requiring OIG action. A number of the findings discussed in our "Government-wide Issues" section (p.37) resulted from "leads" identified by nonfederal auditors. Moreover, one State's first single (statewide) audit under the 1984 Single Audit Act, disclosed that the State improperly spent some $54 million in Federal funds, of which about $30 million pertained to HHS programs. Financial adjustments were recommended accordingly.

In addition to identifying and recommending correction of program inefficiencies, OIG continues its focus on (1) the adequacy of internal controls and the Department's reviews of these controls, (2) the fiscal integrity of cash management and debt collection systems, both departmentwide and by agency, and (3) the efficiency and security of the Department's electronic data processing (EDP) facilities.

Family Support Administration

The Family Support Adminstration, established in April 1986, is the departmental focal point for those financial and other assistance programs designed to promote the stability, economic security, responsibility and self-support of our Nation's families. The FSA provides Federal direction and funding for such State-administered programs as Aid to Families with Dependent Children, Child Support Enforcement, Refugee and Entrant Assistance, Community Service, Work Incentive and Low Income Home Energy Assistance. It is estimated that FY 1987 expenditures for these programs will amount to $13.3 billion. During this period, OIG reviews identified questionable State charges to the programs of $50.1 million.

ILLINOIS AID TO FAMILIES WITH DEPENDENT CHILDREN WELFARE PROJECT

A total of 75 persons have been convicted and $2.5 million ordered in restitution in a project in which the OIG has joined with the Federal Bureau of Investigation (FBI) and Illinois State police to follow up on "hits" from a computer match of welfare rolls against State tax records. In most cases, the fraud uncovered was perpetrated by persons who were obtaining welfare while they had supporting spouses.

AID TO FAMILIES WITH DEPENDENT CHILDREN ADMINISTRATIVE COSTS

The OIG found that over a 5-year period one State overcharged the Aid to Families with Dependent Children (AFDC) program in excess of $13 million for administrative costs that benefited only non-AFDC programs (primarily State assistance programs). This was due to the State's failure to revise, as directed, its plan for allocating costs of administering public assistance programs.

The State was directed to revise its plan so that costs that benefited a single program were directly charged to that program and remaining costs that benefited multiple programs were equitably allocated to each. The OIG's review, however, disclosed that the State did not implement

direct charging of costs. Instead, it continued to allocate administrative costs to all programs. The OIG recommended a financial adjustment of $13 million and specific procedural changes to the State's cost allocation methods. Department officials agreed with our findings and recommendations.

REFUGEE/ENTRANT PROGRAM

The OIG's review of one State's system for charging medical assistance costs to the refugee/entrant resettlement program identified overcharges of $1.2 million. Under the Refugee Act of 1980, States are reimbursed for cash, medical assistance and social services provided to refugees and entrants. The OIG found, however, that an administrative error resulted in overcharges of $700,000. In addition, data omissions resulted in the system failing to identify recipients who were no longer eligible under the program. This resulted in overcharges of $500,000. In addition to a refund of $1.2 million, OIG recommended specific procedural improvements to this State's system.

AID TO FAMILIES WITH DEPENDENT CHILDREN STATES BENEFITS PROJECT

For the past several years, the OIG has been actively engaged in a project assisting State and local law enforcement agencies to obtain the documentation and expertise required to prosecute violators of the requirements of the various AFDC programs. In this reporting period the project reported 37 convictions and $468,000 in recoveries.

GAO REVIEW ON CHILD SUPPORT ENFORCEMENT RECOGNIZES NEED FOR STRONGER OIG PRESENCE

In a review recently conducted by the General Accounting Office (GAO) of the Office of Child Support Enforcement (OCSE), attention was called to the ambiguity in roles between the OCSE and the OIG in meeting respective audit responsibilities. The GAO noted--"Regarding the possible confusion at HHS about audit responsibility, HHS should pursue clarification through appropriate legislative proposals." The President's fiscal year 1985 budget contained a proposal to transfer the OCSE internal audit function to the OIG. (See Appendix B-1, page 54.) This legislation is still needed to improve the effectiveness and efficiency of the Federal internal audit responsibilities over State child support activities and to recognize the cognizant audit responsibility of the OIG.

