Office of Inspector General

Semiannual Report to the Congress

OCTOBER 1, 1987 - MARCH 31, 1988

RICHARD P. KUSSEROW
INSPECTOR GENERAL

STATUTORY AUTHORITIES

P.L. 94-505 - The Inspector General Act of 1976, as amended by P.L. 97-375, December 21, 1982. The Inspector General shall, not later than May 31 and November 30 of each year, submit to the Secretary and the Congress semiannual reports summarizing the activities of the office during the immediately preceding 6 month periods ending March 31 and September 30.

P.L. 98-502 - Single Audit Act of 1984

P.L. 96-304 - Supplemental Appropriations and Rescissions Act of 1980.

OMB CIRCULARS	DESCRIPTION
A-21	Cost Principles for Educational Institutions
A-50	Audit Follow-up. Audit Follow-up provides policies and procedures for use by executive agencies when following up on audit reports issued by IGs, other executive branch audit functions, GAO, and nonfederal auditors.
A-87	Cost Principles for State and Local Governments
A-88	Indirect Cost Rates, Audit, and Audit Follow-up at Educational Institutions. Circular applies to all Federal agencies that administer agreements to educational institutions subject to OMB A-21 and OMB A-110
A-102	Uniform Administrative Requirements for Assistance to State and Local Governments
A-110	Uniform Administrative Requirements for Grants and Other Agreements With Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations. Deals with such issues as: bonding, program income, cost sharing, property management, etc.
A-128	Audits of State and Local Governments. Issued pursuant to the Single Audit Act of 1984. Established audit requirements for State and local governments that receive Federal aid, and defines Federal responsibilities for implementing and monitoring those requirements.

Shaw

REPORT HIGHLIGHTS

The following statistical data and examples highlight Office of Inspector General (OIG) findings and recommendations made during the first 6 months of Fiscal Year (FY) 1988 to improve quality of care, enhance program management and achieve cost savings. Detailed explanations of these topics are provided in the referenced pages.

- This report documents over $2.9 billion in settlements, fines, restitutions, receivables and savings. (See appendices A-C.)

- A total of 643 individuals and entities were convicted for engaging in crimes against Health and Human Services (HHS) programs. (See pages 15 and 30.)

- A total of 177 health care providers and suppliers or their employees were administratively sanctioned for defrauding the Medicare and Medicaid programs or for providing substandard care or excessive services. (See page 41.)

- Convictions resulting from investigations of Medicare and Medicaid fraud by OIG and federally supported State Medicaid Fraud Control Units totaled 264, with financial recoveries and savings of over $33 million. (See page 50.)

- The OIG's audit of the Social Security Administration's (SSA) financial statements, prepared for the first time, offers assurance of the long term solvency of the trust funds. (See page 16.)

- An OIG analysis of Medicare hospital profit margins indicated that profit margins decreased in the third year of the Medicare prospective payment system but are still averaging nearly 10 percent. (See page 32.)

- Fifty-six referrals involving potential hospital patient dumping were received from HCFA for further investigation. Civil monetary penalties in excess of $110,000 were collected. (See page 30.)

- Transferring SSA's data operations centers to the Internal Revenue Service would promote operational efficiency and protect employees' jobs. (See page 18.)

- Amending the Medicare secondary payer provision for end stage renal disease beneficiaries could save the Medicare program $3 billion over the next 5 years. (See page 33.)

- Closing loopholes on fringe benefits under cafeteria plan salary reduction agreements for the Federal Insurance Contributions Act (FICA) and income tax purposes would prevent trust fund losses in the billions of dollars and assure full benefit coverage of young and low-paid workers. (See page 18.)

- A study of home health services revealed that aides performed only half of the tasks necessary to support skilled medical services, and that substantial deficiencies exist in the orientation of aides to patient needs. (See page 34.)

- Three reports on the recovery of supplemental security income overpayments, in the areas of cross program adjustments, income tax offset, and backlogged debt, contained recommendations for recovery of debts that had previously been written off by SSA. (See page 22.)

- A study of at-home oxygen care found that non-Medicare providers have developed reimbursement methods for at-home oxygen which result in monthly rental payments as much as 75 percent lower than Medicare payments for the same services. (See page 37.)

- A national validation study of diagnosis related groups (DRGs) found that hospitals prematurely discharged 1.1 percent of the 7,045 randomly sampled Medicare beneficiaries. The study also found that 20.8 percent of the cases reviewed had been assigned an inappropriate DRG. This miscoding resulted in a 1.3 percent overpayment which projects to $300 million for all Medicare discharges for FY 1985. (See page 38.)

- Modifications to coverage limitations are needed to deal with changed conditions in the delivery of Medicare inpatient psychiatric care. (See page 44.)

- One State improperly claimed $13.2 million in Federal financial participation under the Medicaid program for services provided at six State-owned juvenile facilities. (See page 49.)

TABLE OF CONTENTS

DEPARTMENTAL OVERSIGHT

Chapter I

DEPARTMENTAL OVERSIGHT

INTRODUCTION

This report summarizes the Department of Health and Human Services' (HHS) Office of Inspector General major activities, initiatives and results for the 6-month period ending March 31, 1988.

Under Public Law 94-505, enacted in 1976, the Office of Inspector General (OIG) has a statutory responsibility to protect the integrity of HHS programs which serve 56 million beneficiaries. Three primary components comprise OIG—the Office of Audit, the Office of Investigations, and the Office of Analysis and Inspections. Through a comprehensive program of audits, investigations, inspections and program evaluations, OIG reduces the incidence of fraud, waste, abuse and mismanagement, and promotes the economy, efficiency and effectiveness of HHS programs which are estimated to cost nearly $400 billion in Fiscal Year (FY) 1988.

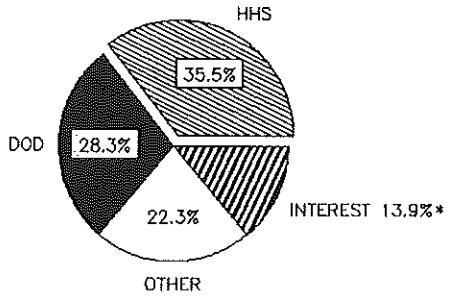
The OIG's activities cover all five operating divisions of the Department. The Social Security Administration (SSA) manages the Nation's retirement and disability programs. The Health Care Financing Administration (HCFA) administers the Medicare and Medicaid programs. The Public Health Service (PHS) promotes biomedical research, disease prevention, safety and efficacy of marketed food and drugs and other activities designed to ensure the general health and safety of American citizens. The Family Support Administration (FSA) provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. The Office of Human Development Services (HDS) provides a variety of social services to American children, families, older Americans, native Americans and the Nation's disabled. The remaining chapters of this report are devoted to OIG activities in each operating division of the Department.

In addition, OIG has departmental management and oversight responsibilities. The Office of the Secretary will spend an estimated $225 million to provide overall direction for departmental activities and to provide common services such as accounting and payroll to departmental operating divisions. The OIG's oversight of these areas includes review of debt management activities, grants and controls, audit resolu-

tion, implementation of the Federal Managers' Financial Integrity Act, and participation in President's Council on Integrity and Efficiency projects. Special reviews requested by the Secretary, the Congress and other departmental policy makers are also conducted. Reviews are directed at ways to strengthen all areas of departmental management.

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

COMPOSITION OF FEDERAL BUDGET
(Outlays in Billions)



TOTAL FY 1988 FEDERAL BUDGET = $1,056 BILLION
* INTEREST ON THE DEBT

AUDIT RESOLUTION

The extent of OIG oversight responsibilities is reflected in the following information on Department audit resolution. This information is provided in accordance with the Senate Appropriations Committee report pertaining to the Supplemental Appropriations and Recissions Act of 1980 (Public Law 96-304). The following table reflects audit activity including number of reports issued and resolved and costs sustained during this reporting period:

Audit Reports with Questioned Costs

Unresolved audits at beginning of period	193[1]
Reports issued during period	179
Reports resolved during period	204
Costs sustained during period (in millions)[2]	$155.5[3]
Unresolved audits at end of period	168
Unresolved audits over 6 months	4[4]

DEBT COLLECTION

The Department's debt collection activities are continually monitored by OIG on a quarterly, cyclical basis. For the period ended September 30, 1987, OIG examined HCFA activities, including actions taken to meet HHS, and Department of the Treasury debt reporting requirements. The OIG previously reported two problems relating to HCFA's debt collection activities. The first, relating to the accounting and reporting of Medicaid disallowances identified by HCFA's analysts, is now being corrected. Beginning in FY 1988, these disallowances will be accounted for and formally reported to the Treasury in accordance with departmental policy. The second problem remains uncorrected; interest on disallowances under appeal is still not being accrued and recorded in the general ledger as required by OMB Circular A-50. The OIG has again reminded Department officials of the need to comply with Federal requirements as they pertain to these two issues.

With respect to the State Buy-In program (i.e., States' "buy-in" to Medicare Part B of eligible Medicaid recipients), delinquent premiums owed by States have been significantly reduced by HCFA's initiation of an automatic offset to States' Medicaid grants of premiums due. In the five quarters ending September 30, 1987, delinquent premiums de-

[1]Detailed audit resolution activity described pertains only to OIG reports.

[2]Subject to reduction as a result of appeal.

[3]Amount includes $22.8 million in sustained disallowances recommended by HCFA.

[4]Includes the following:

OPDIV	Number	Amount	Report Number (s)
HDS	2	$831,489	CINs: A-04-86-65053; A-09-85-50558
PHS	1	322,055	CIN: A-01-86-65200
OS	1	13,981	CIN: A-03-87-05507
Totals	4	$1,167,525	

Due to time required for data compilation, this table reflects the status of reports through February 29, 1988.

AUDIT DISALLOWANCES
(in millions[1])
FOR THE PERIOD ENDING FEBRUARY 29, 1988

OPERATING/ STAFF DIVISION	BEGINNING RECEIVABLES	NEW RECEIVABLES	PAYMENTS OF RECEIVABLES	PAYMENTS IN OFFSETS	RECLASSI-FIED AMOUNT	WRITTEN OFF	ENDING RECEIVABLES
OS	$7.86	$4.10	($0.36)	$0.00	$0.00	$0.00	$11.60
HDS	15.00	22.10	(0.28)	0.00	0.00	0.00	36.82
PHS	6.49	1.20	(0.01)	(0.23)	(1.33)	0.00	6.12
FSA	48.69	3.00	(0.01)	0.00	(15.28)	0.00	36.40
HCFA[2]	87.71	125.13	(0.70)	(106.54)	95.26	(5.50)	195.36
SSA	4.68	0.00	(0.37)	(0.46)	(0.56)	0.00	3.29
TOTAL	**$170.43**	**$155.53**	**($1.73)**	**($107.23)**	**$78.09**	**($5.50)**	**$289.59**

1 Amounts shown are not final and may be subject to change.

2 Includes program disallowances recommended by HCFA. FY88 is the first Fiscal Year HCFA is formally identifying program disallowances and reporting them to the Treasury.

creased by $43 million. Also in FY 1987, HCFA, prompted by an OIG recommendation to improve controls over receivables, began recording Medicare Part B premiums deducted from retirement benefit checks by SSA. Such receivables totaled $5 billion in FY 1987. The transfer of fiscal responsibilities for health maintenance organization loans from PHS to HCFA also occurred in FY 1987. As recommended by OMB, HCFA reported as receivables, portions of loans sold to the Federal Financing Bank. These receivables totaled $104 million.

THE FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

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 the Congress on the status of their systems. The Assistant Secretary for Management and Budget manages the Department's FMFIA effort.

The Department continues to make important improvements in its implementation of FMFIA. During FY 1987, the Department performed 2,060 internal control reviews and 7,477 vulnerability or risk assessments of internal control areas. The OIG sampled 687 internal control reviews and found most to be acceptable. The Department had corrected 231 of the 253 material weaknesses identified from 1983 through 1987.

Despite the Department's accomplishments, a fundamental policy issue remains to be addressed; notably, the clarification and establishment of a suitable departmentwide definition of a material internal control weakness. For example, we noted 11 deficiencies identified by either OIG or the General Accounting Office (GAO) that were not to be included in the Department's proposed FMFIA report to the President and the Congress.

A. Material Weaknesses Reported

After discussion, Department and program officials agreed to add the following six deficiencies to the Department's report as material weaknesses.

- Limits on postpayment utilization review screens of claims under the home health program would continually cause the overpayment of millions of dollars for noncovered services if not corrected.

- Virtually no collection effort has been made on loans to about 2,300 individuals to assist them in returning to the United States from a foreign country because of an emergency situation.

- States were erroneously allowed to exceed the legislative limit of 30 days for emergency assistance payments.

- Housing allowances were not terminated for PHS Commissioned Corps members who elected not to reside in available quarters.

- No practical method has been established by SSA for determining whether benefit payments made after death have been recovered and properly restored to the trust funds.

- The GAO reports that SSA has yet to reconcile significant amounts of workers' earnings reported by employers to the Internal Revenue Service (IRS) with earnings reported to SSA. Reconciliation is now taking place.

B. Other Weaknesses Reported

Other weaknesses noted by OIG on which there is a difference of opinion within HHS as to materiality covered such areas as (1) payments made by Medicare carriers for nonphysician services that should have been included in the diagnosis related group (DRG) rate, (2) the failure by Medicare intermediaries to develop disaster recovery and contingency plans to recover files and records in the event they are lost or destroyed, (3) the use of microcomputers, (4) the improper retention and use of unexpended Federal program funds, and (5) cash management problems at educational institutions participating in two PHS loan programs. More detailed discussion of these weaknesses are included in the appropriate chapters of this report. (CIN: A-12-87-03085)

NONFEDERAL AUDITS

Under OMB Circulars A-73, A-87, A-88, A-110, and A-128, OIG has been assigned greater oversight responsibility for audits of Federal program funds at State and local governments, colleges and universities, and nonprofit organizations than any other audit organization in the Federal Government. About 50 percent of Federal funds awarded these entities comes from HHS programs. The OIG's responsibilities include reviewing administrative costs charged to the Federal Government by State and local governments and all federally charged costs at 95 percent of all colleges and universities.

The OIG oversight function involves evaluating the acceptability of grantee and contractor audits performed by certified public accountants and State audit organizations. This role includes detecting substandard audit work, initiating audit resolution procedures on reported recommendations and analyzing reports for indicators of grantee noncompliance with Federal regulations.

Pursuant to Public Law 98-502, the single audit process is being implemented by State and local governments. As a result of OMB's assignment to OIG of oversight responsibility for a majority of these audits, a significant portion of OIG workload has been to assist governments and their auditors with planning and performing these audits. Of the 924 governments OMB assigned to HHS, 880 submitted single audit reports. These audits were generally performed in accordance with Government requirements and applicable audit standards. The OIG is now developing techniques to use single audit reports as an information source for directing its audit effort. The OIG follows up on reported information that is indicative of noncompliance with Federal regulations and recommends refunds to the Government. Issues related to internal service funds and insurance costs have resulted from their reviews.

A. Potential Recoveries

The OIG review of audit reports prepared by public accounting firms and State auditors results in significant financial adjustments. The OIG reviews audit reports prepared by these nonfederal auditors and initiates audit resolution procedures on reported recommendations. For the 5-month period ending February 29, 1988, audit resolution activity was begun on 1,137 such recommendations. If the report recommendations are implemented, related financial adjustments would total about $36 million.

B. Single Audit Report: An Example

In one State, nonfederal auditors performing a single audit (an audit of all Federal funds administered by the State) identified questionable costs totaling $19.8 million relating to HHS programs. Most of the questionable costs pertained to improper payments made under the State's Medicaid and Alcohol, Drug Abuse, and Mental Health block grant programs.

As prescribed by the Single Audit Act, the single audit report included findings and recommendations for correcting weaknesses identified during internal control and compliance reviews. State agencies generally agreed with recommendations made to correct reported weaknesses.

The single audit report did not, however, have recommendations for the State to review costs which were identified as having been questioned by internal auditors of the State agencies and to refund the Federal share. Therefore, OIG added recommendations regarding these questioned costs to ensure that they are included in the audit resolution process. State officials have not commented on these recommendations. (CIN: A-09-87-05428)

C. Internal Service Funds

Continuing to pursue a "lead" identified in a 1984 nonfederal audit report (see page 55 of our April-September 1984 Semiannual Report), OIG has now reviewed internal service funds of 17 State and local governments, finding significant overcharges to Federal programs.