Public Health Service

The Public Health Service encompasses: the National Institutes of Health (NIH); Food and Drug Administration (FDA); Centers for Disease Control

(CDC); Alcohol, Drug Abuse and Mental Health Administration (ADAMHA); and the Health Resources and Services Administration (HRSA). These agencies promote biomedical research, disease prevention, safety and efficacy of marketed food and drugs, as well as other activities that support better health for Americans. Questionable grantee charges to PHS programs totaled $9.2 million.

NATIONAL INSTITUTES OF HEALTH CONSTRUCTION RECOVERIES

Federal policy and departmental regulations provide general authority for recovery of construction grant funds when facilities are no longer used for program purposes. However, OIG found that the statutes themselves authorizing NIH construction assistance do not specifically provide such a basis for recovery. Since 1972, three institutes at the National Institutes of Health have awarded $258 million in grant support for upgrading, modernizing, renovating and developing extramural biomedical research facilities.

The OIG is recommending that PHS pursue additional legislative authority and implement improved procedures for appropriate recovery of NIH construction grant funds when the basic use of an assisted facility no longer furthers the grant objectives. Although the potential for actual recoveries is not readily quantifiable, we note that the opportunity exists and is likely to grow in the future. The PHS is acting on our recommendations.

NATIONAL HEALTH SERVICE CORPS

An OIG review identified underutilization as a major factor contributing to medical facilities' inability to repay PHS for the cost of National Health Service Corps (NHSC) personnel assigned to free-standing sites (medical facilities not receiving PHS community health or rural health funding).

The Public Health Service Act provides for the assignment of NHSC personnel to public or private nonprofit medical facilities in underserved areas. The Act requires facilities to repay PHS for the cost of personnel but permits full or partial waiver of payment if facilities are financially unable to pay. Historically, facilities have not repaid the majority of PHS' costs for NHSC assignees. Payment was waived for 91 percent (or $21 million) of 1984 costs and for 87 percent ($25 million) of 1983 costs.

According to PHS standards, each full time equivalent physician should have a minimum of 4,200 patient encounters per year. Our review of 1984 encounter rates at 14 facilities in one region disclosed that the average rate was 2,600 encounters, or about 60 percent of the PHS

minimum standard. These facilities also had substandard encounter rates during the 2 preceding years. Low encounter rates experienced were due mainly to overstaffing; many of the facilities had more physicians than was justified by either the total population in the service area or the number of patients that historically used the facility. This also contributed to some facilities routinely using physicians to perform functions, such as social service counseling and administrative duties, that could be performed by nonphysician staff.

The PHS generally concurred with our recommendations and is acting to address deficiencies reported, including action to remove physicians from facilities where they are no longer needed.

Office of Human Development Services

The Office of Human Development Services provides a variety of social services to American children, youth and families, older Americans, Native Americans and the Nation's disabled. During this reporting period, the OIG identified questionable grantee charges to OHDS programs of $16.5 million.

ADMINISTRATION ON AGING

The OIG reported to OHDS that the financial management system of the Commission on Aging of a U.S. territory did not support expenditures claimed--and thus provided no assurance that Federal funds were used effectively and for their intended purpose of providing services to the elderly.

Due to system inadequacies, an independent accounting firm was unable to express an opinion on the allowability of the Commission's $9.4 million in claims for Federal financial participation over a 9-year period. The Commission's financial management system was unable to provide basic information needed to manage Federal and local funds, including the documentation needed to support grant costs claimed. Similar system deficiencies were disclosed in a 1982 financial management system review by a joint Inspectors General task force and again in the task force's 1986 follow-up review.

Considering the long-standing nature of the problem, we are not only recommending the recovery of the $9.4 million, but also that OHDS suspend funding of the Commission unless it obtains assurance that

adequate corrective actions have been taken and that services are being provided to beneficiaries. The OHDS has stated that considering recent improvements in the Commission's systems suspension of Federal funding is not warranted at this time.

Departmental Management

The Office of the Secretary provides overall direction and provides common services such as accounting and payroll to departmental operating divisions. The OIG reviews continue to place emphasis on internal controls, debt management, audit resolution and other mechanisms to prevent, as well as detect, fraud, waste and abuse. Additionally, OIG investigation of fraud in departmental contracts has resulted in potential recoupments of $20 million.

COMPUTER CONTRACT FRAUD

A civil suit and a criminal prosecution were settled with Paradyne Corporation which had been under investigation by the OIG, in cooperation with the FBI, since April 1981. The litigation and prosecution stemmed from a plot involving the bid, award and performance of a contract, ultimately worth $115 million, to supply SSA with 1,800 computer terminals and other equipment. The civil settlement could mean the recoupment of as much as $20 million, with $10.5 million to $11 million in actual recoveries and an additional amount in service and equipment accruing to the Department. In the criminal case, the corporation pled guilty to conspiracy, was fined $1 million and had to pay a restitution of $200,000 to the Office of Inspector General for investigation costs. Two current and two former employees entered a pre-trial diversion program under which they are barred from ever working as part of the corporation's management. (A-81-00057-6)

87:1.54
Paradyne

INTERNAL CONTROLS

The 1982 Federal Managers' Financial Integrity Act (FMFIA) requires Federal agencies, on an ongoing basis, to evaluate and improve internal controls over their administrative and accounting systems, and to report annually to the President and Congress on the status of their systems. The Assistant Secretary for Management and Budget (ASMB) manages the Department's FMFIA effort.

The OIG's final report on the status of the Department's FY 1986 efforts advised the Assistant Secretary that:

- The Department in general has improved the quality of internal control reviews, refined the segmentation of internal control areas, and completed the required vulnerability assessments.

- Fundamental problems persist, however, in the Department's methodology for rating the vulnerability of internal control areas, with the methodology biased towards lower vulnerability ratings. For example, we found that only 16 of the Department's 8,268 identified internal control areas were rated as having a high degree of risk.

- Another stubborn problem continues to be the slippage of considerable work into the latter months of the year--an occurrence which impedes independent evaluation. In FY 1986, for example, PHS did not complete enough of its FMFIA work for OIG to evaluate and reach a conclusion on the adequacy of PHS efforts.

We recommended that ASMB (1) require Department components to spread FMFIA work throughout the year, (2) monitor their progress and act on any slippage, (3) reevaluate the vulnerability assessment methodology, and (4) track and monitor timely correction of material weaknesses identified during the year. Subsequent to our report issuance, ASMB implemented certain corrective actions in response to our recommendations. The ASMB improved reporting requirements to insure accuracy of data and better monitoring of FMFIA activities.

NONFEDERAL AUDITS

The OIG utilizes nonfederal audits (performed by firms and State auditors) to assure basic audit coverage of the thousands of recipient entities over which it has cognizance. Each nonfederal audit report is evaluated by OIG for adherence to generally accepted governmental auditing standards, i.e., that the audit addresses the grantee's compliance with program requirements, the adequacy of its internal controls and the reasonableness of related expenditures.

During this reporting period, OIG issued 1,569 nonfederal audit reports containing recommendations for cost recoveries of $108 million. The reports also identified opportunities for improving the efficiency of grantee management systems. Statistical results of reviews during this period are:

Reports issued without modification	1,214
Reports issued with modifications	355
Returned to auditor	62
Unacceptable reports	44[2]
Total audit reports processed	1,675

Indicators of the significance and sophistication of nonfederal audit findings are illustrated on pages 14, 31 and 37 of this report. The first two discuss major compliance deficiencies that resulted in recommendations for disallowance of significant amounts of program charges. The last, in our "Government-wide Issues" section, is to a large extent a discussion of our follow-up of audit "leads" identified by nonfederal auditors.

[2] One of these nonfederal audit reports (relating to the Medicare and Medicaid Professional Standards Review Organizations program) was not only referred to the appropriate State Board of Accountancy but the cost of the audit was recommended for disallowance.

AUDIT RESOLUTION

The following information on Department audit resolution activity is provided in accordance with the Senate Appropriations Committee report pertaining to the Supplemental Appropriations and Recissions Act of 1980 (P.L. 96-304).

Reports with Questioned Costs

	Total	Over 6-months old
Unresolved audits, September 30, 1986	215	5
Unresolved audits, March 31, 1987	276	5[3]
	Number	
Reports issued during period	346	
Reports resolved during period	285	
	Amount (in millions)	
Costs questioned during period	$154.7	
Costs sustained during period	75.2[4]	

DEBT COLLECTION

A summary of HHS' debt collection activities is shown in the following:

Summary of Receivables, Collections and Write-offs (in millions)*

Receivables at beginning of FY 1985		$3,848.60
Add: New receivables during the period		4,035.20
Less:		
Collections	$3,409.95	
Offsets	140.66	
Write-offs	946.30	
Total		4,496.91
Receivables at end of FY 1986		3,386.90

* Includes audit disallowances as shown in the following chart.