As a result of these audit efforts, OIG recommended that OMB implement Government-wide procedures to facilitate identifying internal service fund profits and obtaining refunds on a nationwide basis. The OMB agreed with these recommendations. The recommendations include (1) advising all Inspectors General to review government financial statements to identify profit accumulations in internal service funds, (2) requiring that agencies responsible for approval of indirect cost plans include internal service funds in their reviews and (3) including review of internal service funds as a part of government single audits.

Internal service funds are used by central service agencies of State and local governments to account for goods and services provided to other agencies within the State and local government. Examples of internal service funds include purchasing departments, motor pools and data processing centers. Internal service funds are intended to operate on a break-even basis through user charges. Charges for goods and services are allocated to programs (both State and Federal) administered by the service agency.

An OIG review in one State found that the State education agency had accumulated an internal service fund surplus of $9.7 million. The surplus resulted because billing rates for goods and services were set higher than actual costs and were not reduced periodically for surpluses. The OIG estimated that about $2.1 million of the surplus resulted from excessive charges to Federal programs. Recommendations called for the State to make a financial adjustment to eliminate the accumulated surplus, and to adjust billing rates at least annually to eliminate surpluses or deficits. Departmental officials concurred with OIG recommendations. (CIN: A-10-87-00006)

D. Self Insurance Funds

A second OIG review in the same State disclosed that an $11 million surplus was transferred from the State's restoration fund to its general fund and other funds. The transfer represented a refund of prior assessments to agencies that contributed to the surplus. The OIG estimated that about $2.7 million of the refund represented charges originally made to Federal programs. However, the Federal programs were not credited with the appropriate share of the refund.

A State Senate bill, which authorized this transfer, precluded participation by federally funded programs. The bill stated that any refund owed the Federal Government would partially offset the Federal obligation to settle the State's claims for expenses incurred during the Civil War. In the past, the State unsuccessfully made repeated attempts to collect this alleged debt of the Federal Government.

Withholding the Federal share of the transfer is a violation of Federal regulations which require that costs charged to Federal programs must be offset by refunds. In addition to a financial adjustment, OIG recommended that future costs charged to Federal programs be offset by refunds. State and departmental officials concurred. (CIN: A-10-87-00005)

E. Information on Grantee Noncompliance

An OIG study of financial statements of 107 State and local governments identified 100 possible instances of grantee noncompliance with Federal cost standards. For example, the Federal Government may have been overcharged $112 million for the cost of funding pension plans at 22 governments. The OIG also identified 15 governments that may have charged Federal programs as much as $185 million for interest related to capital leases. The OIG will supplement its resources with contracted audit services to confirm information developed to date.

F. Quality Control

To ensure that all audits meet generally accepted Government auditing standards, uniform procedures are used to process nonfederal audit reports, perform quality control reviews, and refer substandard audit reports to appropriate State and professional organizations.

The OIG performs desk reviews of all submitted audit reports, as well as working paper reviews of selected audits. Based on the results of these reviews, recommendations are made to Federal users about the reliability of the audit report. In addition, an overall assessment of the quality of the work is made.

During this reporting period, OIG processed 1,284 nonfederal audit reports containing $35.9 million in recommended cost recoveries. The reports also identified many opportunities for improving management operations. The following table summarizes these results.

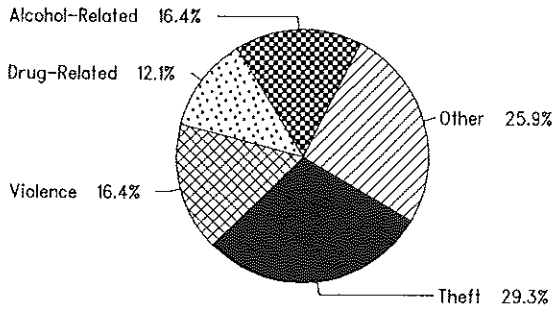
Reports issued without changes or with minor changes	941
Reports issued with major changes	326
Reports with significant inadequacies	17
Total audit reports processed	1,284

Of those reports with significant inadequacies, five were referred to State officials and professional organizations for appropriate action. Several other referrals are pending. In addition, work is continuing with professional auditing associations and State boards of accountancy to improve audit quality.

PERSONNEL SUITABILITY AND SECURITY

In a study entitled "Personnel Suitability and Security," OIG re-screened 41,644 HHS employees and determined that 3 percent of the group screened had arrest records. The study was undertaken to determine the number of HHS employees with criminal records who had access to automated financial systems and whether appropriate personnel suitability and security procedures had been followed for these employees. Earlier studies conducted for the President's Council on Integrity and Efficiency had indicated that almost one-fourth of the employees who stole through Government computer systems had prior criminal records.

OF EMPLOYEES ARRESTED --
Percentage for Each Type of Crime



NOTE: The sum of the totals exceeds 100% because of arrests for multiple crimes.

The OIG screened information on those 41,644 employees who had access to computerized financial or payment systems against Federal Bureau of Investigation files to determine how many had criminal

records. Personnel files of employees with criminal records were reviewed and personnel office staff were interviewed to assess the implementation of personnel suitability and security procedures and controls. A review of personnel files for 131 employees convicted of theft indicated that over 50 percent did not have the required suitability determinations, and that 40 percent gave false statements about their criminal records. The underlying causes were weaknesses in Office of Personnel Management guidance, inadequate implementation within HHS and the lack of accountability and audit trails within the system.

The OIG recommended that the Office of Personnel Management continue efforts to strengthen its personnel suitability and security procedures, and assure accountability for suitability determinations and audit compliance with procedures. The report also recommended that HHS issue new personnel suitability and security procedures which address the vulnerabilities identified. (OAI-02-86-00079)

EMPLOYEE FRAUD

Continuous surveillance over Department programs to insure against employee-related crimes is a significant OIG responsibility. Most of the roughly 123,000 persons employed full time by HHS are dedicated, honest civil servants. Occasionally individuals violate their fiduciary duties. During this reporting period, only 16 employees were disciplined by the Department or the courts, of which the following are examples:

- In Illinois, an employee of the Office of Refugee Resettlement, who was also a licensed attorney, was convicted, placed on 4 years probation and fined for bribing an OIG employee to give her a confidential file. Also convicted and fined was a secretary in that office who helped in the transaction. (Heidekruger + Craig, 5-86-00696-5)

- A financial management specialist employed by FSA was terminated from her job after 25 years of service for falsifying a travel voucher in connection with her relocation from Georgia to Washington, D.C. An investigation showed she also made false claims for her husband and a dependent, who did not accompany her. (Annette Bartlett, W-87-00112)

- A man who had worked at different times as a food handler and a nursing aide for the National Institutes of Health in Maryland was imprisoned for 18 months and ordered to make restitution of $3,000 in unemployment benefits he had received by concealing his work. His crime was uncovered through a match of employees of seven Federal departments against unemployment rolls. (Jerome West, 3-85-40006-8)

COPYING MACHINE: PURCHASE VS. LEASE

The OIG estimated that the Department could save about $5.1 million over a 5-year period by purchasing rather than renting or leasing copying equipment. The Department drafted guidelines in 1983 requiring each organization in the Department to evaluate the costs and benefits of purchasing versus renting or leasing whenever acquiring copying equipment or whenever existing leases and rent agreements are renewed. However, the draft guidelines were not issued in final form.

To determine whether purchasing was the more economical choice, OIG reviewed a random sample of 70 of 431 copying machines rented or leased by the Office of the Secretary, HDS and PHS during FY 1986. Based on the sample, OIG estimated that purchase of the machines would have saved about $5.1 million over a 5-year period.

In order to alleviate the lack of departmentwide criteria and realize the potential savings available through copying machine purchases, OIG recommended a number of adjustments. First, the Department should finalize its guidelines to make their use a requirement. Second, all agencies should be required to purchase existing machines found more economical to purchase. Third, the procurement should be phased in over a reasonable period of time. The Office of Assistant Secretary for Management and Budget concurred and issued a policy memorandum on December 11, 1987 implementing our recommendations. (CIN: A-12-87-03074)

BILLS OF INTEREST TO OIG

Two bills pending in the Congress are very significant to this office. The first, S. 908, the "Inspector General Act Amendments of 1987" (and a similar House bill, H.R. 4054) would repeal the authorizing legislation for the Inspector General at HHS and would transfer this office to the "Inspector General Act of 1978." This transfer (and other technical amendments that have been endorsed by the Administration) would finally ensure that the HHS OIG has identical authorities as other IGs throughout Government. In addition, the bill would impose new and uniform reporting requirements for all OIG semiannual reports. This office has provided a number of suggestions concerning the proper format for these reports.

Senate bill 1975, the "Comprehensive Federal Law Enforcement Improvements Act of 1987," would provide full law enforcement authority (firearms, arrest, search warrants) to OIG investigators, subject to guidelines issued by the Attorney General. More and more often, OIG agents conduct investigations in a dangerous environment. These agents—who are general schedule 1811 criminal investigators trained at the

Federal Law Enforcement Training Center in firearms, self defense, arrest techniques and the law of search and seizure—are hampered in doing their job because they lack full law enforcement authority. It is often difficult to arrange for other agencies to detail their employees to assist in our investigations, and it is inefficient to do so. As a result of these problems, U.S. Attorneys are recommending that our agents obtain temporary authority as deputy U.S. marshals. However, this process takes several months, and is not a satisfactory solution to our growing need for law enforcement authority. Therefore, we strongly support S. 1975. We note that the Administration has not taken a position on the bill at this time, so we speak only for this office.

SOCIAL SECURITY ADMINISTRATION

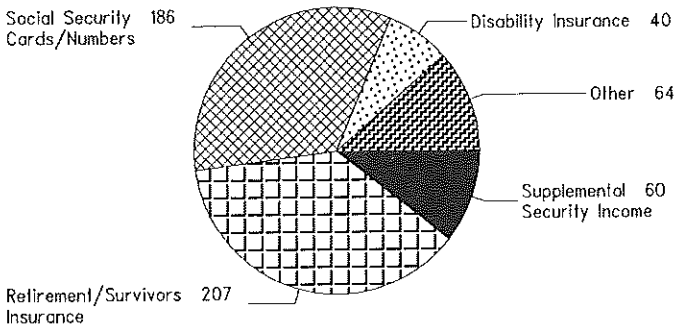
Chapter II

SOCIAL SECURITY ADMINISTRATION

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

A total of $15.5 million in fines, savings, restitutions and settlements resulted from Office of Inspector General (OIG) activities during the first half of Fiscal Year (FY) 1988. In addition, the Social Security trust funds could save billions with implementation of OIG legislative and programmatic recommendations made during the first half of FY 1988. Investigations resulted in a total of 557 convictions during this reporting period.

SOCIAL SECURITY
Successful Judicial Prosecutions



Fifty years ago, the Social Security Act established a national system that would collect a share of workers' earnings and pay them benefits in old age. The national Retirement, Survivors, and Disability Insurance (RSDI) program, popularly called Social Security, is the largest of the Social Security Administration (SSA) programs. In FY 1988, SSA will pay RSDI benefits estimated at $214.5 billion. The program is financed through payroll taxes paid by employees, their employers and the self-employed. Benefits are paid for retired, disabled workers, spouses, certain divorced spouses, children and disabled children of retired and disabled workers; and to widows and widowers, certain surviving divorced spouses, children, and dependent parents of deceased-worker beneficiaries.

In 1974, the Supplemental Security Income (SSI) program consolidated under Federal administration various earlier State-run programs assist-

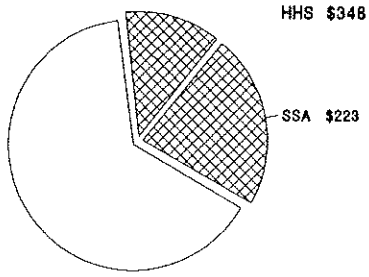
ing the blind, disabled and elderly. The program, financed by general revenues, provides monthly payments to persons age 65 or older who meet a means test and to disabled and blind persons of any age who meet tests of both disability and means. In FY 1988, SSA will pay SSI benefits totaling $11.2 billion. In addition, program expenditures under the Black Lung program will approach $1.6 billion. These monies are expended to pay compensation, medical and survivor benefits to eligible miners and their survivors, where mine employment terminated prior to 1970 or where no mine operator can be assigned liability.

AUDIT OF SSA'S FINANCIAL STATEMENTS

The OIG, aware of the public's concern with the solvency of the RSDI trust funds, audited SSA's FY 1987 financial statements, the first year SSA prepared financial statements. Because auditable statements had not been previously prepared, our opinion was limited to SSA's Statement of Financial Position at September 30, 1987.

The enormity of the audit is better understood when compared to the total budgeted outlays of the Department and all of the Federal Government. The SSA's FY 1987 total expenses of $223.3 billion represents 64.6 percent of total budgeted outlays for HHS and 22.5 percent of the total for the Federal Government.

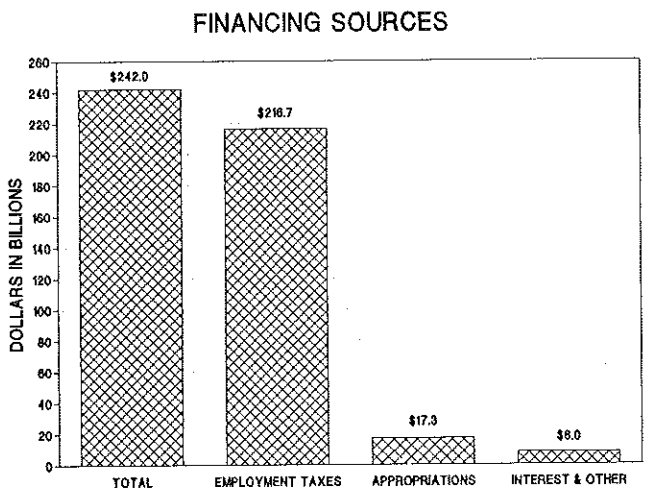
COMPARATIVE BUDGET OUTLAYS
1987 est. in Billions

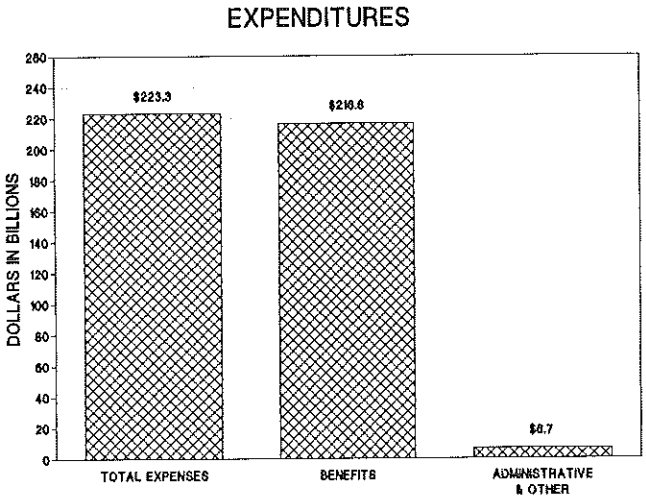


FEDERAL GOVERNMENT
$994 Billion

The Statement of Financial Position at September 30, 1987, included assets totaling $69.2 billion of which the majority were investments in special issue U.S. Treasury securities held by Treasury on behalf of the trust funds. The Statement of Financing Sources and Expenses included total sources of $242 billion and expenses of $223 billion as shown in the

charts below. This resulted in an excess of financing over expenses of about $19 billion for 1987.





In our opinion, SSA's Statement of Financial Position presents accurately the financial position of SSA at September 30, 1987, in conformity with generally accepted accounting principles for Federal agencies. However, there were exceptions resulting from two departures from prescribed accounting procedures. First, no provision for loss contingencies was recorded for pending legal actions, brought by individual claimants or on a class action basis, where it was probable that a loss or expense would be realized and the amounts could be reasonably estimated. Second, the aggregate net book value of land, buildings, and equipment could not be determined because documents of original cost were not readily obtainable and SSA's capitalizing policy for equipment was not always followed.