[3] Includes the following:

OPDIV	Number	Amount
FSA	2	$38,520
PHS	2	86,396
OHDS	1	5,908
Totals	5	$130,824*

* Does not include three ICF/MR reports which are unresolved pending resolution of court case.

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

Disallowances shown in the following chart are OIG-recommended disallowances, such as identified overcharges to the Medicaid program. Disallowances involving public assistance programs and SSA trust fund expenditures are, by law, collected through reduction of future Federal payments. Other receivables include health professions and nursing student loans, hospital and health maintenance organization facility construction loans, as well as overpayments to SSA beneficiaries.

Audit Disallowances Included in Departmental Summary (in millions)		
Beginning FY 1985 receivables[5]		$ 211.63
New receivables added		239.15
Subtotal		450.78
Collections	$ 13.67	
Offsets[6]	140.66	
Write-offs	115.30	
Total		269.63
At end of FY 1986		181.15

Prior OIG reports showed that the Department did not fully account for all audit disallowances and collections of audit disallowances. Department policy for controlling and accounting for audit disallowances was not applied uniformly.

We will continue to monitor the Department's debt collection activities to (1) assess accounting and reporting controls over audit disallowances, (2) identify problem areas, (3) assess efforts made to collect disallowances, and (4) evaluate procedures for controlling collections categorized as cash, expenditure adjustments, and award adjustments (or offsets).

Collections decreased $104 million in FY 1986. Most of the decrease was due in part to unusually large collections last year of receivables established by HCFA for the Medicare Buy-In program (which had been prompted by collection initiatives recommended by OIG). The major write-off of receivables in FY 1986 was for OASDI overpayments that SSA determined to be uncollectible.

[5] The OIG stewardship reports for FY 1984, 1985 and 1986 show that at least $16.7 million in audit disallowances were sustained but not recorded by the various agencies in the Department.

[6] Offset collections include reductions and adjustments made to expenditure reports, as well as reductions of current and future awards, other than public assistance awards made in lieu of cash collections.

The OIG continues to monitor the Department's debt collection activities on a quarterly, cyclical basis. For the period ended September 30, 1986 we examined HCFA activities, including actions taken to meet HHS, Office of Management and Budget (OMB) and Treasury debt reporting requirements. Our review of Office of the Secretary and OHDS activities is currently in process.

In FY 1986, HCFA began assessing interest on delinquent State Medicare Buy-In premiums (i.e., States' "buy-in" to Medicare Part B of eligible Medicaid recipients), collecting $1,430,464 in interest.

Two previously reported problems continue. Medicaid disallowances identified by HCFA analysts continue to be excluded from accounts receivable statistics reported to Treasury. As of June 30, 1986 these disallowances amounted to $157,737,736. Secondly, accrued interest on disallowances under appeal are still not being recorded in the general ledger. We have reminded Department officials of the need for formal guidance in both these areas.

Government-wide Issues

Much of the OIG's grants and internal systems efforts have focused on issues that cut across all HHS programs and in many instances programs of all Federal agencies. Emphasis during this period has been on cost allocation methods, State variation in administrative costs, Freedom of Information costs and fees, and internal control guidance for Federal computerized systems.

COST ALLOCATION

The OIG audits often cover programs of all Federal agencies having contracts and grants with State and local governments, colleges and universities, and nonprofit research organizations. These reviews examine methods used in allocating indirect costs to Federal programs under the statewide public assistance (welfare programs) and grantee cost allocation program. The OIG's audit responsibilities extend to all 50 States. Some examples are discussed below.

- Internal Service Funds - Internal services (such as telecommunications and printing) are provided by one governmental unit to other units on a cost reimbursement basis. Federally assisted programs are charged a

proportionate share of these costs. Pursuing a "lead" identified in a 1984 nonfederal audit report (see p.55 of our April - September 1984 Semiannual Report), OIG has now reviewed internal service funds of 12 State and local governments, finding significant overcharges to Federal programs. Recommended financial adjustments to date total about $40.5 million. Also, recommended improvements in State and local controls will save millions more.

- Self-Insurance Funds - Self-insurance funds absorb casualty and disaster losses internally rather than purchasing protection from insurance companies. A review in one State identified about $2.2 million in overcharges to Federal programs for self-insurance costs. In this instance, the State set billing rates higher than needed with no compensating adjustment.

- Statewide Cost Allocation Plans - In one State costs allocated to Federal programs were overstated by over $1 million. These costs, identified by the State auditor and sustained by the State, pertained to the AFDC, Foster Care, Food Stamps, Refugee Resettlement, and Child Support Enforcement programs. The OIG's review showed that refunds of these overcharges were not made timely because the State agency had not prioritized the calculation of amounts to be adjusted against the individual programs. (A similar finding is discussed on page 28.)

ADMINISTRATIVE COSTS: AID TO FAMILIES WITH DEPENDENT CHILDREN, MEDICAID AND FOOD STAMP PROGRAMS

An OIG program review of States' administrative costs for the Aid to Families with Dependent Children, Medicaid and Food Stamp programs found no logical set of explanations for the wide variations among States' expenditures other than one that included relative State efficiency and local wage rates. The review explored two options for a prospective payment system for the Federal share of administrative costs which could save over $500 million. A prospective system would provide States with a combined per recipient amount based on historical cost. Also, it would increase the flexibility that States have in running their programs, reduce Federal interference by eliminating the cost allocation process and reduce involvement of Federal staff.

Serious questions have been raised by the Administration and members of Congress regarding this variation and a number of reasons have been proposed. These include program complexity, population density, urbanization, State or county administration, and economic condition of the State.

FREEDOM OF INFORMATION ACT

A President's Council on Integrity and Efficiency (PCIE) project was initiated to assist OMB in preparing guidelines for Federal agencies to implement 1986 amendments to the Freedom of Information Act (FOIA). The purpose of the project was to develop Government-wide data on (1) the costs and fees for processing requests under FOIA and (2) the estimated percent of FOIA requestors who are commercial.

The study found that data on FOIA fees and costs show considerable variation between agencies in the ratio of fees to costs and in the percent of commercial users. The majority of the agencies surveyed have a very high percentage of commercial users. Also, there are significant information gaps since a number of agencies do not collect FOIA data on an agency-wide basis. Subsequent to the completion of our project, we provided comments on behalf of the PCIE to OMB in response to the *Federal Register* notice and request for public comment on the Proposed Guidelines and Fee Schedule.

APPENDIX A

APPENDIX A

PROGRAMMATIC RECOVERIES AND COST SAVINGS OCTOBER 1986 THROUGH MARCH 1987

This appendix summarizes recoveries and annual savings as a result of programmatic, administrative and judicial action totaling $200.4 million.

AUDIT RECOVERIES - During this reporting period, management's audit determinations in favor of OIG recommendations resulted in $75.2 million in commitments for recoveries.

	IN MILLIONS
• Payments to ineligible Medicaid recipients, duplicate payments, and billing errors - Georgia - ACN: 04-64648	$12.1
• Charges to Federal programs (HHS and other agencies) in excess of actual costs - Oregon - ACN: 10-60455	$10.5
• Amounts (including interest) owed SSA by Railroad Retirement Board (RRB) for SSA's share of canceled OASDI/RRB combined benefit checks - ACN: 13-67207	$8.0
• Improper Medicaid payments to Institutions for Mental Diseases misclassified as nursing homes - Indiana - ACN: 05-60207	$4.0
• Overstated Medicaid reimbursement rates for Intermediate Care Facilities for the Mentally Retarded - South Dakota - ACN: 08-60218	$2.5
• Unallowable Medicaid abortion-related costs - California - CIN: 09-86-60206	$1.4
• Duplicate and improperly allocated costs for Medicaid management information system - Illinois - ACN: 05-60244	$1.3
• Inequitable allocation to Medicaid of indirect costs - Missouri - ACN: 07-60224	$1.1
• Payments to persons no longer eligible for refugee assistance - California - ACN: 09-62612	$3.1