In accordance with the General Accounting Office's (GAO) Title 2, the financial statements did not include the future liability of the trust funds. However, the supplemental information did include an actuarial projection of the contributions and expenditures for the RSDI and Black Lung programs for the next 75 years. Our audit procedures included having an independent actuary determine that these projections were based on methods and techniques that are generally accepted for use in the annual valuation of SSA's programs. The projections show sufficient trust fund balances to make benefit payments until about the year 2055 for the Retirement and Survivors Insurance trust fund and between the years 2020 and 2025 for the Disability Insurance trust fund. The financial statements with the opinion letter from the Inspector General were included in SSA's Annual Report to the Congress, issued March 1, 1988. (CIN: A-13-87-00035)

LOOPHOLES IN FICA CONTRIBUTION PLANS

The loss of $21.8 billion to the RSDI and Medicare Hospital Insurance trust funds, and $46.9 billion to the U.S. Treasury, over the next 5 years would be prevented if the value of fringe benefits received under salary reduction agreements (cafeteria plans) were taxed for Federal Insurance Contributions Act (FICA) and income tax purposes. This action would also prevent the reduction of future social security benefits to young or low-paid workers and their survivors in the event of disability or premature death.

As of January 1, 1979, cafeteria plans authorized under Section 125 of the Internal Revenue Code, allow salary reduction agreements between an employer and an employee. Compensation can be taken in the form of fringe benefits or set-asides which reduce an employee's salary, thereby reducing the base for computing FICA and income taxes. Fringe benefits may include, for example, health plans, dependent care assistance programs and term life insurance plans while set-asides consist of placing employees' pretax salaries in accounts from which medical, child care and legal expenses for the year will be paid. The popularity of cafeteria plans has led to a 65 percent growth rate in the number of employers offering them between 1984 and 1985.

The OIG determined that cafeteria plans could adversely affect the Social Security benefits of young or low-paid workers and their families in the event of disability or premature death. Despite the decrease in Medicare revenue, the Hospital Insurance trust fund will not experience any decrease in its protection liability. The OIG recommended that SSA and the Health Care Financing Administration (HCFA) seek legislation requiring that salary reduction agreements be included in the definition of wages for FICA purposes. The SSA has decided not to pursue the OIG proposal, believing that the Congress is not amenable to legislative change at this time. The HCFA will give the proposal further consideration should the Administration decide to examine ways to expand the wage base. (CIN: A-05-86-62602)

DATA OPERATIONS CENTERS

Transferring SSA's three data operations centers (DOCs) to the Internal Revenue Service (IRS) would help SSA and IRS to run more efficient operations and the jobs of DOC employees would be protected because IRS has an increasing need for data processing resources. Workloads at the DOCs have been greatly reduced, from 77.3 percent of the annual wage report (AWR) workload in 1978 to 42 percent of the workload in 1987, with a resulting excess resource capacity of 28 percent. In addition, 60 percent of the AWR work at the DOCs is done to

meet the needs of IRS. Transferring the three DOCs would help alleviate the problem of excess resources and allow IRS to perform a timely reconciliation and followup of paper earnings reports submitted annually to SSA which are not in agreement with earnings data submitted quarterly to IRS.

The DOCs were established to convert wage data, reported by employers on paper forms, to electronic media. The wage data is then transmitted to SSA's computer center for posting to employees' accounts (this is referred to as the AWR process). Over recent years, however, employers have been transmitting wage data via electronic media directly to SSA's computer center, bypassing the DOCs. As a result, DOCs currently have an estimated 28 percent excess resource capacity.

The OIG recommended that SSA consider four options to more efficiently use the DOC resources, but believes transferring the DOCs to IRS has the most merit because implementation would result in more efficient SSA and IRS operations and protection of the jobs of DOC employees. Sixty percent of the data conversion work at the DOCs is done to meet the needs of IRS. Our report is with SSA for consideration. (CIN: A-09-87-00076)

REDUCING RSDI OVERPAYMENTS

Net savings to the Retirement and Survivors Insurance trust fund and the Disability Insurance trust fund in the form of program outlays interest and administrative costs of about $48.5 million would accrue over a 5-year period from requiring responses to SSA's direct mail follow-up (DMF) initiative. Under the DMF, selected beneficiaries are requested to submit current earnings estimates. Requiring responses to the DMF could more than double the beneficiary response rate (from 33 to 75 percent) and avoid an additional $90 million in overpayments annually. Although the DMF targets beneficiaries with the greatest likelihood of having their benefits affected by employment earnings, it does not require a response from beneficiaries. In 1984, DMF's initial year, only one-third of the 850,000 beneficiaries that should have responded to the DMF, actually did.

The Social Security Act requires beneficiaries to estimate current year employment income if it is expected to exceed the exempt amount ($6,120 for beneficiaries under 65 years old and $8,400 for beneficiaries between 65 and 70 years old). The SSA uses the estimated earnings amount to prevent overpayments by adjusting the amount of current benefits. One dollar is deducted from benefits for each $2 earned above

the exempt amount. The GAO reported in 1985, however, that beneficiary failure to accurately estimate their earnings was the largest single cause of RSDI overpayments.

The OIG recommended mandatory DMF responses and reduction or suspension of beneficiary payments for failure to respond to the DMF. The SSA agreed with the recommendations. Changes were made in the 1987 DMF initiative and the unenacted legislative proposal remains pending before the current Congress. (CIN: A-03-86-62606)

FALSE IDENTIFICATION AND SOCIAL SECURITY NUMBERS

Use of false identification is a multi-billion dollar problem affecting both Government and business. Congressional estimates place the cost to the American public and business of crimes involving false identification at $24 billion annually. Along with birth certificates and drivers' licenses, the Social Security number (SSN) or card is a foundation document in creating false identification.

A. Undocumented Alien-Related Fraud

The sale of SSNs to illegal aliens, a thriving business, is illustrated in the following examples:

- In Illinois, two men were given jail sentences, put on probation, fined and assigned community service for selling or attempting to sell counterfeit Social Security cards and alien registration cards. While agents were searching one individual's residence, the other suspect arrived to deliver laminating materials needed to produce the cards. A search of the second man's residence turned up more counterfeit documents, for a total of more than 200 Social Security cards and 60 alien registration cards. (Castellanos, 5-86-00622-6, and Cardena-Torres, 5-86-00930-6)
- Three men who worked at meat packing plants in Iowa were sentenced to 6 weeks in jail and deportation from the United States. One had used a fake birth certificate and an SSN which had not yet been issued, and the other two had used counterfeit Social Security cards. (Martin, 8-87-00431-6, Pulido 8-87-00432-6, and Espinoza, 8-87-30456-6)
- A former claims clerk in the New York Social Security office was sentenced to 2 years probation and 100 hours of community service for forging service representatives' names on applications for SSN and accepting bribes for Social Security card applications for illegal aliens. An illegal alien and a travel agent whom he used as "middlemen" have been convicted. (Colon, 2-84-00038-6)

B. Bank Fraud Using SSNs

The use of fraudulent SSNs has a significant impact on the entire credit system of the United States. Because of its responsibilities for assuring

the integrity of the SSN system, OIG frequently assists the Federal Bureau of Investigation, Secret Service and other Federal law enforcement agencies in myriad investigations. The following cases are examples of investigations in which OIG was involved:

- A former loan officer with an Illinois bank was sentenced to over a year in the Federal penitentiary, 5 years probation and restitution of $6,100 for using a false SSN to embezzle money from his bank. He had approved loans to a fictitious person and pocketed the money and had also kept for his personal use loan payments made by customers to their accounts. (Werle, 5-87-00453-6)

- Two men who used numerous aliases, false SSNs and fictitious businesses to open checking accounts in Missouri and Wisconsin were sentenced to 1 year and 5 years in prison and ordered to pay restitutions totaling $11,580. They had used the accounts to negotiate fictitious payroll checks. (Hendrix and Norris, 5-87-00719-6)

- A Texas man was sentenced to two concurrent 5-year jail sentences after conviction for theft. He had used other people's names and SSNs to apply for credit cards and lease vehicles, and then made no payments on the cards or vehicles. (Williams, 6-87-00125-6)

BROKEN MEDICAL APPOINTMENTS

Discontinuing payments for consultative examination appointments broken by claimants of disability insurance and SSI benefits would save SSA about $1.5 million annually. A State's disability determination service is 100 percent federally reimbursed for the costs of obtaining medical evidence and consultative examinations associated with initial disability determinations that supplement evidence obtained from claimants' physicians or other treating sources. Current regulations allow States to establish fees for consultative examinations arranged by the disability determination service to determine initial disability under the RSDI and SSI programs. For those States that so choose, at least partial payment is made for a consultative examination when a disability claimant fails to keep a scheduled appointment.

The OIG found that about $1.5 million is provided for broken consultative examination appointments in 28 States nationwide because these States allow at least partial payment for a consultative examination when a disability claimant fails to keep a scheduled appointment. These States pay an estimated $60 million annually for consultative examinations. Current policy in the remaining 22 States does not provide for payment of broken consultative examination appointments.

The OIG recommended that SSA establish a nonpayment policy with regard to medical appointments not kept by claimants. The SSA concurred with our recommendation and stated that a regulatory change which would preclude payment for broken consultative examination appointments is being developed and will be published shortly. (CIN: A-01-87-02004)

DECEASED BENEFICIARY FRAUD

Conversion of benefits which continue to be sent to deceased persons, either because the person's death goes unreported to SSA or because relatives or friends deliberately conceal it from SSA, constitutes fraud against the SSA programs. The following are examples of some of these cases:

- As the result of follow-up investigations on matching SSA beneficiary rolls against Florida vital statistics records, 14 persons were given a 1-year suspended prison sentence and placed on 5 years probation. Total restitutions ordered amounted to almost $230,000.

- Several family members were involved in negotiating SSA checks sent to a man in Oklahoma after he was deceased. During this reporting period, his son was sentenced to 5 years imprisonment (suspended), 5 years probation, $500 in fines and $219 in restitution. His wife was sentenced in a prior reporting period, and a sister is under indictment as a fugitive. The fraud was uncovered when the U.S. Postal Service informed SSA that the man had died but checks were continuing to arrive at a post office box. (Lacey, 6-87-00103-6)

- A legally blind Wisconsin man with three convictions for narcotics trafficking was sentenced to 6 months in prison and 2 years probation for defrauding SSA of more than $15,700 by negotiating disability checks sent to his deceased mother. He was also ordered to liquidate stock to repay a balance of almost $10,000 within a 10-day period, and to enter an alcohol and drug rehabilitation program. (McIntosh, 5-85-00763)

RECOVERY OF SSI OVERPAYMENTS

A series of three studies was conducted by OIG to determine actions that could be taken to reduce the amount of debt owed by former SSI recipients which was currently being written off as uncollectible. From 1979 to 1982, more than $613 million in SSI overpayments was written off as uncollectible or as delinquent. Of this amount, $278 million pertains to instances in which a decision was made to collect the overpayment by adjustments against current SSI payments but those payments terminated before the debt could be fully collected.

A. Cross Program Adjustments

In the first study, OIG recommended that SSA more aggressively pursue voluntary cross program adjustments as a means of collecting the outstanding debts owed by former SSI recipients who are current RSDI beneficiaries. In addition, SSA should resubmit a legislative proposal authorizing the adjustment of RSDI payments to recover overpayments from former SSI recipients. The study revealed that nearly half of the outstanding debts are owed by former SSI recipients who are currently receiving RSDI payments. As a result of civil suits, the emphasis in SSA's operating guidelines is on the voluntary nature of cross program adjustments. The amount of debts recovered through cross program adjustment has decreased by nearly 50 percent since FY 1983 even though the ending balance of outstanding debt has increased.

Cross program adjustment is potentially a very effective means of reducing the large amount of debt that is currently being written off as uncollectible. The SSA's 1983 "SSI Non-Pay Overpayment" study indicated that recontact with these individuals to remind them of their debt and encourage repayment will produce recoveries of $7.3 million. Achieving an appropriate balance between SSA's collection of a debt and its obligation to protect the rights of program participants was the focus of this report. (OAI-12-87-00029)

B. Backlogged Debt

The second study found that SSA would recover approximately $4.70 for every dollar invested in the collection of the past due debts. The OIG determined that an earlier SSA analysis of the collectibility of $278 million in backlogged debts had seriously underestimated the potential recoveries that would result from active pursuit of these debts.

Releasing all but deceased debtors accounts to SSA field offices for routine collection efforts would produce recoveries of $35.6 million. These recoveries would be partially offset by the costs of collection which are estimated at $7.6 million, based on processing time calculations in SSA's 1983 "SSI Non-Pay Overpayment" study, leaving a net recovery of $27.9 million.

As an alternative to the blanket write-off of these debts, OIG proposed that SSA initiate routine recovery efforts for all except the known deceased debtors in this backlogged debt population. The SSA did not agree to begin full collection efforts. Instead, SSA plans to conduct a study of a second sample of the backlogged debt cases to obtain more current data on the cost-effectiveness of this collection effort. (OAI-12-87-00030)

C. Income Tax Refund Offset

In the final report in the series, OIG, with the assistance of the Internal Revenue Service, compared a random sample of overpayment records to tax return information for tax years 1983 and 1984. This comparison revealed that it would not be cost-effective to include elderly (over 65) individuals in a tax refund offset effort because of their markedly lower incidence of reported earnings and tax refunds. However, nearly 28 percent of the nonaged (under 65), former SSI recipients with actionable debts reported taxable income for the years 1983 and 1984. Income tax refunds were made to 32.5 percent of the nonaged SSI debtors. If they had been withheld, these refunds would have reduced the outstanding debt for all sample cases, excluding aged individuals, by 16.8 percent.

As an alternative to writing off these overpayments as bad debts and as a means of recovery, OIG recommended that SSA begin negotiations with the IRS for income tax refund offsets to recover outstanding debts owed by former SSI recipients who are under age 65. (OAI-12-86-00065)

REGIONAL ASSESSMENT FUNCTION

The regional quality assessment functions for the RSDI and SSI disability programs would be more effective if transferred to SSA's central office in Baltimore, Maryland. There is a clear lack of organizational independence when regional commissioners' offices provide technical and management assistance to States while at the same time assessing the quality of the States' disability determination functions.

To evaluate the performance of a State's disability determination function, SSA (through its regional commissioners) periodically reviews a random sample of cases processed by the State and determines a performance accuracy rating. The State's performance is measured against national performance standards. As warranted, technical and management assistance is provided to States that fail to meet national standards.

The OIG initiated a review when it was alerted to an allegation that a State was substituting errorless cases in the random sample reviewed by the SSA regional commissioner. The State Auditor General pointed out that the SSA review was ineffective because the regional office concluded that sampling procedures were accurate, without investigating indications of improprieties in sampling procedures.

The OIG recommended the transfer of the function to SSA's central office to ensure a higher degree of independence. The SSA agreed and the transfer took place in July 1987. (OIG memorandum to SSA dated April 27, 1987)

SURVIVOR BENEFITS AND REPRESENTATIVE PAYEE FRAUD

By falsifying or concealing events and relationships, some individuals hope to capitalize on benefits intended for minors or incapacitated persons. The following cases are examples of successful actions resulting from OIG investigations of these individuals:

- In Texas, a man was sentenced to 2 years in prison and ordered to make restitution of $5,475 he had illegally obtained in survivor's benefits for himself on behalf of his son. It was discovered that he had relinquished custody of his son but still obtained benefits when the son's actual custodian applied to become representative payee. (Ruiz, 6-85-00652-6)
- A Chicago woman was sentenced to 5 years probation and ordered to make restitution of $20,490 for her scheme to receive Social Security benefits on the accounts of two deceased spouses. She had initiated the scheme, which involved the use of a false SSN, almost 20 years ago. (Stewart, 5-87-00375-6)
- A former clerk for an Ohio children's service agency was sentenced to a year in jail for stealing benefit checks from the accounts of children under the custody of the agency. The checks were later cashed at a drugstore where she also worked as a cashier/clerk. She made restitution of $8,670. (Allen, 5-87-00144-6)

DISABILITY BENEFITS FRAUD

By concealing work activities and other information from SSA, certain individuals fraudulently obtain Social Security benefits. The following are examples of successful judicial prosecutions of cases involving disability benefits fraud:

- A 39-year-old man was put on probation and had to repay more than $20,000 in illegal disability benefits in a case which spanned the Nation. In 1981, a New York City SSA office received an anonymous complaint that the man had excess resources. Thereafter, he moved to Florida, Texas and, finally, California, acquiring along the way $23,900 in accident insurance settlements, a 31-foot sailboat and income from various jobs under different names and SSNs. Charges resulting from an OIG investigation were first lodged against him in Texas, but he was finally prosecuted in California where he now resides. (Carroll, 6-86-00118-6)
- A Louisiana woman was given a suspended sentence and probation, and ordered to pay restitution and fines of almost $27,000, for claiming she was divorced in order to receive disability payments. She and

her spouse were not divorced and they lived in the same house. The spouse was employed and received wages which made her ineligible for benefits. (6-86-00555-6, Middlebrooks)

EVALUATION OF DISABILITY DETERMINATIONS

The SSA has in place a procedure for measuring the cost of operating each of the 52 unique and distinct State disability determination service (DDS) agencies, and for developing a means to determine the ongoing relative cost-effectiveness of each one. The procedure is called the Cost Effectiveness Measurement System (CEMS). The CEMS defines standards which promote a cost-effective, efficient disability determination process. Resulting measurements permit DDS agencies to identify areas for corrective action by comparing the costs of major activities that are common to each DDS, weighing these costs against administrative performance, and identifying economical and uneconomical practices.

Beginning in 1987, and extending over 3 years, a contractor for SSA has been making compliance reviews of the CEMS at State agencies. All 52 DDSs will be reviewed. The OIG has agreed to assist SSA in the implementation and management of the CEMS compliance reviews by serving as the Federal project officer for all compliance review contract activities. Since OIG is responsible for all audit functions within the Department and similarities exist between compliance reviews and audits, our monitoring of the conduct and performance of the CEMS compliance review contractor is critical.

The contractor is on schedule and should complete 12 compliance reviews within the first year of the contract. The objectives of these reviews are, through on-site visits, to (1) assess State capabilities to accurately and consistently collect and report CEMS data in compliance with established procedures through examination of annual DDS CEMS reports, and (2) provide recommendations for improvement in both financial management controls and the collection of CEMS data. (CIN: A-13-88-00009)

INTERNAL CONTROL WEAKNESS

The following internal control weakness was identified by OIG. For further discussion of weaknesses see page 6.

- The SSA should establish controls to limit vulnerabilities to improper use of sensitive data downloaded from mainframe computers to microcomputers. Controls are needed to determine the specific data being downloaded, by whom and for what reason in order to ensure that diskettes containing sensitive information are only used for legitimate purposes. Controls are also needed to protect SSA's micro-

computers, peripheral equipment, and software from damage, theft, environmental hazards and unauthorized use.

HEALTH CARE FINANCING ADMINISTRATION

Chapter III

HEALTH CARE FINANCING ADMINISTRATION

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

This report documents over $2.7 billion in savings to the Medicare and Medicaid programs resulting from actions taken on Office of Inspector General (OIG) recommendations. During this period, OIG identified program areas where legislative action, more efficient management and tightened internal and fiscal controls could result in additional future savings of over $4 billion. An additional $150 million in program expenditures were questioned as to their allowability under law, regulations or cost principles. In these instances, recommendations for financial adjustments and appropriate procedural changes were made.

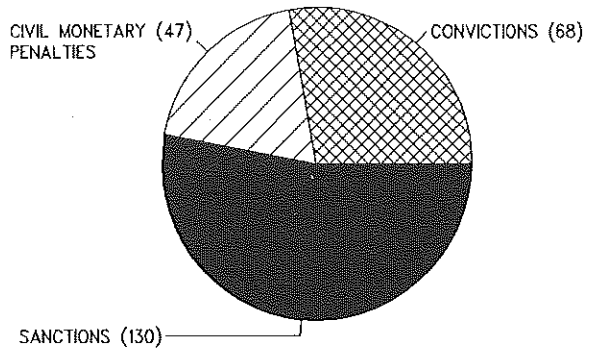
In Fiscal Year (FY) 1987, the Medicare and Medicaid programs, administered by the Health Care Financing Administration (HCFA), provided health care coverage for more than 51 million of the Nation's elderly, poor and disabled. Medicare Hospital Insurance (Part A) provides, through direct payments for specified use, hospital insurance protection for covered services to persons 65 or older and to certain disabled persons. Medicare Part A is financed by the Federal Hospital Insurance trust fund. Total Federal Medicare payments for FY 1988 are estimated at $87.7 billion.

Medicare Supplementary Medical Insurance (Part B) provides, through direct payments for specified use, insurance protection against most of the costs of health care to persons 65 and older and certain disabled persons who elect this coverage. The services covered are medically necessary physicians' services, outpatient hospital services, outpatient physical therapy, speech pathology services, and certain other medical and health services. Medicare Part B is financed by participants and general revenues.

The Federal Medicaid program will provide $30.7 billion in grants to States for medical care to nearly 25 million low-income people in FY 1988. Federal matching rates are determined on the basis of a formula which measures relative per capita income in each State. Eligibility for the Medicaid program is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). States may also cover certain individuals who are not eligible for SSI or AFDC.

Fraud and abuse of Medicare and Medicaid or their beneficiaries and programs may result in criminal, civil, and/or administrative actions against the perpetrators. During this period, OIG was responsible for a total of 245 successful actions against wrongdoers which resulted in $27.2 million in fines, savings, restitutions and settlements.

JUDICIAL & ADMINISTRATIVE ACTIONS



In addition, the State Medicaid Fraud Control Units, for which OIG has oversight responsibility, reported 196 successful actions for the period. Total OIG and State Medicaid Fraud Control Unit monetary returns in fines, penalties, restitutions, recoveries and savings amounted to over $33 million.

HOSPITAL PATIENT DUMPING

The Department is responsible for the enforcement of several Federal laws that pertain to patient transfers. The Office for Civil Rights has responsibility for a portion of the Hill-Burton Act, initially adopted in 1946 and later amended, which provides funding for the construction of hospitals and other health facilities. The legislation imposed on the recipient facilities specific obligations to provide services to people who were unable to pay or were otherwise denied access to health facilities. Regulations issued in 1979 require hospitals that receive Hill-Burton funds to provide emergency services to all service area residents, regardless of ability to pay, and to discharge or transfer an emergency patient only after making a determination that doing so would not result in a substantial risk to the patient. This requirement is perpetual.

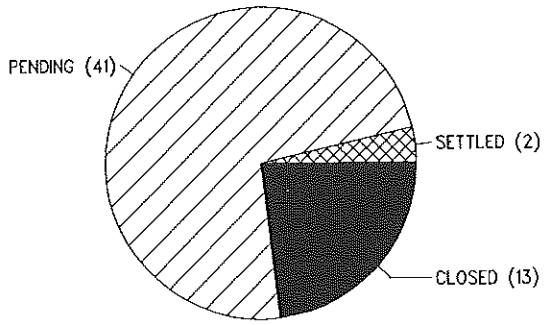
Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in any facility that receives Federal

funds. Section 504 of the Rehabilitation Act of 1973 forbids discrimination in federally funded facilities against persons based on their handicap. These laws are also enforced in the Department by the Office for Civil Rights and apply to all hospitals that are certified to participate in the Medicare program, which includes virtually all hospitals.

In April 1986, the Congress enacted the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). An amendment to COBRA, that took effect on August 1, 1986, established criteria for the safe transfer between hospitals of critically ill or injured patients, and women in active labor. Hospitals which fail to comply with these provisions are subject to termination or suspension and a civil monetary penalty of up to $25,000 for each violation (subsequently modified in December 1987 to $50,000 per violation).

The HCFA has responsibilities for enforcing the anti-dumping provisions of the Medicare conditions of participation. For the period ending March 31, 1988, HCFA had sent notices of proposed termination to 40 hospitals. Hospitals have 30 to 90 days to comply with the Medicare conditions of participation or be terminated. If there is evidence of a pattern of "dumping" patients, HCFA refers the case to OIG for further investigation and possible imposition of administrative sanctions or civil penalties. During this period, 56 referrals for further investigations involving potential sanctioning were initiated and civil monetary penalties in excess of $110,000 were collected.

STATUS OF 56 HCFA REFERRALS



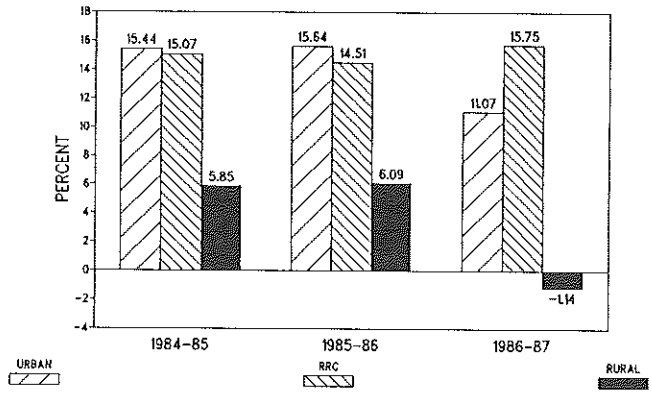
- In a case referred to OIG by HCFA, a settlement agreement was reached with a hospital where five instances had been identified in which patients in active labor or with emergency medical conditions had been inappropriately transferred.

- Another case was settled with a small rural hospital which had inappropriately transferred to another hospital a woman who was in active labor and bleeding. The incident occurred because the physician, who was not present but approved the transfer, was given inadequate information by the hospital staff.

PPS HOSPITAL PROFITS

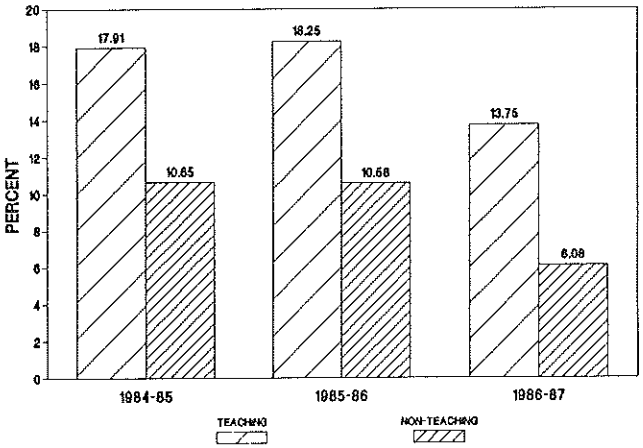
From 1965 (when the Medicare program was enacted) until October 1, 1983, participating hospitals made no profit through the provision of medical services to Medicare beneficiaries. However, with the advent of the Medicare prospective payment system (PPS), participating hospitals had an incentive to keep their costs below predetermined PPS rates and thus earn a profit.

PPS PROFIT MARGINS
BY HOSPITAL LOCATION



Our analysis indicated that in the first year under PPS, hospitals earned estimated Medicare profits of $4.6 billion. In the second, they earned $4.9 billion. And in the third year, they earned $3.8 billion. While the third year aggregate profit amount is reduced from the levels in prior years, the $3.8 billion profit total represents the significant additional reimbursement received by hospitals in 1986 over the amount they would have received had they continued to be reimbursed on the pre-PPS basis of their reasonable costs of providing services to Medicare beneficiaries. A sampling of hospitals showed that the average PPS profit margin was 9.92 percent in 1986, compared to 14.40 percent in 1985 and 14.19 percent in 1984. Rural hospitals had a negative profit rate of 1.14 percent in the third PPS year.

PPS PROFIT MARGINS
BY TYPE OF HOSPITAL



The lower 1986 average profit margin resulted principally from average Medicare costs per discharge increasing at about a 7.6 percent rate over 1985 versus a 2.2 percent annual increase in PPS revenue per discharge. Other factors, such as increases in length of stay and increases in the number of employees, also contributed to the decrease in profit margins. The small increase in revenues per discharge in the third year reflected actions taken by the Congress in response to the high profits earned in the first and second years of PPS coupled with the excessive profits realized by proprietary hospitals and teaching hospitals. These hospitals received additional reimbursement for indirect medical education costs and return on equity capital. (CIN: A-07-88-00101)

END STAGE RENAL DISEASE

The OIG estimated that the Medicare program could save about $3 billion over a 5-year period, if the Medicare secondary payer (MSP) provision was extended to the period of time that end stage renal disease (ESRD) beneficiaries have employer group coverage available. The OIG recommended that a legislative change be proposed to make the MSP provision for ESRD beneficiaries consistent with legislation passed by the Congress for working aged and disabled beneficiaries. Currently, if an ESRD beneficiary has coverage under an employer group health plan (EGHP), that plan is liable for the first 12 months of health benefits. Thereafter, Medicare becomes the primary payer. Extensive research into the history of the MSP provision provided no rationale for the 12-month period, other than to meet a limited cost savings goal.

The HCFA did not concur because of a concern that an indefinite secondary payer provision might encourage insurers to eliminate uneconomical services. Therefore, HCFA favors making Medicare indefinitely secondary for all ESRD services other than facility-dialysis and transplantation services, the most costly. The OIG disagrees. The Internal Revenue Code provides for disallowance of expenses incurred for EGHPs that discriminate against ESRD beneficiaries. Also, to provide an additional safeguard, the OIG recommended that HCFA propose legislation similar to recent disability provisions that provide for double recovery from EGHPs and other sanctions against employers with non-conforming plans. (CIN: A-10-86-62016)

HOME HEALTH

Medicare can pay for part-time skilled health care in beneficiary's home for the treatment of an illness or injury furnished by a participating home health agency. A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy in the home.

Medicare can pay for home health visits if the following four conditions are met: (1) the care includes intermittent part-time skilled nursing care, physical therapy or speech therapy, (2) the patient is confined to the home, (3) a physician determines the need for home health care and sets up a home health plan and (4) the home health agency providing services is participating in Medicare.

A. Home Health Aides

The OIG recommended that HCFA require State survey agencies to take a series of actions to insure that all necessary tasks are performed by home health aides. In a study of home health services, OIG analyzed the type and number of services provided to Medicare beneficiaries by home health aides. The study also determined from States the training and supervision they require aides to have in order to provide the necessary services. The study found that home health aides performed only half of the tasks necessary to support skilled medical services, and that substantial deficiencies exist in the orientation of aides to patient needs. The study determined that poor supervision was the primary reason for aides' failure to provide necessary care.

To correct the deficiencies in orientation of aides to the needs of the patients, OIG recommended that HCFA encourage States, without specific regulations on the training of home health aides, to create such a program. The HCFA agreed with the recommendation and is revising the Medicare conditions of participation to include a home health aide training requirement. To ensure that aides receive adequate supervi-

sion, OIG recommended that HCFA strengthen its instructions to require home health agencies to perform all tasks ordered under the plan of care. This recommendation is still under consideration by HCFA. (OAI-02-86-00010)

B. Home Health Fraud

Examples of successful judicial, civil and administrative actions involving home health aides follow:

- A commissioned officer with the Public Health Service was disciplined for conflict of interest activities in New Jersey. Employed by HCFA to inspect nursing homes, extended care facilities, hospitals and home health agencies to determine whether they met nursing requirements for Medicare and Medicaid certification, he also operated, with his wife, a nursing placement service for these facilities. Investigation showed that he sometimes placed nurses in facilities he had recently surveyed. (Lippert, 2-86-00561-9)

- In Missouri, the corporate secretary and the director of clinical services for a home health agency were given probationary terms for submitting false Medicare claims. They had been charged with making claims for visits never made, changing claim forms to make patients appear to be eligible for Medicare benefits when they were not and forging the names of physicians on patient service orders. Because their scheme was discovered soon after it was put into operation and the carrier withheld payments from the agency, no Medicare money was lost. (Freeman and Wilson, 8-86-00688-9)

MEDICARE AS SECONDARY PAYMENT SOURCE

When enacted in 1965, Medicare was made the first or primary payer for beneficiaries' medical claims, except for services covered by workers' compensation or provided by a Federal hospital. Several times in the early 1980s, the Congress amended the Medicare provisions, making Medicare the secondary payer when beneficiaries were covered by employer-sponsored group health insurance. The OIG conducted the following studies related to the secondary payer provision.

A. Automobile Accident Related Claims

A study of Medicare beneficiaries who were injured in automobile accidents during 1985 identified an overpayment of $30,941 for services reimbursed by Medicare contractors where an automobile insurance company should have been primary payer. The objective of the study was to determine if the Medicare program is reimbursing for medical services which should be covered under automobile, medical, no-fault, or liability insurance.

In 82 percent of targeted claims, Medicare should have been the secondary payer. The OIG estimated that implementation of its recommendations would save over $15 million and HCFA agreed with these recommendations. The OIG recommended that, where possible, HCFA should establish agreements with State automobile accident report depositories to furnish Medicare contractors with information concerning accidents involving Medicare beneficiaries. Second, HCFA should emphasize to Medicare intermediaries and carriers the importance of sharing Medicare secondary payer information among themselves to eliminate overpayments for automobile accident related claims. Third, HCFA should work with Medicare contractors to ensure that claims processing systems are adequately identifying and processing automobile accident related claims. (OAI-07-86-00017)

B. End Stage Renal Disease

A study of beneficiary claims for services in sampled ESRD facilities identified overpayments totaling over $926,000 for services reimbursed by Medicare contractors where an EGHP should have been primary payer. Projecting this figure to all ESRD claims, HCFA could realize savings in excess of $19.5 million.