	IN MILLIONS
• Overclaimed Foster Care administrative costs - Oklahoma - ACN: 06-60253	$2.1
• Interest earned on Federal funds not returned - California - ACN: 09-60550	$1.6
• Interest earned on Federal funds not returned (HHS and other agencies) - Pennsylvania - ACN: 03-60451	$1.3
• Foster Care payments for ineligible children - New York - ACN: 02-60551	$1.1
• Head Start funds used for other programs - New York - ACN: 02-65105	$1.0
• Imputed interest from excess draw down of Federal funds and excessive rental costs - New York - ACN: 02-66155	$2.6
• Central office costs improperly allocated to the Low Income Energy Assistance program - New York - ACN: 02-50251	$2.4
• State claims for services provided after the Cuban Refugee Resettlement program ended - New York - ACN: 02-62607	$1.0
• Documentation not adequate to support the reasonableness, allocability and propriety of costs charged - New York University Medical Center - ACN: 02-67012	$1.9
• Medicaid claims for depreciation did not comply with State plan provisions - Iowa - ACN: 07-60214	$1.4
• State claimed Federal sharing in State warrants that were canceled - California - ACN: 09-62633	$1.3
• Other audit determinations, each under the $1 million threshold used for this report. A complete listing is available upon request.	$13.5

INVESTIGATIVE RECOVERIES AND SAVINGS - A total of $50 million in investigative recoveries and savings was realized during this period.

	IN MILLIONS
• Fines, restitution, interest and community service contributions from Paracelsus Healthcare Corporation: pled guilty to mail fraud in submitting false Medicare cost reports.	$4.5
• Fine and investigation cost compensation from Paradyne Corporation: pled guilty to conspiracy in contract bid, award and performance for SSA computer system.	$1.2
• Civil settlement with Paradyne Corporation in relation to contract bid, award and performance for SSA computer system.	$20.0
• Civil monetary penalties	~~$5.7~~ 1.2
• Other investigative recoveries and savings which did not meet the $1 million threshold for individual reporting.	~~$18.6~~ 23.1

PROGRAMMATIC COST SAVINGS - Total programmatic improvements in the amount of $75.2 million represent funds or resources that will be used more efficiently as a result of management audit determinations in favor of OIG recommendations.

OIG RECOMMENDATIONS	STATUS	SAVINGS IN MILLIONS
PRO Disallowance: Eliminate from contract awards unallowable and overstated costs included in peer review organization (PRO) proposals. (ACN: 14-62158)	HCFA used OIG findings in reducing second cycle (1986-1988) PRO contract awards.	$49.9

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
Clarify ESRD Guidelines: Clarify coverage guidelines for ESRD beneficiaries using ambulance service to and from their homes for regularly scheduled maintenance dialysis treatments at hospital outpatient facilities. (ACN: 01-62037)	In 1986, HCFA issued Medicare Carriers Transmittal No. 1154 to advise carriers to carefully review round-trip ambulance services to outpatient dialysis facilities on a per visit basis for medical necessity.	$9.0
Duplicate Fee-for-Service: Eliminate payment error tolerance levels and require carriers to recover overpayments of fee-for-services rendered to Medicare beneficiaries enrolled in HMOs. (CIN: A-01-86-62012)	In 1986, HCFA issued instructions to carriers to eliminate the tolerance level and recover appropriate overpayments.	$3.0
Indirect Cost Rates: Eliminate from negotiated rate unallowable and overstated costs identified in indirect cost rate proposal of an educational institution. (CIN: A-05-86-67001)	The Division of Cost Allocation's adoption of OIG recommendations (as sustained by the Department's Grant Appeals Board on November 18, 1986), resulted in the establishment of indirect cost rates that were more equitable than those proposed.	$13.3

APPENDIX A-I

APPENDIX A-1

UNIMPLEMENTED PROGRAMMATIC RECOMMENDATIONS THROUGH MARCH 1987

This appendix summarizes OIG recommendations for programmatic or administrative actions that Department management has yet to determine in favor of OIG or has yet to implement. Recoveries or annual cost savings associated with these recommendations are estimated at $2.02 billion.

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
Capital Costs: Discontinue Medicare payments for inappropriate capital cost elements. (ACNs: 09-52032, 09-52020, 09-32607, 07-42019 and 07-52004)	Two of the five cost elements recommended have been acted upon; the remaining are awaiting formulation of Department policy.	$941
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)	HCFA continues to disagree with our recommendation.	$268
ICF/MR Facilities: Eliminate Medicaid payments for care provided by ICF/MR facilities having invalid provider agreements. (ACN: 05-60219)	HCFA is considering our recommendations.	$115.4 one-time recovery.

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
Multiple-Source Prescription Drugs: Reforms are needed in Medicaid payments for multisource prescription drugs. (ACN: 06-40216)	HCFA has evaluated public comments on their proposal to reform Medicaid drug reimbursement. A final regulation is in the clearance process.	$114
Elective Surgeries: Increase use of outpatient facilities for elective surgeries under Medicaid. (ACN: 09-50205)	These recommendations have yet to be implemented.	$110
Prescription Drug Pricing: Better estimates are needed of actual Medicaid prescription drug costs. (ACN: 06-40216)	HCFA has evaluated public comments on their proposal to reform Medicaid drug reimbursement. A final regulation is in the clearance process.	$72
Medicare Ambulance Services: Reasonable charge reimbursement for ambulance providers has resulted in excessive annual increases. Carriers should use their "inherent reasonableness" authority to limit excessive charges. (OAI-3-86-000112)	HCFA has concurred and is exploring options.	$69
Medicaid Recertification: Required Medicaid recertification of ICFs and SNFs not performed by one State. (ACN: 05-60150)	The report is with HCFA for comment.	$42 one-time recovery.

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
Ambulance Claims: Consider requiring use of "place-of-service" coding to detect noncovered ambulance services billed to Medicare. (ACN: 04-62006)	HCFA has not completely implemented corrective action.	$64
Mandatory Second Opinion: Mandate that Medicaid beneficiaries obtain second surgical opinions for selected surgeries. (ACN: 03-30211)	HCFA's expected regulations will be delayed until a report required by the Omnibus Budget Reconciliation Act (OBRA) 1986 is submitted to Congress.	$63
ICF/MR Facilities: Restrict Medicaid reimbursement to State-owned and operated ICF/MRs to actual allowable costs. (ACN: 03-42005)	HCFA is in the process of developing a regulatory change to address this issue.	$50
X-Ray Services: Eliminate Medicare administrative mandates requiring routine chest x-rays for nursing/adult home patients. (ACN: 03-62018)	HCFA is implementing our proposal.	$15
Earnings Enforcement: Accelerate the Title II earnings enforcement operation (used to identify unreported or underreported beneficiary earnings) to ensure timely identification/collection of overpayments. (ACN: 13-62690)	Although SSA agreed with the OIG recommendation, implementation has been sidelined. Higher priority was given to claims and other system modernization.	$15

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
Pacemaker Monitoring: Reclassify pacemaker monitoring under Medicare from the current physician-assisted service to the lower-paying routine service. (ACN: 08-52017)	HCFA issued guidelines as part of studies mandated by the Deficit Reduction Act of 1984, and is exploring alternative approaches to the problem.	$6
Late Payments to SSA: SSA should take the necessary regulatory steps to implement procedures for assessing interest on late State supplementation contributions. (ACN: 13-52637)	SSA disagreed on grounds that charging interest would not be cost-effective.	$1.3

APPENDIX B

APPENDIX B

LEGISLATIVE COST SAVINGS
OCTOBER 1986 THROUGH MARCH 1987

This appendix summarizes savings resulting from legislative actions on OIG recommendations. Savings are calculated using Congressional Budget Office (CBO) 5-year estimates, pursuant to P.L. 93-344, as amended, unless otherwise referenced. The amounts shown, totaling $3.1 billion, represent funds or resources that will result in budgetary savings.

OIG RECOMMENDATIONS	STATUS	SAVINGS IN MILLIONS
Indirect Medical Education Costs: Reduce excessive Medicare payments to teaching hospitals for indirect medical education (IME) costs by halving the PPS adjustment factor to 5.79 percent. (ACN: 09-62003)	Effective May 1, 1986 the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) reduced the IME adjustment factor to 8.1 percent through September 30, 1988 and to 8.7 percent thereafter. Note: Savings based on CBO estimates for FYs 1989, 1990 and 1991 were previously deferred pending adoption of a departmental proposal to reduce the IME factor to a level supported by HCFA's empirical data. Since the proposal has yet to be adopted, we are now showing the COBRA savings for FY 1989.	$1,100.0
Mandatory Second Opinion: Require Medicare beneficiaries to seek mandatory second surgical opinions for selected surgeries. (ACN: 03-30211)	Medicare Part B provisions for mandatory second surgical opinions for selected surgeries have been included in Section 9401 of COBRA.	$425