The OIG recommended that HCFA emphasize scrutiny of all EGHP coverage factors, ensure that Medicare contractors have established mechanisms to share EGHP information, and create an expanded capability to detect those beneficiaries who would be covered by an EGHP. The HCFA should also advise contractors to ensure accurate cross-referencing of those accounts where an ESRD beneficiary is originally entitled as "ESRD currently insured" but is subsequently issued a fully insured health insurance claim number or entitlement to SSA disability. (OAI-07-86-00092)

C. Employer Group Health Plans

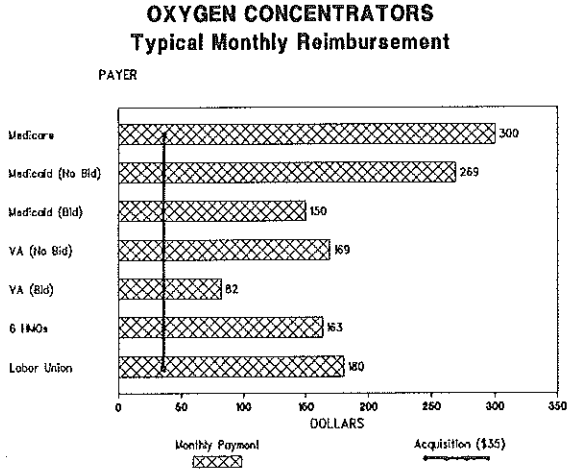
The last in the series of MSP studies found that providers and Medicare contractors had not identified EGHP as the primary payer in more than 3 percent of the sampled hospital discharges. The report identified overpayments in excess of $979,000 and savings of over $222.8 million. The OIG recommended that HCFA direct Medicare contractors to recover overpayments and improve detection of beneficiaries covered by a spouse's EGHP. Furthermore, the report recommended a legislative change to apply Medicare secondary payer provisions to employers with fewer than 20 employees. If enacted, this legislative change is projected to save $478.3 million over a 5-year period. The HCFA agreed with most of the recommendations and is taking steps to recoup the overpayments. (OAI-07-86-00091)

DURABLE MEDICAL EQUIPMENT ISSUES

Medicare will frequently pay for durable medical equipment (DME) such as oxygen equipment, wheelchairs, home dialysis systems, seat-lift chairs, and other medically necessary equipment that physicians prescribe for home use. Medicare will also help pay the approved rental charges if the equipment is rented.

A. At-Home Oxygen Care

An OIG study of at-home oxygen care found that non-Medicare providers have developed reimbursement methods for at-home oxygen which result in monthly rental payments as much as 75 percent lower than Medicare payments for the same services. Also, the current physician certification for medical necessity of at-home oxygen care is not adequate to ensure payment for only those beneficiaries who need oxygen care.



The HCFA agreed with OIG recommendations to develop a strategy to assure that the Medicare carriers implement the existing guidelines in determining inherent reasonableness of oxygen charges. The HCFA has also agreed to add a physician attestation statement to the medical necessity certification form. (OAI-04-87-00017)

B. DME Fraud

Examples of successful judicial, civil and administrative actions against DME suppliers follow:

- An Arkansas DME supplier and his company had to pay more than $58,000 in civil monetary penalties and was excluded from the Medicare and Medicaid programs for 15 years. Almost immediately after the supplier was issued a Medicare provider number, the carrier began receiving complaints from beneficiaries and other suppliers.

The supplier submitted claims for: equipment that was provided without physician orders or was not provided at all, equipment returned to the supplier, and equipment provided to patients in an intermediate care facility. Even after a warning from the carrier, the supplier continued to abuse the program and the carrier had to institute expensive review procedures to prevent losses. Because of these reviews, actual claims losses amounted to less than $50. (, 6-85-30778-9)

- A Wisconsin supplier was given a 24 month probation for perjury to be served concurrently with a previous sentence for submitting false claims for oxygen. In the previous trial he had presented as evidence, and swore to the authenticity of, an invoice which was later found to have come from the oxygen supply company for which his father worked. (Smythe, 5-86-00810-9)

NATIONAL DRG VALIDATION STUDY

A national study was conducted by OIG concerning the accuracy of diagnosis related group (DRG) coding and the appropriateness of medical care performed in Medicare hospitals. The study will result in six special reports concerning separate areas of the DRG issue. The first two reports that have been released pertain to premature discharges and coding accuracy.

A. Premature Discharges

One study found that 1.1 percent of sampled beneficiaries were prematurely discharged from hospitals. This study reviewed the hospital records of 7,045 randomly selected Medicare patients discharged during the period October 1984 through March 1985. When weighted appropriately, the 1.1 percent of the sampled beneficiaries who were prematurely discharged indicates that 0.8 percent of all Medicare discharges were premature. This finding suggests that the occurrences of premature discharges are fewer than previously suspected. While the overall number of identified premature discharges was small, one in every five hospitals reviewed had at least one occurrence of a premature discharge and one in every three rural hospitals reviewed had one or more identified instances.

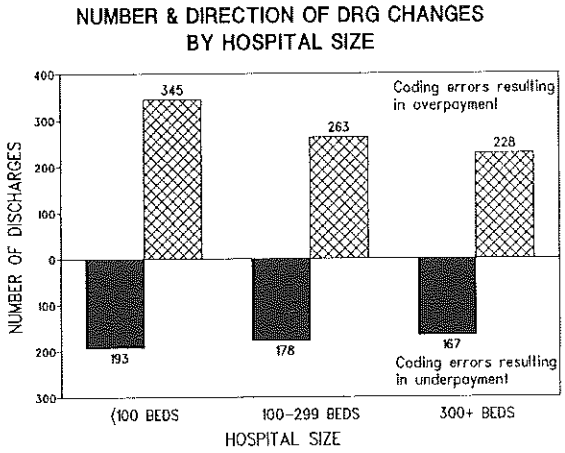
One of the undesired manifestations of PPS that has received national attention has been the premature discharge of patients. Financial incentives might induce some physicians and hospitals to withhold needed services and discharge patients prematurely, thereby increasing profits, while placing beneficiaries at risk. The study showed that discharges appeared to be a measure taken to minimize losses on patients whose hospital costs were nearing or exceeding the DRG payment. Premature discharges occurred most often in small, rural, nonteaching facilities. Of

the patients discharged inappropriately, the majority had quality of care issues associated with their stay in the hospital. Inadequate treatment and incomplete therapies characterized premature discharge cases.

Peer review organizations have received increased authority to deal with instances of premature discharges and/or poor quality of care. Hospital payment for subsequent stays in the same hospital, resulting from a premature discharge, can now be denied. Soon, peer review organizations will be able to deny payment for identified instances of substandard care. Also, peer review organization screens, used to target hospital cases for scrutiny for possible premature discharges, have been expanded to include sampling of all readmissions occurring within 31 days of the initial discharge. This will go into effect in October 1988. (OAI-05-88-00740)

B. Coding Accuracy

The report examined coding errors across a random sample of all hospitals paid under PPS and found that coding errors caused an overall 1.3 percent excess payment rate in the cases reviewed. If these sample results were projected to all PPS hospitals, there was an excess in payments of $300 million during FY 1985.



The OIG study found that an inappropriate DRG was originally assigned in 20.8 percent of the cases reviewed. Smaller hospitals made significantly more errors than mid-size and large hospitals. A significant percentage of the errors (over 61 percent) favored the hospitals (that is, the hospitals were paid more for the hospital stay than they would have been if the correct codes had been submitted). Previous studies had found the direction of errors to be random, overpaying and underpay-

ing the hospitals about equally. More than 39 percent of the errors resulted from physician designations of principal diagnosis, which, although incorrect or insupportable, were not corrected before a claim for payment was submitted. Other causes of these errors included incorrect sequencing of diagnoses or codes and incorrect coding. (OAI-12-88-01010)

INDIVIDUAL DRG VALIDATION

In addition to the overall national study, OIG has done a number of reports on individual DRGs and the problems within each particular code. The OIG is also currently conducting a study of DRG 129 (cardiac arrest).

A. DRG 14

Our report on the study of DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attacks) recommended that HCFA advise all peer review organizations of the vulnerability of DRG 14 and consider an instruction to these organizations to focus reviews in hospitals with large numbers of cases in this DRG. In addition, the report recommended that HCFA instruct the peer review organizations to engage in educational contacts with physicians regarding the selection and correct sequencing of the principal diagnoses and correction of other errors identified in this report, and provide resources and monitoring adequate to insure that fiscal intermediaries have the capability to provide complete claim data for review in a timely fashion. (OAI-09-86-00052)

DRG 14 CLAIMS	
Percent of all cases in error	15.5
Total overpayment for 10 hospitals	$ 108,353
Projected overpayment, San Francisco Region	$ 5,231,871
Projected national overpayment	$ 31,538,229

B. DRG 82

An OIG review of 172 cases assigned to DRG 82 (Respiratory Neoplasms) showed that this DRG was vulnerable to incorrect or manipulative coding. Forty-six percent of the cases reviewed had been incorrectly coded because the physician had erroneously designated the principal diagnosis or a secondary diagnosis had been improperly substituted based on information from the Medicare fiscal intermediary. The HCFA agreed with our recommendations to review the performance of the fiscal intermediaries to assure that the Medicare Code Editor was being correctly used, and that peer review organizations be instructed to

make educational contact with physicians regarding the selection and correct sequencing of the principal and secondary diagnoses. (OAI-05-85-00041)

C. DRG 88

An OIG inspection of DRG 88 (Chronic Obstructive Pulmonary Disease) found that 60 percent of the sample cases reviewed were erroneously assigned. An additional 5 percent of the cases were found to be unnecessary admissions. Our recommendations were similar to those for DRG 82 and HCFA has taken corrective action to address the vulnerabilities that surfaced in both inspections. (OAI-05-85-00003)

SANCTION AUTHORITIES

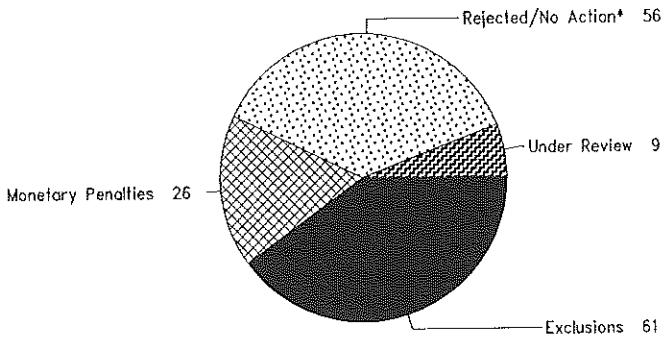
The various sanctioning authorities legislated by the Congress have given OIG some of its most effective weaponry in combatting health care provider fraud. During this reporting period, OIG imposed 177 sanctions, in the form of monetary penalties or exclusions from the Medicare and Medicaid programs.

A. PRO Sanctions

Peer review organizations (PROs) are groups of practicing doctors and other health care professionals who are paid by the Federal Government to review the hospital care of Medicare patients. The PRO designated for each State has responsibility for deciding whether care is reasonable and necessary, is provided in the appropriate setting, and meets the standards of quality accepted by the medical profession. Health care providers can be excluded or required to pay a monetary penalty as a result of a PRO determining that the provider furnished unnecessary services, failed to provide services that met professionally recognized standards of care or failed to document the services as required by the PRO.

Since the advent of PPS in 1984, there have been about 30 million hospital discharges. The OIG has received only 152 recommendations for sanctions from PROs, and sanctions have been effected in only 30 States. Of the 152 recommendations, 143 have been processed and released. The status of the PRO referrals are indicated in the following chart:

STATUS OF PRO REFFERALS



* includes cases where subject was deceased

The following cases are examples of actions taken on the basis of PRO recommendations during this reporting period:

- A physician was excluded for 10 years after having been found to have grossly and flagrantly violated his obligation to provide care that meets professionally recognized standards in his treatment of 13 Medicare beneficiaries. In two of these cases, the care he provided contributed to the death of the patients.

- After receiving a recommendation from a PRO, a physician was excluded for 5 years because of his inappropriate treatment of patients and inappropriate prescription of medications.

- Another physician was excluded for 3 years for failing to adequately treat patients and prescribe medications.

B. Sanctions For Criminal Convictions

Section 1128(a) of the Social Security Act requires that individuals convicted of crimes against the Medicare or Medicaid programs be excluded from participation in these programs. Public Law 100-93 amended section 1128(a) so that, in addition to Medicare and Medicaid, individuals and entities convicted of crimes against the Maternal and Child Health and Block Grants to States programs are excluded for a minimum of 5 years from all four programs. Examples of sanctions under section 1128(a) follow:

- A physician was excluded for 5 years for fraudulently billing Medicaid when patients had already paid him for his services. This physician was also convicted of selling prescriptions for controlled substances. (3-87-40169-9)

- After his conviction for billing Medicaid for laboratory tests which were not performed or which were given free by the city public health laboratory, a physician was excluded for 10 years. (8-87-40201-9)

- A physician was excluded for 5 years for billing Medicaid for services which she did not provide. This physician was also convicted of obstruction of justice. (W-87-40044-9)

- A pharmacist was excluded for 5 years for billing Medicaid a higher price for prescription drugs than he charged to the general public. (3-87-40169-9)

C. Exclusion of Health Care Providers

In addition to sanctions resulting from convictions, health care providers can be excluded for providing excessive and unnecessary services or poor quality of care to patients whether or not these patients are eligible for benefits under Medicare or a State health care program. The following are examples of such cases:

- A chiropractor was excluded for 3 years for exposing beneficiaries to unnecessary levels of radiation and taking x-rays which were not of diagnostic quality to support claims for subluxation. (8-86-40287-9)

- A 2-year exclusion was imposed on a physician for providing excessive or unnecessary injections of antibiotics, steroids and vitamins. (8-86-40297-9)

D. Civil Monetary Penalty Settlements

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

- A surgeon urologist paid a settlement of $50,000 for 134 instances of billing Medicare for pre-operative consultations and post-operative hospital admissions. He had persisted in billing for these items although he had been warned by the carrier that they were included in the overall surgical fee already paid. (3-87-30571-9)

- A physician paid restitution and CMP totaling $150,000 to the Department and the State Medicaid Fraud Control Unit. A general practitioner, he had billed the Medicaid program for office visits as a neurologist. He also billed for vital capacity tests which were not performed. (6-87-30501-9)

- An ophthalmologist who was billing routine eye examinations as though they were expensive consulting procedures had to pay $225,250 in settlement of his CMP liability. (1-86-30290-9)

- An ambulance company owner who billed Medicare for numerous transportation services at the life support level when they were actually less expensive "chair car" services was penalized $245,000. (~~5-86-00287-9~~)(5-87-20011-9)

INPATIENT PSYCHIATRIC CARE

The OIG concluded that the 190-day lifetime limit on Medicare coverage of services in psychiatric hospitals is no longer effective because of changes in the pattern of inpatient psychiatric care. The 190-day, legislatively mandated limit is applied only to psychiatric hospitals because, at the time of the original Medicare legislation, inpatient psychiatric care was rendered, for the most part, in State psychiatric hospitals. Long term care of the mentally ill in State hospitals was generally considered the responsibility of State governments.

The total cost of inpatient psychiatric care has increased significantly and about 82 percent of the payments for these services are now made to general hospitals (where the lifetime limit does not apply). In FY 1986, HCFA considered a proposal to expand the 190-day limit to include general acute-care hospitals. The HCFA contended that this proposal would lead to a more equitable policy. Since most stays in psychiatric units of hospitals are generally shorter and fewer in number, HCFA believed that the impact on beneficiaries would be minimal. The HCFA proposal would save approximately $705 million over the next 5 years. However, OIG believes that it would be detrimental to those beneficiaries most in need of inpatient services.