OIG RECOMMENDATIONS	STATUS	SAVINGS IN MILLIONS
Medicare Reimbursement for Standby Anesthesia: Local standby anesthesia used during cataract surgery and other operations does not require anesthesiologists to perform the full range of services associated with general anesthesia. HCFA should reimburse standby anesthesia during cataract surgery at a lower rate than general anesthesia. (OAI-02-85-010)	Section 9334 of the Omnibus Budget Reconciliation Act of 1986 enacted this policy, but only for cataract surgery.	$405
Medicare Reimbursement for Graduates of Foreign Medical Schools: Inadequate resources and the problem of applying broad U.S. standards to foreign medical school programs makes it difficult for State licensing boards to adequately evaluate the medical education of foreign medical school graduates. Medicare funding for direct medical education should be limited to residents who have passed the Foreign Medical Graduate Examination in the medical sciences. (OAI-01-86-00064)	Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 adopted this recommendation.	$41
Deposits of Contributions: Accelerating State and local deposits of social security contributions by adopting the private sector deposit schedule will increase interest income and trust fund revenues. (ACN: 13-32601)	Section 9002 of the Omnibus Budget Reconciliation Act of 1986 requires State and local employers to follow the private sector schedule for deposits. This is effective for payments due on wages paid after December 31, 1986.	$1,142

APPENDIX B-I

APPENDIX B-1

UNIMPLEMENTED LEGISLATIVE RECOMMENDATIONS THROUGH MARCH 1987

This appendix summarizes OIG recommendations requiring legislative remedy. The projected savings of $18.8 billion are reflected over the 5-year budget cycle as called for by the OMB A-19 process.

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
IME Adjustments: Reduce the Medicare PPS adjustment factor for indirect medical education costs and thus limit the large profits being earned by teaching hospitals. (ACN: 09-62003)	This proposal has been included in the Department's FY 1988 legislative package, as it was in previous years.	$6,040
Matching Rates: Eliminate premium matching rates under Medicaid. (ACN: 03-60223)	The President's FY 1988 budget included a proposal to eliminate all special matching rates in the Medicaid program.	$1,800
HEAL Premium Rates: Seek legislation to link HEAL premium rates to default rates in high-risk disciplines. (ACN: 12-73276)	This proposal has been included in the Department's legislative program.	$605
Medicare Deductibles: Raise the Medicare Part B deductible to $100 and appropriately index it. (ACN: 09-52043)	The Department's FY 1988 legislative package includes a proposal to index the deductible at $75.	$1,400

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
Rounding Medicare Premiums: Round Medicare Part B premium up to the next higher dollar. (ACN: 09-52008)	The Department has not included this proposal in its current legislative package.	$875
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)	This change has not been included in the Department's current legislative program.	$1,270
Black Lung Student Benefits: The Administration should request Congress to eliminate student benefits under Black Lung program since there are a number of other programs which provide educational assistance to students. (First discussed in 1/82-9/82 OIG Abbreviated Annual Report, ACN: 13-22702)	This proposal is under consideration.	$13
Medicare Ambulance Services: Medicare Part B ambulance costs have risen at an average rate of over 20 percent annually since 1974. HCFA should seek legislative authority to establish basic life support ambulance reimbursement rates through competitive bidding. (OAI-P-03-00012)	HCFA is generally supportive of the concept of inherent reasonableness and will study factors and methods for determining reasonableness.	$513

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
Nursing Home Per Diem: Revise Medicare regulations to prohibit suppliers from billing 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)	HCFA has not yet submitted a legislative proposal.	$85
Hospital DRG Rates: Rebase Medicare hospital PPS rates to correct for inclusion of overstated operating costs. (ACN: 09-62021)	The Department has decided not to seek rebasing and favors instead a gradual reduction through the update.	$1,500
Medicare Round Down: Round down to the next whole dollar Medicare Part B and other payments for Medicare services. (ACNs: 03-62006 and 14-52085)	OIG has submitted a second report; however, the Department has not included this proposal in their legislative program.	$315
Buy-In Program: Limit Medicaid "Buy-In" payments for Medicare deductible and coinsurance to the Medicaid fee schedule. (ACN: 02-60202)	This proposal is no longer included in the legislative program for FY 1988.	$500
Federal Subsidy: Trim Federal subsidy for upper-income beneficiaries under Medicare Part B. (OIG position paper issued June 28, 1985) (ACN: 09-52006)	This has not been included in the Department's legislative program.	$6,500

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
OCSE Internal Audits: Transfer of the internal audit function now performed by the Office of Child Support Enforcement to the OIG.	This proposal was included in the President's FY 1985 Budget, but no Congressional action was taken.	Not Determined.

Index of Topics Covered in OIG Semiannual Report

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