Our review showed that a 60-day annual limit on inpatient psychiatric care (which has congressional precedence in a Department of Defense health care program) may be more acceptable than a lifetime limit. The Department of Defense's health care program has an annual rather than lifetime limit. The Social Security Act could be amended to permit a 60-day annual limit, and achieve substantial program savings (as much as $238 million over the next 5 years). The annual limit would lessen the impact on beneficiary care since it does not permanently eliminate care at some arbitrary point in a person's life. The OIG recommended that HCFA initiate further actions to contain rising Medicare costs for inpatient psychiatric care. In addition, HCFA should consider recommending an annual limit on inpatient psychiatric care provided in general and psychiatric hospitals in lieu of the 190-day lifetime limit currently applied only to psychiatric hospital care. The HCFA generally agreed with

our conclusions but believed that further analysis was required before a legislative proposal was advanced. However, during its analysis of alternatives, HCFA agreed to carefully consider OIG's recommendations. (CIN: A-06-86-62045)

MEDICARE EYE WEAR

Eye wear prescribed by physicians after cataract surgery is covered by the Medicare program; other eye wear normally is not. One Medicare carrier elected not to pay for extra eye wear items because these items were deemed not reasonable nor necessary (e.g., supplying another or several more pairs of eyeglasses or lenses on the same day as a convenience to beneficiaries).

The OIG found, however, that during a 2-year period ending September 1985, the carrier made payments of about $1.6 million for noncovered eye wear. Prepayment edits had not been built into the carrier's claims processing system to prevent such unallowable payments.

The carrier has since implemented appropriate prepayment edits, and agreed to seek recovery from providers OIG identified as having been paid for noncovered eye wear. The HCFA agreed with our findings and recommendations. (CIN: A-04-87-01000)

MEDICARE CHECK FRAUD

Persons other than health care professionals occasionally engage in defrauding the Medicare program, usually by diverting payments to their own enrichment or otherwise tampering with the payment system, as illustrated in the following cases.

- In Ohio, two sisters were each sentenced to 3 1/2 years in prison for stealing more than $425,000 in Medicare and private health insurance payments. While working for the State Medicare insurance carrier as a claims examiner, one sister issued over 100 fraudulent checks which the other helped negotiate. (Lyons and Hay, 5-87-00278-9)

- A Medicare beneficiary in Arkansas was given a 2-year suspended prison sentence and 5 years probation for submitting false Medicare claims. She also had to pay $2,000 in restitution and a $75 fine. After the carrier reported to OIG that she was submitting altered claims, it was found that she was adding a "1" to receipts for payments for ostomy supplies, to make them read $100 more. On some she requested duplicate receipts, altered dates and submitted them twice. (Williams, 6-87-00072-9)

- An Indiana woman was given a 2-year suspended sentence and

ordered to repay $900 she obtained by forgery, both in cashing a Medicare check and in obtaining a State identification card she used to cash the check. (Rardon, 6-87-00381-9)

CONTRACTOR PENSION COSTS

Federal regulations require the adjustment of previously allowable pension costs when Government contracts are terminated. Medicare payments to a former Medicare contractor from July 1966 through September 1982 were $1.1 million. Our audit revealed that adjustments for investment earnings, administrative costs, and benefit payments left assets in excess of actuarial liability of over $1 million. The OIG recommended that the contractor refund this amount to the Federal Government. (CIN: A-07-86-62005)

HEART PACEMAKERS

The OIG made a follow-up review on HCFA's implementation of recommendations in our report "Opportunities to Save $230 Million in Medicare Reimbursement for Heart Pacemaker Monitoring Services" (ACN: 08-52017). This 1984 report recommended reductions in excessive frequency and charges for heart pacemaker telephonic monitoring services. The HCFA reduced the frequency of monitoring services by 50 percent but took no action to reduce the allowable level of charges. The OIG originally estimated that this change would save $30 million over 5 years. The HCFA agreed to consider courses of action on this matter. However, since 3 years have elapsed from the issuance of our original report, we again recommended that HCFA take action to reduce reimbursement levels. The HCFA is considering alternatives for controlling excessive payment levels for heart pacemaker monitoring.
(CIN: A-08-87-00043)

FALSE CLAIMS

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

- The owner and operator of a degenerative disease clinic in Nevada was sentenced to a total of 9 years in prison for falsely billing Medicare and private insurance companies. The clinic had advertised nationally offering cures for serious diseases ranging from mental retardation to cancer, through intravenous administration of dimethyl sulfoxide. Dimethyl sulfoxide is a wood by-product used as an industrial solvent and approved by the Food and Drug Administration only for treatment of cystitis. The clinic billed for services not provided and did not reflect use of dimethyl sulfoxide because Medicare would not pay for treatment not approved by the Food and Drug Administration. The

alert carrier consistently refused to pay for any clinic-related claims, thereby preventing Medicare from being defrauded. (Miller, 9-81-09055-9)

- A Texas plastic surgeon was convicted for filing false Medicare claims estimated by the carrier as amounting to more than $1.5 million over a 2-year period. The surgeon, who only treated ulcers or abscesses of nursing home patients hospitalized for these conditions, not only upgraded the billing code for his services but also exaggerated the numbers of sores he treated. He was sentenced to 179 days of confinement in a halfway house, 5 years probation, a $10,000 fine and 500 hours community service. (Huckaby, 6-85-00077-9)

- A university medical center signed an agreement whereby the Department and the State of Colorado will recover more than $1 million in settlement of claims that the center submitted false or improper Medicare and Medicaid billings. Both State and Department audits indicated that the provider billed for arterial blood gas interpretations which were not performed. The investigation also determined that it billed for individual psychotherapy sessions as performed by psychiatrists, when in fact the services were either not rendered or were performed by hospital physician employees. (Colorado Medical Center, 8-87-20247-9)

- A Florida physician was sentenced to 18 months in prison and 5 years probation and ordered to pay a $250,000 fine, $3,000 in restitution and 5,000 hours of community service for filing claims for services never performed. (Hooshmand, 4-84-00647-9)

INSTITUTIONS FOR MENTAL DISEASES

Medicaid regulations prohibit Federal cost sharing for services to persons under the age of 65 in institutions for mental diseases (IMD). Responsibility for caring for these persons rests with State and local governments. An OIG follow-up review in one State found, however, that the State agency continued to claim Federal cost sharing for these services in 11 nursing homes that met the Medicaid definition of an IMD. The homes treated primarily persons with mental diseases; participated in a special State program for the mentally ill; had licenses designating them as specializing in the treatment of mental illnesses; and had staffs that specialized in the care of patients with mental diseases. Improper charges from 1983 through 1985 amounted to $25.5 million. The OIG recommended that the State refund the $25.5 million and discontinue claiming Federal funds under Medicaid for persons under the age of 65 in nursing homes that are IMDs. State and HCFA officials agreed with our findings and recommendations.
(CIN: A-09-86-60205)

In another State, OIG found that privately owned and operated intermediate care nursing facilities had the overall characteristics of IMDs. From October 1982 to December 1985, the State agency improperly claimed about $6.6 million under Medicaid for care provided to persons under age 65 in three such facilities. The OIG recommended a financial adjustment and the establishment of controls to preclude similar improper claims in the future. State agency officials concurred with the recommendations. (CIN: A-05-86-60214)

OUTPATIENT MENTAL HEALTH

An OIG study determined that one State improperly claimed Federal funds for more than one outpatient mental health service per day for certain patients. Although Federal regulations do not set specific limits on the number of daily outpatient mental health visits it will cover, the State's own Medicaid regulations provide that only one visit per day is reimbursable. Federal sharing is not available for costs of services prohibited under State law or regulations.

From January 1983 to June 1986, the State improperly claimed at least $2.2 million under Medicaid for multiple outpatient mental health services provided on the same day to the same patient. The improper payments occurred because there were no edits in place within the Medicaid management information system to detect multiple services on the same day.

In addition to recommending a financial adjustment for the Federal share of improper payments, OIG advocated the implementation of appropriate computer edits in the State's Medicaid management information system. The HCFA concurred. (CIN: A-02-86-60230)

PRESCRIPTION DRUG ABUSE

Vast amounts of money can be made illegally from the billion dollar pharmaceutical industry. The following activities illustrate OIG's efforts to eliminate unjust profiteering in this area.

- In 1982, OIG initiated a project to uncover fraud schemes in the pharmaceutical industry which had an impact on Department program funds. Evidence was found of schemes in which pharmaceuticals were being purchased from nonprofit sources and subsequently resold for a profit. Although they were significantly less expensive at nonprofit rates, these savings were not passed on to the Medicaid program. In addition, improper handling of the pharmaceuticals made them a public health hazard. There were instances of Department employee involvement in the scheme. A joint effort with the Federal Bureau of Investigation was launched which has thus far

garnered 17 convictions. Twelve persons were sentenced during this reporting period to terms ranging from 4 months probation to 3 years in prison, with fines and assessments totaling about $140,000.

- After a decade of trouble with medical authorities related to problems ranging from record-keeping errors to writing improper prescriptions, a New York anesthesiologist had to surrender his license as a result of an OIG investigation. He had to repay $70,000 to Medicare patients he had defrauded and was given a suspended 5-year jail sentence and 5 years of probation. He was also ordered to participate in psychological and drug counseling and to make a personal apology to a former employee, a victim of an intimidation attempt. One of his employees earlier was given a 1-year suspended sentence and 1 year of probation, ordered to continue mental health counseling and told to make a personal apology to the former employee. (Stern and Cartier, 2-85-00199-9)

- A Colorado physician who embezzled Medicare funds from a hospital and obtained drugs by fraud received a suspended sentence after he repaid more than $10,000 in restitution and fines and entered a drug treatment program. (Reiner, 8-87-00071-9)

MEDICAID CLAIMS AT JUVENILE FACILITIES

An OIG report indicated that one State improperly claimed $13.2 million in Federal financial participation (FFP) under Medicaid for services provided at six State-owned juvenile facilities during the period July 1982 through May 1985.

In July 1982, at the request of the State health department, six juvenile detention facilities were licensed as nursing units of the teaching hospital, an existing Medicaid provider. The State health department then began to claim Medicaid reimbursement for services provided at the facilities as hospital inpatient medical services and continued this practice through May 1985. At no time during this period did any of the six facilities meet the criteria for FFP under the Medicaid program. Furthermore, these facilities continued to be a part of the juvenile justice system, and were operated as residential detention centers for juvenile offenders and deprived children. As such, they did not meet the definition of a hospital as set forth in the Social Security Act and applicable Medicaid regulations, and were not eligible to receive Federal matching funds.

The OIG recommended that the State agency not claim additional Medicaid reimbursement for such services, unless all Federal requirements are met, and that they make a financial adjustment of $13.2

million. The HCFA issued a disallowance letter to the State agency for $13.2 million. (CIN: A-06-87-00211)

STATE MEDICAID FRAUD CONTROL UNITS

Medicaid vendor payments total more than $40 billion annually. The 38 State Medicaid Fraud Control Units (MFCUs) have investigative responsibilities for about 91 percent of these funds. Grant funds in support of these units amount to about $45 million annually. During this period, the MFCUs reported 196 convictions and almost $6 million in fines, overpayments and restitutions. The OIG conducted recertification reviews of 10 MFCUs to assure that they were abiding by grant regulations. Several disallowances resulting from previous recertification reviews were finalized, for a total of about $2.7 million.

The following cases are examples of the kind of investigations conducted by the MFCUs:

- Based on the work of the Tennessee MFCU, a mental health center was required to repay more than $320,000. The center had failed to perform a psychiatric evaluation of clients prior to treatment and every 6 months thereafter. In addition, the center had billed for individual therapy when group therapy was provided and allowed social workers not under the instructions or supervision of licensed mental health professionals to render therapy and write prescriptions.

- The owner of a nursing home in Oregon had to repay almost $30,000 in wrongful Medicaid payments, and a $50,000 civil penalty. An audit found that the home's financial statement contained personal expenses not subject to reimbursement by Medicaid, including loan payments, maintenance, hangar rent and other expenses related to a helicopter registered to a business management company partly owned by the nursing home owner.

- In California, a physician was sentenced to 3 years in State prison and fined $10,000 for stealing more than $25,000 from the Medi-Cal program. According to witnesses, he had hired people to bring either Medi-Cal cards or patients eligible for Medi-Cal to his office, then used the cards to file claims for medical services he never provided.

- A training instructor in Florida was found guilty of patient abuse and was placed on 1-year reporting probation and ordered by the court not to work with aged or disabled patients. As a result of the MFCU investigation, charges had been brought against him for striking a

disabled adult in his care and for slapping another patient on the same evening.

INTERNAL CONTROL WEAKNESSES

The following internal control weaknesses were identified by OIG. For a more extensive discussion of internal control weaknesses see page 6.

- The HCFA needs to design and provide intermediaries with computer edits to identify certain nonallowable claims ($34 million in the case of one intermediary) submitted by hospitals for nonphysician services. Under Medicare's PPS intermediaries pay hospitals at a predetermined amount based on classification of the patient's illness under a DRG. Certain nonphysician costs are reimbursed in the DRG such as laboratory tests. Consequently, hospitals should not bill for such costs separately.

- The HCFA needs to require that Medicare intermediaries and contractors take the necessary actions to ensure continued processing and payment of Medicare claims should computer processing capabilities be rendered partially or totally inoperative for an extended period of time. The OIG's review of 16 intermediaries showed that 15 had not taken such action and were totally dependent on computer support for operations and would not be able to fulfill their mission if their data processing capabilities were destroyed.

PUBLIC HEALTH SERVICE

Chapter IV

PUBLIC HEALTH SERVICE

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

During the first half of Fiscal Year (FY) 1988, OIG identified questionable charges to the Public Health Service (PHS) programs totaling $3.5 million.

The activities conducted and supported by PHS represent this country's primary defense against acute and chronic diseases and disabilities and provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. Through PHS, funds are provided to advance knowledge through research; to protect food sources and to assure safe and effective drugs and medical devices; to combat communicable diseases and protect the public health; to assist States, local governments and community organizations in delivering health care; to uncover the physiological and behavioral bases for understanding, preventing and treating mental illness and alcohol and other substance abuse; and to support, through financial assistance, the development of our future generation of health care providers.

The PHS 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 Health Resources and Services Administration (HRSA). These agencies promote biomedical research, disease prevention, safety and efficacy of marketed food and drugs, and other activities designed to ensure the general health and safety of American citizens.

INFANT CARE REVIEW COMMITTEES

The OIG conducted a study entitled "Infant Care Review Committees Under the Baby Doe Program" at the request of the Surgeon General and the Administration for Children, Youth and Families. The term "baby doe" refers to a severely disabled infant with a life-threatening condition who is denied appropriate medical treatment. Two highly publicized court cases called national attention to baby does in the early 1980s. The subsequent debate culminated in the 1984 amendments to the Child Abuse Prevention and Treatment Act. The amendments required the Department of Health and Human Services to publish model guidelines encouraging hospitals to establish infant care review

committees. The guidelines were published in April 1985. (OAI-03-87-00042)

EMBEZZLING PHS FUNDS

An official of an organization receiving PHS grants was found to be embezzling funds. The fiscal officer of a Kentucky family health center was sentenced to 6 months in prison and 5-years probation for embezzling about $18,000 in grant monies. He was also ordered to participate in a mental health program after his release from prison. He had made restitution of the stolen money before sentencing. (Kalb, 4-86-01318-4)

INDIAN HEALTH SERVICE

An OIG review of the utilization of Indian Health Service (IHS) quarters by PHS Commissioned Corps members found that compliance with the statutory requirement that corps members with dependents reside in available quarters, could save the Federal Government approximately $1.3 million annually. A basic allowance for quarters is paid to corps members when adequate IHS quarters are unavailable. The allowance is to defray the cost of acquiring non-IHS housing. Federal statutes provide that, when adequate quarters are available, IHS corps members with dependents be assigned to the quarters and the member's allowance terminated.

The IHS has not enforced applicable Federal statutes requiring the termination of allowances when corps members elect not to reside in available quarters. Consequently, IHS was paying twice for housing corps members. First, IHS constructs quarters for staff critical to its operations. These staff include Commissioned Corps members. Second, IHS paid corps members an allowance to live in private housing rather than in quarters built for them. The OIG recommended that IHS terminate the allowance for corps members with dependents who decide not to reside in available quarters. (CIN: A-09-88-00026)

HEALTH STUDENT LOAN PROGRAM

An OIG review disclosed that from November 1975 to June 1986 interest income of approximately $691,000 had been earned on the investment of program funds and was not credited to the programs as required by the authorizing legislation. Also, cash balances as of June 30, 1986, were approximately $13,000 in excess of the program's needs. Lastly, uncollectible loans were not being submitted to PHS for write-off approval on a timely basis. The OIG identified 64 delinquent loans (valued at $148,235 as of June 30, 1986) which met the criteria established for submission for write-off approval.

In responding to our draft report, the HRSA agreed with the recommendations that the university should reimburse the programs for interest earned on investment of program funds and return unneeded

program funds. However, HRSA believed it was preferable for the university to continue its collection efforts on delinquent loans rather than submit them for write-off approval at this time.
(CIN: A-02-86-61202)

INTERNAL CONTROL WEAKNESS

The following is an internal control weakness that was identified by OIG. For a more extensive discussion of internal control weaknesses see page 6.

- The PHS needs to strengthen external reporting requirements for schools and internal monitoring procedures to identify and correct cash management deficiencies in the Health Professions and Nursing Student Loan programs. The OIG estimates that, nationwide, schools have not credited loan accounts with about $42.1 million earned on the investment of Federal loan funds, nor reimbursed loan fund accounts for the appropriate share of $19.1 million in uncollectible loans. In addition, schools have retained an estimated $22.8 million in unneeded program funds. Each of these practices deprives other schools and needy students of scarce educational assistance.

QUESTIONED COSTS

Reports issued by OIG identified questionable grantee charges to PHS programs of $3.5 million during this 6-month period. These reports included results of OIG reviews and results of nonfederal audits, such as those performed by State auditors of PHS block grant programs and of Federal funds at State health agencies and audits by independent auditors of Federal program funds at colleges and universities.

Prior to issuing nonfederal audit reports to PHS, OIG reviews the reports for matters that require immediate action such as possible fraud or abuse, conformance to established Federal standards and guidelines as well as findings that require departmental action. The following are examples of OIG and nonfederal audit results of PHS programs during the last 6 months.

- A State audit disclosed that various subrecipients of substance abuse grants did not provide the required reports on Federal financial assistance or the subrecipient audit reports did not meet OMB Circular A-128 Single Audit Act requirements. Financial adjustments totaling $1,348,970 were recommended. (CIN: A-07-88-05686)

- An OIG audit disclosed that a university earned investment income of $446,997 on Health Professions Student Loan (HPSL) and Nursing Student Loan (NSL) program funds, but did not credit this income to

the programs. Also the university maintained loan fund balances totaling $66,780 in excess of program needs. Recommended adjustments totaled $513,777. (CIN: A-03-86-61200)

- An audit by a private certified public accounting firm disclosed that the grantee made errors in preparing a financial status report for a PHS health grant. Adjustments increasing the Federal fund balance by more than $144,000 were recommended. (CIN: A-02-87-06088)

- Another audit of a health grant by a certified public accounting firm showed that the grantee did not credit the grant account with income earned and held grant funds in excess of program needs. Recoveries of over $272,000 were recommended. (CIN: A-04-88-06827)

FAMILY SUPPORT ADMINISTRATION

Chapter V

FAMILY SUPPORT ADMINISTRATION

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

The Office of Inspector General (OIG) continues to direct audit emphasis to reviewing recipient eligibility, determining the fairness of program benefits, and evaluating the economy and efficiency of operations. During this reporting period, OIG recommended recovery of $11.2 million in questionable grantee charges.

The Family Support Administration (FSA) provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. These programs include: Aid to Families with Dependent Children (AFDC), Emergency Assistance (EA), Child Support Enforcement (CSE), Low Income Home Energy Assistance (LIHEA), Refugee and Entrant Assistance, Community Services and Work Incentive programs. Expenditures for these programs will total $14.1 billion in Fiscal Year (FY) 1988.

The AFDC program is the fifth largest in HHS with a Federal cost in 1988 of almost $10 billion. The AFDC program is a cooperative program among Federal, State and local governments which will reach 3.8 million families consisting of 11 million individuals each month in 1988. The CSE program provides grants to States to enforce obligations owed by absent parents to their children by locating absent parents, establishing paternity when necessary, and obtaining child support. The LIHEA provides block grants to the States to help offset the increased cost of fuel for recipients of AFDC, food stamps, supplemental security income, as well as certain other individuals.

FEDERAL SHARING UNDER EMERGENCY ASSISTANCE PROGRAM

An OIG review found that one State's claim for $10.5 million under the Emergency Assistance to Needy Families with Children program (EAF), could not be supported by documentation identifying specific clients eligible for emergency assistance. The OIG requested that the State and city governments provide a breakdown of the amounts claimed for families which received emergency assistance. To date, neither has been able to provide us with this information.

In response to our draft report, the State agency presented three alternative plans of action to provide evidence to support a large portion of

its claim. The OIG reviewed these plans and recommended the plan of action the State should utilize. In the meantime, we are recommending a financial adjustment for $10.5 million. If the State agency is able to establish the validity of claims under EAF, then the State agency may submit a new claim for Federal financial participation. Regional FSA officials agreed with our findings and recommendations. (CIN: A-02-87-00003)

WELFARE FRAUD

For several years OIG has routinely assisted State and local authorities in obtaining the evidence and expertise needed to prosecute AFDC fraud. We obtain and authenticate records such as cancelled checks and other original documentation required for prosecution, and provide witnesses and other assistance as requested. During this reporting period, 172 convictions were obtained in cases in which OIG gave this assistance. In addition to this ongoing nationwide activity, OIG is engaged in several other cooperative projects confined to specific geographicf areas. The following results were obtained from some of these projects:

- In southern Illinois, an investigation of a group of about 90 welfare cases was also launched in early FY 1987 by a task force of OIG, Federal Bureau of Investigation, Secret Service, State and local agents. During this period, 29 persons were sentenced bringing the total to 73 since the project began. Overpayments to these defrauders amounted to almost half a million dollars.

- Three Department employees were convicted and sentenced for welfare fraud in Michigan. A benefit authorizer with the Social Security Administration was sentenced to 4 years probation and $6,000 in restitution. A record analysis clerk with SSA was ordered to be placed on 1 year of probation, serve 120 hours of community service and pay $26,000 in restitution. A legal technician with the Office of General Counsel was sentenced to 18 months probation and restitution of $6,000. The OIG investigation was initiated as the result of a Department of Agriculture match of Federal employees with Food Stamp recipient rolls. (McCallister, 5-87-10135-8; Caine, 5-87-10136-6; and Banks, 5-87-10187-8)

COLLECTION AND CREDIT ACTIVITIES UNDER PUBLIC ASSISTANCE PROGRAMS

An OIG review determined that one State needs to strengthen existing procedures to insure that Federal programs receive their share of all identified collections and credits in a timely manner.

During the 2-year period ended June 30, 1985, the State agency did not refund the Federal share ($4 million) of credits and collections attribu-

table to various public assistance programs, primarily the AFDC program and Medicaid. Credits and collections resulted from third party recoveries, medical provider overpayments, vendor cancelled or uncashed checks and from miscellaneous adjustments.

The OIG recommended that the State reduce its claims by $4 million and that accounting controls be established to prevent further misclassification of revenues in order to ensure the timely and accurate reporting of all future recoveries. Aside from some disagreement on the dollar amount of one of the Medicaid findings, the State agreed with our findings and recommendations and adjusted or will soon adjust their claims accordingly. (CIN: A-01-86-60255)

STATE INVESTIGATION OF FRAUD IN AFDC

An OIG report entitled "State Investigation of Fraud in the Aid to Families with Dependent Children (AFDC) Program" focused on identifying those measures taken by States to prevent, detect, investigate, and prosecute fraud in the AFDC program. While many States have initiatives which show promise in these areas, most traditional approaches to reduce AFDC fraud have been ineffective.

Preentitlement fraud screening, used in the California Welfare Fraud Early Detection and Prevention program, has been effective at reducing AFDC fraud. This program investigates irregularities in applications quickly and efficiently, disallowing applicants who provide misinformation on their application. The OIG recommended that FSA revise regulations (45 CFR 235) to require that States implement a preeligibility fraud detection and prevention system similar to the California program as a condition of State plan approval.

The OIG also recommended that FSA work closely with the States, both directly and through the United Council on Welfare Fraud, to develop an improved reporting mechanism. Such a mechanism should collect useful information on incidence and nature of fraud and provide timely feedback to States on this statistical data. This mechanism should also collect information on successful antifraud activities which FSA could disburse to other States. In addition, FSA should develop a broad spectrum of training and information packages to be used by States and localities to combat fraud and increase public awareness. While FSA is in general agreement with many of these recommendations, they also believe that mandating the California early detection program model could result in elimination or dilution of a proven preeligibility verification program in another State.

The FSA also believes that recent developments in the fraud area, such as the provision in Public Law 100-203 which provides for administrative disqualification hearings, should improve the present situation. (OAI-04-86-00066)

INTERNAL CONTROL WEAKNESS

The following internal control weakness was identified by OIG. For a more extensive discussion of internal control weaknesses see page 6.

- The OIG's review of an independent auditor's report disclosed that a substantial amount of unexpended funds, which were part of a grant made by the now-defunct Community Services Administration and which should have been returned to the Federal Government over 5 years ago, remained with the grantee. Also, interest earned on these funds had not been remitted to the Federal Government. The Office of Community Services was unaware that the grantee had these funds remaining because Office of Community Services records did not disclose any evidence of unexpended funds.

QUESTIONED COSTS

Reports issued by OIG identified other questionable grantee charges to FSA programs. These reports included results of OIG reviews and results of nonfederal audits, including those performed by State auditors of the AFDC program and independent audits of Community Services programs. Examples during the last 6 months are:

- An independent organization-wide audit covering an Office of Community Services grant disclosed that $490,000 apparently was not spent in accordance with the terms and conditions of the grant. This amount was recommended for recovery. (CIN: A-01-88-06018)

- An audit of a CSE grant by the Department of Interior Inspector General disclosed that the grantee charged $123,082 for major renovations of office space and moving expenses in violation of the terms of the grant. A financial adjustment was recommended. (CIN: A-02-87-08310)

OFFICE OF HUMAN DEVELOPMENT SERVICES

Chapter VI

OFFICE OF HUMAN DEVELOPMENT SERVICES

STATISTICAL SUMMARY AND PROGRAM OVERVIEW

During this reporting period, the Office of Inspector General (OIG) identified questionable grantee charges to the Office of Human Development Services (HDS) programs of over $4.5 million.

The HDS oversees a variety of programs that provide social services to the Nation's children, youth and families, disabled, older Americans and native Americans. The Head Start program provides grants and contracts to public or not-for-profit agencies to supply educational, nutritional, health and social services to preschool children of the poor. Foster care is an entitlement program that provides grants to States to assist with the cost of foster care maintenance, administrative costs to manage the program, and training for staff. The goal of this program is to strengthen families in which children are at risk and to reduce inappropriate use of foster care.

FOSTER CARE ADMINISTRATIVE COSTS

The OIG conducted a study of the administrative costs of the foster care program because the Federal share of these costs rose from $30.4 million in Fiscal Year (FY) 1981 to $163.4 million in FY 1985. The study found that (1) the definition of foster care administrative costs included a wide variety of program and service activities; (2) the variation among States appeared to be the result of differing State strategies or abilities to claim costs, and not necessarily because of differences in effort or efficiency; and (3) HDS had begun to address some of the issues related to the increase in costs but that additional steps were needed.

The OIG recommended that HDS develop a national protocol for use by regional office staff in the routine evaluations of cost allocation sharing; revise the methodology for conducting retrospective administrative cost reviews; and evaluate the effectiveness of Public Law 96-272 in reforming the foster care delivery system and encouraging adoption.

The HDS agreed with the recommendations and has begun taking steps to implement them. (OAI-05-87-00012)

IMPROPER FOSTER CARE PAYMENTS

An OIG study in one State disclosed improper foster care payments totaling approximately $494,000 in FY 1984. The improper payments were made on behalf of four categories of children. First, those who

were not covered by Aid to Families with Dependent Children (AFDC) nor eligible for AFDC at the time the courts removed them from their homes as required. Second, children who had received a foster care payment in excess of the appropriate foster care payment rate. Third, children who were placed in unlicensed foster care facilities. Fourth, children who did not have court orders to continue in foster care placement for more than the 180 days allowed by statute.

The OIG recommended a financial adjustment and that the State agency revise procedures to assure that foster care payments are made in accordance with Federal requirements. The HDS and State agency officials generally concurred with our findings and recommendations. (CIN: A-05-86-60552)

The HDS requested that OIG review the foster care case records of 61 children in one State to determine the allowability for Federal sharing of claims paid in their behalf. The OIG recommended a financial adjustment for $388,534 for claims that were not allowable for Federal financial participation (FFP) because they did not meet Federal AFDC foster care requirements. Of the 61 cases, case folder documentation could not be located by the State agency in 45 cases and documentation in 2 case folders was inadequate. In addition, FFP was improperly claimed for payments made on behalf of five children who were either ineligible for assistance, or on whose behalf the State agency failed to comply with one or more other Federal program requirements. (CIN: A-02-86-60257)

FRAUD INVESTIGATIONS

Elimination of fraud in the social services block grant programs largely depends on audits and the cooperation of State officials in pursuing allegations. The following cases were resolved during this reporting period.

- As the result of continuing investigations with the State in day care centers in Texas, 32 employees and parents were convicted in two separate cases involving more than $200,000. In one center the director, a teacher and three parents enrolled ineligible children to fraudulently obtain block grant funds. In another, 27 parents were convicted for falsifying employment or other income to receive day care services. (6-87-00451-5, 6-86-00597-5)

- The bookkeeper for a sheltered workshop for the developmentally disabled in Montana was sentenced to 5 years in prison, 5 years probation and restitution of more than $72,000 for embezzling from block grant and patient disability funds. The sentence was the result

of one of several theft schemes, including that of a meat market, a welding company and an airport commission. (Grimmy, 8-87-00165-5)

QUESTIONED COSTS

Reports issued by OIG identified a number of other questionable costs charged to HDS programs. These reports included results of OIG reviews as well as those conducted by nonfederal auditors, such as State audits of the HDS social services block grant program and independent audits of the Head Start program.

Prior to issuance, OIG reviews all nonfederal audit reports for matters that require immediate action such as possible fraud and abuse, conformance to established Federal standards and guidelines as well as findings that require departmental action. Examples during the last 6 months are audits of Head Start grants by private certified public accounting firms which disclosed that:

- A grantee charged the grant more than $2.4 million in excess of budgeted amounts and for items not included in the budget. (CIN: A-02-88-05142)

- Unused grant funds of over $100,000 were not returned to the Federal Government by another grantee. (CIN: A-02-87-05126)

- A grantee overexpended the approved budget by more than $150,000. (CIN: A-04-88-06831)

- A grantee used grant funds totaling over $110,000 to provide services to individuals not eligible to participate in the Head Start program. (CIN: A-09-87-05510)

Appropriate financial adjustments were recommended in all cases.

APPENDICES

APPENDIX A

LEGISLATIVE SAVINGS
OCTOBER 1987 THROUGH MARCH 1988

This schedule documents the budgetary savings resulting from OIG recommendations that have been implemented through legislation. The amounts shown, totaling $2,755 million for this period, represent funds or resources that will result in budgetary savings.

OIG RECOMMENDATION	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. (ACN: 09-62003)	The Consolidated Omnibus Budget Reconciliation Act of 1985 reduced the IME adjustment factor to 8.1 percent through September 30, 1988 and to 8.7 percent thereafter. Note: The OIG had previously deferred reporting savings for FY 1990 and FY 1991 due to continuing congressional and departmental efforts to reduce the IME factor further. At this time, OIG is reporting the remaining savings for COBRA 1985 which are based on CBO estimates.	$2,600

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
PPS Update Factor: The OIG report and testimony pointed out that PPS payments should take into account large Medicare profits being earned by hospitals. (ACN: 09-62021, CIN: A-08-87-00003; and testimony before the Subcommittee on Health of the Ways and Means Committee, U.S. House of Representatives on hospital profits during the second year of PPS, February 6, 1987)	The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100-119) froze PPS rates from October 1, 1987 to November 20, 1987 at 1.15 percent. Savings are based on CBO estimate for this 51-day period.	$155

APPENDIX B

PROGRAMMATIC SAVINGS
OCTOBER 1987 THROUGH MARCH 1988

This schedule documents savings to programs resulting from regulatory actions or policy determinations of management on behalf of OIG recommendations. Savings are calculated using departmental figures for the year in which the change was effected. Total programmatic improvements during the period amounted to $36.3 million.

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Contractor Settlement: Eliminate unallowable and overstated costs from a Medicare contractor's claims for reimbursement for workload increases caused by the Tax Equity and Fiscal Responsibility Act of 1982 and the Deficit Reduction Act of 1984. (CINs: A-05-87-00006 and A-05-87-00099)	The HCFA used OIG findings to negotiate reductions in contractor's reimbursement claims.	$16.3
Coding Changes for Colonoscopies: Change the colonoscopy codes in the current procedures terminology manual, because certain codes were being used to bill for a lesser procedure. (OAI-NOV-0002)	Implemented by HCFA memo to Medicare Part B carriers in December 1987.	$20

APPENDIX C

AUDIT RECEIVABLES
OCTOBER 1987 THROUGH MARCH 1988

This schedule represents significant examples of the dollar amounts placed in accounts receivable for recoupment during this reporting period as a result of management determinations in favor of audit findings and recommendations. Audit receivables for this period totaled $132.7 million with an additional $22.8 million in HCFA program disallowances for a total of $155.5 million.[1]

	DOLLARS IN MILLIONS
• Medicaid reimbursement claimed for uncertified health care facilities in Indiana (CIN: A-05-86-60241)	$ 2.6
• Medicaid reimbursement claimed for services provided in State-owned juvenile detention centers not meeting definition of a hospital in Oklahoma (CIN: A-06-87-00211 - Under appeal by State)	13.2
• Excess pension costs charged to Medicare by Pan American Life Insurance Company (CIN: A-07-86-62020)	2.7
• Federal share of Medicaid overpayments not refunded to the Federal Government in California (CIN: A-09-86-60225 and ACN: 09-60212)	55.6
• Medicaid payments for services to individuals under age 65 in nursing homes that were actually institutions for mental diseases in California (CIN: A-09-86-60205)	25.5
• Unused funds from the Low Income Home Energy Assistance program not returned to the Federal Government from Indiana (CIN: A-05-86-60551)	1.0

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

	DOLLARS IN MILLIONS
• Refugee Resettlement program overcharged for ineligible recipients in New York (CIN: A-02-86-62600)	$ 1.9
• Single Audit discloses unallowable charges to HHS programs in New York (CIN: A-02-87-07059)	19.1
• Unallowable costs charged to Federal programs in Wisconsin (CIN: A-05-87-05668)	2.4
• Foster care payments to ineligible (for profit) child care institutions in California (CIN: A-09-86-62641)	0.9
• Medicaid payments for reserve patient days exceeded the limits imposed by the State plan in Georgia (CIN: A-04-87-02003)	0.6
• Grantee did not meet matching fund requirement in Private Industry Council of the City of New York (CIN: A-02-87-08323)	0.8
• Other audit determinations, complete listing available upon request.	6.4

HCFA Program Disallowances	DOLLARS IN MILLIONS
• Medicaid reimbursement claimed during period of invalid provider agreements.	$5.0
• Medicaid duplicate payments - Capitation and fee-for-service payments made for enrolles in a prepaid health plan.	7.4
• Medicaid payments for ineligible patients in institutions for mental diseases.	1.0
• States failed to refund to Medicaid for rate reduction applied to hospitals resubmitting untimely cost reports.	0.5

HCFA Program Disallowances	DOLLARS IN MILLIONS
• Repayment of Medicaid funds on provider overpayments not recovered by States.	$ 7.3
• Other HCFA program disallowances.	1.6

APPENDIX D

INVESTIGATIVE RECEIVABLES
OCTOBER 1987 THROUGH MARCH 1988

This schedule represents the dollar amount of fines, savings, restitutions, settlements and recoveries determined through judicial or administrative processes in support of OIG investigative findings. These figures include both actual and ordered recoupments for the Treasury of the United States, the Social Security and Medicare trust funds, departmental programs and other entities victimized by fraud and abuse. Receivables of $44.6 million are reported for this period.

Restitutions, Fines and Recoveries:

- Recoveries by the Department and the State from civil settlement with a Colorado medical center for Medicare claims for tests not performed and improper psychotherapy billings. (8-87-20247-9) — $1,118,000
- Recoveries from civil settlement with Pennsylvania clinical psychologists for Medicare claims for patients who had already died. (3-85-20512-9) — $ 347,500
- Recovery of overpayments to Massachusetts drug companies for acetic acid supplied to Medicare patients. (1-86-00554-9) — $ 406,200
- Restitution and fines from New York internist for billing Medicare and Medicaid while under suspension. (2-86-00672-9) — $ 320,600
- Recoveries from New York case involving kickbacks to doctors and illegal billing of Medicaid for ambulance services. (2-86-00129-9) — $ 311,000
- Restitutions, fines and recoveries from scheme certifying fictitious Texas families to collect AFDC and food stamp benefits. (6-86-00321-5) — $ 150,000
- Recoveries from California orthopedic surgeon for Medicare payments obtained by using license numbers of friends. (9-86-01148-9) — $ 209,100
- Recoveries from bookkeeper's embezzlement of Medicare and private insurance checks in Texas. (6-87-00088-9) — $ 209,100
- Civil settlement with the owner of a Florida optical center previously convicted of Medicare fraud. (4-87-20003-9 — $ 150,000

Civil Monetary Penalties:

• Penalties and assessments against an ophthalmologist for billing Medicare for initial ophthalmological examinations as consultations. (2-85-30042-9)	$ 312,400
• Restitution and penalties from a physician for billing services actually provided by chiropractors. (4-86-30050-9)	$ 306,300
• Damages, assessments and penalties against an ambulance company for billing "chair car" level services as advanced life support level services. (5-86-00287-9)	$ 245,000
• Penalties and assessments from a shoe store for billing Medicaid for orthopedic devices while actually providing casual and recreational shoes. (3-86-20254-9)	$ 222,700
• Restitution and monetary penalties by a general practitioner for Medicaid billings as a specialist and for tests not performed. (4-87-20003-9)	$ 150,000
• Penalties against a California hospital for inappropriate transferral of patients in active labor or with emergency medical conditions. (9-87-30038-9)	$ 100,000
• Other receivables which did not meet the $100,000 threshold for individual reporting.	$40,026,200

Should have been major entry

APPENDIX E

PENDING OIG RECOMMENDATIONS THROUGH MARCH 1988

I. **LEGISLATIVE RECOMMENDATIONS** - This schedule represents the estimated savings over a 5-year period that could be realized if concurred in by the Congress and the Administration through legislative action.

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Medicare Deductibles: Raise the Medicare Part B deductible to $100 and appropriately index it. (ACN: 09-52043)	The President's FY 1989 budget does not include a proposal to index the deductible to the Medicare Economic Index.	$ 1,400
Rounding Medicare Premiums: Round Medicare Part B premiums up to the next higher dollar. (ACN: 09-52008)	This proposal has not been included in the President's FY 1989 budget and legislative program.	$ 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 proposal is not included in the President's FY 1989 budget and legislative program.	$ 2,124
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)	This proposal is not included in the President's FY 1989 budget and legislative program.	$ 85

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Hospital DRG Rates: Rebase Medicare hospital PPS rates to correct for inclusion of overstated operating costs. (ACN: 09-62021)	This proposal has not been included in the President's FY 1989 budget and legislative program. However, this report has been generally available and has been considered by the Congress in setting annual updates to the PPS rates in recent years.	$ 1,890
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)	The OIG has submitted a second report; however, this proposal has not been included in the President's FY 1989 budget and legislative program.	$ 315
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)	As in prior years, a proposal to reduce the adjustment factor has been included in the Department's FY 1989 legislative package.	$ 3,500
Bridging the Coverage Gap: Require mandatory Social Security coverage for all part-time and temporary State and local government employees not participating in a public employees' retirement system. (CIN: A-02-86-62604)	This proposal was not included in the President's FY 1989 budget and legislative program.	$ 3,000

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Suspension of Benefits: Suspend RSDI benefits to persons confined in State and Federal mental institutions for committing a felony who were found not guilty by reason of insanity. (CIN: A-07-86-62615)	The SSA agreed in principle, but believes that due to serious legal, equity and administrative issues pertinent to this proposal, it is not appropriate to seek legislation at this time.	$ 52
Mandate Medicare Coverage: Medicare Part A coverage should be extended to all State and local government employees. (CIN: A-09-86-62050)	The proposal was not included in the President's FY 1989 budget.	$10,600
Financing SSA Buildings (Early Repayment of Loans): Use trust fund monies to liquidate the remaining mortgage balances on the three program service centers financed under the purchase contract method of financing. (CIN: A-09-86-62611)	The SSA is reserving action until it has analyzed the financial and legislative implications of the recommendations.	$ 126
Crossover Claims: Limit Medicaid "Buy-In" payments for Medicare deductible and coinsurance to the Medicaid fee schedule. (ACN: 02-60202)	This proposal is not included in the President's FY 1989 budget and legislative program.	$ 500

II. PROGRAMMATIC RECOMMENDATIONS - This schedule represents the estimated annual savings that would result from positive determinations in favor of OIG recommendations.

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Child Support Enforcement: The FSA should require States to annually match SSNs of absent parents of AFDC children without support orders, with low support orders or in arrears against SSA's earnings records. Cases where the absent parent earns in excess of $10,000 would be reopened. (OAI-05-86-00097)	The FSA has agreed with OIG's findings. The FSA is arranging with IRS for States to obtain the required information where earnings information cannot be matched at the State level.	$103.4
Ambulatory Surgeries: Increase use of outpatient facilities for elective surgeries under Medicaid. (ACN: 09-50205)	President's FY 1989 program includes initiatives in ambulatory surgeries with projected savings of $22 million in FY 1989.	$110
Supplemental Security Income: Instead of a blanket write-off, the SSA should initiate efforts to recover SSI overpayments previously written off for all except the known deceased debtors in the backlogged debt population. (OAI-12-87-00030)	The SSA is conducting a study to determine whether pursuing backlogged debt cases is cost effective, with a decision to be made by the end of FY 1988.	$ 28
Supplemental Security Income: The SSA should negotiate with the IRS for income tax refund offset to recover outstanding debts owed by former SSI recipients who are under age 65. (OAI-12-86-00065)	Report issued in final; SSA has indicated that actions geared to use of income tax refund offset for recovering SSI overpayments from former recipients are underway.	$ 58.5

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Supplemental Security Income: The SSA should aggressively pursue voluntary cross program adjustments to collect outstanding debts owed by former SSI recipients who are current RSDI beneficiaries. (OAI-12-87-00029)	Report issued in final; SSA has indicated it will explore the cost effectiveness of reopening previously terminated debt including cases where voluntary cross program adjustments might be applicable.	$ 7.3
Mandatory Second Opinion: Mandate that Medicaid beneficiaries obtain second surgical opinions for selected surgeries. (ACN: 03-30211)	The HCFA's expected regulations will be delayed until a report required by the Omnibus Budget Reconciliation Act of 1986 is submitted to the Congress.	$ 63
Medicare Reimbursement for At-Home Oxygen Care: The HCFA should issue immediately a uniform medical necessity certification form. Included on this form should be a strong physician attestation statement. This attestation places the responsibility with the physician for the accuracy of the information contained on the certification form. (OAI-04-87-00071)	The HCFA is developing, but has not issued a medical necessity certification form and attestation statement.	
Access of Dialysis Patients to Kidney Transplantation: The OIG sent to HCFA a series of recommendations that would help ensure that dialysis patients are afforded a full and fair opportunity to receive a kidney transplant. (OAI-01-86-00107)	Both HCFA and PHS are collaborating with professional societies to develop guidelines for patient transplant suitability.	$418.3

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Medical Licensure and Discipline: The HCFA should amend the PRO regulations and the Medicare carrier instructions to require more extensive and timely reporting to State medical boards of cases involving physician misconduct or incompetence. (OAI-01-86-00064)	The HCFA has agreed to include a regulatory provision to require PROs to report cases involving misconduct or incompetence to medical boards.	Nonfinancial
False Evidence Submitted to Obtain a Social Security Card: The SSA should develop the systems capability to automatically identify all applications for original Social Security numbers from U.S. born applicants age 24 or older (age selected based on the Boston region findings). (OAI-NOV-006)	The SSA believes better results can be achieved through increased field office awareness, of typical fraudulent schemes, planned systems enhancements and a nationwide study of this category of SSN applications.	Nonfinancial
Multiple Surgical Procedures: All carriers should uniformly limit reimbursement for second surgical procedures to 50 percent of reasonable charge. (CIN: A-03-86-62008)	The HCFA has no plans to establish a national limit for multiple surgical procedures at this time, but has agreed to call our findings to the attention of the carrier involved.	$ 5.2
Multiple Visits in SNFs: Apply the "multiple visit" concept to Medicare payments for physician visits to patients in skilled nursing homes and hospitals. (ACN: 03-42005)	The HCFA has not adopted the multiple visit concept.	$240

OIG RECOMMENDATION	STATUS	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)	The HCFA issued guidelines as part of studies mandated by the Deficit Reduction Act of 1984, and is exploring alternative approaches to the problem.	$ 6
Premature Admissions: Minimize premature admissions for Medicaid elective surgeries. (CIN: A-09-86-60213)	The President's FY 1989 program includes initiatives on premature admissions and same day surgery with projected savings of $9.3 million in FY 1989.	$ 18.5
Medicare as Secondary Payer - Automobile Accident Related Claims: Under the provisions of the MSP program, HCFA should ensure identification of all beneficiaries involved in automobile accidents and uncovered by auto or liability insurance. (OAI-07-86-00092)	The HCFA has concurred with OIG findings and is in general agreement with OIG recommendations.	$ 15.2
Child Support Enforcement -Absent Parent Medical Liability: The FSA should enforce the provisions in regulations that require petitioning of courts for insurance coverage of dependent children. (OAI-07-86-00045)	The FSA has concurred with OIG findings and is in general agreement with OIG recommendations.	$111
Medicare as Secondary Payer - End Stage Renal Disease: Under the provisions of MSP, HCFA should ensure identification of all ESRD beneficiaries covered by employee group health plans, and that proper billing for services has been made. (OAI-07-86-00092)	The HCFA has concurred with OIG findings and recommendations and is developing instructions to fiscal intermediaries.	$ 19.6

OIG RECOMMENDATION	STATUS	SAVINGS IN MILLIONS
Organ Acquisition Costs: The HCFA should include Medicare costs for organ acquisition under the diagnosis related group system. (OAI-01-86-00108)	The HCFA agreed in principle with the recommendations, but requires additional investigation of the issues and development of cost data prior to reaching decisions on implementation.	$ 37.5

ACRONYMS

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
AFDC	Aid to Families with Dependent Children
AWR	annual wage report
CABG	coronary artery bypass graft
CBO	Congressional Budget Office
CDC	Centers for Disease Control
CEMS	cost-effectiveness measurement system
CMP	civil monetary penalty
COBRA	Consolidated Omnibus Budget Reconciliation Act
CSE	Child Support Enforcement
DDS	disability determination service
DME	durable medical equipment
DMF	direct mail follow-up
DOC	data operations center
DRG	diagnosis related group
EA	Emergency Assistance
EAF	Emergency Assistance to Needy Families with Children
EGHP	employer group health plan
ESRD	end stage renal disease
FDA	Food and Drug Administration
FFP	Federal financial participation
FICA	Federal Insurance Contributions Act
FMFIA	Federal Managers' Financial Integrity Act
FSA	Family Support Adminstration
FY	fiscal year
GAO	General Accounting Office
HCFA	Health Care Financing Adminstration
HDS	Office of Human Development Services
HHS	Department of Health and Human Services
HMO	health maintenance organization
HPSL	Health Professions Student Loan
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IMD	institutions for mental disease
IME	indirect medical education
IRS	Internal Revenue Service
LIHEA	Low Income Home Energy Assistance
MBR	master beneficiary record
MFCU	Medicaid Fraud Control Unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
NSL	Nursing Student Loan
OIG	Office of Inspector General
OMB	Office of Management and Budget
OS	Office of the Secretary
P.L.	Public Law
PHS	Public Health Service
PPS	prospective payment system
PRO	peer review organization
RRC	rural referral center
RSDI	Retirement, Survivors & Disability Insurance
SNF	skilled nursing facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
VA	Veterans Adminstration

DEPARTMENT OF
HEALTH & HUMAN SERVICES

Office of Inspector General
330 Independence Avenue, S.W.
Washington, D.C. 20201

Official Business
Penalty for Private Use $300

Postage and Fees P
U.S. Dept. of H.H.S.
HHS-391